IN THE 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-1900 (JEB)

MEMORANDUM IN SUPPORT OF FEDERAL DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Other Authorities

INTRODUCTION

In *Stewart v. Azar*, this Court recognized that the Secretary of Health & Human Services (HHS) "is afforded significant deference in his approval of pilot projects," also known as demonstration projects, under 42 U.S.C. § 1315. 313 F. Supp. 3d 237, 243 (D.D.C. 2018). This Court concluded, however, that the Secretary "never adequately considered whether Kentucky HEALTH," which was part of Kentucky's Medicaid demonstration project, "would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." *Id.* The Court thus vacated HHS's approval of Kentucky HEALTH and remanded the matter to HHS for further review. *Id.* In light of the concerns raised by this Court, HHS opened a new comment period that gave stakeholders an opportunity to comment on the issues raised in the litigation. After carefully considering those comments, HHS issued a new letter on November 20, 2018, that approved Kentucky HEALTH and comprehensively explained why that component of Kentucky's demonstration project will help the State furnish medical assistance to its citizens. *See* Ex. A. The reasoning of that new letter applies equally to Arkansas's demonstration project, known as the Arkansas Works Amendments, and provides ample justification to uphold the Arkansas project's approval, which HHS issued before it had the benefit of this Court's opinion in *Stewart*.

As the new Kentucky letter explains, demonstration projects like the ones undertaken by Kentucky and Arkansas further the Medicaid statute's objective to furnish medical assistance because they allow States to experiment with ways to stretch limited Medicaid resources and thus maximize coverage. The Supreme Court and the D.C. Circuit have long recognized that measures designed to stretch state resources further the objectives of programs such as Medicaid. *See N.Y. State Dept. of Soc. Servs. v. Dublino*, 413 U.S. 405 (1973); *PhRMA v. Walsh*, 538 U.S. 644 (2003); *PhRMA v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004). States may "attempt to promote self-reliance and civic responsibility, to assure that limited state welfare funds be spent on behalf of those genuinely incapacitated and most

in need." *Walsh*, 538 U.S. at 666–67 (discussing *Dublino*). In accordance with these decisions, the demonstration projects here and in *Stewart* test measures designed to help adults transition from Medicaid to financial independence or other forms of health coverage, including the subsidized coverage available through the Exchanges. Community-engagement demonstration projects are designed to enhance the financial independence of Medicaid recipients by requiring able-bodied adults to work, look for work, or engage in other activities that enhance their employability, such as job-skills training, education, and community service. Waivers of retroactive eligibility are designed to encourage eligible individuals to enroll in Medicaid while they are healthy, which in turn encourages them to focus on disease prevention and primary care and reduces costs for the Medicaid program—essential to ensure its long-term sustainability and expand the coverage it provides.

Plaintiffs object that the community-engagement aspect of these experiments is novel. But of course it is novel—the purpose of Section 1115 waiver authority is to allow innovation. For example, the work requirements in the Temporary Assistance for Needy Families (TANF) program were informed by earlier demonstration projects such as the one upheld in *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (Friendly, J.). Plaintiffs predict that demonstration projects like the ones undertaken by Arkansas and Kentucky are doomed to fail, but testing such predictions is why Section 1115 demonstration projects exist—*to test* innovations that, in the judgment of the Secretary, are likely to assist in promoting the objectives of the program. The Secretary's considered judgment that an experiment is worthwhile may not be overturned based solely on contrary predictions that the experiment will fail.

Plaintiffs emphasize some individuals will lose coverage for a period of time because they do not comply with the community-engagement requirement. But the same is true of any condition of eligibility—including the work requirements that preceded TANF. For example, individuals may have their Medicaid eligibility terminated for failing to report information to the State that could impact

their eligibility, such as changes in income or residency status. Medicaid eligibility is not a foregone conclusion. Requiring beneficiaries to provide information demonstrating that they are continuing to meet conditions of eligibility through a demonstration project is grounded in the eligibility requirements established elsewhere in the Medicaid Act. Plaintiffs' argument is especially weak in this case because Arkansas has the right to terminate its coverage of the new adult population *entirely*—an option that results from the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 575 (2012) (*NFIB*). As HHS previously emphasized, States "have flexibility to start *or stop* the expansion." Centers for Medicare & Medicaid Services (CMS), *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* (FAQ) 11 (2012) (emphasis added).[1] Plaintiffs note that thousands of members of the Arkansas adult expansion population—the only population subject to the Arkansas Works Amendments—have temporarily lost coverage as a result of their failure to comply with the community engagement requirement. Pls.' Mem. 1, ECF No. 27-1. But hundreds of thousands of adults (including the nine plaintiffs themselves) are receiving coverage *only because* the State made an antecedent discretionary decision to expand coverage to the new adult population. *See id.* at 7. Plaintiffs' observation that the pre-*NFIB* Affordable Care Act (ACA) described this population "as a mandatory coverage group," *id.* at 5, is simply irrelevant after *NFIB*'s contrary holding.

The amendments to Arkansas Works are also independently justified because the Secretary found that they are likely to improve the health of the Medicaid recipients receiving coverage under the demonstration. Plaintiffs argue that it cannot be a freestanding objective of Medicaid to improve the health of the people that program covers. *See also Stewart*, 313 F. Supp. 3d at 266. The Secretary emphatically disagrees. For the people receiving coverage under Arkansas's demonstration, an

[1] Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

important purpose of medical coverage is to improve their health—not to provide emergency, ad hoc treatment of individual ailments after health has already deteriorated. After all, as the new Kentucky letter explains, there is little value in paying for medical services if those services are not actually advancing the health and wellness of the recipients. Plaintiffs' argument also rests on the false premise that measures designed to improve the health of the persons covered under the demonstration have no bearing on the fiscal sustainability of the Medicaid program. Quite the contrary. Policies that help these Medicaid recipients become healthier lower the cost of their care for the simple reason that healthy and productive people are less expensive to insure. Such policies may thus enhance the overall fiscal sustainability of the program and help preserve and expand the health-care safety net for those who need it the most.

Because the relevant features of the Arkansas project are not materially different from the measures that the Secretary addressed in the new Kentucky letter, there is no reason to require the Secretary to recite a similar explanation in the specific context of an Arkansas approval. Indeed, Plaintiffs agree that this case and *Stewart* present identical issues. ECF No. 21 at 3. Should the Court conclude that additional explanation for the Arkansas approval is needed, however, any remand should be without vacatur. In *Stewart*, this Court emphasized that the Kentucky project had not gone into effect and that vacatur would not disrupt the status quo. *See* 313 F. Supp. 3d at 273. Here, by contrast, the Arkansas project has been in effect since June. *See* Pls.' Mem. 11. The Court should not disrupt that status quo, particularly given plaintiffs' delay in bringing suit.

Plaintiffs' remaining claims are baseless. Their challenge to the letter that HHS sent to state Medicaid directors is not justiciable and meritless in any event. And plaintiffs do not even attempt to defend their extravagant claim that the Secretary's approval of amendments to Arkansas's demonstration project violates the President's responsibility to take care that the laws be faithfully executed. Accordingly, the Court should dismiss the complaint or, alternatively, grant summary

judgment to the federal defendants and deny plaintiffs' motion for summary judgment.

BACKGROUND

Because this Court is already familiar with the central issues in this case, we focus the background discussion on the points most pertinent to the dispute.

I. STATUTORY BACKGROUND

The Medicaid program authorizes federal funding to States to assist certain individuals in obtaining medical care. 42 U.S.C. § 1396a(a)(10). To participate in the Medicaid program, a State must submit a plan for medical assistance (a "State plan") for approval by the Secretary. *Id.* § 1396a(b). A State plan defines the categories of individuals eligible for benefits and the specific kinds of medical services the State covers. *Id.* §§ 1396a(10), (17).

Under the traditional Medicaid program, States were required to cover only certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled. *See NFIB*, 567 U.S. at 575. There was no mandatory coverage for most able-bodied, childless adults, and the States typically did not offer any. *Id.*

As enacted, the ACA would have required States to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line (the "new adult group" or the "expansion population"). *Id.* But the Supreme Court ruled in *NFIB* that Congress could not condition a State's preexisting Medicaid funding on the State's compliance with the ACA's adult eligibility expansion. The effect of that ruling was to make coverage of the new adult population optional. Accordingly, in 2012, when many States were deciding whether to expand their Medicaid programs, HHS assured the States that they "have flexibility to start or stop the expansion." CMS FAQ at 11; *see also id.* at 12 ("A state may choose whether and when to expand, and, if a state covers the expansion group, it may later decide to drop the coverage."); Letter of Aug. 31, 2012 from CMS Administrator Cindy Mann to Arkansas Governor Mike Beebe, Ex. B.

Congress has also given the Secretary the authority to approve "any experimental, pilot, or demonstration project" proposed by a State that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid statute. 42 U.S.C. § 1315(a). For such projects, the Secretary may waive "compliance with any of the requirements of section … 1396a" in the Medicaid statute, and may approve waivers "to the extent and for the period he finds necessary to enable such State or States to carry out [the demonstration] project." *Id.* § 1315(a)(1). Separately, the Secretary may treat a State's expenditures for an approved demonstration project that otherwise would not qualify for federal matching funds, *see id.* § 1396b, as expenditures under the State plan that are eligible for federal financial assistance to the "extent and for the period prescribed by the Secretary." *See id.* § 1315(a)(2)(A). Congress enacted Section 1115 to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 1961 (1962) (Conf. Rep.).

II. FACTUAL BACKGROUND

Arkansas has elected to cover the new adult group, and has delivered coverage to this population through a demonstration project it has periodically amended. *See* AR 71. That demonstration project is known as Arkansas Works.

An Arkansas statute enacted in 2016 directed the Arkansas Department of Human Services:

> to explore program design options that reform Arkansas Medicaid so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program using competitive and value-based purchasing to: maximize the available service options; promote accountability, personal responsibility, and transparency; encourage and reward healthy outcomes and responsible choices; and promote efficiencies that will deliver value to the taxpayers.

AR 756–57. The amendments to Arkansas Works at issue here were proposed by Arkansas in June 2017, *see* AR 2057, and approved by HHS in March 2018, *see* AR 1. The State's application explained that the amendments are designed to "increase the sustainability of the Arkansas Works program . . . ,

test innovative approaches to promoting personal responsibility and work, encourag[e] movement up the economic ladder, and facilitat[e] transitions from Arkansas Works to employer-sponsored insurance and Marketplace coverage." AR 2057. Under the terms of the Secretary's approval, the project will be in effect for less than three years—from March 8, 2018, through December 31, 2021. AR 2, 10–12. The project only applies to members of the expansion population who are not medically frail. *See* AR 21–22.

A. Community Engagement

As approved by the Secretary, the amendments to Arkansas Works generally require able-bodied adults in the Medicaid expansion population between the ages of 19 and 49 to complete, and timely report, 80 hours per month of participation in a combination of community engagement activities as a condition of continued Medicaid eligibility. AR 2. There are exemptions for individuals who are (1) identified as medically frail, (2) pregnant or 60 days post-partum; (3) full-time students; (4) exempt from Supplemental Nutrition Assistance Program (SNAP) community engagement requirements; (5) exempt from Transitional Employment Assistance (TEA) Cash Assistance community engagement requirements; (6) receiving TEA Cash Assistance, (7) incapacitated in the short-term, medically certified as physically or mentally unfit for employment, or suffering from an acute medical condition validated by a medical professional that would prevent them from complying with the requirements, (8) caring for an incapacitated person, (9) living in a home with his or her minor dependent child age 17 or younger, (10) receiving unemployment benefits; or (11) currently participating in a treatment program for alcoholism or drug addiction. AR 28. Further, HHS directed Arkansas to:

> assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions or alternative compliance standards from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet in impacted

areas.

AR 33.

Under the terms of the approval, community engagement hours can be fulfilled by a variety of activities, including but not limited to: (1) employment; (2) enrollment in an educational program; (3) on-the-job training; (4) participation in vocational training; (5) community service; (6) searching for a job; (7) job search training; (8) taking a class on health insurance, using the health system, or healthy living; (9) participation in activities or programs available through the Arkansas Department of Workforce Services; and (10) participation in and compliance with SNAP/TEA employment initiative programs. AR 29.

HHS also required that Arkansas give beneficiaries timely and adequate notices about when community engagement requirements will commence for each beneficiary, whether a beneficiary is exempt, how to apply for exemptions, the consequences of non-compliance, and how to apply for a good-cause exemption, among other matters. AR 32. In addition, HHS required Arkansas to conduct active outreach to beneficiaries about how to comply with the requirement. AR 32.

HHS authorized expenditures "to the extent necessary to enable Arkansas to allow a beneficiary to report monthly their community engagement qualifying activities or exemptions using only an online portal." AR 10. HHS also directed Arkansas to "[c]onsider the impact of any reporting obligations on persons without access to the Internet." AR 34. HHS required that, "[t]o the extent practicable, the State shall ensure that the availability of Medicaid services will not be[] diminished under this demonstration for individuals who lack access to the Internet." AR 34.

If a beneficiary who is subject to the community engagement requirement does not fulfill the requirement in a given month, the beneficiary may apply for a good-cause exemption for a variety of reasons, including disability or family emergency. AR 30–31. If a beneficiary fails to comply with the community engagement requirements for three months in a given calendar year and does not receive

a good-cause exemption from compliance for any of those months, she will be disenrolled from Medicaid. AR 30. Disenrollment is effective "the first day of the month after proper notice is provided during the third month of non-compliance, unless an appeal is timely filed . . . or a good cause exemption is requested." AR 31. Once a beneficiary is disenrolled, she may apply during the next calendar year for Medicaid eligibility, and her non-compliance with the community-engagement requirement during the previous year will not be considered in determining her eligibility. AR 31. However, a beneficiary may re-enroll before the start of the next calendar year if (1) she is determined eligible for another Medicaid eligibility group (such as a parent or caretaker relative instead of a member of the new adult group) or (2) Arkansas determines the beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control. AR 31. Arkansas "must ensure compliance with all federal and State requirements related to beneficiary appeal rights" before terminating a beneficiary's Medicaid coverage. AR 27; *see also* AR 33. If a beneficiary is successful in his or her appeal, benefits are reinstated and benefits may be maintained during the appeal process under certain circumstances. *See* 45 C.F.R § 431.230.

B. Waiver of Retroactive Eligibility

The Medicaid statute generally requires States to provide Medicaid eligibility up to 90 days prior to an individual's application for coverage. *See* 42 U.S.C. § 1396a(a)(34). Waivers of this retroactive eligibility requirement have been granted by HHS across different Administrations.[2] Under the waiver at issue here, Arkansas provides Medicaid coverage up to 30 days prior to an individual's application for coverage (rather than 90 days). AR 22. As mentioned above, medically frail individuals

[2] *See* Indiana HIP 2.0 (2015) (Ex. C); Delaware Diamond State Health Plan (2012) (Ex. D); Montana HELP (2016) (Ex. E); Oklahoma SoonerCare (2010) (Ex. F); Healthy Michigan (2013) (Ex. G); Arkansas Safety Net Benefit Program (2011) (Ex. H); New Hampshire Health Protection Program Premium Assistance (2015) (Ex. I); Tennessee TennCare II (2012) (Ex. J); Oregon Health Plan (2002) (Ex. K).

are exempted from this waiver. *See* AR 21–22. Further, if a beneficiary was disenrolled for failure to comply with the community engagement requirement but failed to comply because she experienced catastrophic events or circumstances beyond her control, Arkansas will provide retroactive eligibility to the date that coverage ended, without the need for a new application. AR 31.

III. THIS ACTION

Plaintiffs are nine members of the adult expansion population who receive Medicaid coverage via Arkansas's demonstration project. They filed this suit under the Administrative Procedure Act (APA) in August, seeking to challenge the amendments to the Arkansas demonstration project that HHS approved in March and that took effect on June 1, 2018.[3]

Plaintiffs moved for summary judgment in November. Their central contention is that the Secretary's approval of the amendments to Arkansas's demonstration project is arbitrary and capricious and exceeds the Secretary's authority. *See* Pls.' Mem. 18–37. In addition, plaintiffs purport to challenge a letter that CMS sent to state Medicaid directors in January 2018, after Arkansas had applied for approval of the amendments at issue here. *See id.* at 38-45. The complaint also alleged a claim under the Take Care Clause of the Constitution, *see* Am. Compl. ¶¶ 253–257, ECF No. 26, but plaintiffs' summary judgment motion does not defend that constitutional claim other than to assert in a footnote that they "believe" it is "more than sufficient to overcome a motion to dismiss," Pls.' Mem. 2 n.1.

[3] The original complaint was filed by three individuals; the other six individuals were added as plaintiffs when the amended complaint was filed.

ARGUMENT

I. THE SECRETARY DID NOT ACT ARBITRARILY OR EXCEED HIS AUTHORITY BY APPROVING THE AMENDMENTS TO ARKANSAS'S DEMONSTRATION PROJECT.

A. Legal Standards

Congress enacted Section 1115 of the Social Security Act to ensure that federal requirements do not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 1961. Section 1115 vests the Secretary with authority to approve "any experimental, pilot, or demonstration project" that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Act's programs, including Medicaid. 42 U.S.C. § 1315(a). In the exercise of this authority, the Secretary may waive "compliance with any of the requirements of section … 1396a" in the Medicaid statute "to the extent and for the period he finds necessary to enable such State or States to carry out such project." *Id.* § 1315(a)(1). In addition, the Secretary may treat a State's expenditures for an approved demonstration project that otherwise would not qualify for federal matching funds, *see id.* § 1396b, as expenditures under the state plan that are eligible for federal financial assistance to the extent and for the period prescribed by the Secretary, *see id.* § 1315(a)(2)(A).

"[T]he Congress expressly conferred on the Secretary authority to review and approve" demonstration projects, and the "Secretary's interpretations of the Medicaid Act are therefore entitled to *Chevron* deference." *Thompson*, 362 F.3d at 822. In addition, by authorizing the Secretary to approve a project that "in the judgment of the Secretary" is "likely to assist in promoting the objectives" of the program, and to waive requirements to the extent and for the period "he finds necessary to enable such State or States to carry out such project," Congress used the type of language that commits these

determinations to the Secretary's discretion as a matter of law.[4]

But even if the Secretary's judgments were reviewable, as this Court determined in *Stewart*, they entail the exercise of policy and scientific expertise to make predictive judgments about a project's likely research utility in furthering broad Medicaid goals. Judicial deference is thus at its apex. *See, e.g.*, *Rural Cellular Ass'n v. FCC*, 588 F.3d 1095, 1105 (D.C. Cir. 2009) ("The 'arbitrary and capricious' standard is particularly deferential in matters implicating predictive judgments."); *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 821 (D.C. Cir. 1983) ("[P]redictive judgments about areas that are within the agency's field of discretion and expertise" are entitled to "particularly deferential" treatment.).

B. The Secretary Reasonably Determined That The Community Engagement Requirements And Waiver Of Retroactive Eligibility Promote The Objectives Of The Medicaid Program.

In *Stewart*, this Court vacated the Secretary's approval of Kentucky's demonstration project because it determined that HHS had not adequately explained how the project would "help the state furnish medical assistance to its citizens, a central objective of Medicaid." 313 F. Supp. 3d at 243. The agency has now explained precisely that. *See* Ex. A. As plaintiffs recognize (Pls.' Mem. 1, 23), the community engagement requirements and waivers of retroactive eligibility in the Kentucky and Arkansas projects are substantially similar—hence their representation that this case and *Stewart*

[4] *See, e.g.*, *Drake v. FAA*, 291 F.3d 59, 72 (D.C. Cir. 2002) ("[A] provision that allows the Administrator to act when she '*is of the opinion* that the complaint does not state facts that warrant an investigation,' gives the FAA virtually unbridled discretion over such decisions" because the "only statutory reference point is the Administrator's own beliefs."); *id.* (explaining that the Supreme Court "has relied on an analogous distinction between a subjective standard (whether the agency thinks that a condition has been met) and an objective one (whether the condition in fact has been met) in deciding that agency action was unreviewable") (citing *Webster v. Doe*, 486 U.S. 592 (1988)); *Claybrook v. Slater*, 111 F.3d 904, 909 (D.C. Cir. 1997) ("Finally, section 10(e)'s plain language reinforces the conclusion that the decision whether to adjourn is committed to agency discretion. Rather than allowing adjournment when it *is* in the public interest, section 10(e) authorizes the agency representative to *determine* whether adjournment is in the public interest.").

present identical issues. *See* ECF No. 21 at 3. The reasoning of the Secretary's new Kentucky approval letter thus provides ample justification to uphold his pre-*Stewart* approval of the Arkansas demonstration project.

The community engagement provisions of Arkansas Works generally require able-bodied members of the adult expansion population to spend 80 hours per month working, looking for work, or engaging in activities that enhance their employability, such as job-skills training, education, and community service. There are many exemptions designed to ensure that this requirement is not imposed on those who could not comply, such as the medically frail.[5] The waiver of retroactive eligibility discourages Medicaid-eligible people in the demonstration population from waiting to seek coverage until after they are already sick, and it helps prepare individuals for the commercial market where retroactive eligibility is generally not available.[6]

Arkansas's application explained that these amendments are designed, in part, to "increase the sustainability of the Arkansas Works program," AR 2057, and that the demonstration project is meant to "reform Arkansas Medicaid so that it is fiscally sustainable, cost-effective, personally responsible, and opportunity-driven," AR 756. In the recent approval of Kentucky's demonstration project, the Secretary determined that similar requirements are likely to encourage beneficiaries to attain greater levels of financial independence and prepare them for the commercial health insurance market,

[5] Indeed, three of the plaintiffs indicated that they have received or expect to receive exemptions from the community engagement requirement. *See* Decl. of Charles Gresham ¶ 12, ECF No. 27-2 (received short-term disability exemption through October 2018); Decl. of Treda Robinson ¶ 11, ECF No. 27-9 (received short-term incapacity exemption in September and October 2018); Decl. of Marisol Ardon ¶ 10, ECF No. 27-5 (received short-term incapacity exemption through October 2018 and plans to apply for a consecutive exemption).

[6] To implement the waiver of retroactive eligibility, the Secretary removed a condition on a prior waiver that pertained to hospital presumptive eligibility. AR 3. The Secretary explained that the new waiver will better "align Medicaid and private insurance policies for non-disabled adults to help them prepare for private coverage," which generally does not include retroactive eligibility. AR 5. In addition, no plaintiff has asserted an injury from the Secretary's removal of this condition. *See* ECF No. 27-2–27-10.

including the federally subsidized insurance that is available through the Exchanges. Ex. A at 7.

The Supreme Court has long recognized that, in a cooperative federalism program like Medicaid, measures designed to stretch limited state resources further the program's objectives. In *Dublino*, 413 U.S. 405, the Supreme Court rejected a preemption challenge to a state statute that imposed work requirements as conditions for continued eligibility for benefits under the Aid to Families with Dependent Children (AFDC) welfare program. *See Walsh*, 538 U.S. at 666–67 (plurality opinion). In so ruling, the Court instructed that a State may "attempt to promote self-reliance and civic responsibility, to assure that limited state welfare funds be spent on behalf of those genuinely incapacitated and most in need, and to cope with the fiscal hardships enveloping many state and local governments." *Id.* (discussing *Dublino*); *see also Aguayo*, 473 F.2d at 1103–04 (upholding a Section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility because "Congress must have realized that extension of assistance to cases where parents, relatives or the child himself was capable of earning money would diminish the funds available for cases where they were not" and rejecting the argument "that the objective of federal participation in the AFDC program . . . is to assist the states 'to furnish financial assistance and rehabilitation and other services' . . . not to force their parents or relatives, or themselves, to work").

The Supreme Court and the D.C. Circuit applied the same reasoning in the context of Medicaid in *Walsh*, 538 U.S. 644, and *Thompson*, 362 F.3d 817. Those decisions recognized that there is fluidity in Medicaid eligibility, and that it is a legitimate objective of Medicaid to conserve state resources via measures that reduce the likelihood that borderline populations will become Medicaid-eligible. The measures at issue in *Walsh* and *Thompson* imposed burdens on Medicaid recipients (requiring prior authorization for certain drugs) in order to encourage drug manufacturers to provide rebates for persons who were not Medicaid-eligible. In *Walsh*, 538 U.S. at 663, the Supreme Court agreed with the Secretary that Medicaid-related interests would be served if the rebates reduced costs

enough to prevent their recipients from becoming Medicaid-eligible. *See Thompson*, 362 F.3d at 824-25 (discussing *Walsh*).[7]

Similarly, the D.C. Circuit in *Thompson* accepted as reasonable the Secretary's conclusion that such measures "further the goals and objectives of the Medicaid program." *Thompson*, 362 F.3d at 825. The D.C. Circuit relied on the Secretary's determination that "by making prescription drugs accessible to the [non-Medicaid] populations, which are closely related to Medicaid populations in terms of financial and medical need, it is reasonable to conclude that these populations . . . will maintain or improve their health status and be less likely to become Medicaid eligible." *Id.* The Court further reasoned that:

> [c]onversely, in the Secretary's view, the failure to implement the [measures] could require cuts in the two non-Medicaid programs that "will necessarily result in some individuals enrolling in Medicaid, and for others, lead to a decline in their health status and resources that will result in Medicaid eligibility or increased Medicaid expenses" and the "[i]ncreased Medicaid enrollments and expenditures for newly qualified Medicaid recipients will strain already scarce Medicaid resources in a time of State budgetary shortfalls."

Id. The D.C. Circuit held that the:

> Secretary's conclusion that a prior authorization program that serves Medicaid goals in this way can be consistent with Medicaid recipients' best interests, as required by section 1396a(a)(19), is reasonable on its face. If the prior authorization program prevents borderline populations in Non-Medicaid programs from being displaced into a state's Medicaid program, more resources will be available for existing Medicaid beneficiaries.

[7] Justice Stevens, joined by Justices Souter and Ginsburg, explained that "by enabling some borderline aged and infirm persons better access to prescription drugs earlier, Medicaid expenses will be reduced." *Walsh*, 538 U.S. at 663. "If members of this borderline group are not able to purchase necessary prescription medicine, their conditions may worsen, causing further financial hardship and thus making it more likely that they will end up in the Medicaid program and require more expensive treatment." *Id.* In a separate opinion, Justice O'Connor, joined by Chief Justice Rehnquist and Justice Kennedy, agreed that this rationale would be a basis to uphold the state law if supported by facts in the record. *Id.* at 689.

Id. In other words, the D.C. Circuit concluded that a measure that sought to preserve the fiscal sustainability of the Medicaid program by conserving Medicaid resources plainly furthered the statute's goals.

The logic of *Dublino*, *Aguayo*, *Walsh*, and *Thompson* extends to measures that—like the community engagement requirements—facilitate the transition of Medicaid recipients out of Medicaid eligibility and, potentially, into employer or other coverage. When such transitions occur, the consequence is that "more resources will be available for existing Medicaid beneficiaries," which "further[s] the goals and objectives of the Medicaid program." *Thompson*, 362 F.3d at 825. Arkansas's community engagement requirements advance that objective and thus fall comfortably within the principle of these decisions.

Plaintiffs emphasize that thousands of members of the Arkansas adult expansion population have temporarily lost coverage as a result of their failure to comply with the community engagement requirement. *See* Pls.' Mem. 1. But it is the nature of any condition of eligibility, including those conditions that courts have upheld, that persons who fail to meet the condition may become ineligible for benefits; that fact alone does not render the condition inconsistent with the Medicaid statute. *See Walsh*, 538 U.S. at 667 ("The mere fact that the New York program imposed a nonfederal obstacle to continued eligibility for benefits did not provide a sufficient basis for pre-emption."). Plaintiffs express great confidence that the eligibility condition here may prove to be less workable or more onerous than those previous similar conditions, but it is the very purpose of the demonstration project to test that empirical proposition. *See infra* Section I.C. The mere fact that a demonstration project places an additional condition on eligibility does not itself make it impermissible.

Further, by plaintiffs' own account, hundreds of thousands of adults—including the plaintiffs themselves—are receiving health care coverage in Arkansas only because the State voluntarily chose to provide coverage for the new adult population. *See* Pls.' Mem. 7. The potential impact that

Arkansas's demonstration project may have on coverage is properly viewed in the context of the State's discretion to terminate optional coverage *entirely*. *Cf. Spry v. Thompson*, 487 F.3d 1272, 1276 (9th Cir. 2007) ("People in the [demonstration-only] expansion population [at issue in *Spry*] are not made worse off by inclusion in a demonstration project less favorable to them than to the categorically and medically needy because, without the demonstration project, they would not be eligible for Medicaid at all."). Although Congress purported to make coverage of the adult expansion population mandatory, the Supreme Court held in *NFIB* that the Constitution required that expanded coverage be optional. Thus, in 2012, when many States were considering whether to participate in the adult eligibility expansion, CMS assured the States that they would have "flexibility to start *or stop* the expansion." CMS FAQ at 11 (emphasis added); *see also id.* at 12 ("A state may choose whether and when to expand, and, if a state covers the expansion group, it may later decide to drop the coverage."); Letter of Aug. 31, 2012 from CMS Administrator Cindy Mann to Arkansas Governor Mike Beebe, Ex. B (same). Certainly, there is less risk of a conflict between the Medicaid statute and an experiment designed to help able-bodied adults transition out of Medicaid when the experiment is limited—as Arkansas Works is—to adults that a State has no obligation to cover at all. Accordingly, the fact that some of Arkansas's new adult group beneficiaries have temporarily lost coverage does not mean the project fails to promote the objectives of Medicaid.

The amendments to Arkansas Works are also independently justified because the Secretary found that they are likely to improve the health of Medicaid recipients. Plaintiffs argue it is not a freestanding objective of Medicaid to improve the health of the people that program covers, but that certainly was not the view of the President who signed it. As Lyndon Johnson explained in his 1964 State of the Union address: "Our aim is not only to relieve the symptom of poverty, but to cure it and, above all, to prevent it." Pres. Lyndon B. Johnson, Annual Message to Congress on the State of the

Union (Jan. 8, 1964) (last accessed Nov. 30, 2018).[8] The Secretary shares that view. The purpose of the program is to improve the health and wellness of recipients so they can live happier, more independent lives; health care services are of greatest value when they further those basic public-health objectives. Ex. A at 2. One of the Medicaid program's objectives is thus to advance the overall health and wellness needs of its beneficiaries, such that it is appropriate for a State to structure its demonstration project in a manner that prioritizes meeting those needs. *Id.* That is why, in 2012, HHS explicitly encouraged States to develop initiatives "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes." CMS FAQ at 15.

Plaintiffs' argument assumes that making people who receive Medicaid healthier will have no impact on the Medicaid program generally. But that is plainly false. Healthier people who are more engaged in their communities tend to consume fewer medical services and are generally less costly to cover. Ex. A at 2. Measures that promote those objectives thus redound directly to Medicaid's benefit by saving money, *id.*, at the same time that they improve quality of life for recipients. And by encouraging individuals to enroll in Medicaid *before* they become sick, waivers of retroactive eligibility are expected to encourage primary and preventive care, *id.* at 7, which is likewise cost-effective. By contrast, individuals who have the option of enrolling in Medicaid *before* they are sick, but choose to wait until *after* they are sick to enroll, have a disincentive to seek preventive health services before they enroll, since they would have to pay for those services themselves. *Id.* By discouraging last-minute enrollment and encouraging individuals not to delay care for serious ailments that could have been avoided or more easily managed by earlier enrollment and care—at much lower cost to Medicaid and

[8] Available at http://www.lbjlibrary.net/collections/selected-speeches/november-1963-1964/01-08-1964.html.

often with a better health outcome—the amendments to Arkansas Works are expected to help preserve the fiscal integrity of the program.

C. Plaintiffs Misread The Record and The Law And Misunderstand The Nature Of A Demonstration Project.

Plaintiffs' assertion that a community engagement requirement would "fundamentally transform" Medicaid, Pls.' Mem. 1, confuses a demonstration project with a statutory amendment. The decision whether to amend the Medicaid statute to include a community engagement requirement is, of course, for Congress to make, just as the decision to include a work requirement in the TANF legislation was a matter for Congress. But the decision to allow States to *test* community engagement requirements as part of a Section 1115 *demonstration* is well within the Secretary's authority. The very purpose of Section 1115 is to ensure that federal requirements do not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 1961. And unlike a statutory amendment—which is typically permanent—a demonstration project is for a specified term. Here, for example, the term of the amended Arkansas demonstration project is less than three years. AR 2, 10–12.

HHS has long recognized that demonstration projects of this kind can "influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other States." Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules, 77 Fed. Reg. 11678, 11680 (Feb. 27, 2012). Indeed, many States tested innovative welfare-reform initiatives through demonstration projects under AFDC, leading Congress to incorporate these policies into the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the legislation that replaced AFDC with the TANF program. Likewise, demonstration projects that allowed States to implement managed care and benchmark plans informed Congress's addition of Section 1932 of the Social Security Act in the Balanced Budget Act of 1997. *See* Pub. L. 105-33, 111

Stat. 251 (permitting States to implement managed care and benchmark plans through the State plan amendment process without having to seek waivers of Medicaid rules). And after demonstration projects tested the efficacy of family-planning services, the ACA incorporated these into an optional eligibility group that States can include in their plans, *see* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXI).

Plaintiffs emphasize that "prior to 2017, in the 50-plus years of Medicaid, CMS ha[s] neither authorized nor approved a work requirement as a condition of Medicaid eligibility." Pls.' Mem. 33. But that is no basis to overturn demonstration projects, as the whole point of Section 1115 is to allow for this sort of experiment and every experiment has a first time. Moreover, as a result of the ACA's adult eligibility expansion that began in 2014, many able-bodied adults are now covered by Medicaid—a stark departure from the 50-plus years of Medicaid in which eligibility was confined to vulnerable populations such as children and persons with disabilities.

Plaintiffs' position ultimately reduces to their assertion that Arkansas Works will not accomplish its goals. They contend that the adults who are subject to the community engagement requirements will be unwilling or unable to find opportunities for work, study, vocational training, community service, job searches, job search training, or any of the many other activities that qualify as community engagement under the terms of the project. Pls.' Mem. 18-19. They deny that the waivers of retroactive eligibility approved across different Administrations, *see supra* p.9 n.2, can achieve their objectives of encouraging early enrollment and primary and preventive care that can stop diseases from occurring or progressing. Pls.' Mem. 23. And they fault the Secretary for failing to provide a "bottom-line estimate" of the number of people who will lose coverage as a result of the demonstration project. Pls.' Mem. 22-23.

These arguments reflect a fundamental misunderstanding of the nature of demonstration projects—which are, again, temporary experiments rather than a permanent revamp of Medicaid. "It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve

particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making." Ex. A at 13. Even when a demonstration project does not succeed in achieving the desired results, the information it yields provides policymakers real-world data on the efficacy of such policies. *Id.* "That in itself promotes the objectives of the Medicaid statute," *id.* at 7, because Section 1115 "experiments are supposed to demonstrate the failings or success of such programs." *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 187 (3d Cir. 1996); *see also Aguayo*, 473 F.2d at 1103 (explaining that the Administrator may set "lower threshold for persuasion" when evaluating experimental project of limited duration); *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 498 (N.D. Cal. 1972) ("[T]he co-payment project is designed to collect data which may well be of significance both in the administration of the present Medicaid program and in the process of proposing legislative modifications to it. As such, the project meets the requirements imposed by § 1115.").

Because a demonstration project is an experiment, it is neither necessary nor practical for the Secretary to produce a "bottom-line estimate" of the number of individuals who may gain or lose coverage as a result of a project's features.[9] Demonstration projects are designed to test innovations, and the actual impact on enrollment is not known in advance. That is particularly true in this case, where the State is testing the effect of an incentive on human behavior—whether individuals subject to a new incentive-structure will comply with new incentives is inherently difficult to predict. For example, the waiver of retroactive eligibility in Arkansas Works is "testing whether eliminating 2 of the 3 months of retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy." AR 5. The State's goal is thus to *increase* coverage, though plaintiffs predict that the effect will be the opposite. "[P]redictive calculations are a murky science in

[9] As the Secretary recently explained, the plaintiffs misunderstood the budget-neutrality chart from which they purported to derive such a bottom-line estimate in *Stewart*. *See* Ex. A at 13–14.

the best of circumstances," *Cablevision Sys. Corp. v. FCC*, 597 F.3d 1306, 1314 (D.C. Cir. 2010), and the Secretary is not required to quantify the expected outcome of an experiment in advance. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009) ("It is one thing to set aside agency action under the [APA] because of failure to adduce empirical data that can readily be obtained. It is something else to insist upon obtaining the unobtainable." (internal citation omitted)).

Rather than require the Secretary to quantify the expected outcome of an experiment, Section 1115 provides for two comment periods on a State's application for a demonstration project that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the State's application and the second occurs at the federal level after the application is received by the Secretary. The comment periods must be "sufficient to ensure a meaningful level of public input," 42 U.S.C. § 1315(d)(2)(A) & (C), but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might be required under a general rulemaking. Hence the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments. 42 C.F.R. § 431.416(d)(2); *see also* 77 Fed. Reg. at 11685. Here, the Secretary surpassed his obligations by not only considering the submitted comments, but by responding to certain categories of significant comments as well. AR 5–8, 1265–1343. Plaintiffs' apparent assumption that the Secretary must *do more*, by reciting and refuting every objection submitted in opposition to the proposed demonstration, is entirely without merit. Pls.' Mem. 18–29; c*f. Vt. Yankee Nuclear Power Corp. v. NRDC*, 435 U.S. 519, 524 (1978) ("Agencies are free to grant additional procedural rights in the exercise of their discretion, but reviewing courts are generally not free to impose them if the agencies have not chosen to grant them.").

Plaintiffs are equally wrong in their claim that the Secretary did not adequately examine relevant evidence. Pls.' Mem. 18. In addition to comments from the public, the Secretary considered

more than 700 pages of research on topics relevant to Arkansas's proposed project. *See generally* AR 1344–2055. This research encompassed topics such as the approval and performance of prior state demonstration projects, AR 1476, 1601, 1609, the connection between volunteering and health, AR 1463, 1483, 1683, 1700, 1713, 1731, 2031, the connection between employment and health, AR 1686, 1693, 1711, 1751, 2025, the connection between income and health, AR 1479, 2008, the experience of community engagement requirements in other public welfare programs, AR 1344, 1400, 1416, 1723, the feasibility of community engagement requirements, AR 1397, 1472, and the expected fiscal implications of such requirements, AR 2049. The research included evidence that tended to support the efficacy of community engagement requirements, *see, e.g.*, AR 1463, 1751, as well as evidence that called their efficacy into question, *see, e.g.*, AR 1397, 1472. Although plaintiffs stand their case on the latter evidence, its existence merely reflects that the science in this area is not settled, and that experiments like Arkansas's are necessary and appropriate.

The Secretary also engaged with Arkansas in a lengthy process for assessing the state's application, during which the State and CMS worked out the details of the amended program and developed the applicable Special Terms and Conditions (STCs). *See* AR 13. A substantial part of this process involved CMS obtaining "specific state assurances around [] protections to further support beneficiaries." AR 6. These protections ranged from ensuring timely and adequate notice for beneficiaries, AR 31, to requiring full appeal rights, AR 33. *See* AR 31–36 (full list of state assurances).

In addition, the Secretary took account of Arkansas's own experience with encouraging healthy behaviors through Medicaid. As part of a prior iteration of Arkansas Works, the Secretary had permitted the State to maintain a voluntary work-referral program, pursuant to which certain individuals enrolled in Arkansas Medicaid would be referred to the Arkansas Department of Workforce Services for employment assistance. AR 4. That program, however, was regarded as unsuccessful. From January through October 2017, "only 4.7 percent of beneficiaries followed

through with the referral," and of those who did, only "23 percent ha[d] become employed." AR 4. The Secretary determined that "referrals alone, without any further incentive, may not be sufficient to encourage the Arkansas Works population to participate in community engagement activities." AR 4–5. The Secretary concluded that it would therefore be reasonable to "allow Arkansas to test whether the stronger incentive model is more effective in encouraging participation." AR 5. "Whether [the court] would have been convinced by the State's case if [it] had been in the Secretary's shoes is immaterial. 'The court is not empowered to substitute its judgment for that of the agency.'" *Aguayo*, 473 F. 2d at 1107 (quoting *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971)).

Plaintiffs additionally insist that the Secretary ignored coverage considerations. Pls.' Mem. 18. But as explained, *supra*, community engagement requirements in fact promote coverage by ensuring the sustainability of the Medicaid program and enabling states to cover optional populations like the new adult group, or to enhance resources spent on other populations that the State believes are in need of extra assistance. It is true, of course, that "[a]ny system that requires individuals to fulfill certain requirements as a condition of receiving benefits necessarily places some degree of responsibility on these individuals," and that some individuals may choose not to comply. AR 7. But Section 1115 contemplates that demonstrations may result in effects on eligibility or enrollment. *See* 42 U.S.C. § 1315(d)(1) ("An application or renewal of any experimental, pilot, or demonstration project . . . that *would result in an impact on eligibility, enrollment*, benefits, cost-sharing, or financing . . . shall be considered by the Secretary in accordance with [certain] regulations"). And Arkansas tailored the scope of the population subject to the community engagement requirement so as to minimize the risk of unnecessary coverage losses. As mentioned, those who are, for example, medically frail,

pregnant, or full-time students are exempt from the requirement.[10] And those individuals that experience a loss in coverage for failure to comply with community engagement requirements can re-enroll in coverage during the next calendar year, regardless of compliance during the prior year.

For beneficiaries subject to—*i.e.*, not exempt from—the community engagement requirement, further steps were taken to minimize effects on coverage. AR 4, 2112. These steps include the opportunity to demonstrate good cause to excuse a failure to report community engagement hours, for reasons including serious illness, hospitalization, or family emergency. AR 4, 30–31; *see, e.g.*, Decl. of Jaime Deyo, ECF No. 27-10 ¶¶ 10 (plaintiff received good cause exemption because he did not realize that he was subject to the community-engagement requirements). Arkansas is also required to provide retroactive eligibility in the event that a failure to report is due to a catastrophic event or a circumstance beyond the beneficiary's control. AR 4, 31; *see also* AR 6. Furthermore, beneficiaries have a right to appeal any loss of eligibility, and the State must maintain coverage for any beneficiary who submits an appeal prior to disenrollment. AR 30. To ensure that beneficiaries would not lose coverage because they are unaware of their community engagement obligations, the State is also required to "provide written notices to beneficiaries that include information such as how to ensure that they are in compliance with the community engagement requirements," and to "implement an outreach strategy to inform beneficiaries how to report compliance" with the requirements. AR 6–7; *see also* AR 255.

In addition to these coverage-focused guardrails, the Secretary required Arkansas to conduct ongoing monitoring of the effects of the demonstration on Medicaid coverage. AR 253 ("The state

[10] Of the three plaintiffs that appear to be subject to the community-engagement requirement, all three appear to be capable of satisfying the requirement. *See* Decl. of Cesar Ardon ¶ 3, ECF No. 27-4 (self-employed, with variable work hours); Decl. of Anna Book ¶ 3, ECF No. 27-6 (has a job where she is scheduled to work 24 hours a week, sufficient to satisfy the 80-hour-per-month requirement); Decl. of Veronica Watson ¶ 3, ECF No. 27-8 (has a full-time job).

must submit an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration."). As part of that plan, the State is required to ensure that "processes are in place to accurately identify," among other things, the "[n]umber and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements." AR 254. "CMS may withdraw waivers or expenditure authorities at any time if federal monitoring of data indicates that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of [Medicaid]," such as if the demonstration results in unexpected coverage loss. AR 6; *see Aguayo*, 473 F.2d at 1106 (explaining that the "Secretary could properly give weight to the fact that the programs were of limited duration and would remain under the ongoing supervision (with the power to terminate approval) of [CMS].").

Plaintiffs' objection to the online reporting of community engagement hours, Pls.' Mem. 34-35, again underscores their basic misunderstanding of the nature of Section 1115 experiments. Congress vested the Secretary with responsibility to work out the details of demonstration projects with the States and to oversee their implementation. Here, the Secretary required Arkansas to "[c]onsider the impact of any reporting obligations on persons without access to the Internet," and, to the extent practicable, to "ensure that the availability of Medicaid services will not be diminished under this demonstration for individuals who lack access to the Internet." AR 34. Furthermore, as discussed above, beneficiaries have a right to appeal any loss of eligibility, while the State must maintain coverage for any beneficiary who submits an appeal prior to disenrollment. AR 30. And the final approval requires the State to provide retroactive eligibility in the event that a failure to report is due to a circumstance beyond the beneficiary's control. AR 4, 31; *see also* AR 6. If the Secretary's ongoing monitoring shows that, despite these protections, beneficiaries are losing coverage as a result of a lack of Internet access, the Secretary will work with the State to modify the terms of the project. Indeed, CMS has been informed that Arkansas has implemented measures that are intended to

substantially mitigate whatever problems online reporting has posed. In any event, issues that arise in the implementation of a demonstration project provide no ground to vacate the entire approval.

Plaintiffs' further contention that online-only reporting of community engagement hours is contrary to statute is mistaken. Pls.' Mem. 34–35. The Secretary authorized non-compliance with provisions in 42 U.S.C. § 1396w-3(b) to the extent necessary to implement the online-only reporting requirement. The Secretary was permitted to do so because 42 U.S.C. § 1315(a)(2) allows federal Medicaid expenditures notwithstanding a State's failure to meet requirements in 42 U.S.C. § 1396w-3(b).

Plaintiffs are also mistaken to claim that the online reporting for community engagement hours prevents the State from providing medical assistance "in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19); Pls.' Mem. 36. The Secretary concluded otherwise in light of the specific protections that the approval requires for beneficiaries, and that judgment is a quintessential matter of agency discretion. *See* AR 6 (explaining that the online reporting system is meant to make reporting "easy for enrollees").

Plaintiffs' complaint regarding the manner in which the Secretary waived the Medicaid statute's provision for retroactive eligibility is equally meritless. There is no dispute that Section 1115 allows the Secretary to waive compliance with the requirements found in Section 1396a(a), which sets forth in 83 subparagraphs the requirements with which a state Medicaid plan must comply. There is likewise no dispute that in approving the amendments to Arkansas Works, the Secretary waived compliance with Section 1396a(a)(34), which sets forth the requirement of retroactive eligibility.[11] Plaintiffs assert

[11] Under Section 1396a(a)(34), a state Medicaid plan must "provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, 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 (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon

that this waiver was somehow ineffectual because Section 1396a(a)(10) requires state plans to provide for making "medical assistance" available, and Section 1396d defines "medical assistance" to include three months of retroactive eligibility. Pls.' Mem. 37. But as plaintiffs acknowledge, Section 1396d is merely definitional; the substantive requirements for the content of state plans are found in Section 1396a(a). Plaintiffs cannot seriously contend that the Secretary's waiver of the requirement of retroactivity in Section 1396a(a)(34) may be deemed a nullity simply because the Secretary did not also waive Section 1396a(a)(10) in that section of the approval letter. The Secretary's intent to waive the requirement of retroactive eligibility is entirely clear, and his action cannot be nullified on the basis of a technicality. *See Aguayo*, 473 F.2d at 1107 (Section 1115 "does not require that, before the Secretary approves an experiment, every i must be dotted and every t crossed.").

D. Any Remand Should Be Without Vacatur.

For the reasons discussed above, the Secretary's approval of the amendments to Arkansas Works was not arbitrary or in excess of his statutory authority, and plaintiffs' attempts to show otherwise fail. If the Court nonetheless concludes that additional action or explanation is warranted, any remand should be without vacatur.

In *Stewart*, this Court concluded that vacatur of the Secretary's approval of Kentucky HEALTH was warranted under the two factors set forth in *Allied–Signal, Inc. v. U.S. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150–51 (D.C. Cir. 1993), which looked to the "seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change." *See Stewart*, 313 F. Supp. 3d at 273. At the time of this Court's decision in *Stewart*, the Court determined that the Secretary had not explained why the demonstration project would further the Medicaid statute's objective of providing coverage to needy individuals. *See*

application would have been) eligible for such assistance at the time such care and services were furnished."

id. at 243. Moreover, this Court emphasized that Kentucky HEALTH had not yet gone into effect, and that vacatur of the approval thus would not disrupt the status quo. *See id.* at 273.

Here, the opposite is true. In the recent new approval of Kentucky HEALTH, the Secretary comprehensively explained why the demonstration project is likely to further the Medicaid program's objective of providing coverage to needy individuals. That explanation is fully applicable to the amendments to Arkansas Works. And pursuant to the Secretary's March 8 approval of those amendments, implementation began on June 1. Thus, the project has already been in effect for over eight months and hundreds of thousands of Arkansans receive coverage pursuant to its features. Beneficiaries are becoming more familiar with their obligations under the project and how to report their hours, if necessary. Arkansas, moreover, has begun collecting data to test the efficacy of its demonstration project. Vacatur would interrupt that data collection effort and would cause confusion among beneficiaries, as the obligations with which they are becoming familiar would suddenly change. And then, if the project is reapproved on remand, may suddenly change again. In short, vacatur would be extremely disruptive of the state's Medicaid program and policy experiment. *See, e.g.*, *Defs. of Wildlife v. Jackson*, 791 F.Supp.2d 96, 119 (D.D.C. 2011) (remanding deficient agency action without vacating it because the action "at issue is in effect" and "vacatur would cause significant disruption"). There is no sound reason to impose the "disruptive consequences of an interim change," *Allied–Signal*, 988 F.2d at 151, particularly in light of plaintiffs' delay in filing this suit.

III. PLAINTIFFS' CHALLENGE TO CMS'S LETTER TO STATE MEDICAID DIRECTORS IS NON-JUSTICIABLE AND ALSO MERITLESS.

Plaintiffs also purport to challenge a January 11, 2018 letter that CMS sent to state Medicaid directors. *See* AR 74-83. That claim is not justiciable and, in any event, has no merit.

As noted above, plaintiffs are nine members of the adult expansion population who are receiving Medicaid coverage by virtue of Arkansas's demonstration project. To the extent that these

individuals have Article III injury at all, it would be attributable to the Secretary's approval of the amendments to Arkansas Works. That approval was final agency action within the meaning of the APA because it marked the "consummation of the agency's decisionmaking process" and, as a result of the approval, "rights or obligations" were determined and "legal consequences" flowed. *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (citation omitted); *see also CSI Aviation Servs., Inc. v. U.S. Dep't of Transp.*, 637 F.3d 408, 412 (D.C. Cir. 2011) (citation omitted).

By contrast, the earlier CMS letter to state Medicaid directors was not the consummation of the agency's decisionmaking process, nor did it determine the rights or obligations of plaintiffs or anyone else. The letter simply provided guidance for state Medicaid directors interested in pursuing demonstration projects and indicated that CMS was prepared to assist States in their efforts to encourage work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability. AR 74. The letter explained that CMS would "support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects." *Id.* The letter noted that such projects "should be designed to promote better mental, physical, and emotional health in furtherance of Medicaid program objectives." *Id.* And the letter indicated that demonstration projects are intended to give States "more freedom to test and evaluate approaches to improving quality, accessibility, and health outcomes in the most cost-effective manner." AR 76. The letter provided "a number of issues for states to consider" in developing such demonstration projects, such as the project's alignment with other state welfare programs, the population that would be subject to any community-engagement requirements, and considerations of budget neutrality, monitoring, and evaluation. AR 77, 91–98. And it provided guidance to assist the States in developing successful demonstration projects. *See, e.g.*, AR 78 ("Individuals enrolled in and compliant with a TANF or SNAP work requirement, as well as

individuals exempt from [those] requirement[s], must automatically be considered to be complying with the Medicaid work requirements."); AR 78–79 ("States must also create exemptions for individuals determined by the state to be medically frail and should also exempt … any individuals with acute medical conditions … that would prevent them from complying with the requirements.").

Guidance of this sort is commonplace for CMS, and it neither commits CMS to a course of action nor requires state Medicaid directors to act. For example, in 2012 guidance, CMS explained that it was "interested in working with states to promote better health and health care at lower costs and have been supporting, under a demonstration established by the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors." CMS FAQ at 15. CMS "invite[d] states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes," and noted "in particular that states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level."

Such CMS guidance does not constitute final agency action. "No legal consequences flow from the agency's conduct …, for there has been no order compelling [the regulated party] to do anything." *Reliable Automatic Sprinkler Co. v. Consumer Prod. Safety Comm'n*, 324 F.3d 726, 732 (D.C. Cir. 2003). The "long-standing practice in circumstances like this is to require the complaining party to challenge the specific implementation of the broader agency policy." *Fund for Animals, Inc. v. U.S. Bureau of Land Mgmt.*, 460 F.3d 13, 22 (D.C. Cir. 2006). Here, of course, plaintiffs have done exactly that by challenging the Secretary's approval of the amendments to Arkansas Works.

There is thus no reason or authority to adjudicate a freestanding challenge to the letter. CMS itself characterizes the letter as nonbinding guidance. AR 74. Moreover, CMS did not cite the letter as the source of legal authority for its approval of Arkansas's demonstration project (or any other

State's project), but rather merely referred back to its guidance in explaining some of the reasoning behind its policy decision to allow States to submit proposed demonstration projects with community-engagement requirements. *See id.* The Secretary's approval of the Arkansas demonstration project is supported "just as if the [letter] had never been issued," because the agency considered the specifics of the project and supporting record in deciding to approve the amendments. *Nat'l Min. Ass'n v. McCarthy*, 758 F.3d 243, 253 (D.C. Cir. 2014) (citation omitted).[12]

In any event, plaintiffs' challenge to the letter has no merit. For largely the same reasons that the letter is not final agency action, it is also not a legislative rule subject to the APA's notice-and-comment requirement. "General statements of policy" are exempt from notice-and-comment unless another statute provides otherwise, 5 U.S.C. § 553(b)(3)(A), and no statute does so here. The letter "compels action by neither the recipient nor the agency" and thus cannot be a legislative rule. *Holistic Candlers & Consumers Ass'n v. FDA*, 664 F.3d 940, 944 (D.C. Cir. 2012). By contrast, a State's submission of a proposed demonstration project *is* subject to specified public notice procedures, further demonstrating why the earlier letter is not subject to such procedures. *See* 42 C.F.R. §§ 431.408(a)(1), (3). Plaintiffs' contention that the Secretary lacks authority to approve demonstration projects with community-engagement requirements, or that he has failed adequately to explain the reasons for doing so, is meritless for reasons discussed at length above.

III. THE CLAIM UNDER THE "TAKE CARE CLAUSE" SHOULD BE DISMISSED.

Plaintiffs make no effort to defend Count Three of their complaint, which alleges that the

[12] Plaintiffs' reliance on the Secretary's approval of Kentucky's and Indiana's demonstration projects is misplaced. In approving the Indiana demonstration project, the Secretary simply noted that the project conformed with the guidance provided in the letter before delving into pages of analysis on how the project was specifically likely to assist in promoting Medicaid's objectives, in accordance with Section 1115. *See* Ex. L, Letter from Demetrios Kouzoukas, Dep. Admin., Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs., to Allison Taylor, Medicaid Dir., Ind. Family and Social Servs. Admin. (Feb. 1, 2018). And in the recent approval of Kentucky's project, there is no mention of the SMD letter. *See* Ex. A.

Secretary's approval of the amendments to Arkansas Works is a violation of the President's responsibility to "take Care that the Laws be faithfully executed." U.S. Const. art. II, § 3.

This is not a suit against the President; it is an APA action against the Secretary of Health & Human Services and other agency officials. Congress expressly vested the Secretary with authority to approve "any experimental, pilot, or demonstration project" that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of Social Security Act programs including Medicaid. 42 U.S.C. § 1315(a). Plaintiffs never explain how the Secretary's approval of the amendments to Arkansas Works could be regarded as a violation of the President's duty to take care that the laws be faithfully executed.

A conclusory footnote stating that plaintiffs "believe" their Take Care Clause claim "is more than sufficient to overcome a motion to dismiss," Pls.' Mem. 2 n.1, is not a substitute for legal authority. The Supreme Court has held that "the duty of the President in the exercise of the power to see that the laws are faithfully executed" is not judicially enforceable. *Mississippi v. Johnson*, 71 U.S. (4 Wall.) 475, 499 (1866). Moreover, plaintiffs have no cause of action to raise that constitutional claim, because neither the APA nor the Take Care Clause itself furnishes a right to sue the President. *See Franklin v. Massachusetts*, 505 U.S. 788, 796 (1992); *cf. Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1383–1384 (2015). Count Three, accordingly, should be dismissed.

CONCLUSION

For the foregoing reasons, the Court should dismiss plaintiffs' Complaint, or, in the alternative, grant summary judgment to the federal defendants and deny plaintiffs' motion for summary judgment.

Dated: November 30, 2018

Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

JAMES BURNHAM

Deputy Assistant Attorney General

MICHELLE R. BENNETT
Assistant Branch Director
Federal Programs Branch

/s/ Vinita Andrapalliyal
VINITA ANDRAPALLIYAL
MATTHEW SKURNIK
Trial Attorneys
U.S. Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, N.W.
Washington, D.C. 20005
(202) 305-0845 (telephone)
Vinita.b.andrapalliyal@usdoj.gov

Counsel for the Federal Defendants