UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM, *et al.*, Plaintiffs, v. ALEX M. AZAR II, *et al.*, Defendants.	Civil Action No. 1:18-cv-01900 (JEB)

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BRIEF FOR DEANS, CHAIRS AND SCHOLARS AS *AMICI CURIAE*
IN SUPPORT OF PLAINTIFFS

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**Pro hac vice* motion pending

Date: November 7, 2018
Washington, D.C.

CORPORATE DISCLOSURE STATEMENT

Amici are individuals and as such do not have a parent company and no publicly held company has a 10% or greater ownership interest in any *amici*.

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INTEREST OF *AMICI CURIAE*

Pursuant to Local Civil Rule 7(o), *amici* have sought leave for filing the instant brief. *Amici* are researchers and academics who are experts in the fields of health law, health policy, health services research, and national health reform. They seek to inform the Court about the history of Section 1115 of the Social Security Act, the essential elements of Medicaid demonstration evaluation, the validity of the assumptions on which Defendants' actions rest, and the likely effects of permitting Defendants' actions to continue to take effect in Arkansas. Given the scope of Defendants' actions and that they have authorized or will authorize similar activities in other states, *amici* believe this case provides an appropriate vehicle for the Court to find that Defendants' actions are contrary to federal law.

No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party or any other person contributed money that was intended to fund preparing or submitting the brief.

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STATEMENT

The purpose of Medicaid is to provide medical assistance to people whose income and resources are insufficient to pay for the cost of necessary care. *See* 42 U.S.C. § 1396-1. The Patient Protection and Affordable Care Act of 2010 (the "ACA"), Pub. L. 111-148, extended medical assistance to "the entire nonelderly population with income below 133 percent of the poverty level." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012); *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (extending Medicaid coverage effective January 1, 2014 to the "expansion population"). States may choose not to cover the ACA expansion population. *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 587. However, as this Court has held, "if the state decides to provide coverage, those individuals become part of its mandatory population" and "the state must afford the expansion group 'full benefits' – i.e., it must provide 'medical assistance for all services covered under the State plan that are substantially equivalent 'in amount, duration, or scope …to the medical assistance available for [other] individual[s] covered under the Act.'" *Stewart v. Azar*, 313 F.Supp.3d 237, 244 (D.D.C. 2018) (*citing* 42 U.S.C. § 1396d(y)(2)(B), 42 C.F.R. § 433.204(a)(2), and *Jones v. T.H.*, 425 U.S. 986 (1976)).

Arkansas's Medicaid expansion began under auspicious circumstances in 2014. Utilizing his "demonstration authority" in Section 1115 of the Social Security Act ("SSA") ("Section 1115"), 42 U.S.C. § 1315, the Secretary of Health and Human Services ("HHS") authorized Arkansas (or the "State") to use Medicaid funds to pay premiums for "expansion" beneficiaries to enroll in qualified health plans in the private marketplace instead of enrolling them in the fee-for-service program available to "traditional" Medicaid populations. The demonstration, originally known as "Arkansas Health Care Independence Program (the "Private Option"), renamed "Arkansas Works," is expected to run through 2021. By 2017, enrollment of the State's

expansion population reached 280,000. *See* Arkansas Center for Health Improvement, *Arkansas Health Care Independence Program ("Private Option") Final Report* at i (June 30, 2018) (hereinafter "ACHI"). However, as discussed below, in 2018 the Secretary approved an amendment to Arkansas Works that will permit the State to exclude thousands of expansion beneficiaries from Medicaid, contrary to Medicaid's core objective.

On June 30, 2017, three and a half years after implementing its expansion, the State proposed to amend Arkansas Works to require certain expansion beneficiaries ages 19 through 49 to log 80 hours of employment or "community engagement" activities monthly. Those who fail to report that they satisfied the 80-hour requirement during any three months of the calendar year are locked out of coverage for the rest of the year and must reapply in the following year. Since the Medicaid statute contains no work or community engagement requirement, the Secretary relied on his Section 1115 authority to permit the State to disenroll Medicaid expansion beneficiaries who do not comply with the work requirement.

Even though it had nothing to do with the Private Option demonstration, other than to make newly eligible people ineligible, Arkansas submitted its proposed demonstration amendment to Defendants as a series of redlined revisions buried in the original Private Option Special Terms and Conditions ("STCs"). AR 2057-2100. The State simply pasted the work requirements into an existing, completely unrelated 1115 demonstration without providing the slightest evidence of a research design. It did not offer a single hypothesis for how a work requirement would affect the receipt of medical assistance under the Private Option or an estimate of the number of people who would be affected. Paradoxically, at the same time the State sought to add a work requirement, the State also proposed to eliminate part of the Private Option that permitted it to spend federal funding to help low income workers meet the cost of

available, but unaffordable, workplace health plans. The State offered absolutely no rationale for doing so at the very moment it proposed to push people off Medicaid and into the workplace. Forty individuals had received help under this provision. Kathleen Gifford et al., *States Focus on Quality and Outcomes Amid Waiver Changes*, KAISER FAMILY FOUNDATION at 13 (Oct. 2018) (Table 2). Finally, Arkansas also proposed, again without compelling justification, to limit the retroactivity of benefits (to new enrollees) from three months to one. AR 2061, 2072.

In January 2018, the Centers for Medicare and Medicaid Services ("CMS") issued a State Medical Directors Letter (the "SMDL"), inviting states to submit Medicaid "community engagement" "demonstration" proposals. *See* AR 74-83. Upending its long-standing position that mandatory Medicaid work requirements do not promote Medicaid objectives, CMS made this dramatic reversal of prior policy without the opportunity for notice and comment, and in the wake of the submission of work requirement proposals by states such as Arkansas. The letter also promoted other coverage restrictions such as premiums and "lock-out" periods that could bar coverage for months at a time. Two months later, despite federal regulations requiring not one but three rounds of notice and comment at state and federal levels, CMS approved the State's work requirements for expansion beneficiaries aged 19 through 49 as a condition of eligibility in the Medicaid program (the "Arkansas Works Approval"). AR 1-73. CMS also approved the use of an online reporting system and acquiesced to the State's request to eliminate financial help for low income workers unable to afford their workplace coverage. Defendants further agreed to an implementation date of June 1, 2018, allowing implementation to begin before the submission of an evaluation design for a momentous and completely untested Medicaid eligibility restriction.

Arkansas Works Approval reflected the bizarre logic of CMS' earlier SMDL letter: the purpose of depriving Medicaid beneficiaries of medical assistance is to improve their health. Defendants assert, without explanation or evidence, that Medicaid work requirements create "appropriate" incentives for beneficiaries to gain employment or help individuals and families attain or retain capability for independence or self-care. Defendants also assert, without evidence, that people subject to the work requirement will gain income and access to affordable private insurance coverage as a result. *See* AR 3, 6. However, Defendants cite no authority to support their assertion that part time work raises income and employer insurance prospects. In fact, all available data contradicts Defendants' assertion. For instance, in 2017, only 8.6 percent of Arkansas part-time employees were eligible for employer-sponsored insurance (5.2 percent in small firms). Emily M. Johnston et al., *Arkansans losing Medicaid due to work requirements are likely to face limited private insurance options*, THE URBAN INSTITUTE (Oct. 30, 2018). In short, Defendants failed to explain how jobs without health insurance promote Medicaid's purpose of providing medical assistance to individuals whose income and resources are insufficient to meet the cost of necessary medical care. *See* 42 U.S.C. § 1396-1.

Starting June 1, 2018, Arkansas implemented the work and reporting requirements, which were followed by the loss of benefits for those unable to demonstrate compliance. In its first five months, the demonstration has led to the disenrollment of thousands of beneficiaries for failure to certify their monthly 80 hours of work or "community engagement." Because no evaluation is in place, the underlying causes of this large-scale failure to demonstrate compliance are unknown. What is known is that, in September alone, 98.7 percent of individuals who failed to report 80 hours of work or other qualifying activities in fact reported no hours at all. However, there is no way to know whether these enrollees are not working at all or are working but unable

to navigate the online reporting system. *See* Johnston, *supra*. Evidence suggests that beneficiaries did not know about the work requirement or had no means of using the State's online reporting system. Anuj Gangopadhyaya et al., *Under Medicaid work requirements, limited internet access in Arkansas may put coverage at risk*, THE URBAN INSTITUTE (Oct. 30, 2018). Indeed, nearly 20 percent of the Arkansas population had no household internet access in 2016. Among all states, only New Mexico and Mississippi had a greater proportion of the population without internet access. *Id.*

The Medicaid Act does not permit this scenario. Once again in 2018, the Court is called upon to review whether the Secretary has exceeded his authority in approving a state proposal to strip Medicaid beneficiaries of their coverage. In this case, brand-new eligibility restrictions unlike anything in the State's prior approved demonstration are operational and have been permitted to launch without any evaluation design critical to the exercise of experimental power under Section 1115. Thousands simply are losing Medicaid each month.

The inquiry at hand requires reviewing the administrative record to assess whether the Secretary fulfilled his legal responsibility to examine "'the impact of the state's project' on the individuals whom Medicaid was enacted to protect.'" *Stewart*, 313 F.Supp.3d at 265 (internal citation omitted). If the record shows that the Secretary did not "adequately consider the effect of any demonstration project on the State's ability to help provide medical coverage," the Court must vacate the Secretary's approval of the Arkansas Works Amendment. *Stewart*, 313 F.Supp.3d at 272 (emphasis in original). As in *Stewart*, the Court in the instant case will find that "'the record contains rather a stunning lack' of discussion about the effect of [the Arkansas Works Amendment] on health coverage." *Id*. at 263 (*quoting Beno v. Shalala*, 30 F.3d 1057,

1074 (9th Cir. 1994)). Consequently, the Court should vacate the Secretary's approval of the Arkansas Works Amendment and remand to the agency.

The Secretary's approval of the Arkansas Works Amendment does not further Medicaid's objectives. Instead of increasing access and expanding eligibility, in just five months of implementation, the State has already reduced coverage, likely limiting access to care itself. As of October 2018, the State has disenrolled 8,462 people from Medicaid for failure to comply with work requirements. *See* Kacey Buderi, *Update on Implementation of Work and Community Engagement Requirements in Arkansas*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION ("MACPAC") at 9 (Oct. 25, 2018). Disenrollments are "expected to keep growing as Arkansas continues implementing the work requirement program." James Romoser, *Arkansas Kicks 4,000 More Off Medicaid for not Meeting Work Requirements*, IWP NEWS (Oct. 15, 2018). Rather than improve Medicaid, Arkansas Works culls the rolls of eligible beneficiaries. Extensive evidence in the administrative record demonstrates that the downward Medicaid enrollment spiral will continue if Arkansas Works is not halted. For instance, following the imposition of similar work requirements in the Supplemental Nutrition Assistance Program ("SNAP" or "Food Stamps"), several states saw participant rates decline from 50 percent to 85 percent within a year. A similar, precipitous drop will likely occur in Arkansas Medicaid by the time the demonstration's term ends in 2021.

This is not what Congress envisioned when it permitted experimentation under § 1115. Congress sought to give the Secretary authority to test improvements in the major SSA programs by waiving certain requirements for demonstration projects that "promote[] the objectives of the program," and by expending funds in ways not ordinarily permissible under federal law.

Defendant's work policy and approval of Arkansas Works are simply an assault on Medicaid utterly lacking the necessary indicia of experimentation. 42 U.S.C. § 1315(a).

Arkansas Works, and other similar demonstration proposals, will result in millions of low-income individuals losing coverage under untested conditions designed to drive people off Medicaid – a purpose directly counter to the Medicaid Act. [1] To accomplish this aim, CMS fabricated an entirely new Medicaid purpose – to encourage work – in order to shoehorn a blatantly political agenda into its demonstration authority. In doing so, the agency mischaracterizes crucial research to support its unproven theory and ignores its own record, including comments regarding the health risks its actions create. CMS' approval of the Arkansas Works Amendment is therefore arbitrary and capricious and contrary to law.

ARGUMENT

Arkansas Works undermines Medicaid's purpose as a safety net insurer.

I. The Purpose of § 1115 Medicaid Demonstrations is to Improve the Program, Not to Remove Thousands of Eligible People

Section 1902 of the SSA sets forth Medicaid eligibility criteria and detailed operational requirements. *See* 42 U.S.C. § 1396a. While states have the option to expand eligibility and

[1] CMS approved work requirements and other eligibility conditions in amendments to existing demonstrations in Indiana, New Hampshire and Wisconsin, all scheduled to launch in 2019. *See* Letter from Demetrios Kouzoukas, CMS Principal Deputy Administrator to Allison Taylor, Indiana Medicaid Director (Feb. 1, 2018); Letter from Seema Verma, CMS Administrator to Henry D. Lipman, New Hampshire Medicaid Director (May 7, 2018); Letter from S. Verma to Casey Himebauch, Wisconsin Deputy Medicaid Director (Oct. 31, 2018). Other states have pending work "demonstration" applications, including Alabama, Arizona, Kansas, Maine, Michigan, Mississippi, Ohio, South Dakota, and Utah; Virginia is expected to apply. *See* KAISER FAMILY FOUNDATION, *Medicaid Waiver Tracker: Which States Have Approved and Pending Section 1115 Medicaid Waivers*? (Sept. 28, 2018); *see also* James Romoser, *CMS Approves Medicaid Expansion in Virginia; Enrollment to Start Nov. 1*, IWP NEWS (Oct. 18, 2018). CMS denied North Carolina's attempt to implement a Medicaid workforce development program. Letter from S. Verma to Dave Richard, North Carolina Deputy Secretary for Medical Assistance (Oct. 19, 2018) at 5-6 (State legislature has not approved program).

improve coverage and delivery, they have never been able to impose eligibility or coverage restrictions not authorized by law. *See T.H. v. Jones*, 425 F.Supp. 873, 877 (D. Utah 1975), *aff'd sub nom. Jones v. H.*, 425 U.S. 986 (1976) (invalidating Utah's parental consent requirements for Medicaid family planning services); *Comacho v. Tex.Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005) ("Texas cannot add additional requirements for Medicaid eligibility."); Congressional Research Service, ., R44802, JUDICIAL REVIEW OF MEDICAID WORK REQUIREMENTS UNDER SECTION 1115 DEMONSTRATIONS at 3, n. 17 (Mar. 28, 2017). Moreover, Section 1115 authorizes the Secretary to add flexibility by waiving State compliance with § 1902 requirements "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of…[Medicaid]." 42 U.S.C. § 1315(a)(1). This provision, by both its terms and history, allows the Secretary to test program innovations, not to introduce restrictions that defeat the purpose of Medicaid.

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

In 1962, the Kennedy Administration asked Congress to enact legislation authorizing "[d]emonstration projects that states could undertake without having to meet all the conditions of the federal [Social Security] act." Public Welfare Amendments of 1962, P. L. No. 87-543 § 122, 76 Stat. 172, 192; *see also* S. Rep. No. 1589 at 1 (1962), *reprinted in* 1962 U.S.C.C.A.N. 1947. The President identified "needed improvements" in safety net programs including liberalization of eligibility requirements and benefit rules. *See* SOCIAL SECURITY ADMINISTRATION, SOCIAL SECURITY HISTORY: KENNEDY'S STATEMENTS ON SOCIAL SECURITY (Feb. 20, 1961). President Kennedy viewed this additional authority, which later extended to Medicaid, as a way to help, not penalize, the poor: "[c]ommunities which have – for whatever motives – attempted to save money through ruthless and arbitrary cutbacks in their welfare rolls have found their efforts to

little avail. The root problems remained . . . ." *President's Special Message to the Congress on Public Welfare Programs* (Feb. 1, 1962).

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

Clearly, when the Secretary acts under Section 1115, he has authority to permit experiments that test methods to promote the objectives of the Medicaid program, not to terminate the provision of medical assistance to statutorily eligible individuals.

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

In implementing Section 1115, the Secretary's waiver policy sought to "develop and improve the methods and techniques of administering assistance and related services designed to help needy persons achieve self-support or self-care or to maintain and strengthen family life." Dep't of Health, Educ. & Welfare, *Handbook of Public Assistance Administration*, H.T. No. 4, pt. IV, § 8421 (1963). Early Section 1115 demonstrations focused on child care development programs and expanding benefits. *See* Williams, *supra*, at 14. Subsequent 1967 Department policy guidelines reaffirmed that demonstrations ought to strengthen programs by "provid[ing] assistance to needy individuals *who would not otherwise be eligible*; increas[ing] the level of

payments; provid[ing] social services not presently available…; [and] experiment[ing] with new patterns and types of medical care…." Dep't of Health, Educ. & Welfare, *Handbook of Public Assistance Administration*, H.T. No. 109, pt. IV, § 8432 (Feb. 17, 1967) (emphasis added) (*cited in* Williams, *supra*, at 14, n. 29); *see also* S. Rep. No. 744 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 2863 (appropriating additional funds for Section 1115 projects "to develop demonstrations in improved methods of providing service to recipients or in improved methods of administration").

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

Since Medicaid's enactment, Congress has taken additional steps to ensure Section 1115 promotes the statute's purpose. In 1982, Congress added § 1916 to the SSA to restrict Section 1115 waivers that compel beneficiary participation in premium or cost-sharing demonstrations. *See* Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248 § 131(b), 96 Stat. 367 (1982) (codified at 42 U.S.C. § 1396o(f)). When Congress enacted the ACA, it further amended § 1115 to require the Secretary to permit public notice and comment at both the state and federal level prior to approving demonstrations and to ensure that demonstrations comply with the Medicaid law. Pub. L. 111-148, § 2601(b)(2), § 10201(i), 124 Stat. 119, 922 (2010) (codified at 42 U.S.C. § 1315(d)(2)). In 2012, CMS promulgated regulations to require that demonstrations serve a legitimate experimental purpose. 42 C.F.R. §§ 431.400-431.428. States must submit for CMS approval detailed evaluation designs of demonstrations' "key programmatic features," including testable hypotheses, valid designs, reliable collection methods and approaches to minimize burdens on beneficiaries. *Id*. at § 431.424.

Over decades, Medicaid demonstrations have tested new strategies for delivering health care or expanding services for program beneficiaries. The text and history of Section 1115

clearly show that demonstration authority is not a blank check to circumvent Medicaid eligibility and coverage protections. As the U.S. Court of Appeals for the Ninth Circuit warned: "we doubt that Congress would enact such comprehensive [*Social Security Act*] regulations, frame them in mandatory language, require the Secretary to enforce them, and then enact a statute [Section 1115] allowing states to evade these requirements with little or no federal agency review." *Beno*, 30 F.3d at 1068-69; *see also Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011). The administrative record must show that the Secretary's approval of states' proposals that leave eligible individuals without medical assistance was the result of reasoned decision-making, weighing potential harm against expected benefits, and not mere rubber stamping.

Defendants have not disclosed an evaluation design or hypothesis to test the work requirements. In fact, the Arkansas Works demonstration is being implemented without any evaluation on the impact of requiring work, of locking non-compliant beneficiaries out of coverage, or of restricting retroactive eligibility to one month. Defendants promised an evaluation to measure the impact of the new work component on beneficiaries. *See* AR at 5. No evaluation of this complete departure from the original demonstration has been launched.

D. The Administrative Record Shows that Approval of the Arkansas Works Amendment was Arbitrary, Capricious and Contrary to Federal Law: § 1115 Cannot be a Pretext to Restrict Medicaid Eligibility or Coverage

The Secretary approved the Arkansas Works Amendment notwithstanding overwhelming evidence in the record of the harm it will cause and no evidence that supports the claim that the demonstration will produce health gains. Rather than waiving conditions, the Secretary adds conditions of eligibility that frustrate Medicaid's core objective to provide medical assistance to all eligible individuals. *See* 42 U.S.C. §§ 1396a(a)(8), (10). The Secretary's approval only encourages states to pile on new eligibility requirements and coverage restrictions, erect barriers

to medical assistance, and push people out of the program. This demonstration is not a valid exercise of the Secretary's waiver authority.

1. CMS' New § 1115 Policy Contradicts Consistent Agency Views that Work Requirements Have No Place in Medicaid and that Demonstrations Must Test Program Improvement Innovations

The January SMDL admits that requiring work or community engagement as an eligibility condition "is a shift from prior agency policy regarding work and other community engagement as a condition of Medicaid eligibility or coverage." AR 76. Yet, the agency glossed over this drastic policy change stating that "it is anchored in historic CMS principles that emphasize work to promote health and well-being." *Id*. There are, however, no "historic CMS principles."

Until very recently, CMS has opposed work requirements consistently. In 2015, the Deputy Administrator and Director for the Center for Medicaid and CHIP Services told Congress that "the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work or receive job training because that is not an objective of [Medicaid]." Vikki Wachino, Hearing on "Medicaid at 50," Responses to Additional Questions for the Record, U.S. House of Rep. Energy and Commerce Health Subcommittee (July 8, 2015) at 37. Moreover, in 2016, CMS denied Arizona and New Hampshire's proposals because work requirements "undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program." Letter from Vikki Wachino, Director, Center for Medicaid & CHIP Services to Jeffrey A. Meyers, Commissioner, New Hampshire Dept. of HHS (Nov. 1, 2016); *see also* Letter from Andrew M. Slavitt, CMS Acting Administrator to Thomas Betlach, Director, Arizona Health Care Cost Containment System (Sept. 30, 2016). In short, "[t]he Secretary has no Section 1115 authority to allow a work requirement or work incentive." Sidney

D. Watson, *Out of the Blackbox and into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y L. & ETHICS 213, 227 (Winter 2015).

Based on years of Congressional enactments, HHS has consistently viewed Medicaid eligibility as a matter entirely "decoupled" from programs whose express purpose is to promote work, such as Temporary Assistance for Needy Families ("TANF"), which statutorily ties benefits to work activities. *See* Letter from Olivia Golden, Assist. Secretary for Children and Families and Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration to State Medicaid Directors and TANF Administrators (June 5, 1998). As such, CMS' recent change of heart deserves little deference: "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view.'" *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n. 30 (1987).

2. <u>Extensive Commentary in the Administrative Record Made Clear the Risks Created by Work Requirements and Coverage Restrictions</u>

An experiment to reduce Medicaid coverage flies in the face of extensive research demonstrating the adverse effects of denying low income people access to health insurance. *See, e.g.*, KAISER FAMILY FOUNDATION, *Sicker and Poorer: The Consequences of Being Uninsured* (Apr. 2002). Yet CMS simply ignored or provided unresponsive answers to extensive public comments presenting well-supported research opposing its assumptions in the SMDL and the Arkansas Works Amendment. Repeated comments in the record underscore how the demonstration would harm beneficiaries while doing little to improve incomes or access to employer insurance or to promote better health outcomes. CMS responded that "[w]e believe

that the community engagement requirements create appropriate incentives for beneficiaries to gain employment," without citing specific evidence to explain how gaining employment promotes the Medicaid objective to furnish medical assistance. AR 6. The agency also invoked vague notions of experimentation to justify the community engagement requirement, stating, again without any basis in the record, that "it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence." *Id*.

For instance, the record contains extensive opposition to CMS' new policy of requiring work (or "community engagement") as an eligibility condition, based on the large body of evidence showing the catastrophic impact of work requirements seen in programs such as cash assistance or TANF. *See, e.g.*, AR at 1269-73, 1276-8, 1301-05, 1330-43. The only experimental question CMS conceivably could be trying to answer – so harmful as to take one's breath away – is whether attaching a similar requirement to medical assistance would produce similar catastrophic results. To the many concerns raised in the record, CMS provided a cursory response best summarized as it "has considered those comments," and embracing uncritically the premise that a work requirement somehow "improves beneficiaries' health" or "promote[s] beneficiary independence." AR 6.

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

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

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

3. CMS Misrepresented the Research on Which it Claims to Rest Its Approval of the Arkansas Works Amendment

The cornerstone of CMS' new Section 1115 policy is that employment leads to improved health outcomes and that research supports this assertion: "Arkansas Works' community engagement requirement is designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness." *See* AR at 4, 75. There is no such research.

First, CMS incorrectly relies on a 2016 Journal of the American Medical Association ("JAMA") study for the proposition that employment is associated with better health outcomes and "higher earnings are positively correlated with longer lifespan." AR 75. In fact, the study authors concluded that "[u]nemployment rates, changes in population, and changes in the size of the labor force …*were not significantly associated with life expectancy among individuals in the bottom income quartile*." Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States*, JAMA 315 (2016) at 1759 (emphasis added). Thus, CMS has relied on a study that appears to directly contradict the agency's premise that employment will lead to better health outcomes among the poor. Indeed, a recent, systematic review of ninety-four high quality rigorous research studies concluded that experiments in which receipt of cash assistance hinges on work are unlikely to have tangible health effects. This study, which most closely examines the potential effects of work requirements on health, found no significant health improvements from welfare-to-work policies, either in the short- (12-18 months) or long-term (48-72 months). Moreover, the review found that such programs had no substantial long-term effects on employment or income. *See* M. Gibson et al., *Welfare-to-work interventions and their effects on the mental and physical health of long parents and their children*, COCHRANE DATABASE OF SYSTEMATIC REVIEW (Feb. 26, 2018).

Second, CMS cites a 2002 article from the International Journal of Epidemiology for the claim that "education…can lead to improved health by increasing health knowledge and healthy behaviors." AR at 75, n. 3 *and accompanying text*. However, that study examined long-term effects of social class status and unemployment on limiting long-term illness among males in England and Wales, jurisdictions that guarantee universal health care access. This study did not explore health knowledge or healthy behavior as outcomes; indeed, it concluded that "[s]hort

term improvements in health inequality may not prove easy to obtain in areas of large scale de-industrialization, where many citizens have experienced two decades or more of economic hardship and its social consequences." Mel Bartley and Ian Plewis, *Accumulated labour market disadvantage and limiting long-term illness: data from the 1971-1991 Office for National Statistics' Longitudinal Study*, INTERNATIONAL JOURNAL OF EPIDEMIOLOGY 31:336 at 340 (2002). This study provides no support to CMS' view that work requirements lead to improved health outcomes.

Third, CMS relies on a 2014 study for the proposition that there is "a protective effect of employment on depression and general mental health." AR at 75, n. 6 *and accompanying text*; *see also* AR at 4, n. 3. However, the study's authors state that "…the relationship between employment and health can be bi-directional. …the positive health effects of employment can be affected by the fact that healthier people are more likely to get and stay in employment." Van der Noordt et al., *Health effects of employment: a systematic review of prospective studies*, JOURNAL OF OCCUPATIONAL AND ENVIRONMENT MEDICINE (10):730, 735 (Oct. 7, 2014). This study then took a commonsense view exactly opposite of the position espoused by CMS, *i.e.*, healthy people are more likely to work, not that working makes people healthier.

Moreover, CMS ignored numerous studies that have found a positive economic impact of the Medicaid expansion, both for people able to return to work because of improved access to medical care and as a jobs-creating economic engine. *See* Angshuman Gooptu et al., *Medicaid Expansion Did Not Result in Significant Employment Changes or Job Reductions in 2014*, 35 HEALTH AFFAIRS 111 (2016); Bowen Garrett and Robert Kaestner, *Recent Evidence on the ACA and Employment: Has the ACA Been a Job Killer?* THE URBAN INSTITUTE AND THE ROBERT WOOD JOHNSON FOUNDATION (Aug. 2015); *and* Robert Kaestner et al., *Effects of ACA Medicaid*

Expansions on Health Insurance Coverage and Labor Supply, JOURNAL OF POLICY ANALYSIS AND MANAGEMENT 36(3): 608-642 (May 2017). Individual states have also found that Medicaid enabled greater work engagement from people previously unable to do so because of poor health.[2] *See, e.g.*, OHIO DEPARTMENT OF MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT at 4 (2016) (Ohio) *and* Renuka Tipirneni et al., *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, UNIVERSITY OF MICHIGAN (Jun. 2017) (Michigan).

Medicaid's positive impact on work underscores a fundamental truth about the poor: research shows that two-thirds are either working or looking for work, while the rest overwhelmingly cannot work because of their own poor health or that of a family member or are caring for young children. In other words, CMS' authorized "experiment" to measure the impact of depriving thousands of people of Medicaid coverage in Arkansas is a dangerous solution in search of a problem, launched with no formal evaluation in place. *See* Erin Brantley and Leighton Ku, *Medicaid Work Requirements: Who's at Risk?* HEALTH AFFAIRS BLOG (Apr. 2017).

4. Arkansas Works's Community Engagement Requirement Lacks the Requisite Experimental Soundness for a Valid § 1115 Demonstration

Consistent with applicable decisions, *see, e.g.*, *Newton-Nations*, 660 F.3d 370 (Medicaid) *and Beno*, 30 F.3d 1057 (Aid to Families with Dependent Children), the record must show the basic methodological soundness of the experiment. The demonstration must produce valuable

[2] By contrast, reversing Arkansas's gains likely will carry major economic and employment consequences. One expert estimates that by 2021, when the work demonstration ends, Arkansas could forgo between $220 million and $340 million annually in federal funding, which would have major implications for the health care industry. Sherry A. Glied, *How a Medicaid Work Requirement Could Affect Arkansas' Economy*, THE COMMONWEALTH FUND (Oct. 31, 2018).

information that could lead to program improvements, facilitate "true research data and serve interests beyond state fiscal concerns." *Recent Case: Ninth Circuit Holds Statutory Waivers for Welfare Experiments Subject to Judicial Review*, 108 HARV. L. REV. 1208, 1212 (1995). "[T]he Secretary must make at least some inquiry into the merits of the experiment-she must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration." *Beno*, 30 F.3d at 1069. Moreover, "[t]he Secretary's second obligation under *Beno* is to 'consider the impact of the state's project on the' persons the Medicaid Act 'was enacted to protect.'" *Newton-Nations*, 660 F.3d at 381. In the absence of a true experimental design, the risks are confusion, contamination of research findings, and additional hardship to people who depend on the program. Like all sound experimentation, the demonstration must yield new knowledge, be methodologically sound, and benefits should outweigh risks.

The work requirements of Arkansas Works do not even rise to the level of experiment. The State's proposal was no more than a convenient insert into an approved, carefully designed demonstration focused on an alternative means of achieving coverage of hundreds of thousands of people through use of a private option in lieu of traditional Medicaid coverage. Defendants grafted this amendment into the demonstration devoid of a valid experimental theory or justification. *See* AR 2057-2120.

CMS compounded the problem by not requiring submission of even a proposed evaluation design before allowing the State to launch requirements that will affect coverage for tens of thousands of beneficiaries. Its approval letter requires the State to perform an evaluation by an independent party and to submit an evaluation plan. There is no approved evaluation design to test the effects of an experiment that is baseless to begin with. As of October 2018 – the fifth month since implementation – over 8,000 have lost coverage with no hint of an

objective evaluation. *See* AR at 5 ("The impact of this [work or community engagement] incentive, as well as other aspects of the demonstration, will be assessed through an evaluation designed to measure how the demonstration affects eligibility, and health outcomes over time for persons subject to the demonstration's policies."); *see also* AR 45-52 (XIV. EVALUATION OF THE DEMONSTRATION) (referencing only premium assistance; no hypotheses or evaluation design to test work requirements or coverage lock-out impacts). The Arkansas Works Amendment falls well short of quality experimental standards. *Generally, see* Gov't Accountability Office, GAO-18-220, MEDICAID DEMONSTRATIONS: EVALUATIONS YIELDED LIMITED RESULTS, UNDERSCORING NEED FOR CHANGES TO FEDERAL POLICIES AND PROCEDURES (Feb. 20, 2018) (citing CMS' poor record of Section 1115 research oversight and failure to produce evaluation results). Indeed, the approval documents contain no sound evaluation hypotheses related to the effects of work requirements, only tropes about the value of working.

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

A. Arkansas's Almost 30 Percent Reduction in Total Uninsured Adults in the First Three Years of its Medicaid Expansion Ranked Second in the Nation

The Arkansas Center for Health Improvement has documented the state's impressive achievements in providing medical assistance to the expansion population. By the end of 2016, the Arkansas expansion had reduced the proportion of uninsured low-income adults from 42 percent to 14 percent. *See* ACHI at i. Between 2013 and 2016, only Kentucky showed a greater percentage drop in the overall uninsured rate. *See* Dan Witters, *Kentucky, Arkansas Post Largest Drops in Uninsured Rates*, GALLUP (Feb. 8, 2017). In addition, extensive evaluation has shown the enormous success of Arkansas's expansion in achieving stable coverage and more accessible health care. ACHI, *supra*, at ii-iii; *see also* Bethany Maylone and Benjamin D. Sommers,

Evidence from the Private Option: The Arkansas Experience, THE COMMONWEALTH FUND (Feb. 2017) *and* Lara Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUNDATION (Mar. 2018).

To lock thousands of beneficiaries out of Medicaid based on noncompliance with arbitrary work requirements will reverse this enormous record of success in achieving Medicaid's purpose. Recent data from similar SNAP work requirements, which CMS cites as a model for Medicaid work requirements (*see* AR at 77), show that reductions in enrollment could range from 50 percent to 85 percent of the target population in the first year alone.

There is no reason to expect a different outcome from Arkansas Works. Even a more conservative estimate reflecting the actual current rate of disenrollment finds that between 19 percent and 30 percent of the approximately 161,000 people subject to work requirements in Arkansas, or 30,700 to 48,300, will lose coverage by June 2019, the first year of the amended Arkansas Works demonstration, clearly a devastating result. *See* Erin Brantley & Leighton Ku, *Arkansas's Early Experience with Work Requirements Signals Larger Losses to Come*, THE COMMONWEALTH FUND (Oct. 31, 2018).

B. There is No Realistic Expectation That Those Leaving Medicaid for Work will Find Alternative Sources of Health Insurance Following Loss of Medicaid Coverage

In approving the Arkansas Works Amendment, the Secretary believes, without explaining on what basis, that work requirements create "appropriate" incentives for beneficiaries to gain employment or help individuals and families attain or retain capability for independence or self-care. *See* AR at 3, 6. Defendants' assertion rests on two assumptions: (1) part time work at low wages offers employer health benefits and (2) threatening people with the loss of Medicaid will lead them to find the jobs with generous benefits. CMS cites no evidence to support its

assertions. Indeed, as noted, in the very same approval, CMS permitted the state to abandon the subsidized employer insurance component of the original Arkansas demonstration – one that produced exactly 40 participants. AR 3. All evidence points in the opposite direction: part-time, low wage jobs come without health benefits.

Extensive evidence from TANF work programs shows that jobs gained, if any, are low-wage jobs without employer health benefits. In an examination of eight pending state Medicaid work demonstration proposals, MACPAC reported that: (1) only one third of people losing TANF benefits found jobs that included employer-sponsored coverage; (2) almost half of the jobs held by Medicaid beneficiaries were at small firms not required under the ACA to provide health insurance; and (3) 40 percent worked in the agriculture and service industries, known for their low employer-sponsored insurance offer rates." MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, *Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF* (Oct. 2017); *see also* MaryBeth Musumeci and Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience*, KAISER FAMILY FOUNDATION (Aug. 2017). Employee health benefits for low wage workers are uncommon: an average of 16 percent of poor adults had access to employer-sponsored insurance in the United States in 2016. *See Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUNDATION (2016). There is zero evidence to suggest that depriving people of Medicaid will lead to greater levels of employer-sponsored insurance. For the people who lose Medicaid because they fail to satisfy work and "community engagement" requirements, a return to persistently uninsured status will be the norm. Unsurprisingly, MACPAC has expressed its alarm "about the large numbers of beneficiaries being kicked off Medicaid in Arkansas" and is expected to request HHS to halt

work requirement approvals in other states. James Romoser, *MACPAC to Call on HHS to Pause Medicaid Work Requirements*, IWP NEWS (OCT. 26, 2018).

III. The Arkansas Works Amendment will Produce A Major Spillover Impact, Affecting Access to Health Care Community-wide

Arkansas Works's new requirements will trigger a substantial insurance rollback. This demonstration has already shown that a large number of beneficiaries will lose coverage, either permanently or with increasingly frequent breaks in coverage because of the additional burdens imposed by the work requirements. Indeed, one study projects that work requirements may literally double the Medicaid disenrollment rate over a two-year period, thereby significantly increasing the proportion of Medicaid beneficiaries who experience major gaps in coverage. Sara Collins et al., *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky*, THE COMMONWEALTH FUND (2018).

With this insurance rollback will come important spillover effects. However, since there is no evaluation in place, these effects are going undocumented. A major examination of the community-wide effects of uninsurance found that communities with high levels of uninsured persons lack critical services even for insured people, because these communities lack the market conditions essential to financing health care. *See America's Uninsured Crisis: Consequences for Health and Health Care*, INSTITUTE OF MEDICINE (2009) at 4. Arkansas's Medicaid expansion produced major health system gains; for example, the State's hospitals reported significant annualized reductions in uninsured outpatient visits (45.7 percent reduction), emergency room visits (38.8 percent reduction), and hospital admissions (48.7 percent reduction). ACHI, *supra*, at i. The Arkansas Works Amendment will likely reverse these gains, with real adverse health consequences for the entire population. One estimate, using Kentucky's similar Medicaid work experiment as a model, finds that the resulting enrollment reduction could double hospital

uncompensated care rates and cause a 20 percent decline in Medicaid revenue. Randy Haught et al., *The Potential Financial Impact of Medicaid Work Requirement on Kentucky Hospitals*, THE COMMONWEALTH FUND (Nov. 1, 2018).

Arkansas's community health centers offer insight into this spillover phenomenon. Health centers are major Medicaid providers in the State and treat thousands of uninsured patients. They operate pursuant to Section 330 of the Public Health Service Act, 42 U.S.C. § 254b, to make health care accessible and affordable to medically underserved urban and rural populations regardless of ability to pay. CMS required the State to notify people losing Medicaid that they could get free or low-cost coverage at health centers – a remarkable, if tacit admission by Defendants regarding the impact of work requirements on insurance coverage. *See* AR at 34 (Arkansas Works Amendment Approval STCs, paragraph 54.q).

In 2017, twelve health centers operating 133 sites furnished primary and preventive care to 210,380 people – 7 percent of Arkansas residents and one in six low-income residents. *See* HHS, Health Resources and Services Administration, Bureau of Primary Healthcare, *2017 Health Center Data: Arkansas Data* (2018). Of the individuals served by these health centers, approximately 84,000 were Medicaid beneficiaries. *See* Peter Shin et al., *The Projected Effects of the Arkansas Medicaid Work Requirement Demonstration on Community Health Centers*, GW HEALTH POLICY MATTERS (Oct. 31, 2018).

As this analysis shows, expansion has dramatically affected Arkansas's health centers. Between 2013 and 2017, the number of Medicaid and privately insured patients served by health centers in Arkansas increased by 89 and 71 percent respectively. The number of operating health center sites grew by about one-third (to 133 sites), while the number of patients grew by 46,583 (a 28 percent growth). Medical and mental health full-time equivalent staff grew by 49 and 223

percent respectively; medical visits grew by 45 percent, while mental health visits surged by 106 percent. *Id.*

With coverage expansion came added Medicaid revenue. Between 2013 (one year prior to implementation of the ACA in Arkansas) and 2017 (four years after expansion went into effect), total health center revenue increased from $111 to $169 million, with Medicaid revenue increasing by 86 percent and private insurance revenue by 307 percent, compared to only a 47 percent growth over the same period in health center grant revenue. *Id*.

Many of the estimated 30,700 to 48,300 people projected to lose coverage during year one of the work requirement will be health center patients. Brantley & Ku, *supra*. Based on health centers' share of the State's total Medicaid patient population, health centers can expect to incur revenue losses between $1.5 million and $2.3 million, leading to an estimated decline in patient capacity of 1,811 to 2,859 patients and an estimated drop in patient visits between 6,827 to 10,779 annually. Shin, *supra*. This spillover effect, which Defendants disregarded in their directive to the State to steer people losing Medicaid coverage to seek health center services, will affect entire communities.

CONCLUSION

For the foregoing reasons, the amended Arkansas Works demonstration falls short of the applicable standard of review and short-changes Medicaid participants in Arkansas, which justifies enjoining its further implementation. Moreover, Defendants' approval of the amendment should be vacated and remanded to the agency.

Respectfully submitted,

Dated: November 7, 2018

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**Pro hac vice* motion pending

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Local Civil Rule 7(o). This brief consists of 25 pages of text, exclusive of the Table of Contents, Table of Authorities, Attorney identification and Certificate of Compliance, and contains two (2) footnotes containing nineteen (19) aggregate lines of text.

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CERTIFICATE OF SERVICE

I hereby certify that on November 7, 2018, I caused the foregoing document to be served on the parties' counsel of record electronically by means of the Court's CM/ECF system.

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