**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

Civil Action No. 1:18-cv-152 (JEB)

RONNIE MAURICE STEWART

KIMBERLY KOBERSMITH

SHAWNA NICOLE McCOMAS

MELISSA "MISSY" SPEARS-LOJEK

DAVID ROODE

SHEILA MARLENE PENNEY

LINDA KEITH

DEBRA WITTIG

HUNTER MALONE

ALTHEA HUMBER

RANDALL YATES )

DIIKA:NÉHI SEGOVIA )

ROBIN RITTER )

SARAH MARTIN )

TERI BLANTON )

RODNEY LEE )

on behalf of themselves and all others similarly situated, )

Plaintiffs, )

v. )

ALEX M. AZAR II )
SECRETARY, )
UNITED STATES DEPARTMENT OF )
HEALTH AND HUMAN SERVICES )
in his official capacity )
200 Independence Avenue, S.W., )
Washington, DC 20201 )

SEEMA VERMA )
ADMINISTRATOR, )
CENTERS FOR MEDICARE AND MEDI- )
CAID SERVICES )
in her official capacity )
7500 Security Boulevard )
Baltimore, MD 21244 )
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PAUL MANGO )
CHIEF PRINCIPAL DEPUTY ADMINIS- )
TRATOR, THE CENTERS FOR MEDI- )
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in his official capacity )
7500 Security Boulevard )
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DEMETRIOS L. KOUZOUKAS )
PRINCIPAL DEPUTY ADMINISTRATOR, )
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UNITED STATES DEPARTMENT OF )
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200 Independence Avenue, S.W., )
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THE CENTERS FOR MEDICARE AND )
MEDICAID SERVICES )
7500 Security Boulevard )
Baltimore, MD 21244 )
)
Defendants, )
)
and )
)
COMMONWEALTH OF KENTUCKY, )
1024 Capital Center Drive, )
Frankfort, KY 40601 )
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Defendant-Intervenor. )

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**FIRST AMENDED CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

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**PRELIMINARY STATEMENT**

1. The Court previously found the Defendants' efforts to transform the Kentucky Medicaid program were arbitrary and capricious. *See Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018). Nevertheless, the Federal Defendants have once again approved the Kentucky HEALTH project, which conditions Medicaid coverage on work requirements, mandatory premiums, and other restrictions that the State has estimated will jettison 95,000 Kentuckians from the Medicaid program. *Id*. at 260. As with its first attempt, the Federal Defendants' re-approval fails—for many of the same reasons that it failed before.

2. The Federal Defendants are engaging in an ongoing effort to bypass the legislative process and unilaterally act to "comprehensively transform" Medicaid, a cornerstone of the social safety net that exists to furnish medical assistance to low-income people whose incomes are insufficient to meet the costs of medically necessary health care. Purporting to invoke a narrow statutory waiver authority that allows experimental projects "likely to assist in promoting the objectives" of the Medicaid Act, the Secretary is working to effectively rewrite the Medicaid statute, ignoring congressional restrictions, overturning a half century of administrative practice, and threatening irreparable harm to the health and welfare of the poorest and most vulnerable in our country.

3. The Medicaid program provides health insurance to more than 75 million low-income people in the United States. Medicaid enables states to provide a range of federally specified preventive, acute, and long-term health care services to individuals "whose income and

resources are insufficient to meet the costs of necessary medical services." As described in more detail below, the core populations covered by Medicaid include (among others) children; pregnant women; the aged, blind, or disabled; and adults with household income of less than 133% of the federal poverty level (currently $33,383 for a family of four).

4. The program offers a deal for states. If a state chooses to participate in the program, the federal government will contribute the lion's share of the cost of providing care. In return, the state agrees to pay the remaining portion of the costs of care and to follow all federal requirements, including those regarding the scope of coverage and eligibility for the program. States may not impose additional eligibility requirements other than those set forth in the Medicaid Act, and states cannot pick and choose among individuals within a covered population group.

5. The Social Security Act, of which Medicaid is a part, does permit experimental waiver projects, but only in narrow circumstances, pursuant to a waiver by the Secretary of Health and Human Services, and only if such project is likely to promote the objectives of the Medicaid Act.

6. On August 24, 2016, Kentucky Governor Matt Bevin submitted an application to the Secretary requesting a waiver to implement the "Kentucky HEALTH" project. Kentucky was candid about its goal: it aimed "to comprehensively transform Medicaid." True to its word, the Kentucky HEALTH program sought to radically alter Medicaid in Kentucky by conditioning access to health care on compliance with onerous work requirements and the payment of premiums, as well as imposing other restrictions like the elimination of retroactive coverage and coverage lockouts for program noncompliance. By the State's own estimate, Kentucky HEALTH would reduce Medicaid enrollment over a five-year period by over 95,000 adults and significantly reduce payments for health care for low income Kentuckians. The Kentucky HEALTH application

was subject to state and federal public comment in 2016 and 2017, and the Center for Medicaid Services ("CMS") received over 3,000 comments.

7. On January 11, 2018, after the comment period closed on the Kentucky HEALTH application, CMS announced a new approach to Medicaid waivers. Reversing decades of agency guidance, and consistent with the administration's own expressed view of the need to "fundamentally transform Medicaid," CMS issued a letter to State Medicaid Directors announcing its intention to, for the first time, approve waiver applications containing work requirements and outlining "guidelines" for states to consider in submitting such applications.

8. The next day, the Secretary granted the Kentucky HEALTH application, asserting that this grant and Kentucky's imposition of work requirements are consistent with CMS's newly minted approach set out in its letter to State Medicaid Directors.

9. Sixteen Kentuckians enrolled in Medicaid filed suit on January 24, 2018, challenging the Federal Defendants' authority to approve Kentucky HEALTH. ECF 1. Shortly thereafter, the Commonwealth of Kentucky intervened in the case. *See* ECF 32.

10. On June 29, 2018, this Court vacated and remanded the Secretary's approval as arbitrary and capricious under the Administrative Procedure Act, finding, among other things, that Defendants ignored "the basic purpose of Medicaid: reimburs[ing] certain costs of medical treatment for needy persons." *Stewart*, 313 F. Supp. 3d at 268.

11. On remand, Kentucky did not amend its waiver application. The Federal Defendants re-opened public comment on the application and the Special Terms and Conditions ("STCs") it had previously approved. Over 12,000 new comments were submitted.

12. CMS reapproved Kentucky HEALTH on November 20, 2018. It made no changes to the key features of the project, which continues to include work requirements, heightened

premiums and cost sharing, lockouts, and termination of retroactive coverage and transportation for non-emergency medical care. The project is scheduled to begin on April 1, 2019.

13. Kentucky HEALTH will harm Kentuckians across the state—custodians and cashiers, ministers and morticians, fast-food workers, musicians, students, caregivers, and retired workers—who need a range of health services, including check-ups, diabetes treatment, mental health services, blood pressure monitoring and treatment, and vision and dental care.

14. The Secretary's issuance of the State Medicaid Directors letter and re-approval of Kentucky's application are unauthorized attempts to re-write the Medicaid Act, and the use of the statute's waiver authority to "transform" Medicaid is an abuse of that authority. The Federal Defendants' actions here thus violate both the Administrative Procedure Act and the Constitution and cannot survive.

**JURISDICTION AND VENUE**

15. This is a class action for declaratory and injunctive relief for violation of the Administrative Procedure Act, the Social Security Act, and the United States Constitution.

16. The Court has jurisdiction over Plaintiffs' claims pursuant to 28 U.S.C. §§ 1331 and 1361 and 5 U.S.C. §§ 702-705. This action and the remedies it seeks are further authorized by 28 U.S.C. §§ 1651, 2201, and 2202, and Federal Rule of Civil Procedure 65.

17. Venue is proper under 28 U.S.C. § 1391(b)(2) and (e).

**PARTIES**

18. Plaintiff Ronnie Maurice Stewart is 63 years old and lives in Lexington, Fayette County, Kentucky. Mr. Stewart is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

19. Plaintiff Kimberly Kobersmith is 47 years old and lives in Berea, Madison County, Kentucky, with her husband, and their two sons, ages 14 and 12. Ms. Kobersmith is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

20. Plaintiff Shawna Nicole McComas is 35 years old and lives in Lexington, Fayette County, Kentucky, with her husband and four children. Ms. McComas is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

21. Plaintiff Melissa "Missy" Spears-Lojek is 39 years old and lives in Covington, Kenton County, Kentucky. Ms. Spears-Lojek is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky Health project.

22. Plaintiff David Roode is 40 years old and lives in Ludlow, Kenton County, Kentucky. Mr. Roode is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

23. Plaintiff Sheila Marlene Penney is 54 years old and lives in Louisville, Jefferson County, Kentucky. Ms. Penney is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

24. Plaintiff Linda Keith is 63 years old and lives in Lexington, Kentucky. Ms. Keith is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

25. Plaintiff Debra Wittig is 62 years old and lives in Frankfort, Franklin County, Kentucky. Ms. Wittig is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

26. Plaintiff Hunter Malone is 21 years old and lives alone in Berea, Madison County, Kentucky. Mr. Malone is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

27. Plaintiff Althea Humber is 56 years old and lives in Lexington, Fayette County, Kentucky, with an unrelated roommate. Ms. Humber is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

28. Plaintiff Randall Yates is 48 years old and lives in Martin, Floyd County, Kentucky. Mr. Yates is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

29. Plaintiff Diika:néhi Segovia is 21 years old and lives in Lexington, Fayette County, Kentucky. Mx. Segovia is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

30. Plaintiff Robin Ritter is 54 years old and lives in Waddy, Shelby County, Kentucky. Ms. Ritter is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

31. Plaintiff Sarah Martin is 35 years old and lives in Covington, Kenton County, Kentucky. Ms. Martin is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

32. Plaintiff Teri Blanton is 61 years old and lives alone in Berea, Madison County, Kentucky. Ms. Blanton is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

33. Plaintiff Rodney Lee is 50 years old and lives in Lexington, Fayette County, Kentucky. Mr. Lee is currently homeless. Mr. Lee is enrolled in the Kentucky Medicaid program and will be enrolled in the Kentucky HEALTH project.

34. Defendant Alex M. Azar is Secretary of the United States Department of Health and Human Services ("HHS") and is sued in his official capacity. Defendant Azar ("the Secretary") has overall responsibility for implementation of the Medicaid program, including responsibility for federal review and approval of state requests for waivers pursuant to Section 1115 of the Social Security Act.

35. Defendant Seema Verma is Administrator of CMS and is sued in her official capacity. Defendant Verma is responsible for implementing the Medicaid program as required by federal law, including as amended by the Patient Protection and Affordable Care Act. Secretary Verma recused herself from consideration of the Kentucky HEALTH application because she was a paid consultant with the Commonwealth of Kentucky and helped design the program. Nonetheless, the Governor of Kentucky reported that she personally informed him that the original waiver application was granted.

36. Defendant Paul Mango is Chief Principal Deputy Administrator of CMS and is sued in his official capacity. Defendant Mango has responsibility for disposition of matters relating to the Kentucky HEALTH waiver. Defendant Mango signed the November 20, 2018 re-approval of the Kentucky HEALTH program.

37. Defendant Demetrios L. Kouzoukas is Principal Deputy Administrator of CMS and is sued in his official capacity. Defendant Kouzoukas is responsible for disposition of all matters, including the Kentucky HEALTH waiver, from which Administrator Verma is recused.

38. Defendant HHS is a federal agency with responsibility for, among other things, overseeing implementation of the Medicaid Act.

39. Defendant CMS is the agency within HHS with primary responsibility for overseeing federal and state implementation of the Medicaid Act.

40. Defendant-Intervenor, the Commonwealth of Kentucky (the "State" or "Kentucky"), filed an unopposed motion for intervention, which was granted on March 30, 2018. Min. Order (Mar. 30, 2018).

## CLASS ACTION ALLEGATIONS

41. Plaintiffs bring this suit both individually and on behalf of a statewide proposed class of persons similarly situated pursuant to Federal Rule of Civil Procedure 23(a) and (b)(2). The class consists of all residents of Kentucky who are enrolled in the Kentucky Medicaid program and who will be enrolled in the Kentucky HEALTH project.

42. The prerequisites of Federal Rule of Civil Procedure 23(a) are met in that:

a. The class is so numerous that joining all members is impracticable. The State estimates that hundreds of thousands of adults will be enrolled in Kentucky HEALTH in each year of its demonstration. Commonwealth of Ky., Kentucky HEALTH: Helping to Engage and Achieve Long Term Health at Attachment A (2017) ("Application Modification"), ECF 1-1 (Administrative Record ("AR") 5422, 5427). The class members are geographically dispersed throughout Kentucky, by definition have limited financial resources by virtue of their Medicaid eligibility and enrollment status, and are unlikely to institute individual actions;

b. There are questions of fact and law, particularly as to the legality of the Federal Defendants' policies and decisions with respect to issuance of the letter to State Medicaid Directors and approval of the Kentucky HEALTH waiver, that are common to all members of the class;

c. The claims of the named plaintiffs are typical of the claims of the class; and

d. The named plaintiffs and their counsel will fairly and adequately protect the interests of the class. Each plaintiff is an adult resident of Kentucky who is enrolled in Kentucky HEALTH and will be subject to the requirements of the Kentucky HEALTH waiver.

43. The requirements of Federal Rule of Civil Procedure 23(b)(2) are met in that the Federal Defendants have acted or refused to act on grounds that apply generally to the class, making final declaratory and injunctive relief appropriate with respect to the class as a whole.

## STATUTORY AND REGULATORY BACKGROUND

### A. The Medicaid Program

44. Title XIX of the Social Security Act establishes the cooperative federal-state medical assistance program known as Medicaid. *See* 42 U.S.C. §§ 1396 to 1396w-5. Medicaid's stated purpose is to enable each state, as far as practicable, "to furnish [] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id.* § 1396-1.

45. States do not have to participate in Medicaid; however, all states have chosen to do so.

46. Each participating state must maintain a comprehensive Medicaid plan for medical assistance that the Secretary has approved. *Id*. § 1396a. The statute defines "medical assistance" to include a range of health care services that participating states must cover or are permitted to cover at state option. *Id.* § 1396d(a).

47. A state's Medicaid plan must describe its program and affirm its commitment to comply with the requirements imposed by the Medicaid Act (listed at 42 U.S.C. § 1396a *et seq.*) and its associated regulations.

48. State and federal governments share responsibility for funding Medicaid. Section 1396b of the Medicaid Act requires the Secretary to pay each participating state the federal share (which is based on the state's relative per capita income) of "the total amount expended . . . as medical assistance under the State plan." *Id*. §§ 1396b(a)(1), 1396d(b).

**B. Medicaid Eligibility and Coverage Requirements**

49. Using household income and other specific criteria, the Medicaid Act delineates who is eligible to receive Medicaid coverage. *Id*. § 1396a(a)(10)(A), (C). The Act contains required coverage groups as well as options for states to extend Medicaid to additional population groups. *Id.*

50. States participating in Medicaid must provide medical assistance to individuals who meet the eligibility standards applicable to required coverage groups (so-called "mandatory populations"). *Id.* § 1396a(a)(10)(A)(i).

51. To be eligible for federal Medicaid funding, states must cover, and may not exclude from Medicaid, individuals who: (1) are part of a mandatory population group; (2) meet the minimum financial eligibility criteria applicable to that population group; (3) are residents of the

state in which they apply; and (4) are U.S. citizens or certain qualified immigrants. *Id.* §§ 1396a(a)(10)(A), 1396a(b)(2), (3); 8 U.S.C. §§ 1611, 1641.

52. The mandatory Medicaid population groups include children; parents and certain other relatives (who are not elderly, blind, or disabled); pregnant women; the elderly, blind, or disabled; and individuals under age 26 who were in foster care until age 18 ("former foster care youth"). 42 U.S.C. § 1396a(a)(10)(A)(i).

53. In 2010, Congress passed, and the President signed, comprehensive health insurance reform legislation, the Patient Protection and Affordable Care Act ("ACA"). Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. "The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012).

54. As part of its effort to ensure comprehensive health insurance coverage, Congress amended the Medicaid Act to add an additional mandatory population group. Effective January 1, 2014, the Medicaid Act requires states to cover adults who are under age 65, not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household income below 133% of the federal poverty level ("FPL"). 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14); *see also id.* at § 1396a(e)(14)(I) (requiring income disregards that effectively bring the income cut-off to 138% of FPL). This group is often called the "expansion population," and it includes adults in a variety of family circumstances: parents living with children (whose income exceeds the state-established limit for the mandatory parents/caretaker relatives population group); parents of older children who have left the home; and adults without children.

55. States receive enhanced federal reimbursement for medical assistance provided to the Medicaid expansion population: 94% federal dollars in 2019, and 90% for 2020 and each year thereafter. *Id.* § 1396d(y).

56. The Supreme Court's decision in *National Federation of Independent Business* barred HHS from terminating Medicaid funding to states that choose not to extend Medicaid coverage to the expansion population. 567 U.S. 519 (2012).

57. States that choose to cover the expansion population submit state plan amendments electing to provide this coverage. To date, 37 states, including the District of Columbia, have approved state plans or have passed referenda that require the state to submit a state plan amendment covering the expansion population. Kentucky is one of those states.

58. Once a state elects to expand coverage to the expansion population, it becomes a mandatory coverage group.

59. As noted above, the Medicaid Act also allows states to extend Medicaid eligibility to certain optional population groups, including children and pregnant women with incomes between 133% and 185% of FPL, *see* 42 U.S.C. § 1396a(a)(10)(A)(ii)(IX), limited-income aged, blind, and/or disabled individuals receiving home and community-based services, *id.* § 1396a(a)(10)(A)(ii)(VI), and "medically needy" individuals who would fall within a mandatory population but for excess income, *id.* § 1396a(a)(10)(C).

60. The Medicaid Act requires a participating state to cover *all* members of a covered population group. In other words, the state may not cover subsets of a population group described in the Medicaid Act. *See id.* § 1396a(a)(10)(A)-(B). This requirement applies to optional and mandatory population groups: if a state elects to cover an optional group, it must cover all eligible individuals within that group. *Id.*

61. States cannot impose additional eligibility requirements that are not explicitly allowed by the Medicaid Act. *See id.* § 1396a(a)(10)(A).

62. The Medicaid Act requires states to "provide such safeguards as may be necessary to assure that eligibility . . . and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." *Id.* § 1396a(a)(19).

63. In addition to addressing *who* is eligible for medical assistance, the Medicaid Act delineates how states must make and implement eligibility determinations to ensure that all eligible people who apply are served and get coverage. States must determine eligibility and provide medical assistance to all eligible individuals with "reasonable promptness." Social Security Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(8), 79 Stat. 286, 344 (codified at 42 U.S.C. § 1396a(a)(8)); 42 C.F.R. § 435.912(c)(3) (requiring states to determine eligibility within 90 days for individuals who apply on the basis of disability and 45 days for all other individuals).

64. In addition, since its enactment, the Medicaid Act requires states to provide retroactive coverage to individuals who have been determined eligible to ensure that low-income individuals can obtain timely care and avoid incurring medical debts. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1905(a), 79 Stat. 286, 351. Specifically, states must provide medical assistance for care provided in or after the third month before the month of application, as long as the enrollee would have been eligible for Medicaid at the time the services were received. 42 U.S.C. §§ 1396a(a)(34), 1396a(a)(10), 1396d(a).

65. When re-determining the eligibility of current Medicaid enrollees, states must follow certain procedures to ensure continuity of coverage for eligible individuals. Among other requirements, states must complete the renewal process on the basis of information available to the agency (for example through state or federal data sources), without seeking additional

information from the individual, if possible. Otherwise, the state must provide the enrollee with a pre-populated eligibility renewal form and at least 30 days to return the form. It then must timely reconsider (without a new application) the eligibility of an individual who was terminated for failure to submit the renewal form or necessary information, but who then submitted the form within 90 days after termination. *See* 42 C.F.R. § 435.916(a)(3).

66. The Medicaid Act sets forth mandatory services that participating states must include in their Medicaid programs and optional services that participating states may include in their Medicaid programs. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a).

67. States must ensure that Medicaid enrollees have necessary transportation, often referred to as non-emergency medical transportation ("NEMT"), to and from Medicaid services. *See* 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.53.

68. The Medicaid Act also establishes the states' options for imposing premiums and cost sharing on enrollees. To ensure affordability, the Act permits states to impose premiums and cost sharing only in limited circumstances.

69. Congress amended the Medicaid Act in 1982 to remove the substantive premium and cost sharing provisions from 42 U.S.C. § 1396a, amend them, and place them in a new provision, Section 1396*o*. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.

70. As a result of that amendment, Section 1396a, which generally lists the requirements that a state plan must satisfy, provides that "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges" may be imposed "only as provided in section 1396*o*." 42 U.S.C. § 1396a(a)(14).

71. With respect to premiums, Section 1396*o* of the Medicaid Act provides that "no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c))." *Id.* § 1396*o*(a)(1). Subsection (c), in turn, authorizes certain premiums, but generally prohibits a state from imposing any premiums on individuals whose income falls below 150% of FPL. *Id.* § 1396*o*(c)(1).

72. Section 1396*o*-1, which Congress passed in 2006 to give states additional flexibility to impose premiums and cost sharing on enrollees, likewise prohibits a state from imposing any premiums on individuals with household income below 150% of FPL. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4, 82 (codified at 42 U.S.C. § 1396*o*-1(b)(1)(A)).

73. Nothing in Section 1396*o* or 1396*o*-1 gives the Secretary authority to waive these limits on premiums.

74. The Medicaid Act permits states to impose cost sharing, defined as a "deduction, copayment, or similar charge," on program beneficiaries only in limited circumstances. 42 U.S.C. § 1396*o*-1; *see also id.* § 1396*o*.

75. No deduction, copayment, or similar charge may be imposed except as provided under Sections 1396*o* and 1396*o*-1.

76. For non-emergency use of the emergency room, the Medicaid Act generally allows states to charge individuals with household income below 150% of FPL a deduction, copayment, or similar charge up to twice the "nominal" amount, as determined by the Secretary in regulations. *Id.* § 1396o-1(e). The regulations set this amount at $8, subject to increases for inflation. 42 C.F.R. § 447.54; *see* 42 U.S.C. § 1396*o*-1(e)(4)(A) (defining non-emergency services). To implement such cost sharing, a state must meet several conditions. First, any individual subject to the charge must have an alternate non-emergency services provider "actually available and

accessible." 42 U.S.C. §§ 1396*o*-1(e)(1)(A), 1396*o*(a)(3). Second, the hospital must conduct a screening (required under the Emergency Medical Treatment and Active Labor Act) to determine that the individual does not need emergency services. Third, before providing the non-emergency services and imposing the cost sharing, the hospital must inform the individual of the cost sharing obligation; provide the name and location of an "actually available and accessible" alternate non-emergency services provider who can provide the services without cost sharing; and provide a referral to coordinate scheduling with that alternate provider. *Id*. § 1396*o*-1(e)(1)(B).

77. The Secretary's authority to waive the limits on deductions, cost sharing, or similar charges is tightly circumscribed and applies only to a project that:

> (1) will test a unique and previously untested use of copayments,
>
> (2) is limited to a period of not more than two years,
>
> (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,
>
> (4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and
>
> (5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

*Id.* § 1396*o*(f)(1)-(5).

### C. The Secretary's Section 1115 Waiver Authority

78. Section 1115 of the Social Security Act grants the Secretary authority to waive a state's compliance with certain requirements of the Medicaid Act under certain conditions. *Id.* § 1315.

79. The Secretary may grant a Section 1115 Medicaid waiver only in the case of an "experimental, pilot, or demonstration project which . . . is likely to assist in promoting the objectives" of the Medicaid Act. *Id*. § 1315(a).

80. The Secretary may waive only the requirements of Section 1396a for Section 1115 waivers relating to Medicaid. *Id*. § 1315(a)(1).

81. The Secretary may not waive compliance with requirements that Congress has placed outside of Section 1396a.

82. The Secretary may grant a Section 1115 waiver only to the extent and for the period necessary to enable the state to carry out the experimental, pilot, or demonstration project. *Id*.

83. The Secretary must follow certain procedural requirements before he may approve a Section 1115 project. *Id*. § 1315(d); 42 C.F.R. §§ 431.400-431.416. In particular, after receiving a complete application from a state (following a state-level public comment period), the Secretary must provide a 30-day public notice and comment period. 42 U.S.C. § 1315(d); 42 C.F.R. § 431.416.

84. The Secretary does not have the authority to waive compliance with other federal laws, such as the United States Constitution, the Americans with Disabilities Act, or other federal statutes.

85. For example, the Fair Labor Standards Act ("FLSA") requires that all individuals, including individuals receiving public benefits, be compensated at least the minimum wage in exchange for hours worked. *See* 29 U.S.C. § 206(a)(1)(C); Dep't of Labor, *How Workplace Laws Apply to Welfare Recipients* at 2 (1997), http://nclej.org/wp-content/uploads/2015/11/LaborProtectionsAndWelfareReform.pdf. Notably, the Supplemental Nutrition Assistance Program ("SNAP") and Temporary Assistance for Needy Families ("TANF") statutes specifically refer to work requirements and further describe how the benefits interact with the FLSA minimum wage protections. *See* 7 U.S.C. § 2029(a)(1) (SNAP); 42 U.S.C. § 607 (TANF). In contrast, there is no such reference or description in the Medicaid Act. And, according to the Department of

Labor, medical assistance, unlike SNAP and TANF cash benefits, may not be substituted for a wage. *See How Workplace Laws Apply to Welfare Recipients* at 4.

**D. Medicaid in Kentucky**

86. Kentucky, like all other states, has elected to participate in Medicaid. The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services ("DMS"), administers the program at the state level. *See* Ky. Rev. Stat. Ann. §§ 205.510-205.50; 907 Ky. Admin. Regs. 1:005-23:020e.

87. Effective January 1, 2014, Kentucky amended its state Medicaid plan to include the Medicaid expansion group—*i.e.*, adults who are not elderly, disabled, or pregnant; do not fit into another Medicaid (or Medicare) eligibility category; and have household income below 133% of FPL.

88. By the end of 2014, over 375,000 Kentuckians had enrolled in Medicaid through the expansion. *See* Deloitte Development LLC, Commonwealth of Ky., *Medicaid Expansion Report 2014*, at 10 (2015) ("*Medicaid Expansion Report*"), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf, AR 4974. The proportion of low-income adults in Kentucky without insurance coverage plummeted over the course of the year, from 35% to under 11%. Joseph A. Benitez et al., *Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care*, 35 Health Affairs 528 (2016). Enrollment has continued to grow, albeit at a slower pace, with data as of April 2016 indicating that over 428,000 individuals had access to medical assistance as a result of Medicaid expansion. Commonwealth of Ky., Kentucky HEALTH: Helping to Engage and Achieve Long Term Health 4 (2016) ("Application"), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf

89. Large numbers of these individuals have made use of their Medicaid coverage, receiving critical preventive care and treatment. In 2014 alone, over 232,000 enrollees in the expansion population had a non-annual office visit, almost 160,000 received medication monitoring, over 89,000 had their cholesterol tested, over 80,000 received preventive dental services, and 13,000 sought treatment for a substance use disorder. *Medicaid Expansion Report*, AR 5019, 5037. Also, 26,000 women in the expansion population received breast cancer screenings, and 34,000 were screened for cervical cancer. AR 5037. As a result of Medicaid expansion, hospitals' uncompensated care costs were $1.15 billion lower in the first three quarters of 2014 than during the same time period in 2013. AR 5004.

90. Medicaid expansion in Kentucky has been associated with a variety of positive health outcomes, including increased use of preventive services, decreased reliance on the emergency room, fewer skipped medications due to cost, lower out-of-pocket spending on medical services, and improved self-reported health. Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA Internal Med. 1501, 1505-06 (2016).

91. Although initial estimates predicted that the Medicaid expansion would create about 7,300 jobs in health care and related fields, the expansion created more than 12,000 in the first year of implementation alone. *Medicaid Expansion Report*, AR 4996-97.

**E. The Kentucky HEALTH Project**

92. After more than two years of implementation of the Medicaid expansion under the state Medicaid plan and without a waiver, on August 24, 2016, Kentucky Governor Matt Bevin submitted an application to the Secretary requesting a waiver of various Medicaid Act requirements, pursuant to Section 1115, to implement the Kentucky HEALTH project. The

application presented Kentucky HEALTH as "the terms under which the Commonwealth will continue Medicaid expansion." Application, ECF 1-2 (AR 5437).

93. The application declared that, in implementing Kentucky HEALTH, the State "seeks to comprehensively transform Medicaid." Application, ECF 1-2 (AR 5447).

94. The State described Kentucky HEALTH as an initiative not just "to empower individuals to improve their health and gain employer sponsored coverage or other commercial health insurance coverage," but also to ensure the financial stability of Kentucky's Medicaid program. Application, ECF 1-2 (AR 5437, 5440).

95. The State estimated that Kentucky HEALTH would save it approximately $2.4 billion over a five-year period, with the savings resulting largely from a reduction in Medicaid enrollment. Application Modification, ECF 1-1 (AR 5423).

96. The State anticipated that over the course of the Kentucky HEALTH project, more than 95,000 adults would lose Medicaid coverage altogether. Application Modification, ECF 1-1 (AR 5423).

97. CMS provided a public comment period on the Kentucky HEALTH application from September 8, 2016, through October 8, 2016. Over 1,800 comments were submitted through the CMS website. *See* Medicaid.gov, Kentucky HEALTH, https://public.medicaid.gov/connect.ti/public.comments/view?objectId=1888067 (last visited Jan. 8, 2019).

98. On July 3, 2017, Governor Bevin proposed modifications to the Kentucky HEALTH application. Application Modification, ECF 1-1 (AR 5410-28). CMS held a public comment period on the proposed modifications from July 3, 2017, to August 2, 2017. Over 1,200 comments were submitted through the CMS website. *See* Medicaid.gov, Kentucky HEALTH –

Proposed Modifications to Application, https://public.medicaid.gov/connect.ti/public.comments/view?objectId=1891139 (last visited Jan. 8, 2019).

99. On January 12, 2018, the Secretary approved Kentucky HEALTH through September 30, 2023. Approval Letter ("First Approval Letter") & Special Terms & Conditions ("First Approval STCs"), from Demetrios L. Kouzoukas, Principal Deputy Adm'r, Ctrs. for Medicare & Medicaid Servs., Ctr. for Medicaid & CHIP Servs. to Adam Meier, Deputy Chief of Staff, Office of Governor Matthew Bevin (Jan. 12, 2018), ECF 1-3 (AR 0001-0082). The following population groups will be included in Kentucky HEALTH: the Medicaid expansion population; parents and caretaker relatives (who were covered prior to expansion); individuals receiving transitional medical assistance; pregnant women; and former foster care youth. First Approval STCs ¶ 17, AR 0025.

100. The approval allowed Kentucky to begin implementing the majority of the project on July 1, 2018. First Approval STCs ¶ I, AR 0017.

101. On January 24, 2018, Plaintiffs filed the Complaint challenging the approval of Kentucky HEALTH under the Administrative Procedure Act (the "APA") and the U.S. Constitution. ECF 1. On June 29, 2018, the Court granted Plaintiffs' motion for summary judgment; denied Defendants' cross-motions for summary judgment; and vacated and remanded the Kentucky HEALTH approval. ECF 73.

102. The Court found the approval of the Kentucky HEALTH project arbitrary and capricious because "[t]he Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." Mem. Op. at 3, *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018), ECF 74.

103. Following remand, Kentucky did not amend the Kentucky HEALTH waiver application.

104. On July 19, 2018, CMS "re-opened" the public comment period on Kentucky HEALTH, inviting comment on: "(1) Kentucky's original demonstration proposal from August 24, 2016, (2) Kentucky's revised proposal from July 3, 2017, and (3) the special terms and conditions (STCs) that CMS approved on January 12, 2018." *See* Medicaid.gov, Kentucky HEALTH– Application and CMS STCs, https://public.medicaid.gov/connect.ti/public.comments/view?objectID=1897699 (last visited Jan. 8, 2019).

105. The comment period closed on August 18, 2018. Almost 12,000 comments were submitted through the CMS website. *See id*.

106. On November 20, 2018, the Secretary once again approved Kentucky HEALTH, effective April 1, 2019, for a five-year period. *See* Approval Letter (the "Re-approval Letter") & Special Terms & Conditions (the "Re-approval STCs"), from Paul Mango, Chief Principal Adm'r & Chief of Staff, Ctrs. for Medicare & Medicaid Servs., to Carol H. Steckel, Comm'r, Dep't for Medicaid Servs. of Commonwealth of Ky., Cabinet for Health & Fam. Servs. (Nov. 20, 2018), AR 6718-6853 (attached as Exhibit A to this Complaint).

107. The core components of the Kentucky HEALTH project are nearly identical to those approved on January 12, 2018. The key features of Kentucky HEALTH are described below.

Rewards and Deductible Accounts

108. The State designed Kentucky HEALTH to resemble a high-deductible commercial health plan. Application, ECF 1-2 (AR 5442-43).

109. As such, all enrollees except for pregnant women will have a deductible account. At the beginning of every 12-month eligibility period, the account will have a $1,000 balance.

When an enrollee uses non-preventive services, the cost of the services will be deducted from the initial balance. Individuals who have money remaining in their deductible account at the end of the 12-month eligibility period may transfer up to 50% of the balance to a *My Rewards* account. Enrollees will receive monthly account statements detailing the cost of services received and the account balance. Re-approval STCs ¶ 28 (AR 6763).

110. According to the State, the purpose of the deductible account is to "expose[] members to the cost of health care and encourage[] them to act as consumers of health care by evaluating cost and quality as they seek care." Application, ECF 1-2 (AR 5461).

111. The State's fee-for-service payment schedules are already available to enrollees and the public, *see* Ky.gov, KY Cabinet for Health & Family Servs., Fee and Rate Schedules, https://chfs.ky.gov/agencies/dms/dmps/psb/Pages/feesrates.aspx (last visited Jan. 8, 2019), as are the per-member, per-month payment rates Kentucky Medicaid pays participating managed care organizations ("MCOs"), *see* Ky.gov, KY Cabinet for Health & Family Servs., Managed Care Organization (MCO) Contracts, https://chfs.ky.gov/agencies/dms/dpqo/Pages/mco-contracts.aspx (last visited Jan. 8, 2019). Thus, on information and belief, the monthly account statement will detail the payments that the MCOs make to each network provider for the non-preventive services utilized by the enrollee the previous month.

112. In addition, all Kentucky HEALTH enrollees will have a *My Rewards* account to pay for care and services that Medicaid will no longer cover for these enrollees. Re-approval STCs ¶¶ 25, 29 (AR 6762-63). Individuals accrue money in the rewards account by engaging in certain "healthy behaviors," completing certain work-related activities (above those required to maintain Medicaid coverage), and not seeking care in the emergency room. Re-approval STCs ¶ 29 (AR 6763).

113. In its application, Kentucky listed how much money enrollees can earn for completing various activities. For example, enrollees can earn $25 for completing a health risk assessment (one per year); $10 for receiving certain preventive services ($40 maximum per year); $50 for attending certain disease management courses; $25 for completing a job skills training course ($50 maximum per year); $10 per month for completing job search activities; $10 for participating in community service (maximum $50 per year); and $20 for avoiding inappropriate use of the emergency room (one per year). Application, ECF 1-2 (AR 5462).

114. Kentucky HEALTH will not cover certain services for individuals in the expansion population (who are not "medically frail") that were previously covered, including vision services, dental services, and over-the-counter medications. Individuals enrolled in Medicaid through the expansion will use the rewards account to pay for these services. Re-approval STCs ¶¶ 25 & 29 (AR 6762-64). In addition, Kentucky HEALTH enrollees may use the rewards account to pay for limited fitness-related services, such as a gym membership. *Id.*

Work and Community Engagement Requirements

115. As noted above, the Medicaid Act requires a participating state to cover *all* members of covered population groups. In other words, the state may not cover only subsets of a population group described in the Medicaid Act. *See* 42 U.S.C. § 1396a(a)(10)(A)-(B).

116. This requirement applies to optional and mandatory population groups: if a state elects to cover an optional group, it must cover all eligible individuals within that group. *Id.*

117. States cannot impose additional eligibility requirements that are not explicitly allowed by the Medicaid Act.

118. Kentucky HEALTH adds a new, unprecedented condition of eligibility that is not permitted under the Act.

119. Kentucky HEALTH enrollees must engage in 80 hours per month of specified employment or community engagement activities and must document and report their participation each month, as a condition of eligibility. Re-approval STCs ¶¶ 44 & 45(AR 6774-75). The requirement does not apply to pregnant women, former foster care youth, or “medically frail” individuals. Re-approval STCs ¶¶ 43 (AR 6774). In addition, individuals who meet certain other criteria will be exempt from the requirements or deemed to have met them. Re-approval STCs ¶ 43 (AR 6774-75).

120. The State described the work requirements as the “cornerstone” of Kentucky HEALTH. Application, ECF 1-2 (AR 5445).

121. Enrollees who are subject to the requirement for a particular month, do not meet it, and are unable to show that one of the narrow “good cause” exceptions applies, will have their eligibility and their health care coverage under Medicaid suspended. Re-approval STCs ¶ 46 (AR 6775-77). However, individuals can avoid the suspension if, in the following month, they meet the requirement and: (1) make up the hours missed in the prior month; or (2) take a health or financial literacy course approved by the state. Re-approval STCs ¶ 46 (AR 6776).

122. If the State suspends medical assistance, the penalty continues until: (1) the first day of the month after the enrollee completes 80 hours of work activities within a 30-day period; (2) the enrollee completes a health or financial literacy course approved by the State; or (3) the redetermination date, at which point the State will terminate eligibility. Re-approval STCs ¶ 46 (AR 6776-77). Enrollees may take a health or financial literacy course to prevent or end a suspension only once in a 12-month period. Re-approval STCs ¶ 46 (AR 6776).

123. According to the State, the purpose of the work requirements is to increase workforce participation and reduce poverty among Kentucky HEALTH enrollees, ultimately

leading to a reduction in Medicaid enrollment and lower state spending. Application, ECF 1-2 (AR 5446, 5451).

Monthly Premium Payments and Penalties for Failure to Pay

124. As noted above, the Medicaid Act prohibits states from charging premiums to individuals with household income below 150% of FPL. 42 U.S.C. §§ 1396*o*(a)(1), (c)(1), 1396*o*-1(b)(1).

125. The Medicaid Act requires states to provide medical assistance to all individuals who fall within a covered population group, *id*. § 1396a(a)(10)(A)-(B), and States must provide this assistance with reasonable promptness, *id*. § 1396a(a)(8).

126. The Kentucky HEALTH project requires enrollees at all income levels to pay a monthly premium. Re-approval STCs ¶ 30 (AR 6766).

127. MCOs that accept Kentucky HEALTH enrollees will bill for and collect the premiums. Re-approval STCs ¶ 31 (AR 6766).

128. According to the State, the purpose of the premium requirement is to discourage "Medicaid dependency by preparing individuals for the costs associated with commercial or Marketplace coverage." Application, ECF 1-2 (AR 5465).

129. All enrollees must pay a premium unless they are pregnant, former foster care youth, "medically frail," or survivors of domestic violence. Re-approval STCs ¶ 30 (AR 6766).

130. The Secretary has approved Kentucky to set the premium amounts up to 4% of household income. For example, a one-person household with income at 133% of FPL ($16,146) could have a $53 per month premium. Individuals with no or very low income will be required to pay a minimum premium of $1 per month. Re-approval STCs ¶ 33 (AR 6769).

131. The Secretary has authorized the State to vary the amount of the premium (up or down) based on household income, length of time enrolled in Kentucky HEALTH, and/or other grounds "consistent with how premium requirements vary in the commercial insurance market in Kentucky." *Id.*

132. In its application, Kentucky set the premium amount to vary as follows: $1 per month when the enrollee's household income is 0-25% of FPL; $4 per month, when 25-50% of FPL; $8 per month, when 51-100% of FPL; and $15 per month, when 101-133% FPL during the first and second year of enrollment. Application, ECF 1-2 (AR 5464). For individuals with household income over 100% of FPL, Kentucky set the premium to increase to: $22.50 per month in year three, $30 per month in year four, and $37.50 per month in year five. Application, ECF 1-2 (AR 5465). As noted, CMS has authorized Kentucky to further adjust premium amounts without obtaining additional CMS approval. Re-approval STCs ¶ 33(a) (AR 6769).

133. If all household members who are subject to the premium requirement are enrolled in the same MCO, the premiums will be charged on a per-household basis. Re-approval STCs ¶ 34 (AR 6769-70).

134. If household members are enrolled in different MCOs, the premiums will be assessed on a per-person basis, meaning the total premium amount could be greater than 4% of household income. Re-approval STCs ¶ 33 (AR 6769). However, the State will cap aggregate household premiums and cost sharing at 5% of household income for each quarter. If a household reaches that cap, the premium amount will drop to $1 per month and no cost sharing will be charged for the remainder of the quarter. *Id.*

135. On information and belief, the Kentucky HEALTH premiums are the highest premiums ever permitted in the Medicaid program.

136. In general, Kentucky HEALTH enrollees subject to the premium requirement will not receive Medicaid coverage of needed health care until the first day of the month in which they pay the premium. Re-approval STCs ¶ 17 (AR 6754-55).

137. Individuals with household incomes above 100% of FPL who do not pay the initial premium within 60 days after their eligibility determination will not be enrolled in Kentucky HEALTH. Re-approval STCs ¶ 17 (AR 6755). Once enrolled, individuals above 100% of FPL who do not pay their monthly premium within 60 days of the due date will be terminated from Medicaid and prohibited from re-enrolling for six months (the "lockout period"). Re-approval STCs ¶ 38 (AR 6770). The State will also deduct money from their rewards accounts. *Id.*

138. Individuals below 100% of FPL who do not pay the initial premium within 60 days of their eligibility determination will be enrolled as of the first day of the month in which the 60-day period ends. Re-approval STCs ¶ 17 (AR 6755). However, as a penalty for not paying the premium, the State will deduct money from their rewards accounts. In addition, during the next six months, they will be subject to cost sharing (as detailed in the state plan) in lieu of premiums and will not have access to their rewards accounts. Re-approval STCs ¶¶ 17 & 38 (AR 6755, 6771). Individuals below 100% of FPL—as well as individuals in the Transitional Medical Assistance eligibility category—face the same consequences when they do not pay a subsequent premium. Re-approval STCs ¶ 38 (AR 6771).

139. To end the lockout or penalty period early, enrollees must: (1) demonstrate that one of the narrow "good cause" exceptions applies; or (2) pay all past-due premiums owed, pay the premium for the month of re-enrollment, and complete a financial or health literacy course. Re-approval STCs ¶¶ 38 & 40 (AR 6771-73). Individuals may only end the lockout or penalty period early once every year. Re-approval STCs ¶ 40 (AR 6772-73).

140. Although former foster care youth, "medically frail" individuals, and survivors of domestic violence are exempt from the premium requirement, if they do not pay the premium, they will nonetheless be penalized by having their rewards accounts suspended for six months. Re-approval STCs ¶ 38 (AR 6772). Unlike the population groups subject to the premium requirement, they do not need to pay all past-due premiums to end the penalty period early. *Id.*

Cost Sharing for Non-Emergency Use of the Emergency Department

141. As explained above, the Medicaid Act limits the ability of a state to impose cost sharing on Medicaid beneficiaries. For non-emergency use of the emergency room, the Medicaid Act generally allows states to charge individuals with household income below 150% of FPL up to twice the "nominal" amount, as determined by the Secretary in regulations. 42 U.S.C. § 1396*o*-1(e)(2)(A); *see* 42 C.F.R. § 447.54(b) (setting this amount at $8, subject to increases for inflation); 42 U.S.C. § 1396*o*-1(e)(4)(A) (defining non-emergency services). If a State wishes to impose a deduction, copay, or similar charge outside of the Medicaid Act limits, then it must persuade the Secretary that the charge will meet the five requirements of Section 1396*o*(f), such as testing a previously untested use of copayments, lasting no more than two years, and using a methodologically sound hypothesis, with control groups.

142. Under Kentucky HEALTH, the State will deduct $20 from an enrollee's *My Rewards* account for an inappropriate emergency room visit, thus reducing funds in that account that are available to pay for the enrollee's medically necessary vision and dental care and non-prescription drugs. The charge will increase to $50 for the second such visit and $75 for additional visits. Application, ECF 1-2 (AR 5463); *see also* Re-approval STCs ¶ 28 (AR 6763).

143. The Kentucky HEALTH assessment for inappropriate use of the emergency room is a deduction, copay, or similar charge under 42 U.S.C. §§ 1396*o* and 1396*o*-1.

144. According to the Secretary, the goal of the policy is to discourage inappropriate emergency room use. *See* Re-approval Letter at 19 (AR 6736); Application, ECF 1-2 (AR 5463).

145. The Kentucky HEALTH program does not meet any of the pre-conditions set out in 42 U.S.C. § 1396*o*(f).

146. The Federal Defendants approved the Kentucky HEALTH policy without requiring the State to meet any of the requirements of 42 U.S.C. § 1396*o*(f).

<u>Lockout Penalty for Not Meeting Administrative Requirements</u>

147. Consistent with federal Medicaid law, the State will re-determine the Medicaid eligibility of Kentucky HEALTH enrollees every 12 months and will terminate those who do not complete the redetermination process by the end of their eligibility period. Also consistent with federal law, individuals who have been terminated will then have three months to re-enroll by submitting their redetermination forms; no new application is required. Re-approval STCs ¶ 21 (AR 6756).

148. However, in a dramatic departure from federal law, Kentucky will impose a lockout penalty on individuals (other than those who are pregnant, former foster care youth, those found to be "medically frail," or survivors of domestic violence) who have not re-enrolled by the end of the three months. Re-approval STCs ¶ 21 (AR 6756-57). The State will prohibit them from re-enrolling in Medicaid for an additional six months.

149. The State will impose the same lockout penalty on individuals (other than pregnant women, former foster care youth, those found to be "medically frail," and survivors of domestic violence) who do not timely report changes in circumstances that affect their eligibility for Medicaid. Re-approval STCs ¶¶ 22, 23 (AR 6757-60).

150. State regulations already require Medicaid enrollees to report these changes within 10 days. 907 Ky. Admin. Regs. 20:010. With Kentucky HEALTH, however, the State is imposing an additional six-month lockout penalty on enrollees who do not meet the existing administrative requirement.

151. Individuals can re-enroll before the end of the lockout period only if they: (1) demonstrate that one of the narrow "good cause" exceptions applies; or (2) pay the premium for the first month of re-enrollment and complete a financial or health literacy course. Re-approval STCs ¶¶ 22, 24, 40 (AR 6758, 6760-61, 6772-73). Individuals may end the lockout early only once every year. Re-approval STCs ¶ 40 (AR 6772-73).

152. The only stated purpose of the lockout penalty for failure to complete the redetermination process is to "help familiarize Kentucky HEALTH members with this commercial market policy." Application, ECF 1-2 (AR 5453). Similarly, the State describes the lockout penalty for failure to timely report changes in circumstances as a "learning tool" that will help prepare enrollees for commercial insurance coverage. Application Modification, ECF 1-1 (AR 5416).

No Retroactive Eligibility

153. As noted above, the Medicaid Act requires that medical assistance be provided to enrollees retroactively. Retroactive coverage is mandated in two locations within the Medicaid Act. First, the statute requires that states must provide that:

> in the case of any individual who has been determined to be eligible for medical assistance . . . such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application . . . for such assistance if such individual was . . . eligible for such assistance at the time such care and services were furnished.

42 U.S.C. § 1396a(a)(34). Second, in a provision *outside* Section 1396a, Section 1396d(a) defines "medical assistance" to include coverage for services received by eligible individuals during the three-month period prior to the month of application. *Id.* § 1396d(a).

154. Under the Kentucky HEALTH project, enrollees (other than pregnant women and former foster care youth) will not receive the retroactive eligibility required by statute. Re-approval STCs ¶ 19 (AR 6756). Instead, as outlined above, the State will generally only pay for services received on or after the first day of the month in which enrollees pay their initial monthly premium.

155. By eliminating retroactive eligibility, the State claims it intends to "encourage[] individuals to obtain and maintain health insurance coverage, even when the individual is healthy." Application, ECF 1-2 (AR 5453).

Elimination of Non-Emergency Medical Transportation

156. States must ensure that Medicaid beneficiaries have necessary transportation, often referred to as non-emergency medical transportation ("NEMT"), to and from Medicaid services. *See* 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.53.

157. Between June 2014 and June 2015, individuals enrolled in Medicaid through the Kentucky expansion used 140,000 NEMT trips to get to and from medically necessary health services. Application, ECF 1-2 (AR 5478).

158. The Secretary approved Kentucky's request, under the Kentucky HEALTH project, to no longer provide NEMT for the expansion population, with the exception of enrollees who are pregnant, former foster care youth, aged 19 or 20, survivors of domestic violence, or "medically frail" individuals. Re-approval STCs ¶ 26 (AR 6762).

159. According to the Secretary, the purpose of eliminating NEMT is to offer Kentucky HEALTH enrollees "a commercial health insurance market experience," which does not offer NEMT. Re-approval Letter (AR 6735); Application, ECF 1-2 (AR 5438).

**F. Action Taken by the Federal Defendants to Allow Work Requirements and Approve the Kentucky HEALTH Program**

160. Prior to 2017, CMS's website stated that the purpose of Section 1115 waivers is to "demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs."

Medicaid.gov, *About Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Jan. 8, 2019). The "general criteria" for CMS to use when assessing waiver applications looked at whether the demonstration would:

1. increase and strengthen overall coverage of low-income individuals in the state;
2. increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3. improve health outcomes for Medicaid and other low-income populations in the state; or
4. increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

*Id.*

161. Prior to 2017, CMS recognized that work requirements do "not support the objectives of the [Medicaid] program" and "could undermine access to care." Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., HHS to Thomas Betlach, Dir. Az. Health Care Cost Containment Sys. (Sept. 30, 2016); *see* Sec'y of Health & Human Servs.

Sylvia Burwell, *Hearing on The President's Fiscal Year 2017 Budget*, Responses to Additional Questions for the Record, U.S. House of Rep. Energy & Commerce Health Subcommittee at 13 (Feb. 24, 2016), http://docs.house.gov/meetings/IF/IF14/20160224/104521/HHRG-114-IF14-Wstate-BurwellS-20160224-SD002.pdf.

162. The current HHS abruptly reversed course to revise its use of the Section 1115 waiver authority and to authorize work requirements in Medicaid as part of President Trump's vow to "explode" the ACA and its Medicaid expansion. *See* Amy Goldstein & Juliet Eilperin, *Affordable Care Act Remains "Law of the Land," but Trump Vows to Explode It*, Wash. Post, Mar. 24, 2017, https://www.washingtonpost.com/national/health-science/affordable-care-act-remains-law-of-the-land-but-trump-vows-to-explode-it/2017/03/24/4b7a2530-10c3-11e7-ab07-07d9f521f6b5_story.html.

163. As soon as he took office, President Trump signed an Executive Order calling on federal agencies to undo the ACA "to the maximum extent permitted by law." Executive Order 13765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal,* 82 Fed. Reg. 8351 (Jan. 20, 2017).

164. On March 14, 2017, Defendant Seema Verma was sworn in as the Administrator of CMS. Defendant Verma immediately issued a letter to state Governors announcing CMS's disagreement with the purpose and objectives of the law, as established by the Affordable Care Act, stating that "[t]he expansion of Medicaid through the Affordable Care Act ("ACA") to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program." *See* Sec'y of Health & Human Servs., Dear Governor Letter, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf, AR 0115.

165. Since then, Defendant Verma has made repeated public statements criticizing the expansion of Medicaid to "able-bodied individual[s]," advocating for lower enrollment in Medicaid, and outlining plans to "reform" Medicaid through agency action. *See* Casey Ross, *Trump Health Official Seema Verma has a plan to slash Medicaid Rolls. Here's how*, Stat, Oct. 26, 2017, https://www.statnews.com/2017/10/26/seema-verma-medicaid-plan/ (last visited Jan. 8, 2019).

166. For instance, on June 27, 2017, Defendant Verma wrote an Opinion piece in the Washington Post observing, "U.S. policymakers have a rare opportunity, through a combination of congressional and administrative actions, to fundamentally transform Medicaid." Seema Verma, *Lawmakers have a rare chance to transform Medicaid. They should take it*, Wash. Post, June 27, 2017, https://www.washingtonpost.com/opinions/lawmakers-have-a-rare-chance-to-transform-medicaid-they-should-take-it/2017/06/27/f8e5408a-5b49-11e7-9b7d-14576dc0f39d _story.html?utm_term=.11a4dfe727df (last visited Jan. 8, 2019).

167. On November 7, 2017, at a speech before the National Association of Medicaid Directors, Defendant Verma declared that the ACA's decision to "move[] millions of working-age, non-disabled adults into" Medicaid "does not make sense," and announced that CMS would resist that change by approving state waivers that contain work requirements. Speech: Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference, CMS.Gov (Nov. 7, 2017), https://www.cms.gov/newsroom/fact-sheets/speech-remarks-administrator-seema-verma-national-association-medicaid-directors-namd-2017-fall (last visited Jan. 8, 2019).

168. On November 10, 2017, Defendant Verma gave an interview in which she declared that one of the "major, fundamental flaws in the Affordable Care Act was putting in able bodied

adults," declaring that Medicaid was "not designed for an able bodied person," and announcing that CMS is "trying" to "restructure the Medicaid program." http://www.wsj.com/video/the-future-of-health-care/D5B767E4-B2F2-4394-90BB-37935CCD410C.html.

169. In or around early November 2017, CMS revised its website to invite states to submit Section 1115 waivers that would:

1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;

2. Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;

3. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;

4. Strengthen beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making;

5. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and

6. Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

Medicaid.gov, *About Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Jan. 8, 2019).

170. On January 11, 2018, well after the federal comment periods for the Kentucky HEALTH application had closed, Defendant CMS issued a letter to State Medicaid Directors ("SMD Letter"), ECF 1-4 (AR 0090-99), titled "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," which, for the first time, announces its intention to approve state waiver applications with punitive work requirements on Medicaid beneficiaries. The SMD Letter also outlines the "guidelines" for states to consider in submitting applications containing work requirements.

171. The nine-page document "announc[es] a new policy" to allow states to apply "work and community engagement" requirements to certain Medicaid recipients—specifically, "non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability." Dear State Medicaid Director Letter, ECF 1-4 (AR 0090).

172. The Dear State Medicaid Director Letter acknowledges that allowing states to implement work requirements "is a shift from prior agency policy." Dear State Medicaid Director Letter, ECF 1-4 (AR 0092).

173. The Dear State Medicaid Director Letter was not submitted for notice and comment, and was not published in the Federal Register.

174. The same day CMS issued the Dear State Medicaid Director Letter, it received several letters critical of this novel policy position, including from members of Congress and nonprofit organizations. The National Health Law Program ("NHeLP") noted that by announcing the policy change after the Kentucky HEALTH comment period had closed, CMS had not given the public the ability to comment meaningfully on the pending Kentucky waiver requests in light of the policy change. NHeLP noted that the Dear State Medicaid Director letter "entirely ignore[d] the wealth of literature regarding the negative health consequences of work requirements, which was repeatedly cited by NHeLP and others in those state-specific comments." Letter from Jane Perkins, Legal Director, Nat'l Health Law Program, to Brian Neale, Dir., Ctrs. For Medicare & Medicaid Servs. (Jan. 11, 2018),https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/01/NHeLP-Letter-Re-Work-DSMD.pdf (last visited Jan. 8, 2019).

175. NHeLP requested that CMS re-open public comment on the Kentucky HEALTH project to allow the public a meaningful opportunity to comment.

176. The Federal Defendants ignored this request. On January 12, 2018, Defendant HHS approved the Kentucky HEALTH application.

177. In granting the waiver, CMS imposed a variety of terms and conditions on Kentucky's program. Several of those terms and conditions require that Kentucky abide by the requirements set out in CMS's Dear State Medicaid Director letter. *See*, *e.g.*, Re-approval STCs ¶ 43 (AR 6774) (exempting from work requirement beneficiaries diagnosed with an acute medical condition); Re-approval STCs ¶ 44 (AR 6774) (requiring that participation in substance use disorder treatment is a qualifying activity, and that beneficiaries who meet or are exempt from SNAP/TANF employment initiatives "will be deemed to satisfy community engagement requirements"); Re-approval STCs ¶ 45 (AR 6775) (requiring reasonable modifications for beneficiaries with ADA-protected disabilities, including exemption from participation); Re-approval STCs ¶ 47 (AR 6778-79) (promising that Kentucky will ensure access to sufficient work and community engagement activities for curing a failure to meet the eighty-hour requirement, at no cost to the beneficiary); Re-approval STCs ¶ 47 (AR 6779) (promising that Kentucky will assess areas with fewer qualifying activities or higher barriers to participation to determine whether further exemptions or modifications are needed to the work requirement).

178. On or about January 18, 2018, CMS further emphasized that it disagrees with the legislative expansion of Medicaid under the Affordable Care Act and that it had announced a "new policy guidance" to support state implementation of work requirements intended to target that expansion population. CMS, Community Engagement Initiative Frequently Asked Questions, https://www.medicaid.gov/medicaid/section-1115-demo/community-engagement/index.html (last visited Jan. 8, 2019).

179. Since approving Kentucky HEALTH, the Secretary has implemented the new policy guidance and approved similar work requirements in New Hampshire, Arkansas, Indiana, Wisconsin, Michigan, and Maine. *See* CMS, State Waivers List, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html (last visited Jan. 8, 2019); see *also* Seema Verma, Admin., Ctrs. for Medicare & Medicaid Servs. (@Seema CMS), Twitter (Mar. 5, 2018, 9:45 AM), https://twitter.com/SeemaCMS/status/970716905379123205 (last visited Jan. 8, 2019) ("#Arkansas Works is the 3rd community engagement demonstration we've approved since releasing guidance in January.").

180. The Federal Defendants have continued to express their opposition to the Medicaid expansion and their intent to transform the Medicaid program through work requirements. For example, Defendant Verma stated: "As you know, Obamacare put millions of people, millions of able-bodied individuals, into a program that was built for our most needy, for our most vulnerable citizens. And so, we think that the program needs change. It needs to be more adaptable and more flexible to address the needs of the newly-covered population." Interview by Bertha Coombs, CNBC, with Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., (May 1, 2018).

181. After the Court vacated approval of Kentucky HEALTH, Defendant Verma reiterated that CMS is "very committed" to work requirements and wants "to push ahead with our policy initiatives and goals." Dan Goldberg, *Verma: Court ruling won't close door on other Medicaid Work requests*, Politico, July 17, 2018, https://www.politico.com/story/2018/07/17/trump-medicaid-work-requests-states-verma-726303 (last visited Jan 8, 2019).

182. After the Court's decision, Defendant Azar stated: "We are undeterred. We're proceeding forward. We're fully committed to work requirements and community participation in the Medicaid program . . . we will continue to litigate, we will continue to approve plans, we will

continue to work with states. We are moving forward." Colby Itkowitz, *The Health 202: Trump administration 'undeterred' by court ruling against Medicaid work requirements,* Wash. Post, July 25, 2018, https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/07/27/the-health-202-trump-administration-undeterred-by-court-ruling-against-medicaid-work-requirements/5b5a10bb1b326b1e64695577/?utm_term=.7ba76e8a0719 (last visited Jan. 8, 2019); *see also* Alex M. Azar II, Secretary, U.S. Dep't of Health & Human Servs., Remarks on State Healthcare Innovation at the American Legislative Exchange Council Annual Meeting (Aug. 8, 2018) ("[Defendant Verma] is now overseeing the next great generation of transformation in Medicaid, through our efforts to encourage work and other forms of community engagement.").

183. On December 21, 2018, Administrator Verma tweeted, "The Christmas sleigh has made deliveries to Kansas, Rhode Island, Michigan, and Maine to drop off signed #Medicaid waivers. Christmas came early for these Governors. . . ." Seema Verma, Admin., Ctrs. for Medicare & Medicaid Servs. (@Seema CMS), Twitter (Mar. 5, 2018, 1:13 PM), https://twitter.com/seemacms/status/1076224135037108224?lang=en (last visited Jan. 8, 2019).

**G. The Effects of Kentucky HEALTH's Re-approval on Plaintiffs**

184. By approving Kentucky HEALTH, the Secretary has enabled the State to impose unprecedented work and premium requirements and to punish Plaintiffs who are understandably unable to meet those and other administrative requirements by prohibiting them from obtaining Medicaid coverage.

185. By approving Kentucky HEALTH, the Secretary has permitted Kentucky to eliminate critical Medicaid services for Plaintiffs enrolled in the project.

186. By approving Kentucky HEALTH, the Secretary has permitted Kentucky to exclude retroactive coverage for necessary health services received in the three months prior to the

date of application. If a Plaintiff loses coverage and then reapplies, the Plaintiff will not have retroactive coverage for health services received during the gap in coverage.

187. By approving Kentucky HEALTH, the Secretary has permitted Kentucky to impose cost sharing on Plaintiffs if they need to seek care in an emergency department and their condition is determined not to require urgent medical attention. The cost sharing amount will increase with each subsequent visit.

188. Continuous and adequate health insurance coverage is fundamental for each Plaintiff's ability to work.

189. The Secretary's action approving Kentucky HEALTH will cause harm to Plaintiffs. Specifically:

190. **Plaintiff Ronnie Maurice Stewart** is 63 years old and lives alone in Lexington, Fayette County, Kentucky. He has adult children who live elsewhere.

191. Mr. Stewart is a college graduate who worked in mental health clinics in North Carolina. He was laid off in his fifties and could not find work. Mr. Stewart moved to Kentucky in 2014 when he was offered a job in Bowling Green. After losing that job, Mr. Stewart was homeless for about six months, until he got a job as a medical assistant at the University of Kentucky Hospital.

192. Mr. Stewart retired at age 62 because he could no longer do heavy work that required him to stand all day. He receives Social Security retirement benefits of $863 per month. He recently began working 15 hours a week at Goodwill Industries, earning $523.90 per month. His total annual income is $16,642.80—137% of FPL for a single person ($12,140).

193. Plaintiff Stewart enrolled in Kentucky's Medicaid program in March 2014 with the in-person assistance of a kynector/assister. He has limited computer skills and has not attempted to enroll online or by phone.

194. Before Mr. Stewart enrolled in Medicaid, he could not afford to purchase individual or employer-based insurance. His only source for treatment and medications was a free clinic at the homeless shelter where he lived.

195. Mr. Stewart suffers from diabetes, arthritis, and high blood pressure. Medicaid coverage has allowed him to get treatment for these conditions. Medicaid also paid for his cataract surgery, which kept him from going blind and allowed him to return to work.

196. Mr. Stewart requires prescription glasses to correct his astigmatism. He also needs dentures or dental implants to replace two front teeth that were knocked out and several other missing teeth.

197. Ms. Stewart received a notice, dated June 9, 2018, informing him that the state Medicaid agency had designated him medically frail and exempting him from work requirements. Mr. Stewart does not know why he has been designated medically frail. He understands that Medicaid or his MCO could revoke his medically frail status at any time. If his medical conditions are under control, he could be found to no longer be medically frail. If this happens, Mr. Stewart would have to comply with the work requirement until he turns 64 or else lose his Medicaid coverage. Currently, his 60 hours of work per month would not be sufficient to meet this requirement.

198. Likewise, if Mr. Stewart is no longer considered medically frail, he worries that he will be locked out of Medicaid for six months if fails to recertify or report a change in income on

time. This reporting requirement could be a problem if Mr. Stewart's hours at Goodwill Industries vary.

199. Even if he keeps his medically frail status, if Mr. Stewart loses coverage and then reapplies, any medical bills he incurs while uninsured will not be covered, given the waiver's elimination of retroactive coverage. Mr. Stewart worries he will end up with unpaid medical bills, as he cannot afford to pay medical bills out of pocket.

200. Mr. Stewart will be subject to an optional premium payment under Kentucky HEALTH. He expects his premium to increase from $8 to $15 per month, based on his current income. Premium payments are a significant concern for Mr. Stewart. He thinks he can afford the premium so long as he is able to continue working part-time. But if he is unable to pay the premium, his *My Rewards* account will be suspended.

201. Had Mr. Stewart known about the SMD Letter and that it would allow states to condition Medicaid eligibility on work, he would have wanted to weigh in by submitting comments.

202. **Plaintiff Kimberly Kobersmith** is 47 years old and lives in Berea, Madison County, Kentucky, with her husband, and their two sons, ages 14 and 12. The Kobersmiths both work part-time, so that they can jointly home school and care for their sons.

203. Mrs. Kobersmith is a college graduate who works as a freelance writer for local newspapers and magazines. She currently works roughly 10 to 12 hours each week as a writer. In addition, she has a contract job running a day camp for kids focusing on positive conflict resolution. The job requires her to work full-time for one week out of the year (when the camp is in session) and about 2 hours each week for the rest of the year. Between her writing and the contract job, she works on average 13 to 15 hours per week. Her income is approximately $375 to

$450 per month, or $4,800 per year. Her hours and income fluctuate throughout the year. Mr. Kobersmith works 20 hours each week as an administrator at the Union Church in Berea. His annual income is approximately $1,878 per month. Together, the Kobersmiths earn approximately $27,336 per year, which is 109% of FPL for a family of four ($25,100).

204. The Kobersmiths signed up for Medicaid in 2014. Before 2014, they had several high-deductible, catastrophic coverage plans, only one of which covered preventive services. When they were enrolled in these plans, they knew that at any time a serious medical issue could become a financial disaster.

205. Their children were enrolled in KCHIP in 2011, but are now on Medicaid.

206. Medicaid has enabled the Kobersmith family to get the services they need, including preventive care services. Mr. and Mrs. Kobersmith both get an annual check-up and go to the dentist at least one every year. In addition, a few years ago Mrs. Kobersmith's doctor discovered that she was pre-diabetic. She has been able to improve this condition through exercise and her diet. Mr. Kobersmith also sees a urologist several times a year and a chiropractor once every two months for back issues. Both Mr. and Mrs. Kobersmith wear glasses. Through Medicaid, their children get well-child check-ups and dental and vision check-ups.

207. The Medicaid agency sent the Kobersmiths two notices—one dated June 9, 2018, and one dated June 29, 2018—both indicating that Mrs. Kobersmith will be required to work 80 hours each month to maintain her Medicaid eligibility. It is unlikely that she will be able to comply with the requirement because she currently has only 12 to 15 hours of work per week. As a result, Mrs. Kobersmith is afraid that she will lose Medicaid coverage and be locked out of the program.

208. Mrs. Kobersmith is particularly concerned about the reporting requirements because her work hours and income vary every week. She is afraid she could be locked out of

Medicaid coverage because she does not know how she will be able to report every change in income or verify her work hours or income because she is self-employed. Mrs. Kobersmith is also concerned that she will be locked out of the program if she cannot complete the redetermination process by the deadline.

209. The notices also indicated that Mrs. Kobersmith will have to pay a $15 premium every month. Because her husband's income decreased by approximately $4,500 this year, it will be more difficult for her family to afford the premium. If Mrs. Kobersmith is unable to pay the premium, she will lose coverage and be locked out of Medicaid for up to six months.

210. The only way Mrs. Kobersmith will be able to obtain the vision and dental care she and her family need is if she has money in her *My Rewards* account to pay for it. If Mrs. Kobersmith does not earn sufficient money in her account, she will be unable to obtain necessary vision and dental care.

211. **Plaintiff Shawna Nicole McComas** is 36 years old and lives in Lexington, Fayette County, Kentucky, with her husband and four children, ages 17, 14, 10, and 5.

212. Ms. McComas works 40 hours per week in a housekeeping position at the University of Kentucky Hospital. She also works approximately 12 hours overtime per week. Her overtime hours vary weekly and monthly.

213. Ms. McComas's husband is unemployed. In September 2017, he secured a job at a restaurant, but he was only able to work one week. He suffers from post-traumatic stress disorder, which makes it difficult for him to keep a job.

214. Ms. McComas estimates that her household income is $3,833 per month, or an annual household income of $45,997, which is 136% of FPL for a family of six ($33,740).

215. Ms. McComas enrolled in Kentucky's Medicaid program in August 2017 with the help of an in-person assister. She was previously on Medicaid, but her coverage was terminated when she moved and did not receive the notice about the need to re-determine her eligibility. She cannot afford health insurance through her job, which would cost $190 per week just for herself.

216. Ms. McComas has multiple medical conditions, including chronic hip pain, congenital hip dysplasia, osteoarthritis in her hips, a bunion on her right foot due to her hip problems, chronic back pain, arthritis, and sciatic nerve damage. Medicaid coverage has enabled her to access medical care to manage these conditions. Ms. McComas sees a primary care physician and specialists—including an orthopedist, an orthopedic surgeon, and a podiatrist—for hydrocortisone injections, numerous prescription medications, and other treatments. Though an orthopedic surgeon recommended hip replacement and bone reconstruction surgery over a year ago, Ms. McComas did not have the procedure because she felt she could not afford to miss three to nine months of work during the post-surgical recovery period. Her primary care physician recently recommended that she have the surgery soon to prevent further hip displacement.

217. Ms. McComas also has multiple dental issues, including gum disease, gingivitis, and pain and sensitivity near her teeth. She has had four or five teeth removed. She wears prescription glasses for nearsightedness and an astigmatism.

218. Before Ms. McComas enrolled in Medicaid, she was not able to visit doctors, receive hydrocortisone injections, or pay for prescription medications. She was in pain all the time at work.

219. The state Medicaid agency sent Ms. McComas a notice dated June 9, 2018, indicating that under the Kentucky HEALTH waiver, she and her husband will both be subject to work requirements. Ms. McComas is currently working more than 20 hours a week. However,

she could be locked out of coverage if her hours decrease or if she does not report changes that would affect her eligibility within ten days. Because she does not have a computer at home, she might need to go to the library or the Medicaid office to report changes in her hours or income. Her work schedule and lack of a car will make complying with this reporting requirement difficult.

220. The June 9 notice also indicated that Ms. McComas will be required to pay a monthly premium of $8. The amount will likely increase to $15 a month because her income has risen. Premium payments are a significant concern for her. She was unable to pay a premium in the past when she had a subsidized plan, and as a result, she lost her coverage. If Ms. McComas is unable to pay the required premium amount, she will lose coverage and be prohibited from re-enrolling in Medicaid for up to six months.

221. Ms. McComas fears that she will not be able to accrue enough funds in her *My Rewards* account to cover her vision and dental care needs.

222. Ms. McComas is also concerned that if she has to go to the emergency room, and Medicaid does not think she needed emergency treatment, Medicaid will deduct funds from her *My Rewards* account, leaving her with even less money to pay for vision and dental care. Ms. McComas has gone to the emergency room twice for fast-onset urinary tract infections, which Medicaid would likely deem non-emergencies.

223. Ms. McComas does not have a car. She takes buses to get to appointments with doctors, which takes roughly an hour and a half each way. She therefore fears that the waiver of non-emergency medical transportation could become a problem for her.

224. If Ms. McComas had known about the SMD letter and that it was allowing states to condition Medicaid coverage on work, she would have submitted a comment opposing the policy.

225. **Plaintiff Melissa ("Missy") Spears-Lojek** is 39-years-old and lives in Covington, Kenton County, Kentucky.

226. Ms. Spears-Lojek is a self-employed and owns and operates a t-shirt business, Keep Your Shirt On Covington, LLC ("KYSOC"). Her hours of work at, and income from, KYSOC vary throughout the year depending on the season. For example, during the summer, she works twenty to forty hours per week, but in the winter, she works significantly fewer hours. She also has worked other jobs in the past, and plans to begin working at a bagel shop part-time in January 2019.

227. In 2018, she earned approximately $14,000 in annual income—which is 115% of the FPL for a family of one ($12,140).

228. Ms. Spears-Lojek has been enrolled in Medicaid since 2015. Before Medicaid, she experienced periods where she had no insurance because she could not afford it.

229. Ms. Spears-Lojek uses Medicaid to stay healthy, including to pay for vaccinations and visit her family doctor. Without Medicaid, she does not know how she would pay for health care.

230. Ms. Speaks-Lojek worries about loss of coverage under Medicaid due to her inability to fulfill the reporting requirements under the waiver. The variation in her income and work hours with KYSOC will make it difficult to timely report every change.

231. Ms. Speaks-Lojek fears that she will also be locked out of the Kentucky HEALTH project due to clerical errors and issues with the transmission of documents that she has experienced with Medicaid in the past. For example, the process to change her name with Medicaid several years ago became too complicated and lengthy to complete. She has also

experienced issues with her managed care organization and the state Medicaid agency exchanging incorrect information about her enrollment.

232. She will also be required to pay a $15 premium under the project, but Ms. Spears-Lojek, who maintains careful budgets of her income and expenses, does not expect to be able to cover even this small premium. If Ms. Speaks-Lojek is unable to pay the premium, she will lose coverage and be locked out of Medicaid for up to six months.

233. If Ms. Spears-Lojek loses coverage and then reapplies, any medical bills she incurs while uninsured will not be covered due to the waiver's elimination of retroactive coverage.

234. The elimination of NEMT under the Kentucky HEALTH project will also be problematic for Ms. Spears-Lojek. Because Ms. Spears-Lojek does not own, or have access to, a drivable car, she relies on NEMT to travel to and from her doctors' appointments. Without NEMT, she cannot access her doctors' appointments.

235. **Plaintiff David Roode**, who is 40 years old, lives with his wife in Ludlow, Kenton County, Kentucky. They do not have children.

236. Mr. Roode is self-employed as a classical musician and plays with various symphony orchestras, usually on a contract basis.

237. Because he is a self-employed contractor, Mr. Roode's income varies each month, and he often has to pay his own Medicare and Social Security taxes, in addition to income taxes. He generally works 20 to 30 hours per week, although his hours sometimes fall below 20. His wife is also self-employed and works roughly 10 hours per week. Their adjusted gross income is about $1,829 per month, which annually amounts to approximately $21,955—133% of FPL for a family of two ($16,460).

238. Mr. Roode enrolled in Medicaid at the end of 2015 or early 2016. He was able to enroll online but once had to go to the local Medicaid office when there was confusion over whether he should be on Medicaid or on subsidized private insurance.

239. Mr. Roode is healthy and has no ongoing health conditions. With Medicaid, Mr. Roode has been able to get preventive care—including an annual check-up and flu shot. Preventing illness is very important to him in light of his busy schedule and contract status, as it is critical that he does not miss performances. Medicaid coverage is essential to Mr. Roode's ability to stay healthy and keep working as much as possible. Without Medicaid, he would be forced to give up his music career and try to find a job that offers health insurance.

240. Mr. Roode will be subject to work requirements under` the Kentucky HEALTH waiver. He is concerned that he will be locked out of Medicaid coverage if his work hours fluctuate below 80 hours per month, which they sometimes do.

241. Mr. Roode is also at risk of being locked out of Medicaid coverage if he is unable to file required reports, including reports about changes in his income that would affect his eligibility. His income changes every month, so reporting these changes will be difficult.

242. Under the Kentucky HEALTH waiver, Mr. Roode will be required to pay a monthly premium of $15 for Medicaid coverage. If he is unable to pay the premium, he will be locked out of Medicaid coverage for up to 6 months.

243. In April 2018, the state Medicaid agency terminated Mr. Roode's coverage due to one month of increased income. With the help of an attorney at the Kentucky Equal Justice Center, he appealed, reapplied, and was again determined eligible for Medicaid. Only because of retroactive coverage, he did not have a lapse of coverage during the time he was not enrolled in

Medicaid. He is concerned that if he is terminated again from Medicaid, he might incur medical bills that would not be covered due to the elimination of retroactive coverage.

244. Mr. Roode will have a *My Rewards* account under the waiver. He wears prescription eyeglasses, and as a brass player, it is essential that he maintain excellent dental health. Mr. Roode does not believe that he could earn enough money in his *My Rewards* account to pay for vision and dental needs.

245. If Mr. Roode had known about the SMD Letter announcing the federal government's support for conditioning Medicaid on work requirements, he would have submitted comments weighing in on those requirements, as he did during both public comment periods on the Kentucky HEALTH waiver.

246. **Plaintiff Sheila Marlene Penney** is 54 years old and lives alone in Louisville, Jefferson County, Kentucky. She has an adult son who lives elsewhere.

247. Ms. Penney was born in Fleming, Letcher County. Her father and grandfather were coal miners. The family moved to Louisville when Ms. Penney was an infant because coal jobs were drying up.

248. Ms. Penney has worked her whole adult life as much as possible. She has worked as a package handler, boat reservations manager, and kynector/assister for Medicaid enrollment. She has also worked with victims of domestic violence and in the Jefferson County Drug Court. Ms. Penney has not worked since March 2016 due to depression and anxiety.

249. Ms. Penney currently does not have a regular income. She makes roughly $100 a month selling items online that her mother has bought at thrift stores. On an annual basis, she earns approximately $1,200—10% of FPL for a single person ($12,140).

250. Ms. Penney has been covered through Kentucky's Medicaid program since 2015. She was able to enroll online and by phone.

251. Having Medicaid has allowed Ms. Penney to obtain consistent treatment to manage her health conditions. Ms. Penney has suffered from depression and anxiety for 30 years. Without Medicaid, her mental health would deteriorate, making it much harder, or even impossible, for her to work. Ms. Penney also has sleep apnea and allergies. Recently, Medicaid covered a surgical procedure to treat her sleep apnea. Additionally, Ms. Penney wears glasses and has a broken tooth that needs to be removed.

252. Prior to enrolling in Medicaid, Ms. Penney had trouble getting health care. She had to piece together treatment for her depression and anxiety through visits to a family health clinic that charged a sliding-scale fee. Sometimes, she could get prescriptions filled through a free pharmaceutical plan. She was unable to pay out-of-pocket expenses for therapy and other needed treatment.

253. On June 9, 2018, the state Medicaid agency sent Ms. Penney a notice indicating she will be subject to work requirements under the Kentucky HEALTH waiver. Ms. Penney is very concerned that she will lose her health coverage—and her mental health coverage in particular—if she is unable to find a job or a volunteer position that meets her needs. She believes she could work part-time in an environment that is not stressful. But, so far, she has not found this kind of work.

254. Ms. Penney also worries that she will be locked out of Medicaid for six months if she cannot timely report changes in her income and work hours or complete the annual redetermination process.

255. Under the waiver, Ms. Penney will be required to pay a monthly premium of $1. It will be hard for her to pay the premium given that she does not have a job and must rely on others to pay some of her expenses. She will try to pay the premium but will be able to do so only by letting other bills go unpaid or by relying on others to help her. If Ms. Penney does not pay the premium, she will have to pay copayments for certain services, her *My Rewards* account will be suspended, and money will be taken from the account.

256. The *My Rewards* account is the only way Plaintiff Penney can afford to get vision and dental care. She worries that she will not be able to earn enough money in her account to pay for glasses or the extraction of her broken tooth.

257. Ms. Penney is also concerned that if she has to use the emergency room for a reason the state Medicaid agency considers a non-emergency, the agency will deduct funds from her *My Rewards* account. In the past, she has had to use the emergency room to address mental health issues.

258. When Kentucky first proposed the Kentucky HEALTH project, Ms. Penney submitted comments opposing many aspects of the project, including the work requirement. If she had known about the SMD Letter and that it would allow states to start conditioning her health insurance coverage on a work requirement, she would have wanted to weigh in with the federal government.

259. **Plaintiff Linda Keith** is 63 years old and lives alone in Lexington, Kentucky. She is divorced and has one adult daughter.

260. Ms. Keith works as a cashier at a supermarket. In the past, she worked as a cleaner and later a cashier at Cracker Barrel restaurant. Currently, she makes approximately $1,371 per

month from her job. Her annual income is roughly $16,448, which is 135% of FPL for a household of one ($12,140).

261. Ms. Keith has been enrolled in Medicaid since 2014, when her daughter helped her enroll online. Before enrolling in Medicaid, Ms. Keith had no health insurance for several years because she could not afford coverage and went roughly two years without seeing a doctor. During that time, her thyroid condition dangerously deteriorated. She took herbs to try to treat her thyroid condition, but they made things worse, and Ms. Keith developed a tumor. Without her thyroid medication, Ms. Keith was depressed, tired, and did not think clearly, which made it very difficult for her to work.

262. There were also instances before Ms. Keith enrolled in Medicaid where she had no choice but to go to the doctor and as a result, incurred medical bills, which she had to pay in $50 monthly payments for two years. Making the payments was very difficult given her limited income.

263. Ms. Keith has several medical conditions that require ongoing treatment and care covered by Medicaid, including a thyroid condition, which has improved with medication; kidney stones; a cyst in her kidney; arthritis in her hands; and rectal bleeding. She also wears glasses and bifocals, has cataracts, and has age-related macular degeneration that could lead to blindness and requires routine dental care.

264. Last year, when she felt very sick and could not even stand up, Ms. Keith went to the emergency room, where she was diagnosed with vertigo. Ms. Keith also uses Medicaid to get annual check-ups.

265. Ms. Keith believes that if she had not enrolled in Medicaid to cover her hospital visits and tests, she would have accumulated significant medical debt and would have even lost

her life. Without Medicaid, she would not be able to afford her medication and treatment and as a result, would not be able to work.

266. The Medicaid agency sent Ms. Keith a notice dated June 9, 2018, indicating that she will be subject to the work requirement. While she is currently working 80 hours per month, Ms. Keith is concerned that she cannot maintain her current schedule for much longer without significantly compromising her health. She leaves work at 1:00 am, gets between four and six hours of restless sleep each night, and then gets up to help care for her grandchildren. This schedule is very hard on her body and makes it difficult for her to keep her health problems, particularly her vertigo and thyroid condition, under control. As a result, Ms. Keith is considering retiring next year, but is very concerned that she would lose her Medicaid coverage if she did so.

267. Ms. Keith is also concerned that she will lose coverage and be locked out of the program if she does not report her monthly hours or any change of income by the deadline, or recertify her eligibility on time. Her Medicaid notices often arrive late in the mail, causing a delay in her recertification.

268. The June notice also indicated that Ms. Keith will have to pay a monthly premium of $8. Because her household income is now roughly 135% of FPL, she will have to pay $15 every month, which will be difficult for her to afford. If she is not able to pay the premium, she will lose her Medicaid coverage and be locked out of the program for up to 6 months.

269. If Ms. Keith loses coverage and then reapplies, she worries about incurring additional medical bills during the periods of non-coverage because of the elimination of retroactive coverage under the waiver.

270. Ms. Keith fears she will be unable to earn sufficient money in her *My Rewards* account, on which she will depend for vision and dental care. She is also concerned that money

from the account will be deducted as a penalty for emergency room visits, given her past use of the emergency room for an ongoing vertigo condition that she considered, but that Medicaid may not consider, an emergency.

271. If Ms. Keith had known about the SMD Letter and that it would allow states to impose a work requirement on individuals in Medicaid, she would have sent a letter to the federal government opposing that policy.

272. **Plaintiff Debra Wittig** is 62 years old and lives alone in Frankfort, Franklin County, Kentucky. She is a widow and has two grown children and seven grandchildren.

273. For much of her adult life, Ms. Wittig worked full-time as a cardiovascular technician and in other health field jobs. In 1994, her career fell apart due, in part, to her health problems. Since that time, she briefly worked in a factory and in fast food restaurants.

274. Currently, Ms. Wittig works between 12 and 14 hours per week as a cashier at a fast food restaurant, where she makes approximately $541 per month. Ms. Wittig also receives Social Security benefits of $624 per month. Her annual income is roughly $13,988—115% of FPL for a household of one ($12,140).

275. Ms. Wittig first enrolled in Medicaid in 2014 in-person at her county office. She also goes there to recertify her eligibility. She has tried to renew her coverage over the phone but found the process frustrating and time-consuming.

276. Before enrolling in Medicaid, Ms. Wittig lived without health insurance for twenty years. During that time, her untreated health problems became so severe and debilitating that she had to use a walker, could not walk up and down stairs, and was often bound to her bed due to arthritis and migraines. The lack of treatment contributed to an attempted suicide in 1995 or 1996, and two additional attempts after 2008.

277. When Ms. Wittig periodically went to the doctor and emergency room when she was not insured, she was left with at least $36,000 of medical debt. It has been difficult for her to pay these bills because she has had to spend most of her income on living expenses and she no longer has any savings.

278. Ms. Wittig has several ongoing medical conditions that require monitoring and treatment that Medicaid covers. She has had skin cancer and migraines and currently has rheumatoid arthritis, psoriatic arthritis, osteoarthritis, degenerative spinal disease, gout, and colitis, as well as several mental-health conditions, including manic depression, anxiety, and insomnia. To treat her health conditions, Ms. Wittig sees a primary care doctor, rheumatologist, ophthalmologist, and dermatologist and currently takes ten prescription medications. Ms. Wittig also wears glasses; needs an annual eye examination because of the medications she takes; and recently underwent cataract surgery on both eyes. Medicaid also covers all of her medications, as well as her annual check-ups and other preventive services.

279. Ms. Wittig credits Medicaid with helping her to function, relieve her pain, work, and live a closer-to-normal life. Without Medicaid coverage, Ms. Wittig would not be healthy enough to work and to support herself and worries that she would again attempt suicide.

280. Ms. Wittig received a notice from the Medicaid agency, dated June 9, 2018, telling her that she will be required to work 80 hours every month to keep her coverage. She is very concerned she will lose coverage due to her inability to meet the work requirement because the restaurant where she works only gives her 12 to 14 hours every week. Moreover, the last time that Ms. Wittig worked even just 20 hours a week, she had to increase her pain medication and sleep.

281. Additionally, Ms. Wittig worries that she will be locked out of coverage if she does not timely report any change in income or recertify her eligibility, which will also cause her to lose Medicaid coverage.

282. The notice also indicated that Ms. Wittig will have to pay a $15 premium. She did not pay her premium for July 2018 and received a notice telling her the premium was overdue. Ms. Wittig worries that if she is unable to pay the premium, she will lose coverage and be locked out of the Medicaid program for up to six months.

283. Ms. Wittig is concerned that she will not be able to earn enough money in her *My Rewards* account to pay for necessary vision and dental services, including the root canal she currently needs.

284. In addition, the elimination of NEMT poses problems for Ms. Wittig. She has frequently used NEMT, which allowed her to access life-saving services. Although she recently bought a used car, it is a 2003 model that needs significant repair. If her car breaks down, she will not have reliable transportation to her medical appointments.

285. **Plaintiff Hunter Malone** is 21 years old and lives alone in Berea, Madison County, Kentucky.

286. Mr. Malone is a full-time student at Berea College. He works approximately 15 hours per week at the College's Center for Excellence and Learning through Service and another five hours per week at a second job. He currently earns about $350 per month, or $4,200 per year—35% of FPL for a single person ($12,140), although his income varies each semester.

287. Mr. Malone enrolled in Medicaid in 2016. He needs Medicaid for health care because he cannot afford private insurance due to his low income.

288. Medicaid has allowed Mr. Malone to stay in school and keep working. Medicaid covers his prescription medications, including an anti-depressant to treat his mental health conditions and an HIV antiviral to lower his risk of contracting HIV.

289. In 2018, Mr. Malone temporarily lost his Medicaid coverage. He could not afford to pay the $3,000 out-of-pocket cost for a one-month supply of his medications, so he stopped taking them. During this time, he struggled at school and was forced to take a week off from work due to health issues he experienced from not taking his medications. Without Medicaid coverage, he would be forced to drop out of school and work full-time to afford private health insurance to pay for health care and medications.

290. Mr. Malone worries that he will not be able to keep track of, and satisfy, changing eligibility requirements under Kentucky HEALTH and will therefore lose Medicaid coverage. Every time he sees a notice in the mail that looks like it concerns Medicaid, he worries if this will be day he must choose between staying in school or surviving. He also worries his fears associated with this project will have long-term effects on him.

291. Mr. Malone is concerned about the reporting and recertification requirements under Kentucky HEALTH. He worries the agency may not receive, or file with his account, the income or employment reports he submits. He also finds the notices and mailings he receives from the state Medicaid agency confusing. When he has called the Medicaid agency for clarification, staff members have told him to disregard the notices as “spam.” For these reasons, he fears that he will be locked out of Medicaid for failure to recertify or report changes in his income by the deadline.

292. If he loses coverage and later reapplies, he could incur uncovered medical bills or go without treatment, as he previously did, due the elimination of retroactive coverage under the project.

293. Mr. Malone received a notice that he will be required to pay a premium of $1 per month under Kentucky HEALTH. Paying the premium will be difficult for him, given his limited income. He is concerned he will not be able to afford stamps to mail in the payment, but he will make every effort to prioritize paying the premium because paying it is the only way Mr. Malone can afford his medications.

294. **Plaintiff Althea Humber** is 56 years old and lives with an unrelated roommate in Lexington, Fayette County, Kentucky. She is a widow and has three adult children.

295. Ms. Humber is currently unemployed. She left her housekeeping job in April 2018 due to illness. Before that, she worked as a custodian at Kentucky Utilities.

296. Ms. Humber has no income. One of her adult daughters, who is autistic and has PTSD, receives Social Security Disability income of $770 per month. Ms. Humber claims her daughter on her taxes, so for Medicaid purposes, Ms. Humber's annual household income is $9,240—76% of FPL for a family of two ($12,140). However, Ms. Humber reserves that money for her daughter.

297. In 2014, Ms. Humber enrolled in Medicaid at the health department. Since then, she has renewed her Medicaid enrollment with help from an application assister who comes to a shelter near her apartment twice monthly.

298. Ms. Humber has medical conditions that must be monitored and treated. She has chronic anemia and osteoarthritis, for which she sees a medical specialist and takes multiple

prescription drugs. Medicaid has covered these services in the past, as well as her annual check-ups. She also needs to have a cavity filled and a rotten tooth extracted.

299. Before enrolling in Medicaid, Ms. Humber could not afford to purchase health insurance. While uninsured, she often avoided seeking the medical care she needed. In 2012, she spent 2.5 days in the hospital receiving a blood transfusion for anemia. She currently owes more than $10,000 in medical bills, paying it off as she can. She paid at least $90 this year.

300. On June 9, 2018, the Medicaid agency sent Ms. Humber a notice indicating she will be subject to the work requirements under the Kentucky HEALTH waiver. Ms. Humber worries that she will not be able to satisfy the 80-hour requirement. She has worked and applied for multiple jobs this year but has trouble finding and keeping a job. She does not have internet access and must walk, take the bus, or use a daytime homeless shelter van for transportation. Therefore, it would be difficult for her to get to many volunteer and community service opportunities.

301. Ms. Humber is also concerned that she will be locked out of Medicaid if she doesn't recertify or report her work hours and changes in income by the deadline. Because she doesn't have internet access or a car, it will be more difficult for her to satisfy these reporting requirements. Additionally, her Medicaid notices often arrive late in the mail, preventing her from timely recertifying.

302. The June 9 notice also indicated that Ms. Humber must pay a monthly premium of $8. She did not pay her July 2018 premium, and because she has no income, it will be difficult for her to pay the premium in the future. If she is unable to pay, she will have to pay copayments for certain services, her *My Rewards* account will be suspended, and funds will be deducted from the account.

303. Ms. Humber needs access to her *My Rewards* account to pay for vision and dental care. She worries that the she will not be able to accumulate enough money in the account to pay for vision and dental services as well as over-the-counter medications.

304. Ms. Humber has gone to the emergency room twice since 2017. The first time, she thought she might be experiencing a heart attack. The second time, she was diagnosed with pneumonia and was prescribed multiple medications and referred to a specialist. The pneumonia kept her from working for several weeks. Ms. Humber is concerned that she could have another medical issue that might seem like an emergency to her, but that the Medicaid agency will consider a non-emergency. The resulting deduction from her *My Rewards* account will make it even less likely that she will have enough money to cover her vision and dental care.

305. Had Ms. Humber known about the SMD Letter and that it allowed states to condition health insurance coverage on work, she would have submitted a comment opposing the work requirement.

306. **Plaintiff Randall Yates**, who is 48 years old, lives in Martin, Floyd County, Kentucky.

307. Mr. Yates has not been able to consistently work. In the past, Mr. Yates has worked as a roofer and as a miner, when the mine companies in his area were still operating. More recently, to make ends meet, Mr. Yates has worked as a caretaker for the elderly and as a home health care worker, as well as completed odd-jobs, such as changing locks.

308. Mr. Yates receives Social Security benefits of $750 per month. His annual income is below 100% of the federal poverty line.

309. Mr. Yates first enrolled in Medicaid in 2015. Before enrolling in Medicaid, he did not have any health insurance.

310. Mr. Yates has ongoing health issues that require medicine for high blood pressure and damage to his nerves. Medicaid has also enabled Mr. Yates to get a knee replacement.

311. Without Medicaid, Mr. Yates would not be able to afford his nerve and blood pressure medications. He worries his blood pressure would rise and as a result, that he would have a stroke.

312. Mr. Yates will be subject to work requirements under the Kentucky HEALTH waiver. However, he risks losing his health coverage under Kentucky HEALTH due to his inability to consistently locate and maintain employment of 80 hours per month.

313. Mr. Yates also risks loss of coverage because it will be difficult for him to meet the reporting requirements and recertify his eligibility by the deadline. He does not own a telephone, have access to the internet, or know how to use a computer. Mr. Yates also has missed Medicaid notices in the past because he has not been able to retrieve his mail and has had trouble updating his address since he moved to a new address three months ago.

314. Mr. Yates also worries about his inability to pay any premiums because of his limited income. He does not have any additional money to spend to comply with the waiver, not even $1.

315. Under the Kentucky HEALTH project, Mr. Yates will have a *My Rewards* account. Earning money in the account will be the only way he will be able to pay for routine vision and dental care. If he is unable to pay his premium for 60 days, however, he will be required to pay copayments for certain services, his *My Rewards* account will be suspended, and money will be taken from the account.

316. Because Mr. Yates does not own or have access to an automobile or transportation, he has used NEMT to travel to and from his doctor's appointments in Lexington and Louisville,

as well as locally. Accordingly, he worries about the elimination of NEMT under the Kentucky HEALTH waiver because without NEMT, he would not be able to go to the doctor.

317. **Plaintiff Diika:néhi Segovia** is 21 years old and lives with an unrelated housemate in Lexington, Fayette County, Kentucky.

318. Mx. Segovia was enrolled as a full-time student at the University of Kentucky prior to September 2018 but is not enrolled this semester due to trouble securing funding.

319. Mx. Segovia works 30 hours per week as a barista at a local coffee shop. Before that job, they worked 10 to 15 hours per week as a social media manager and studio assistant for an artist. They have also worked as a cashier at a local grocery store.

320. Mx. Segovia makes approximately $867 per month at the coffee shop. Their annual income is approximately $10,400, which is 86% of FPL for a household of one ($12,140).

321. Mx. Segovia has ongoing medical conditions that need to be treated. They have chronic pain in the rib, back, jaw, and hip; epilepsy; borderline personality disorder; C-PTSD: and major depressive disorder. They also have dyslexia, which includes auditory processing disorders. Mx. Segovia sees a chiropractor, therapist, and psychiatrist regularly. They take medications, including Effexor as a mood stabilizer and anti-convulsant, Prozosin for C-PTSD, and Neoproxin for chronic pain. Medicaid covers all of these services and medications.

322. Mx. Segovia enrolled in Medicaid in 2017 with the help of a certified application counselor. They could not enroll online on their own because benefind rejected their login information and the online application was generally confusing.

323. Before enrolling in Medicaid, Mx. Segovia was uninsured and did not get the medical care that they needed. As a result, they often self-medicated with drugs and had no control or hope. Medicaid coverage has allowed them to work on years of trauma and unnecessary coping

behaviors and to start working to fix their body pain. Now, Mx. Segovia is productive, putting energy into what they love in their life.

324. On June 9, 2018, the Medicaid agency sent Mx. Segovia a notice that, under the waiver, they will not have work requirements. This exception to work requirements is presumably a result of their being a student. Because Mx. Segovia is no longer enrolled in school, they worry that they will be required to work 80 hours a month under the waiver. If they cannot meet this requirement, they will be terminated from Medicaid. Although they usually work 30 hours per week, some days their physical pain and mental illness prevents them from working or being physically active.

325. Mx. Segovia is concerned that they will lose coverage and be locked out of Medicaid if they fail to report income changes by the deadline or recertify on time. Mx. Segovia missed their last recertification deadline in 2018 because the notice from the Medicaid agency arrived late in the mail. They did not realize they missed the deadline until their psychiatrist alerted them that they had lost coverage. While they were re-enrolling in Medicaid, they had to postpone a psychiatrist appointment and were unable to refill their medications. They worry that if they lose coverage again and then reapply, they will have to pay for any care that they receive in the interim, given the waiver's elimination of retroactive coverage.

326. The June 9 notice indicated the Mx. Segovia will have to pay a monthly premium of $4. Mx. Segovia expects the premium to increase to $8, based on their current income. While they can afford the premium during stable times, re-enrolling in school will reduce their work hours and income and likely diminish their ability to pay the premium. If Mx. Segovia does not pay the premium, they will have to pay copayments for certain services, their *My Rewards* account will be suspended, and money will be taken from the account.

327. Mx. Segovia will depend on their *My Rewards* account for routine vision and dental care, as well as over-the-counter medications. They worry that they will be unable to accumulate enough money in their account to pay for those services.

328. Had Plaintiff Segovia been aware of the SMD Letter and that it would allow Kentucky to start conditioning their Medicaid coverage on work, they would have sent a letter to the federal government opposing that policy.

329. **Plaintiff Robin Ritter** is 54 years old and lives in Waddy, Shelby County, Kentucky, with her husband, Stephen, and their 13-year-old daughter and 18-year-old grandson.

330. Mrs. Ritter is the primary caregiver for her daughter, who suffers from neurological and physical challenges and learning disabilities, and for Mr. Ritter, who has back and other medical conditions that restrict or slow his mobility.

331. Both Mrs. and Mr. Ritter are unemployed. Their sole source of income is the $1,715 in Social Security income that Mr. Ritter receives each month for disability due to a recent knee surgery. Their annual household income is about $20,580, which is 82% of the FPL for a family of four ($25,100).

332. The Ritters have been enrolled in Medicaid since 2014.

333. Before Mrs. Ritter enrolled in Medicaid, Mrs. Ritter had health insurance through Mr. Ritter's employer over a decade ago. Even with private insurance, however, the Ritters incurred significant medical debt due to a high deductible for hospital and doctors' visits that they could not afford. As a result, a collection agency attempted to garnish their wages, and the Ritters were forced to file for bankruptcy. Shortly thereafter, Mr. Ritter's employer stopped offering health insurance.

334. Between the time when they lost private insurance and when they enrolled in Medicaid, the Ritters avoided seeing a doctor for their health conditions because they lacked health insurance or any other way to pay for medical care.

335. The Ritters temporarily lost coverage in 2015 and 2016 due to clerical and technological issues with the state Medicaid program. During the 2016 period of coverage loss, the clinic they visited could not provide Mrs. Ritter all of the services she required, including x-rays, because the Ritters did not have insurance to pay for them.

336. Mrs. Ritter suffers from seizures, irritable bowel syndrome, high blood pressure and cholesterol, migraines, back problems, and chronic fever blisters—all of which she treats through medications covered by Medicaid. Medicaid also enables Mrs. Ritter to see a neurologist as needed and a gynecologist yearly; receive weekly physical therapy and annual checkups; and receive vision care, including her bifocals and eye implants.

337. In recent years, Medicaid has also covered Mrs. Ritter's hernia surgery and numerous medical tests, including an EEG, a CAT scan, and an MRI, as well as an emergency room visits for a migraine she suffered.

338. Mrs. Ritter's ability to access health care through Medicaid is a matter of life and death: without it, she cannot see a doctor or receive her life-saving medications and fears she would either die or be left disabled.

339. The state Medicaid agency recently sent the Ritters two notices—one dated June 9, 2018, and a second dated July 1, 2018—both of which indicated that Mrs. Ritter will be required to work 80 hours each month to maintain her Medicaid eligibility.

340. Mrs. Ritter fears she will not be able to comply with the work requirements due to her medical conditions and caretaking responsibilities for her family that prevent her from working

80 hours. Mrs. Ritter also would find it difficult to afford gas to pay for unpaid volunteer or community service. Thus, Mrs. Ritter fears losing Medicaid coverage and being locked out of the program for up to six months.

341. In addition, Mrs. Ritter is concerned that she will be locked out of the program if she cannot timely complete the redetermination process by the deadline, considering her previous difficulties in recertifying by phone and her inability to use a computer to recertify through the internet. When Mrs. Ritter tried to renew her Medicaid coverage over the telephone in previous years, she experienced difficulties, including 4- to 5-hour waits, disconnections, and lack of callbacks from Medicaid, and she has never attempted to renew over the internet because she does not understand how to use computers. She also fears losing coverage if she does not timely report any changes in income or work by the deadline.

342. Mrs. Ritter will have a *My Rewards* account under the Kentucky HEALTH waiver. Earning money in the account will be the only way she will be able to pay for necessary vision and routine dental care. She worries, however, that she will not have sufficient money in her *My Rewards* account to pay for such care.

343. The June 9, 2018 notice also indicated that she must pay an $8 premium. But if Mrs. Ritter is unable to pay her premium for 60 days—which she expects to occur due to her household's limited income—she will be required to pay copayments for certain services; her *My Rewards* account will be suspended for six months; and money will be deducted from the account.

344. Mrs. Ritter is also concerned that if she has to go to the emergency room—as she has had to in the past for her and her grandson's medical needs—and Medicaid does not think she needs emergency treatment, Medicaid will deduct money from her *My Rewards* account, reducing the available funds in her account to pay for dental and vision care.

345. Had Mrs. Ritter known about the SMD Letter and that it would allow states to start conditioning her health insurance coverage on a work requirement, she would have sent a letter to the federal government opposing that policy.

346. **Plaintiff Sarah Martin** is 35 years old and lives in Covington, Kenton County, Kentucky.

347. In January 2014, Ms. Martin left her long-time job as a department supervisor at a supermarket to seek different career opportunities. In the spring of 2017, she returned to school to study information technology. She is currently a part-time student at Northern Kentucky University. Depending on class availability, she fluctuates between part-time and full-time enrollment.

348. Ms. Martin has no annual income—0% FPL for a family of one.

349. Ms. Martin reenrolled in Medicaid in the summer of 2017, when she returned to school. A kynector assisted Ms. Martin each time she enrolled.

350. Ms. Martin is concerned that she will not be able to meet the Kentucky HEALTH work requirements without changing her school schedule and potentially delaying graduation. Working twenty hours per week is not feasible for her, as this burden would force her to lighten her course load, cut back on study time, and jeopardize her place on the college's Scholar's List.

351. Additionally, Ms. Martin fears that her health insurance will be terminated if she is unable to meet the waiver's reporting requirements.

352. On June 14, 2018, Ms. Martin was sent and paid a health insurance premium bill of $1.00. She has not received any additional notice or explanation about the premium.

353. **Plaintiff Teri Blanton** is 61 years old and lives alone in Berea, Madison County, Kentucky.

354. Ms. Blanton began working part-time at a convenience store in October 2018, earning approximately $175 that month. Because her pain level has increased dramatically while working, she knows that she will eventually have to quit. Seven years ago, she had to quit her job at Kentuckians for the Commonwealth to have surgery and has not been able to maintain employment since then.

355. Before enrolling in Medicaid in 2014, Ms. Blanton could not afford private health insurance. She had employer-based insurance for a brief period while working at Kentuckians for the Commonwealth.

356. Ms. Blanton has several medical conditions that require treatment and monitoring. She has fibromyalgia, degenerative disc disease, Irritable Bowel Syndrome, and Crohn's disease. Medicaid coverage gives Ms. Blanton the stability to attempt to work. Without her medications, she would not be able to leave the house for periods long enough to even consider working. Still, these health issues prevented Ms. Blanton from maintaining steady work over the past seven years and make long-term employment at the convenience store unlikely.

357. Ms. Blanton received a notice indicating that she must pay a monthly premium of $1 under the Kentucky HEALTH waiver. At the time, she did not have a source of income, and paying the premium would have been very difficult for her. Even with her current job with a monthly income of $175, a $1 premium will be a burden.

358. Ms. Blanton worries that she will not be able to keep track of the changing Medicaid reporting requirements. She has always had difficulty updating her Medicaid account information, and the more stringent reporting requirements under the waiver will add stress to her life. Her health conditions are exacerbated by stress, and her ability to work depends on maintaining low levels of stress. Even thinking about the new reporting requirements causes Ms. Blanton significant

stress. Because that stress manifests as physical pain due to her fibromyalgia and Crohn's disease, she fears that the reporting requirements will prevent her from working.

359. **Plaintiff Rodney Lee** is 50 years old and lives alone in Lexington, Fayette County, Kentucky.

360. Mr. Lee is currently homeless and does not have a home address. He also does not have a car or internet access and must walk or take the bus.

361. Mr. Lee works 20 hours per week as a greeter with the Lexington-Fayette County Urban Government. He also volunteers with New Life Day Shelter. Previously, Mr. Lee worked construction jobs through a temp service and helped move furniture for a rescue mission on an as-needed basis.

362. Mr. Lee earns approximately $867 per month and $10,400 per year, which is 86% of the FPL for a family of one ($12,140).

363. Mr. Lee enrolled in Medicaid in January 2014 through kynect with assistance from staff at the New Life Day Shelter. Before enrolling, he had no health insurance options for several years; could not afford medical care, including check-ups with the doctor; and would self-diagnose any illnesses.

364. Medicaid enables Mr. Lee to stay healthy by accessing a range of health care services, including medications, vaccinations, and routine medical and dental appointments. For example, Medicaid covered Mr. Lee's visit to the emergency room in May 2017, when he was suffering from a sinus infection and walking pneumonia. The emergency room was the only place he could access care on the weekend. Medicaid also pays for the glasses Mr. Lee requires for his farsightedness. Without Medicaid, it would be difficult for Mr. Lee to afford health care, and he would no longer seek care from a doctor.

365. On June 13, 2018, and June 26, 2018, the Medicaid agency sent Mr. Lee notices that he will have a $1 premium and he will be required to work 80 hours a month, which he must report by a designated deadline.

366. Because Mr. Lee does not have a car, internet access, or a home address, he worries that he will not be able to with timely reporting his monthly hours or recertify his eligibility on time and will be locked out of Medicaid. Mr. Lee lost Medicaid coverage briefly in 2016 and again for six months beginning in November 2017 because he was unable to timely submit verification documents.

367. If Mr. Lee again loses coverage and then reapplies, any medical bills he incurs while uninsured will not be covered due to the waiver's elimination of retroactive coverage.

368. Mr. Lee will have a *My Rewards* account under the Kentucky HEALTH waiver. Earning money in the account will be the only way he will be able to pay for routine vision and dental care, including checks ups, exams, X-rays, and his glasses. He worries, however, that he will not have sufficient money in the account to pay for such care under the waiver.

369. In addition, if Mr. Lee is unable to pay the premium, he will have to pay copayments for certain services; his *My Rewards* account will be suspended; and money will be taken from the account.

370. Mr. Lee is also concerned that he will have to go to the emergency room again for something like a sinus infection—which he has done before, and which he believes was an emergency in that instance. He fears that if Medicaid does not think he needs emergency treatment, Medicaid will deduct money from his *My Rewards* account, reducing the available funds to pay for dental and vision care.

371. While Mr. Lee may be able to meet the work requirement, had he known about the SMD letter and the work policy it announced, he would have sent a letter to the federal government opposing the policy.

**COUNT ONE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (DEAR STATE MEDICAID DIRECTOR LETTER)**

372. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

373. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

374. In issuing the Dear State Medicaid Director Letter, the Federal Defendants purported to act pursuant to Section 1115 of the Medicaid Act.

375. Authorization of work and community engagement requirements is categorically outside the scope of the Secretary's Section 1115 waiver authority.

376. The Dear State Medicaid Director Letter was required to be, but was not, issued through notice and comment rulemaking.

377. In the Dear State Medicaid Director Letter, the Federal Defendants relied on factors which Congress has not intended them to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for their decision that runs counter to the evidence.

378. The Federal Defendants' issuance of the Dear State Medicaid Director Letter exceeded the Secretary's Section 1115 waiver authority; otherwise violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

**COUNT TWO: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (WORK REQUIREMENTS)**

379. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

380. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

381. In approving the work and community engagement requirements of Kentucky HEALTH, the Secretary purported to waive 42 U.S.C. § 1396a(a)(8) and (a)(10) pursuant to Section 1115.

382. Authorization of work and community engagement requirements is categorically outside the scope of the Secretary's Section 1115 waiver authority.

383. In addition, Kentucky HEALTH's work and community engagement requirements are not an experimental, pilot, or demonstration project, nor are they likely to promote the objectives of the Medicaid Act.

384. In approving the Kentucky HEALTH work and community engagement requirements, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

385. The Secretary's decision to approve Kentucky HEALTH's work and community engagement requirements exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

**COUNT THREE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (PREMIUM REQUIREMENTS)**

386. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

387. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

388. In approving Kentucky HEALTH's premium requirements and its associated delays in coverage, penalties, and lock-out provisions, the Secretary purported to waive 42 U.S.C. § 1396a(a)(10)(B), (a)(17), and (a)(14) (insofar as it incorporates Sections 1396*o* and 1396*o*-1) pursuant to Section 1115.

389. Authorization of premium requirements, or penalties for not satisfying such requirements, is categorically outside the scope of the Secretary's Section 1115 waiver authority.

390. In addition, Kentucky HEALTH's premium requirements and associated penalties are not an experimental, pilot, or demonstration project, nor are they likely to promote the objectives of the Medicaid Act.

391. In approving the Kentucky HEALTH premium requirements, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several

important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

392. The Secretary's decision to approve Kentucky HEALTH's premium requirements and associated penalties exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

**COUNT FOUR: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (COST-SHARING FOR NON-EMERGENCY USE OF EMERGENCY ROOM)**

393. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

394. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

395. Authorization of heightened cost sharing for non-emergency use of the emergency room is categorically outside the scope of the Secretary's Section 1115 waiver authority.

396. Kentucky HEALTH's imposition of heightened cost sharing for non-emergency use of the emergency room is not an experimental, pilot, or demonstration project, nor is it likely to promote the objectives of the Medicaid Act.

397. In approving the Kentucky HEALTH heightened cost sharing for non-emergency use of the emergency room, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

398. The Secretary's decision to allow Kentucky HEALTH's imposition of heightened cost-sharing for non-emergency use of the emergency room violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

**COUNT FIVE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (LOCKOUT PENALTIES)**

399. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

400. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

401. In approving Kentucky HEALTH's imposition of lockout penalties, the Secretary purported to waive the requirements of 42 U.S.C. § 1396a(a)(8), (a)(10), and (a)(52), pursuant to Section 1115.

402. Kentucky HEALTH's imposition of lockout penalties is not an experimental, pilot, or demonstration project, nor is it likely to promote the objectives of the Medicaid Act.

403. In approving the Kentucky HEALTH lockout penalties, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

404. The Secretary's decision to approve Kentucky HEALTH's imposition of lockout penalties exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

## COUNT SIX: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (RETROACTIVE COVERAGE)

405. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

406. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

407. In approving Kentucky HEALTH's refusal to provide the retroactive coverage required by the Medicaid Act, the Secretary purported to waive 42 U.S.C. §§ 1396a(a)(34) and 1396a(a)(10) pursuant to Section 1115.

408. Authorization of refusal to provide the retroactive coverage required by the Medicaid Act is categorically outside the scope of the Secretary's Section 1115 waiver authority.

409. In addition, Kentucky HEALTH's refusal to provide such retroactive coverage is not an experimental, pilot, or demonstration project, nor is it likely to promote the objectives of the Medicaid Act.

410. In approving the Kentucky HEALTH refusal to provide the retroactive covered required by the Medicaid Act, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

411. The Secretary's decision to approve Kentucky HEALTH's refusal to provide the retroactive coverage required by the Medicaid Act exceeded his Section 1115 waiver authority;

otherwise violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

**COUNT SEVEN: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (NON-EMERGENCY MEDICAL TRANSPORTATION)**

412. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

413. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

414. In approving Kentucky HEALTH's withdrawal of non-emergency medical transportation benefits from the expansion population (other than for "medically frail" individuals), the Secretary purported to waive 42 U.S.C. § 1396a(a)(4) insofar as it incorporates 42 C.F.R. § 431.53 pursuant to Section 1115.

415. Kentucky HEALTH's withdrawal of non-emergency medical transportation benefits from the expansion population is not an experimental, pilot, or demonstration project, nor is it likely to promote the objectives of the Medicaid Act.

416. In approving the Kentucky HEALTH withdrawal of non-emergency medical transportation benefits from the expansion population, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

417. The Secretary's decision to approve Kentucky HEALTH's withdrawal of non-emergency medical transportation benefits from the expansion population exceeded his Section

1115 waiver authority; otherwise violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

**COUNT EIGHT: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (KENTUCKY HEALTH PROJECT AS A WHOLE)**

418. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

419. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

420. In approving the Kentucky HEALTH project, the Secretary purported to waive various requirements of the Medicaid Act, pursuant to Section 1115.

421. The Kentucky HEALTH project is not an experimental, pilot, or demonstration project, nor is it likely to promote the objectives of the Medicaid Act.

422. In approving the Kentucky HEALTH project, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

423. The Secretary's decision to approve Kentucky HEALTH exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; was arbitrary and capricious and an abuse of discretion; and ran counter to the evidence in the record.

**COUNT NINE: VIOLATION OF THE TAKE CARE CLAUSE, ARTICLE II, SECTION 3, CLAUSE 5**

424. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

425. Plaintiffs have a non-statutory right of action to enjoin and declare unlawful official action that is ultra vires.

426. The United States Constitution provides that "All legislative Powers herein granted shall be vested in a Congress of the United States." U.S. Const., art. I, § 1. Congress is authorized to "make all laws which shall be necessary and proper for carrying into Execution" its general powers. *Id.* §§ 1, 8.

427. After a federal law is duly enacted, the President has a constitutional duty to "take Care that the Laws be faithfully executed." *Id.* art. II, § 3.

428. The Take Care Clause is judicially enforceable against presidential action that undermines statutes enacted by Congress and signed into law. *See, e.g.*, *Angelus Milling Co. v. Comm'r*, 325 U.S. 293, 296 (1945) ("Insofar as Congress has made explicit statutory requirements, they must be observed and are beyond the dispensing power of [the Executive Branch]."); *Kendall v. United States ex rel. Stokes*, 37 U.S. (12 Pet.) 524, 612-13 (1838).

429. The Take Care Clause limits the President's power and ensures that he will faithfully execute the laws that Congress has passed.

430. Under the Constitution, the President lacks the authority to rewrite congressional statutes or to direct federal officers or agencies to effectively amend the statutes he is constitutionally required to execute.

431. In implementing Kentucky HEALTH, the State has sought to "comprehensively transform Medicaid."

432. The Director of CMS has expressed the need to "fundamentally transform Medicaid."

433. The power to “transform” a congressional program is a legislative power vested in Congress. An effort to “transform” a statute outside that legislative process is at odds with the President’s duty to take care that the laws be faithfully executed.

434. The Medicaid population targeted by the waiver here is the so-called Medicaid “expansion population.” That population was added by Congress in the Affordable Care Act. The Executive Branch has repeatedly expressed its hostility to the Affordable Care Act and its desire to undermine its operation. An effort to undermine the Affordable Care Act by undoing the extension of Medicaid to the expansion population is at odds with the President’s duty to take care that the laws be faithfully executed.

435. The President’s Executive Order set out herein direct agencies to take action contrary to the ACA, Medicaid, and other laws passed by Congress.

436. The Federal Defendants’ actions, as described herein, followed that Executive Order.

437. The Federal Defendants’ actions, as described herein, seek to redefine the purposes and objectives of the Medicaid Act, including through the granting of the Kentucky HEALTH waiver, and represent a fundamental alteration of Medicaid.

438. The Federal Defendants’ actions, as described herein, seek to undermine the ACA, including its optional expansion of Medicaid, and represents a fundamental alteration to those statutes.

439. Accordingly, the Federal Defendants’ actions are in violation of the Take Care Clause and are ultra vires.

440. Plaintiffs will suffer irreparable injury if the Secretary's actions following the President's Executive Orders are not declared unlawful and unconstitutional because those actions have injured or will continue to harm Plaintiffs.

441. Plaintiffs are in danger of suffering irreparable harm and have no adequate remedy at law.

## PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully ask that this Court:

1. Certify this case as a class action pursuant to Federal Rule of Civil Procedure 23(a) and (b)(2);
2. Declare that Federal Defendants' issuance of the Dear State Medicaid Director Letter violates the Administrative Procedure Act, the Social Security Act, and the United States Constitution in the respects set forth above;
3. Declare that the Federal Defendants' re-approval of the Kentucky HEALTH waiver application violates the Administrative Procedure Act, the Social Security Act, and the United States Constitution in the respects set forth above;
4. Preliminarily and permanently enjoin the Federal Defendants from implementing the practices purportedly authorized by Dear State Medicaid Director Letter and the re-approval of the Kentucky HEALTH waiver application;
5. Award Plaintiffs their reasonable attorneys' fees and costs pursuant to 28 U.S.C. § 2412; and
6. Grant such other and further relief as may be just and proper.

January 14, 2019

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 14, 2019, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to all authorized CM/ECF filers in this case.

By: /s/ Jane Perkins
Jane Perkins