UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	
ALEX M. AZAR II, et al.,	)	No. 1:18-cv-01900-JEB
	)	
Defendants,	)	
	)	
STATE OF ARKANSAS,	)	
	)	
Defendant-Intervenor.	)	

PLAINTIFFS' REPLY MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT AND PLAINTIFFS' UNIFIED RESPONSE IN OPPOSITION TO FEDERAL DEFENDANTS' MOTION TO DISMISS AND FEDERAL DEFENDANTS' AND STATE INTERVENORS' MOTIONS FOR SUMMARY JUDGMENT

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INTRODUCTION

According to Defendants, the Court should affirm the Secretary's approval of the Arkansas Works Amendment because his recent re-approval of Kentucky HEALTH cures not only the shortcomings the Court identified in the original approval of Kentucky HEALTH but also by extension justifies the approval of the Arkansas Works Amendment. That argument all but concedes that the administrative record in this case is lacking for the same reasons this Court found the Kentucky record lacking in *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018). It does nothing to remedy the shortcomings of the Secretary's quixotic endeavor to "fundamentally transform" the Medicaid program through his liberal and unprecedented use of Section 1115 waivers.

What the Secretary cannot escape is a single, critical fact: the authority Section 1115 confers on him to waive certain federal Medicaid requirements. As this Court recognized in *Stewart*, a project approved under Section 1115 is valid only if the Secretary reasonably concludes that it "would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." *Id*. at 243. Flouting that simple directive, Defendants continue to question the Court's straightforward reasoning, arguing above all else that any project that saves a state money necessarily passes muster under Section 1115. As this Court well knows, that is not the law. Congress did not grant the Secretary the power to approve any waiver that ostensibly furthers his preferred policy objectives, whatever they may be.

It is apparent that when Defendants defend approval of the Arkansas Works Amendment on its own terms, they have no option but to skirt the central issues. Most of all, when faced with abundant, uncontroverted evidence showing that the Amendment would reduce, rather than promote, Medicaid coverage, Defendants resort to ignoring that critically "important aspect of the problem" this Court told the Secretary he must consider. *Stewart*, 313 F. Supp. 3d at 264-65.

Indeed, commenters warned the Secretary that the Amendment would have a catastrophic effect on coverage, and those warnings have come to pass. Since the Plaintiffs filed their opening brief, more than 8,500 additional people have lost Medicaid coverage due to the work requirements. Over the course of just four months, Arkansas has terminated over 16,900 individuals from the Medicaid program for not meeting the requirements.

Ultimately, the Secretary's efforts are doomed. Regardless of his ideological beliefs, bedrock separation of powers principles preclude him from defying the clear text of Section 1115 in his effort to transform Medicaid from a program designed to provide medical assistance to a program intended to "help individuals and families rise out of poverty and attain independence." AR 0074; *see* also Pls.' Mem. in Supp. of Mot. for Summ. J., ECF 27-1, at 9, n.2 ("Pls. Br."). Because Defendants cannot use Section 1115 to circumvent Congress in this way, the Court should grant summary judgment in Plaintiffs' favor on their APA claims.

ARGUMENT

I. The Secretary's Approval of the Arkansas Works Amendment is Reviewable and the Plaintiffs Have Standing to Challenge It.

The Secretary seeks to insulate his Section 1115 authority from judicial review by arguing that it is committed to the unbridled "judgment of the Secretary." Fed. Defs.' Mem. in Supp. of Mot. to Dismiss, or in the Alternative, for Summ. J., and in Opp'n to Pls.' Mot. for Partial Summ. J., ECF No. 38 ("Fed. Br.") at 11-12. But as the Secretary acknowledges, this Court rejected that argument in *Stewart* and held that his waiver authority under Section 1115 is properly subject to APA review. *Id.* at 12. In so doing, the Court agreed with "every court which has considered the issue." *Stewart*, 313 F. Supp. 3d at 256 (quotation marks and brackets omitted). As the Court explained, the criteria Congress imparted with respect to the Secretary's approval of Section 1115

waivers are clear, "readily app[licable]," and "a far cry from those traditionally deemed unreviewable." *Id.* at 255.

Equally meritless are Defendants' standing arguments. Defendants do not challenge Plaintiffs' standing in the main. *Cf. Stewart*, 313 F. Supp. 3d at 251-52 (finding Plaintiffs have standing to challenge approval writ large where they showed injury from one component of the approval). Instead, Arkansas contends that the Plaintiffs cannot challenge the Secretary's approval of the online-only reporting requirement because the State's post-approval "implementation choices" allegedly allow reporting by telephone or in person. Ark.'s Mem. in Supp. of Mot. for Summ. J. & Resp. to Pls.' Mot. for Summ. J., ECF No. 39-1 ("Ark. Br.") at 34-35. The argument is both factually and legally incorrect. As a factual matter, Arkansas cannot escape that its own eligibility and enrollment plan states that "[b]eneficiaries *must use the online portal* to report exemptions and completion of work and community engagement activities." ECF No. 26-3, at 10 (emphasis added).[1] Arkansas may provide assistance to beneficiaries in "using the portal," but nowhere in the plan does Arkansas provide for alternative reporting methods. *Id.*[2] In addition, although the assurances in the approval say the State will "consider the impact of any reporting obligations on persons without access to the Internet," the approval does not provide for alternative

[1] While the Secretary included the implementation plan in the record (AR 0055-68), Arkansas submitted the plan to CMS in May 2018, after the Secretary had already approved the Amendment in March 2018. Medicaid.gov, State Waivers List, Arkansas Works, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=15033 (last visited Dec. 21, 2018).

[2] Arkansas highlighted that the online-only requirement "is administratively efficient" because it allows the State to implement the work requirement "without worker intervention" and "without additional resources." ECF No. 26-3 at 5. Department of Human Services Director Cindy Gillespie was clear that the basis for the online-only requirement was to conserve state resources, and not to benefit Arkansas Works participants. *See* Am. Compl., ECF No. 26, ¶ 92

reporting methods nor does it restrict the state from returning to online only reporting even if it begins to offer alternatives. AR 0034.

Further, Plaintiffs' firsthand experiences are inconsistent with Arkansas's claim that it permits in person and over the phone reports in spite of the terms of its own plan. One Plaintiff tried to call and report his work activity to the local DHS office, but "they would not help [him] and told [him he] could only report online." McGonigal Decl. ECF No. 27-3, ¶ 8. Another attempted to get help at her local office multiple times—the first time, she gave DHS information about a possible exemption but never received a confirmation of approval, and later, she was referred back to the online system (that she could not navigate in the first place). M. Ardon Decl., ECF No. 27-5, ¶¶ 8,11. Yet another attempted to use a computer at his local DHS office, but despite asking for help from a DHS worker, was unable to report his hours there. C. Ardon Decl., ECF No. 27-4, ¶ 15.

As a legal matter Arkansas's argument also fails. Regardless of whether Arkansas's current implementation choices have created alternative means of reporting that do not require use of the online portal—a claim for which there is no record evidence—the Plaintiffs have suffered and will continue to suffer injury as a result of the Secretary's approval of the online-only reporting requirement. *See* AR 0010, 0028-29. The "possibility of an alternative remedy, of uncertain availability and effect" does not cause the Plaintiffs to lack standing because they are otherwise injured by the policy. *Okla. Dep't of Envtl. Quality v. EPA*, 740 F.3d 185, 190 (D.C. Cir. 2014). The Secretary permitted Arkansas to *require* individuals enrolled in Arkansas Works to report their work or exemptions through an online portal. Plaintiffs are challenging that approval. Even attempting to use the alternatives Arkansas now claims to have, the Plaintiffs experienced non-compliance, *see* C. Ardon Decl., ECF No. 27-4, ¶ 9; M. Ardon Decl., ECF No. 27-5, ¶¶ 10-11, had

frequent panic attacks, M. Ardon Decl., ECF No. 27-5, ¶ 9, and lost health insurance and employment, McGonigal Decl., ECF No. 27-3, ¶¶ 9-12. All of these injuries confer standing.

II. The Secretary Cannot Fundamentally Restructure Medicaid by Rewriting the Act's Core Objectives.

A. The Secretary's Interpretation of the Objectives of the Medicaid Act is Not Entitled to *Chevron* Deference.

Defendants seek to avoid meaningful scrutiny by arguing that the Secretary is entitled to deference from this Court pursuant to *Chevron U.S.A. v. Nat'l Res. Def. Council, Inc.*, 467 U.S. 837 (1984). Fed. Br. 11-12; Ark. Br. at 5-6. Defendants are wrong, for at least three reasons.

First, the Supreme Court repeatedly has held that deference is not appropriate when an agency decision touches on issues "of deep 'economic and political significance' that [are] central to [a] statutory scheme." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (quoting *Util. Air. Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444 (2014)). That is especially true where, as here, the "agency claims to discover in a long-extant statute an unheralded power to regulate a significant portion of the American economy" and asserts that power in a way that would "bring about an enormous and transformative expansion" in the agency's authority "without clear congressional authorization." *Util. Air Regulatory Grp.*, 134 S. Ct. at 2444 (internal quotation marks omitted).

Here, the Secretary and CMS freely admit their intent to "fundamentally transform Medicaid," Am. Compl. ECF No. 26, ¶ 110, from a program designed to ensure health care coverage for needy individuals to a work program that strips their coverage for the purpose of "promot[ing] upward mobility" and "responsible decision-making," AR 0084; Pls.' Br. at 9. The Secretary's approval of the Arkansas Works Amendment thus "carries national consequences . . . that will likely be felt . . . broadly across the nation." *Stewart v. Azar*, 308 F. Supp. 3d 239, 249 (D.D.C. 2018); *see also* AR 0074-83. Given the breadth of the Secretary's ambition, this is simply

not a case where the Secretary can constrict the scope of this Court's review through the mere incantation of *Chevron*. *See King*, 135 S. Ct. at 2489.

Second, even if *King* did not displace *Chevron* when it comes to this sort of broad reimagining of Medicaid, the Secretary's legal interpretations still are not entitled to deferential review because they are plainly "inconsisten[t] with the design and structure of the statute as a whole." *Util. Air Regulatory Grp.*, 134 S. Ct. at 2442 (alteration in original). The central goal of Medicaid is to "furnish medical assistance . . . and rehabilitation and other services" to low-income populations who cannot otherwise afford needed care and services. 42 U.S.C. § 1396-1; *see Stewart*, 313 F. Supp. 3d at 270. The Secretary's interpretation, on the other hand, seeks to *restrict* coverage for such persons. No deference is owed to an agency interpretation of a statute that on its face is so fundamentally at odds with the statute's express purpose.

Third, this Court owes no deference to the Secretary's interpretation of Medicaid because it falls "outside the bounds of reasonableness." *Goldstein v. Sec. & Exch. Comm'n*, 451 F.3d 873, 880-81 (D.C. Cir. 2006); *ACA Int'l v. FCC*, 885 F.3d 687, 698 (D.C. Cir. 2018). The Secretary cannot fundamentally reconstruct the core tenants of Medicaid through paeans to individual "accountability," "fiscal integrity," and "deliver[ing] value to . . . taxpayers," *e.g.*, Fed. Br. at 6, 13, 19, that entirely dispense with any mention of Medicaid's foremost goal—making "healthcare more affordable for [needy populations]," *Stewart*, 313 F. Supp. 3d at 267; *see W. Va. Univ. Hosps. Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989) ("[T]he primary purpose of [M]edicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it."). As this Court has held, an interpretation of Medicaid's objectives that does "not include 'furnish[ing] . . . medical assistance' to the expansion group . . . would be 'utterly unreasonable'

in light of Medicaid's text, structure, and legislative history." *Stewart*, 313 F. Supp. 3d at 270 (brackets, ellipses, and quotation marks in original).

Defendants' citations to *Pharm. Research & Mfrs. of America v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004) ("*Thompson*"), do not change this outcome. Fed. Br. at 11; Ark. Br. at 6. There, the Court of Appeals concluded that state plan amendments (SPAs) are generally the kind of agency action that can be entitled to *Chevron* deference. *Thompson*, 362 F.3d at 822. But, of course, that does not mean *every* approval receives deference; courts still must determine if deference is warranted in a particular case. *See Cal. Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1014 (9th Cir. 2013) (no deference to approval of SPA because statute unambiguous); *Christ the King Manor, Inc. v. Sec'y U.S. Dep't of Health & Human Servs.*, 730 F.3d 291 (3d Cir. 2013) (SPA approval not entitled to deference when it rests on incorrect interpretation). Thus, Defendants' argument that all Section 1115 approvals are entitled to deference—regardless of content, context, or scope—misconstrues *Thompson* and *Chevron* itself.

B. The Secretary's Approval Is Inconsistent with Medicaid's Core Purposes.

Quoting 42 U.S.C. § 1396-1, *Stewart* focuses on the objective of enabling states, as far as practicable, to "furnish medical assistance" to needy persons, including low-income adults made eligible for Medicaid by the ACA. *Stewart*, 313 F. Supp. 3d at 261. Defendants disagree with the Court's assessment of the Medicaid Act's objectives.

Arkansas acknowledges that Section 1396-1 sets forth objectives of the Medicaid Act. Ark. Br. at 7. However, the State claims these objectives are no longer relevant and do not limit the Secretary's ability to approve the Arkansas Works Amendment based on new, broad, and open-ended objectives of promoting health, transitioning adults off Medicaid, and maintaining Medicaid for the most vulnerable. *Id.* at 7-22; *see also* Fed. Br. at 3. ("The Secretary emphatically disagrees"

that promoting health "cannot be a freestanding objective of Medicaid"); Fed. Br. at 1-2, 14-17 (arguing that any project designed to promote fiscal sustainability automatically furthers the objectives of the Medicaid Act).

The Court should reject this effort to "throw[] away" the parts of the statute Defendants do not like. *Michigan v. EPA*, 135 S. Ct. at 2708. Any contrary result would vest the Secretary with unbridled authority to waive the requirements Congress has imposed to further the Secretary's preferred self-selected objectives. As this Court has already concluded, the Secretary cannot "singlehandedly rewrite the Medicaid Act." *Stewart*, 313 F. Supp. 3d at 255. The "objectives" set forth in the Act limit the Secretary's authority under Section 1115.

1. The Secretary Cannot Promote His Own Agenda at the Expense of Medicaid's Stated Objectives.

In *Stewart*, the Court correctly held that the overarching and fundamental "purpose" of the Medicaid program is to enable states to "furnish medical assistance" to needy persons. *Stewart*, 313 F. Supp. 3d at 261. Arkansas responds by complaining that this straightforward act of statutory analysis improperly "conceive[s] of Section 1901 as a complete statement of Medicaid's objectives." Ark. Br. at 8-9 (citing cases and noting other courts "found some guidance in Section 1901, but reasoned that other sections of the Act would also furnish the basis for discerning the Act's objectives").[3] The argument is incorrect as a factual matter. While *Stewart* did find that Section 1396-1 contains an explicit statement of the Medicaid Act's objectives, 313 F. Supp. 3d at 260 (quoting § 1396-1); *see also id.* at 261 (finding a "fundamental failure" when the Secretary ignored those objectives in evaluating Kentucky HEALTH), it is not true that the Court stopped there. Notably, the Court also looked to other parts of the Medicaid Act, such as the 2010 Medicaid

[3] Section 1901 of the Social Secretary Act is codified at 42 U.S.C. § 1396-1.

expansion provision, which Congress enacted to provide "'quality, affordable care for all Americans,'" including by expanding the "'role of public programs—like Medicaid—in achieving that goal.'" *Id*. at 261 (citation omitted). Citing that provision, the Court found that "as amended, one objective of Medicaid thus became 'furnishing . . . medical assistance' for this new group of low-income individuals" *Id*. (citing *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 634 (2012) ("*NFIB*").

As the Court explained in *Stewart*, the Secretary cannot avoid the express language of Section 1396-1 by simply proclaiming that the Arkansas Works Amendment may improve health outcomes through upward mobility, greater independence, and improved quality of life. Nothing in the Medicaid Act even remotely suggests that the Secretary can approve a program that undermines the expressly stated goals identified in Section 1396-1 by vastly shrinking available Medicaid coverage, so long as that program furthers the unstated objective of "improving health outcomes."

What is more, Arkansas's effort is inconsistent with the record. The Secretary pointed only to Section 1396-1 as the authority for issuing the new objectives. *See* AR 0074; AR 0004.

2. Section 1396-1's Role as an Appropriations Statute Does Not Undermine Its Statement of Objectives.

Arkansas attempts to prop up the Secretary's decision by disassociating Medicaid's purposes from Medicaid's appropriations. Ark. Br. at 10. The effort is puzzling. Medicaid is a spending program, which means Congress accomplishes the purposes of the program by appropriating funds for use by the states and attaching conditions to the appropriations. *See generally NFIB*, 567 U.S. at 576 (spending power allows Congress to "condition . . . a grant upon the States' taking certain actions . . . [to] encourage a State to regulate in a particular way") (internal

quotation marks omitted). Accordingly, the purposes for the appropriations are the purposes of the program.

The cases Arkansas cites are inapposite. *See* Ark. Br. at 10-11. They refer to time-limited appropriations riders that conflict with previously enacted authorizing legislation. *See Donovan v. Carolina Stalite Co.*, 734 F.2d 1547, 1557 (D.C. Cir. 1984) (one-year funding limit in a non-spending program directed to a separate sub-agency did not override authorizing legislation); *Calloway v. D.C.*, 216 F.3d 1, 2-3 (D.C. Cir. 2000) (capped, one-year appropriation to District of Columbia to pay attorneys' fees in Individuals with Disabilities Education Act cases did not amend authority of courts to award fees in such cases); *Nevada v. Dep't of Energy*, 400 F.3d 9, 10 (D.C. Cir. 2005) (specific one-year appropriation to Nevada precluded agency from distributing additional funds to the State absent continuing authorization).

What Arkansas gets wrong is that Section 1396-1 is Medicaid's authorizing legislation, not a later-enacted appropriations rider. *See* Social Security Amendments of 1965, Title XIX, Pub. L. No. 89-97, 79 Stat. 344 (1965); *see also Heritage Ops. Grp., LLC v. Norwood*, No. 17-CV-8609, 2018 WL 4467152, at *1 (N.D. Ill. Sept. 18, 2018) ("States . . . must administer their programs in accordance with the authorizing legislation in Title XIX of the Social Security Act. . . ."). As explained in *Andrus v. Sierra Club*, authorizing legislation is the "[b]asic substantive legislation enacted by Congress which sets up or continues the legal operation of a Federal program or agency either indefinitely or for a specific period of time or sanctions a particular type of obligation or expenditure within a program." *Id.* at 358 n.18 (1979). Congress passed Section 1396-1 as the first section of the new title XIX, establishing the Medicaid program indefinitely and authorizing "a particular type of . . . expenditure within [that] program." *Id.*

As the original authorizing legislation, Section 1396-1 is the guiding star for divining Medicaid's objectives. That guiding star makes clear that the purpose of the program is to "furnish medical assistance . . . and rehabilitation and other services" for those who cannot afford them. 42 U.S.C. § 1396-1. This means the Secretary may not prioritize other goals at the expense of the primary objective of furnishing such assistance.[4]

3. The Subsequent Enactments Upon Which the Secretary Relies Did Not Alter Medicaid's Purpose.

Arkansas argues that a provision in the Deficit Reduction Act ("DRA") changed Medicaid so dramatically that Section 1396-1 "can no longer limit the Secretary's policy choices." Ark. Br. at 17. It is difficult to see how this provision, 42 U.S.C. § 1396u-7, could possibly work such a fundamental change: it is an optional coverage provision that applies only to some population groups.

This argument also ignores how Congress historically has defined and adjusted what counts as "medical assistance." Since its enactment in 1965, Congress has recognized differences among population groups, and consistent with Section 1396-1, accounted for those differences with state options regarding what care and services (*i.e.*, "medical assistance") the states must or can provide to those groups. There are numerous examples. The Act has long-authorized states to offer more limited coverage to the medically needy (those with the characteristics of the categorically needy whose incomes exceed the categorically needy eligibility levels). *See* 42 U.S.C. § 1396a(a)(10)(C) (enacted by Pub. L. No. 89-97, § 1901, 79 Stat. 286, 343-48 (1965)). Since 1968, most Medicaid-

[4] Arkansas appears to argue that because Congress defined what is included within "medical assistance," that somehow means the statutory objectives are broader than furnishing that assistance. Ark. Br. at 12-13. Not so. Congress's attention to the scope of services included within "medical assistance" merely emphasizes that the primary and overarching goal of the program is precisely to enable states to pay and provide for such assistance.

eligible children and young adults under age 21 have been eligible for broad early and periodic screening, diagnostic, and treatment coverage that is not available to older adults. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396d (enacted by Pub. L. No. 90-248, § 302, 81 Stat. 821, 929 (1967), amended by Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2262 (1989)). An amendment added in 1986 allows states to limit the medical assistance available to some low-income women to pregnancy and pregnancy-related services. *See* Pub. L. No. 99-272, § 9501, 100 Stat. 82, 201 (1986). As noted, the DRA authorized states to "provide for medical assistance" for some population groups through "benchmark coverage." 42 U.S.C. § 1396u-7(a)(1)(A) (enacted by Pub. L. No. 109-171, § 6044, 120 Stat. 4, 88 (2006)).[5]

Variation in what specific "medical assistance" must be furnished is entirely consistent with Section 1396-1's primary objective of enabling states to furnish "medical assistance" in the first place.[6] The program's evolution over time thus does not detract from Section 1396-1's indispensable statement of the Medicaid Act's objectives.

[5] Arkansas also cites the DRA's authorization for the Secretary to approve demonstration projects for states to implement "health opportunity accounts" and the ACA's authorization for the Secretary to approve demonstration projects for states to implement chronic disease programs that include incentives for healthy behavior. Ark. Br. at 15-16. Rather than undermining the Medicaid Act's central objective of furnishing medical assistance, these enactments show that Congress has tightly circumscribed the Secretary's authority to approve such demonstrations projects, setting forth the terms of their content, describing how they are to operate, and limiting the number of state projects that the Secretary can approve.

[6] Congress has also described states' flexibility with respect to imposing premiums and cost sharing. *See, e.g.*, Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 131, 96 Stat. 324, 367 (1982) (allowing states to impose premiums on medically needy enrollees while prohibiting premiums and cost sharing for mandatory services provided to categorically needy); 42 U.S.C. § 1396o(f) (defining states' options for imposing heightened cost sharing through waivers); Deficit Reduction Act of 2005, Pub. L. No. 109-171, tit. VI, §§ 6041(a), 6042(a), 6043(a), 120 Stat. 4, 81-86 (2006) (adding additional premium and cost sharing options for some groups).

4. The Section 1396-1 Objectives Apply to All Medicaid Population Groups.

Arkansas next argues that the Court cannot know Congress's purpose when it expanded Medicaid to low-income adults in 2010 because Congress did not amend Section 1396-1 to refer to the adult group. Ark. Br. at 17-19. The Court already rejected this argument stating, "it is inconceivable that Congress intended to establish separate Medicaid programs, with differing purposes. . . ." *Stewart*, 313 F. Supp. 3d at 270.

As the Court explained, Congress has repeatedly added mandatory population groups without listing them in Section 1396-1. *Id.* (collecting citations). Indeed, when expanding Medicaid, Congress takes a consistent approach: Section 1396-1 establishes the program purpose of furnishing "medical assistance." To expand Medicaid to a new mandatory group, Congress adds the group to Section 1396a(a)(10)(A)(i), which requires states to make "medical assistance" available to all individuals within that group. This is what Congress did when it added the Medicaid expansion population, directing states to make the "medical assistance" referenced in Section 1396-1 available to that group. *See* Patient Protection and Affordable Care Act, § 2001, 124 Stat. 119, 271 (2010).[7] Congress's actions do not support the State's "separate purpose" argument.

5. The Secretary Cannot Limit Access to Coverage in the Name of Promoting "Independence."

Arkansas's final argument re-hashes the meaning of "independence" in Section 1396-1, arguing that this term includes broad concepts like "economic self-sufficiency" and "independence from needing state-furnished medical assistance." Ark. Br. at 19-20. This Court has already expressed "doubts [about] whether such an objective is proper," noting that this reading requires

[7] The ACA amended the definition of "medical assistance" to mean "payment of part or all of the cost of . . . care and services *or the care and services themselves, or both*. . . ." 42 U.S.C. § 1396d(a) (emphasis added to show changes in ACA, § 2304, 124 Stat. 119, 296 (2010)).

"excising" the term independence from its context, which "limits its objectives to helping States furnish *rehabilitation and other services* that might promote self-care and independence." *Stewart*, 313 F. Supp. 3d at 271. As the Court correctly concluded, "[i]t does not follow that *limiting* access to medical assistance would further the same end." *Id.*

Arkansas points to the distinct purposes of other public benefit programs, Ark. Br. at 20-21, but these programs simply confirm that Congress knows how to express a law's purpose. The TANF statute expressly includes as a purpose to "end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage." 42 U.S.C. § 601. If Congress intended Medicaid to include these same objectives, it would have said so. *Digital Realty Tr., Inc. v. Somers*, 138 S. Ct. 767, 777 (2018) ("[W]hen Congress includes particular language in one section of a statute but omits it in another[,] . . . this Court presumes that Congress intended a difference in meaning.") (alterations in original) (internal quote omitted).

Nor does Arkansas's appeal to TANF's predecessor AFDC provide insight into the objectives of Medicaid. First, Arkansas asserts that the phrase "self-support and personal independence," which appeared in the AFDC statute, is "eerily similar" to "self-care and independence" and argues that the repeated use of "rehabilitation and other services" should lead the Court to find parallel meanings between the two provisions. Ark. Br. at 20-21. The State's argument turns statutory construction on its head. It is well-settled that courts "presume differences in language like this convey differences in meaning." *Wis. Cent. Ltd. v. United States*, 138 S. Ct. 2067, 2071 (2018) (internal quote omitted); *see also Loughrin v. United States*, 573 U.S. 351, 359 (2014) (relying on "notable textual differences" between two similar statutes to find different meanings). Congress meant something different by "self-care and independence" in the Medicaid

Act than it did by "maximum self-support and personal independence," in AFDC.[8] Arkansas's reading erases these differences.

Arkansas's argument also excises terms from their context. Arkansas focuses exclusively on the repetition of the terms "independence" and "rehabilitation and other services" in the two laws to conclude that the provisions mean the same thing. But this "argument for uniform usage ignores the cardinal rule that statutory language must be read in context since a phrase gathers meaning from the words around it." *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 596 (2004). Here, the vastly different contexts in which these terms appear overcomes any presumption of parallel construction. *Id.* at 595–96. The AFDC goals of keeping children in their own homes, "maintaining and strengthening family life," and "achieving maximum self-support," *see* 42 U.S.C. § 601 (1994), are nowhere to be found in the Medicaid statute. And the cases Arkansas cites interpret Section 601 and, therefore, offer no insight into the meaning of Section 1396-1. *See C.K. v. New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171, 178, 184 (3d Cir. 1996); *Aguayo v. Richardson*, 473 F.2d 1090, 1103-04 (2d Cir. 1973).

The different goals of the various statutes are also reflected in their statutory structures. As Plaintiffs explained, a comparison between Medicaid, on the one hand, and TANF and SNAP, on the other, underscores that Congress did not intend for Medicaid to be a work program. Pls.' Br. at 31-33. Both the TANF and SNAP statutes include work requirements, as did AFDC. *See* 42 U.S.C. § 607; 7 U.S.C. § 2015(d), (o). Public Welfare Amendments of 1962, Pub. L. No. 87-543,

[8] The contrast between self-support and self-care bolsters Plaintiffs' interpretation that Medicaid is concerned with helping individuals attain *functional* independence and capacity to accomplish activities of daily living. For instance, federal regulations defining persons eligible for institutional-level care describe individuals whose conditions "result[] in substantial functional limitations in three or more of the following areas of major life activity," such as "self-care" and "capacity for independent living." 42 C.F.R. § 435.1010.

§ 105, 76 Stat. 172, 186. Medicaid does not. Plaintiffs' interpretation—that independence in Medicaid refers to functional, not financial, independence—properly gives the statutes distinct meaning based on their distinct language, structure, and context. *See* Pls.' Br. at 17.

6. The Secretary's Desire to Save Money Does Not Permit Him to Approve Programs that Subvert the Act's Core Purpose.

Finally, the Secretary seeks to justify approval of the Arkansas Works Amendment by claiming that Medicaid has an additional, implicit purpose: to save money. Fed. Br. at 14 (arguing that measures "designed to stretch limited state resources" further the objectives of Medicaid). That argument gets the Secretary nowhere for two reasons. First, as set forth more fully in Section III.A. below, he did not use that rationale to approve the Arkansas Works Amendment, and "[i]t is axiomatic that [a court] may uphold agency orders based only on the reasoning that is fairly stated by the agency in the order under review." *Williams Gas Processing – Gulf Coast Co., v. FERC*, 373 F.3d 1335, 1345 (D.C. Cir. 2004). More fundamentally, even had the Secretary invoked that argument, it could not withstand judicial review.

As other courts have held, if the "purpose of [a Section 1115] waiver application [i]s to save money," the application cannot meet the standards of Section 1115. *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011). That is because "[a] simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy the [Section 1115] requirement." *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). And make no mistake, the Arkansas Works Amendment is a simple benefits cut. Over a period of just four months, Arkansas has terminated the coverage of more than 16,900 people for failing to meet the work requirement alone. *See* Arkansas Works Program June-November 2018 Reports (attached as Exhibit 1).

In response, the Secretary argues that *New York State Dept. of Social Services v. Dublino*, 413 U.S. 405 (1985), *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S.

644 (2003) ("*Walsh*") and *Thompson*, 362 F.3d 817 (D.C. Cir. 2004), establish that saving money is a permissible purpose for an experimental, pilot, or demonstration project to further. Fed. Br. at 14-16. But those cases are inapposite.

Initially, none of the cases involved Section 1115 projects, and none decided that fiscal sustainability is an affirmative goal of the Medicaid Act. Initially, not one of them arises from a Section 1115 project, let alone addresses what permissible purposes such a project may advance. They therefore cannot suffice to establish that a Section 1115 project is valid if it seeks only to cut costs. The irrelevance of these cases is most apparent in *Dublino*, which arises from the congressional implementation of work requirements in the AFDC program, not the Medicaid program. In upholding a New York law requiring individuals to engage in certain work activities to retain AFDC benefits, the court focused on the text of the AFDC statute, which included work requirements and listed promoting work as a purpose of the program. *Dublino*, 413 U.S. at 419-420 (stating "it would be incongruous for Congress on the one hand to promote work opportunities for AFDC recipients and on the other to prevent States [from supplementing the same]."). In contrast, the Medicaid Act does not authorize such work requirements, nor does its purpose reflect the language in the AFDC statute. Although the court acknowledged that a state may consider financial sustainability, it stated that such considerations cannot lead to "interpret[ing] federal statutes to negate their own stated purposes." *Id.* Thus, the *Dublino* decision in fact suggests that a state may not pursue fiscal sustainability at the expense of the programmatic objectives established by Congress.

As for *Walsh* and *Thompson*, while both cases at least involved the Medicaid program, neither purported to define or determine the objectives of the Medicaid Act for the purpose of Section 1115. These cases examined whether or not the Medicaid Act preempted state statutes

establishing prescription drug rebate programs designed to reduce drug costs for individuals not enrolled in Medicaid. *See Walsh*, 538 U.S. at 653-54, *Thompson*, 362 F.3d at 821 & n.4. The courts considered whether the state statutes were in *conflict* with the objectives of the Medicaid program. The Section 1115 standard is different and much more affirmative – it requires the Secretary to find that the project in question is likely to *promote* the objectives of the Medicaid Act. In finding that those state programs serve "some Medicaid-related goals," the courts focused on their aim to provide broader access to prescription drugs. *See Walsh*, 538 U.S. at 662-63. And, for individuals enrolled in Medicaid, the programs did not restrict access to prescription drugs other than as already explicitly allowed by the Medicaid Act (through the use of prior authorization). *Id.* at 664; *Thompson*, 362 F.3d at 823; *see also Walsh*, 538 U.S. at 664-65 (stating providing benefits to individuals not enrolled in Medicaid and saving money "would not provide a sufficient basis for upholding [the supplemental drug rebate program] if it severely curtailed Medicaid recipients' access to prescription drugs.").

Moreover, to the extent that the Secretary now argues that he appropriately found that saving money would ultimately promote coverage by enabling Arkansas to continue to cover the expansion population, *see* Fed. Br. at 1, that argument is completely unsupported by the record. In approving the Amendment, the Secretary did not mention the need for Arkansas to save money to keep its Medicaid program afloat. Indeed, nothing in the administrative record suggests that the Medicaid program in Arkansas is "actually at risk" of financial collapse. *Stewart*, 313 F. Supp. 3d at 271. There is no evidence about Arkansas's current state revenues or its budget. *See id.* And, even assuming the State did need to take steps to curb its Medicaid costs, nothing in the record explains "why cuts to the expansion population would be the best remedy for any budget woes" given the enhanced federal matching rate for services provided to that population. *Id.*; *see also* 42

U.S.C. § 1396d(y) (setting the reimbursement rate for the expansion population at 93% in 2019 and 90% for 2020 and each year thereafter). In fact, a 2016 Arkansas legislative report found that continuing the Medicaid expansion through 2021 would *save the State* more than half a billion dollars. AR 757 (citing Ark. Health Reform Legislative Task Force, *Final Report* (2016), http://www.arkleg.state.ar.us/assembly/Meeting%20Attachments/836/I14805/Final%20Approved%20Report%20from%20TSG%2012-15-16.pdf). According to the Report, preserving the expansion would continue to be cheaper than the pre-expansion status quo even after the federal match percentage fell to 90 percent. Ark. Health Reform Legislative Task Force, *Final Report* 10 (2016). Thus, Defendants' counsel may not now rely on the completely unsupported notion that reducing coverage for the expansion population is necessary to enable the State to continue covering that population at all.

More fundamentally, the argument strains all logic. While the Secretary points to *Spry v. Thompson*, it does not support his view. 487 F.3d 1272 (9th Cir. 2007) That case involved a population group that, at the time, was not described in the Medicaid Act. *Id.* However, the Medicaid Act now includes that group—the expansion population—as a mandatory eligibility category. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Relatedly, while *NFIB v. Sebelius* did prohibit the federal government from withdrawing all Medicaid funding should a state refuse to cover the expansion population in the first place, that decision did not categorize the expansion population as an optional-coverage population going forward. *NFIB v. Sebelius*, 567 U.S. 519. Rather, the expansion population remains listed in the statute as a mandatory-coverage population to this day. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). So once a state, like Arkansas, extends Medicaid coverage to include the expansion population, that state can no more choose to eliminate coverage for that group of Medicaid recipients than it could for pregnant women, individuals with

disabilities, or any other mandatory-coverage population. However, this gets to the crux of the problem with the argument the Secretary now advances– states do not have an obligation to cover *any* of the populations outlined in the Medicaid Act. *All* of Medicaid is optional for states. Defendants' reasoning would allow the Secretary to approve any proposed project that would save money on the grounds that without the proposed project in place, the state may choose to terminate optional populations or its Medicaid program entirely. In other words, any project that reduces Medicaid spending would be likely to promote the objectives of the Medicaid Act. This cannot be what Congress intended when it enacted Section 1115.

III. Approval of the Arkansas Works Amendment is Arbitrary and Capricious and Exceeds Statutory Authority.

A. The Secretary Cannot Rely on the Findings He Made Regarding Kentucky HEALTH to Justify Approval of the Arkansas Works Amendment.

Recognizing that the rationale the Secretary used to approve the Arkansas Works Amendment is legally deficient, Defendants' ask the Court to examine the reasoning the Secretary used to re-approve the Kentucky HEALTH project. Defendants argue that the rationale used in the Kentucky HEALTH re-approval "applies equally" to a project approved in Kentucky, Arkansas, or any other state. Fed. Br. at 6, 18, 34. As a result, they claim "there is no reason to require the Secretary to recite a similar explanation in the specific context of an Arkansas approval," Fed. Br. at 9. The Kentucky letter "provides ample justification to uphold" approval of the Arkansas request. Fed. Br. at 6, 18; *id*. at 1-4. The Court should reject this line of reasoning.

It is a "foundational principle of administrative law that a court may uphold agency action only on the grounds that the agency invoked when it took the action." *Michigan*, 135 S. Ct. at 2710; *see also Ass'n of Civilian Technicians v. Fed. Labor Relations Auth.*, 269 F.3d 1112, 1117 (D.C. Cir. 2001) (**"**Agency decisions must generally be affirmed on the grounds stated in them . .

. ."). Here, the Secretary approved the Arkansas Works Amendment in a letter dated March 5, 2018. *See* AR 0001-0010 (setting forth rationale for approval). The Secretary did not re-approve Kentucky HEALTH until November 20, 2018, more than eight months later. Furthermore, the Kentucky HEALTH re-approval letter does not incorporate, discuss, or even mention the Arkansas Works Amendment. The Kentucky HEALTH re-approval applies to a different Section 1115 project in a different state. *See* Def's Obj. to Related-Case Designation, ECF No. 17, at 2 (federal Defendants arguing that *Stewart* and *Gresham* "involve two separate approvals of two distinct projects in two different States."); Ark. Br. at 1 (acknowledging "profound differences between the administrative record in this case and [*Stewart*]"). *See also Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut Auto. Ins. Co.*, 463 U.S. 29, 50 (1983) (noting that the "court may not accept" post hoc rationalizations of counsel).

Moreover, the rationale means that CMS does not in fact perform a case-by-case review of each Section 1115 application – CMS simply ignores the various "state-specific" evidence in separate administrative records and approves all similar programs regardless of content. *Cf*. Def's Obj. to Related-Case Designation, ECF No. 17, at 2 (noting that in *Stewart* and *Gresham*, the court will be resolving legal questions "on the basis of different administrative records"). This directly contradicts the repeated assurances by CMS that it considers (and approves or denies) each Section 1115 application on its own merits on a case-by-case basis. *See* AR 0077 (noting that applications "will be reviewed on a case-by-case basis to determine whether the proposed approach is likely to promote the objectives of Medicaid" and that "CMS will evaluate each demonstration project application on its own merits"),[9] AR 0084 (describing the purpose of Section 1115 projects as "to

[9] The Secretary seeks to have it both ways, arguing that the Kentucky re-approval letter, in silence, establishes the work requirement policy in all states, while the State Medicaid Director letter on work requirements, which on its face applies in all states, does not.

demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations" and stating that the agency "performs a case-by-case review of each proposal").

Finally, even if the Kentucky HEALTH re-approval letter were properly considered here, it would not, as the Secretary assumes, definitively cure the defective reasoning that the Court identified in *Stewart*. As the Court is aware, that approval is the subject of ongoing litigation. *See Food Marketing Inst. v. ICC*, 587 F.2d 1285, 1290 (D.C. Cir. 1978) (cautioning that where an agency reaches "precisely the same conclusion" after remand, the court "must recognize the danger that an agency, having reached a particular result, may become so committed to that result as to resist engaging in any genuine reconsideration of the issues" and ensure that the agency action is "more than a barren exercise of supplying reasons to support a pre-ordained result.") It thus is premature for the Secretary to hold up the Kentucky re-approval letter as a paradigm of defensible decision-making.

B. The Record Establishes that the Secretary Failed to Adequately Consider if the Approval Met the Section 1115 Conditions.

The Secretary contends that the Court must be particularly deferential when reviewing his "predictive judgment" that the Arkansas Works Amendment is likely to promote the objectives of the Medicaid Act. *See* Fed. Br. at 12; *see also* Ark. Br. at 22. However, courts do not "treat the predictive nature of the judgment as though it were a talisman under which any agency decision is by definition unimpeachable." *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 821-22 (D.C. Cir. 1983) (vacating agency action where the agency did not give "sufficient consideration to factors that may be highly relevant to" its predictive judgment) (quotation marks omitted). To do so would leave "the arbitrary and capricious standard of judicial review . . . effectively nullified," as "new agency policies often will involve some element of prediction about the future effects of those policies." *Id*. at 822. In short, a "[p]redictive judgment must be based on

reasoned predictions."[10] *Metlife Inc. v. Fin. Stability Oversight Council*, 177 F. Supp. 3d 219, 237 (D.D.C. 2016). The Secretary did not satisfy that standard, as he "entirely failed to consider" whether the Arkansas Works Amendment would help the State furnish medical assistance to low-income individuals. (quotation marks omitted) *Stewart*, 313 F. Supp. 3d at 262.

1. Simply Labeling the Arkansas Works Amendment an "Experiment" Does Not Relieve the Secretary of His Obligation to Engage in Reasoned Decision-making.

The Secretary contends that Plaintiffs "misunderstand the nature of a demonstration project." Fed. Br. at 19, 20. Not so. Plaintiffs understand that Section 1115 allows states to carry out experimental projects designed to test out novel ideas and that Congress has used the results of past projects to inform its Medicaid policy decisions. *Id.*[11] But nothing in the record indicates

[10] None of the cases Defendants cite hold otherwise. *See* Ark. Br. at 22-23, Fed. Brf. at 12. Contrary to Defendants' suggestion, Plaintiffs do not contend that the Secretary needed to demonstrate "certainty" or "complete factual support" in the record for his predictive judgment, but rather that he needed to operate within the limits of the law and to engage in reasoned decision-making. For example, Arkansas pointed to *Baltimore Gas & Electric Co. v. NRDC*, 462 U.S. 87 (1983), but the record in that case revealed that the agency "made the careful consideration and disclosure required by" the statute, "digested [a] mass of material," and summarized the uncertainty surrounding its predictions about matters "at the frontiers of science." *Id*. at 98-99, 103. That certainly was not the case here, as the Secretary entirely ignored the effect of imposing work requirements and limiting retroactive eligibility on coverage, hardly a topic "at the frontiers of science." *Id*. at 103.

[11] Plaintiffs do contest any suggestion that the Secretary abides by the limits in Section 1115 and only approves experimental, pilot, or demonstration projects. To the contrary, he routinely approves Section 1115 proposals that no longer have experimental value. For example, even though Congress made it possible for states to use managed care and to cover a family planning eligibility category through a state plan amendment (as opposed to a Section 1115 project), *see* Fed. Br. at 19-20, the Secretary continues to use Section 1115 to allow states to implement these very policies. In fact, CMS has stated that Section 1115 projects need not be innovative or experimental or time limited. *See* Ctrs. for Medicare & Medicaid Servs., CMCS Informational Bulletin: Section 1115 Demonstration Process Improvements 4 (2017), https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf (announcing that CMS will approve certain "routine, successful" Section 1115 projects for a period of up to 10 years).

that Arkansas designed and the Secretary approved the Arkansas Works Amendment as a legitimate experiment.[12]

First, there is ample reason to doubt that the true purpose of the Arkansas Works Amendment is experimental. That is because, as the Secretary points out, CMS has allowed a number of states to repeatedly waive retroactive eligibility over the course of almost two decades. *See* Fed. Br. at n.2. The Secretary presumably required those states to evaluate the effect of those waivers and is aware of the results of those evaluations, including whether waiving retroactive eligibility changed individuals' behavior in the expected way or otherwise promoted coverage. Permitting yet another state to limit retroactive eligibility is not likely to yield additional useful information. *See Beno v. Shalala*, 30 F.3d 1057, 1069. And while work requirements have never been a condition of Medicaid eligibility, they have long been a condition of eligibility in other public programs (as a result of those programs' governing statutes) and are the subject of a large body of research with consistent findings regarding their effectiveness. *See* Pls.' Br. at n.15; *see also* Section III.B.3, *infra*.

Moreover, it is not enough under Section 1115 for a state simply to propose an experimental, pilot, or demonstration project. The project must also be likely to promote the objectives of the Medicaid Act. Accordingly, even assuming *arguendo* that the Arkansas Works Amendment is experimental, the Secretary needed to consider its impact (*i.e.*, coverage loss and promotion) on the individuals that the Medicaid program was enacted to protect. *See Newton-*

[12] The Arkansas Works Amendment is better understood as an approval in search of an experiment. The Secretary permitted Arkansas to implement the Amendment before having an evaluation plan in place or collecting any serious baseline data. *See* AR 0028 (permitting Arkansas to implement the work requirement June 1, 2018); AR 0045 (initial evaluation design draft not due until 120 days after March 5, 2018 approval, and final evaluation design not due until 60 days after CMS comments on the draft). *See also* Br. for Deans, Chairs, and Scholars as *Amicus Curiae*, ECF No. 33, at 18-20 ["Scholars Br."].

Nations, 660 F.3d at 381. He cannot escape that obligation—which he failed to meet, as detailed below—by declaring that the Amendment is a demonstration, the exact outcomes of which are unknowable.[13] *See* Fed. Br. at 20-21. Nor can he justify approval by contending that it was impossible for him to predict the exact number of individuals who will lose coverage.[14] *See id*. at 21-23. Plaintiffs do not claim that the Secretary must perfectly predict the outcomes of a Section 1115 proposal. But when the Secretary is faced with abundant and uncontroverted evidence indicating that the Amendment will substantially reduce coverage, he cannot "entirely fail[] to consider [that] important aspect of the problem." *See Stewart*, 313 F. Supp. 3d at 264 (quoting *State Farm*, 463 U.S. at 43); AR 0004 (listing the factors the Secretary considered when approving the Amendment).

2. The Secretary Ignored Evidence that the Amendment Would Result in Substantial Coverage Loss and Could Not Reasonably Have Concluded that it Would Promote Coverage.

This Court found that when considering a Section 1115 application, the Secretary must properly examine whether it "would cause recipients to lose coverage [and] whether the project would help promote coverage." *Stewart*, 313 F. Supp. 3d at 262. The Secretary failed to do so here.

Coverage Loss

Commenters raised voluminous and well-founded concerns regarding coverage loss. The record shows that instead of grappling with this issue, the Secretary failed to adequately consider

[13] Defendants rely throughout their briefs on *Aguayo* and *C.K.*, but these cases do not engage in the "searching" assessment of the record demanded under Supreme Court and D.C. Circuit precedent. *See C.K.*, 92 F.3d at 183; *Aguayo*, 473 F.2d at 1103-05. And *Aguayo*—on which *C.K.* rests—was decided in 1973, when HHS reviewed Section 1115 waivers under federal human subject protections—meaning that HHS used technical review panels of outside experts who evaluated the research design and possible harmful effects of the proposed experiment on its participants. *See* 42 U.S.C. § 3515b.

[14] To the extent that the Secretary also claims that he could not have come up with an estimate at all—let alone an accurate estimate—he is incorrect. *See* n.18, *infra*.

whether the Amendment would reduce, rather than promote, access to medical assistance. *See Stewart*, 313 F. Supp. 3d at 263 (faulting the Secretary for failing to "offer 'any information refuting plaintiffs' substantial documentary evidence' that the action would reduce healthcare coverage") (quoting *Beno*, 30 F.3d 1057, 1074 (9th Cir. 1994)). The Secretary failed to provide a "bottom-line" estimate or otherwise consider the magnitude of the coverage loss. *Stewart*, 313 F. Supp. 3d at 262-263.

The record contains redundant, unrebutted warnings that the Arkansas Works Amendment would result in significant coverage loss and harm to Medicaid beneficiaries. *See, e.g.*, A.R. 1268, 1270, 1278-79 (supported with citations to research predicting coverage loss); *see also* Pls.' Br. at 18-29. Contrary to Defendants' claims that these warnings were speculative, they were supported by evidence showing the effect of similar work and administrative requirements in TANF and SNAP and grounded in an understanding of the realities of the Arkansas Works population, including problems regarding access to regular work, transportation, and the internet.[15] Pls.' Br. at 24-29. Commenters have vast experience with public benefit programs, the Medicaid program, and the causes and effects of coverage loss.[16] Many of the commenters also have specific experience with the Arkansas Works population and have seen firsthand how similar work requirements in SNAP and TANF have created significant barriers to accessing those benefits. *See*

[15] Arkansas argues that the number of individuals who have lost Medicaid coverage post-approval is "entirely legally irrelevant" to the question of whether the approval of the Amendment was arbitrary and capricious. Ark. Br. at 27. Plaintiffs do not contest that these figures fall outside of the record. However, they further reveal that commenters did not simply provide overly pessimistic predictions, *id*., but rather rational, evidence-based predictions that have proven accurate.

[16] *See, e.g.*, AR 1311-16 (comments that "draw on CLASP's deep experience with TANF and SNAP" to explain how similar work requirements will create barriers to getting and retaining health care benefits); AR 1281, 1290, 1330 (national advocacy organizations well versed in health policy for low-income individuals); AR 1276, 1296, 1306 (providers explaining how their experience informs their comments); and AR 1265, 1274, 1294, 1317, 1340 (national disease groups citing the high risk of coverage loss for individuals with particular chronic conditions).

AR 1270 (Arkansas Advocates for Children and Families citing its experience, recent problems with access to care, and the impact of SNAP and TANF reporting issues); AR 1326-28 (Legal Aid of Arkansas describing its clients and experience, as well as how many Arkansans lost benefits when the State re-instituted heightened work requirements for certain SNAP beneficiaries); and AR 1308 (Arkansas Hospital Association raising concerns about the rural nature of the state, transportation challenges, administrative burdens, and other issues leading to coverage loss). Despite this rich information, the record reveals that the Secretary "entirely failed to consider" whether the Arkansas Works Amendment "would help provide health coverage for Medicaid beneficiaries." *Stewart*, 313 F. Supp. 3d at 262.

Defendants' various attempts to side-step this "signal omission" fail. *Id.* at 243.Defendants argue that the Secretary responded adequately to commenters' concerns by pointing to: (1) the requirement that Arkansas inform individuals about the work requirement through written notices and outreach, Ark Br. at 24-25; Fed. Br. at 25; (2) the exemptions and good cause exceptions to the work requirement, Fed. Br. at 25; and (3) the fact that the potential nine-month lockout only affects individuals who do not satisfy the work requirements for three months, Ark. Br. at 25. But as Plaintiffs discussed in their opening brief, Pls.' Br. at 21-22, simply reiterating these features of the work requirement amounts to "no answer at all." *Stewart*, 313 F. Supp. 3d at 263. Arkansas included all of these features in its application to CMS, AR 2107 (outreach), 2080-82 (exemptions, good cause exceptions, and termination after three months of noncompliance), meaning that commenters expressed their concerns about coverage loss with these "safeguards" in mind.[17]

[17] Arkansas claims that "the agency specifically addressed these concerns by requiring as several commenters suggested Arkansas to exempt the medically frail. . . ." Ark. Br. at 27. But, Arkansas never proposed to subject medically frail individuals to the work requirement. AR 2071. And although the State did submit a state plan amendment to change how it identifies individuals as medically frail, it did so months before the federal comment period on the Arkansas Works

Pointing to the exemptions and good cause exceptions, the Secretary asserts that "Arkansas tailored the scope of the population subject to the community engagement requirement so as to minimize the risk of unnecessary coverage losses." Fed. Br. at 24. However, the record shows that the work requirement is not a narrowly tailored or precise policy tool designed to avoid coverage loss. Had Defendants examined their own data, they would have seen that only a narrow subset of the Arkansas Works population was not already working or exempt from the requirement. *See, e.g.*, AR 1267, 1278, 1312-13, 1335 (citing reports regarding how many Medicaid participants are already working or are not working for specific reasons); *see also* AR 1269, 1285. Although the purported target of the Amendment is that narrow subset, the entire demonstration population must go through the confusing process of reporting hours or seeking an exemption, with only some exempt automatically through data matching. *See, e.g.,* AR 1303, 1308, 1312, 1336 (describing how individuals who may be exempt are likely to lose coverage because of reporting). Plaintiffs' experiences illustrate that individuals who are meeting the substantive requirement or should be exempt for a particular month have still been found to be non-compliant and have lost coverage. *See, e.g.*, McGonigal Decl., ECF No. 27-5 ¶¶ 2-12, Deyo Decl., ECF No. 27-10 ¶¶ 6-15.

Defendants also make much of the fact that the STCs allow the Secretary to suspend or terminate waivers at any time if he determines that they are no longer "in the public interest or promote the objectives of" the Medicaid Act. Ark. Br. at 25; Fed. Br. at 26. However, that standard provision appeared in Arkansas's application (which was nothing more than a line edited version of the STCs approved in 2016). *See* AR 2069. Thus, it is disingenuous to characterize it as a special

Amendment. *See* Ark. State Plan Amendment 17-001, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AR/AR-17-0002.pdf (submitted March 31, 2017 and approved June 23, 2017). Arkansas cannot seriously claim that the Secretary addressed the concerns commenters raised by requiring the State to alter its definition of medically frail.

protection intended to mitigate potential coverage loss. *See* AR 0005; *see also* Fed. Br. at 26 (emphasizing that the authority would allow the Secretary to rescind waivers in the event of "unexpected coverage loss"). Given that over 16,900 people have lost coverage as a result of the work requirements in just four months, one wonders what circumstances would prompt the Secretary to exercise that authority. The Secretary also highlights the right of individuals to appeal any loss of eligibility. Fed. Br. at 26. The right is not an "assurance" added by the Secretary, *id*., but rather one guaranteed by the Due Process Clause of the Constitution. *See Goldberg v. Kelly*, 374 U.S. 254 (1970). Moreover, the appeal process will only help individuals who were terminated erroneously or who belatedly realize they qualify for one of the narrow good cause exceptions. It will not help individuals who did not complete the work hours or report their compliance on time.

Defendants' now also argue, without any support in the record, that the Secretary could not produce a "bottom-line estimate" of the coverage loss and that no such estimate was necessary. Fed. Br. at 20-21, Ark. Br. at 24. Yet, the Secretary had more than sufficient information to examine coverage loss. Non-governmental entities with far less access to information and data were able to do so.[18]

[18] *See, e.g*, Anuj Gangopadhyaya, et al., Urban Inst., *Medicaid Work Requirements in Arkansas: Who Could Be Affected* (May 2018), https://www.urban.org/sites/default/files/publication/98483/2001846_2018.05.23_arkansas_medicaid_finalized.pdf (estimating at least 39,000 Arkansans would be at risk of not being exempt and not meeting the work requirements in the first year); s*ee also* Rachel Garfield, et al., Kaiser Family Found., *Implications of a Medicaid Work Requirement: National Estimates of Coverage Losses* (June 27, 2018), https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/. Notably, in reaching their estimates, these reports analyzed many of the factors raised by commenters such as the labor market and employment statistics, limited access to the internet, limited access to transportation, health conditions and disabilities among Medicaid enrollees, and the education level of the relevant populations. Gangopadhyaya, at 13-20; Garfield, at 2-5. The amicus briefs also address this issue, Scholars Br. at 18; Br. for the Nat'l Alliance on Mental Illness as *Amicus Curiae*, ECF No. 36, at 4-7.

Finally, Defendants contend that the coverage loss that will result from the Arkansas Works Amendment, particularly from the work requirements, "is properly viewed in the context of the State's discretion to terminate optional coverage entirely." Fed. Br. at 22. For the reasons described in Section II.6 above, the Court should reject this argument.

Promote Coverage

The Secretary also failed to adequately consider whether the Arkansas Works Amendment would promote coverage. The approval letter contained "a single sentence," *Stewart*, 313 F. Supp. at 265, addressing coverage promotion: "[A] more limited period of retroactive eligibility will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy," AR 0008; *see also* Ark. Br. at 28. Here, just as in *Stewart*, "[t]his sort of 'conclusory' reference cannot suffice, 'especially when viewed in light of' an obvious counterargument." *Stewart*, 313 F. Supp. 3d at 265 (quoting *Getty v. Fed. Sav. & Loan Ins. Corp.*, 805 F.2d 1050, 1057 (D.C. Cir. 1986)). The record is replete with evidence of an obvious counterargument: Truncating retroactive coverage from three months to one month reduces coverage for newly eligible beneficiaries and depresses access to medical providers by discouraging them from participating in the program. *See* Pls.' Br. at 21. Faced with this evidence, the Secretary could not have reasonably concluded that *reducing* health coverage by limiting retroactive eligibility was likely to *promote* health coverage. *See Stewart*, 313 F. Supp. 3d at 265 ("As is documented in the comments, restricting retroactive eligibility will, by definition, *reduce* coverage for those not currently on Medicaid rolls.").

Arkansas seeks to dodge this deficiency. The State asserts that "it was not necessary . . . under *Stewart*'s rationale" for the Secretary to consider how the Arkansas Works Amendment would promote Medicaid coverage because unlike Kentucky, Arkansas "did not project significant

coverage loss" in its Section 1115 waiver application. Ark. Br. at 28. This argument is a non-starter.

First, it would absolve the Secretary from considering whether a project is likely to promote coverage when a State omits any quantitative estimate of coverage losses. *Stewart* makes clear that because the central purpose of the Medicaid Act is to enable states to provide medical assistance, Section 1115 requires the Secretary to evaluate whether a proposed project is likely to promote coverage. 313 F. Supp. 3d at 262 (describing the "two basic elements" of coverage – coverage loss and coverage promotion). Second, even assuming an inquiry into coverage promotion is only necessary when a project threatens coverage loss, the administrative record presented the Secretary with ample reason to predict coverage loss and even without that evidence, the Secretary reasonably should have anticipated coverage loss given that it is an inherent feature of the Arkansas Works Amendment, as the lockout penalty and restriction on retroactive coverage make patently obvious. *See* Pls.' Br. at 20-21. Third, the logic of Arkansas's position—that where a State chooses not to submit an estimate of coverage loss, the Secretary has no obligation to consider coverage promotion—would incentivize states to ignore the risk of coverage loss altogether. *See Stewart*, 313 F. Supp. 3d at 262. Such a perverse scheme is an anathema to the text of Section 1115 and turns *Stewart* on its head.

3. The Secretary Could Not Have Reasonably Concluded that the Amendment Would Further His Preferred Alternative Objectives for the Medicaid Program.

Even if the Court accepts Defendants' argument that promoting health and financial independence are freestanding objectives of the Medicaid Act, the Secretary did not reasonably conclude that the Arkansas Works Amendment is likely to promote those objectives. He failed to consider important aspects of the problem and selectively read the evidence in the record. *Genuine*

Parts Co. v. Envtl. Prot. Agency, 890 F.3d 304, 312 (D.C. Cir. 2018).

With respect to the limitation on retroactive coverage, the Secretary concluded that the waiver would incentivize individuals to enroll in Medicaid even when healthy, thereby reducing gaps in coverage and improving health outcomes. AR 0005, 0008. However, as Plaintiffs set forth in their initial brief, nothing in the record indicates that individuals delay enrolling in Medicaid until they are sick, much less that they do so because they know they can rely on retroactive eligibility. *See* Pls.' Br. at 28-29. The evidence in the record does indicate that limiting retroactive eligibility will exacerbate gaps in coverage, decrease continuity of care, lead to worse overall health outcomes, and force more low-income individuals into medical debt and bankruptcy. *Id*.

As to work requirements, the Secretary said "the overall health benefits to the effected [sic] population through community engagement outweigh the health-risks with respect to those" who lose coverage. AR 0007. This conclusory statement is not sufficient. *See Genuine Parts Co.*, 890 F.3d at 312 ("Conclusory explanations for matters involving a central factual dispute where there is considerable evidence in conflict do not suffice to meet the deferential standards of our review.") (internal quotations omitted); *Stewart*, 313 F. Supp. 3d at 259 ("stating that a factor was considered is not a substitute for considering it.") (internal quotations and alterations omitted).

First, the Secretary did not adequately consider the health and financial consequences for individuals who lose coverage due to the Amendment. *See* Pls.' Br. at 25-27. Indeed, although the Secretary emphasizes his consideration of the research showing a positive correlation between work and health, *see* Fed. Br. at 23, he does not dispute that he never grappled with the other side of the equation—the substantial, unrefuted evidence that coverage loss harms both health and

financial independence.[19] *See* Pls.' Br. at 27 (citing AR 1265-66, 1295, 1320, 1276, 1311-14, 1270, 1304); *see also* Br. for the Nat'l Alliance on Mental Illness as *Amicus Curiae*, ECF 36, at 8-12, 17-21 [hereinafter "NAMI Br."]. Moreover, the evidence the Secretary relied on to support his conclusion that work improves health is primarily from European countries, where access to health coverage is nearly universal. *See* AR 1463, 1751, 2025; *see also* Scholars Br., ECF No. 33, at 16-17. The results of these studies, therefore, do not, and could not, account for the financial and health harms that stem from the penalty—loss of health care coverage—the Secretary approved for failure to meet the work requirement. In fact, the Waddell and Burton study CMS relied on, and which Defendants now cite, *see* AR 0004, 0075; Ark. Br. at 29-30, notes this specific limitation and expressly cautions that "interventions which simply force claimants off benefits are more likely to harm their health and well-being." [20] AR 1791. *See Genuine Parts Co.*, 890 F.3d at 313 ("It was arbitrary and capricious for EPA to rely on portions of studies in the record that support its position, while ignoring [portions] in those studies that do not."). Thus, the Secretary relied solely on the potential *benefits* of work to allow Arkansas to terminate health care coverage as a penalty for failure to work. *See Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017) (agency must "adequately analyze the . . . consequences" of its action).

Second, the Secretary overstated and oversimplified the evidence regarding the relationship between health and working or volunteering. Defendants selectively cite evidence to

[19] Defendants also concede that the Secretary failed to respond to the ample evidence showing that providing Medicaid coverage itself promotes work and improves health outcomes and financial security, and therefore, the penalties the Secretary approved will be counterproductive to his stated goals. *See* Pls.' Br. at 26 (citing AR 1314, 1285, 1304, 1335, 1419).

[20] These concerns and limitations were raised directly to the Secretary several months before he approved the Amendment. *See* Letter from Jane Perkins, Legal Dir., Nat'l Health Law Prog., to Brian Neale, Dir., Ctrs. For Medicare & Medicaid Servs., 3 (Jan. 11, 2018), http://bit.ly/2Par8Pf (cited in Am. Compl. ¶ 119).

suggest simple causation: that forcing people to work will improve their health. *See, e.g.*, Ark. Br. at 29-30; AR 0004, 0075. The studies they cite, however, either show only correlation or describe a very complex relationship between employment and health. *See* AR 1691, 1779-80; *see also* Scholars Br. at 16-17. For example, Waddell and Burton repeatedly stress that the health benefits associated with employment largely depend on the quality and security of the work. Unstable, low-wage work—such as the jobs that Medicaid recipients often hold—has been associated with similar or even poorer health outcomes than no work at all. AR 1780, 1795-96. Van der Noordt, another cited literature review, specifically acknowledges that health selection effects—that healthier people are more likely to find work—"may have caused an overestimation of the findings." AR 1691; *see also* Pls.' Br. at 25 n.14. Moreover, the studies discussing volunteering examine willing, not obligatory, participation, which undermines the application of this evidence in this context. *See* AR 1483, 1683, 1733-34. Thus, in addition to failing to consider the likely harms, the Secretary vastly overstated the evidence of benefits from work activities, rendering his reasoning arbitrary and capricious.[21] *See Tex Tin Corp. v. U.S. EPA*, 992 F.2d 353, 355-56 (D.C. Cir. 1993) (rejecting agency prediction where agency's reading of the studies "confuses correlation with causation").

Finally, even assuming that work improves health outcomes, the Secretary did not rationally conclude that the work requirements would increase employment and income.

[21] The Secretary further misconstrued this evidence by citing it to support what is effectively a minimum income requirement. As Arkansas acknowledges, individuals do not have to complete a precise number of hours of work activities, but can merely show income consistent with working those hours. *See* Ark. Br. at 2; AR 0029. For example, someone who rents two rooms in their home for $750 a month would satisfy the requirement without completing any hours. The studies the Secretary cites do not discuss or support imposing a *minimum* income requirement. Moreover, such a requirement directly conflicts with the Medicaid Act's purpose of furnishing medical assistance to the lowest income populations.

Defendants are quick to point out that the Secretary cited evidence that he believed showed Arkansas's one-year-old work referral program (which included no positive incentives whatsoever) was ineffective and concluded something "stronger" was needed. AR 0004-05. But the Secretary ignored evidence in the record suggesting an alternate explanation for the low utilization rate: most people enrolled in Arkansas Works are already working or have good reasons for not working, and therefore did not stand to benefit from the referral. AR 1267, 1278-79, 1303, 1468. The Secretary likewise ignored, without explanation, the substantial, longitudinal evidence showing that the "stronger incentive model" he did approve—*requiring* work as a condition of eligibility—is ineffective at promoting stable jobs and may increase extreme poverty and financial insecurity.[22] *See* Pls.' Br. at 26 (collecting AR cites and studies). Arkansas belatedly tries to discount this large body of evidence. *See, e.g.*, Ark. Br. at 26 (citing AR 1268 and 1269); *see also* Scholars Br. at 16. Nothing in the record, however, indicates that the Secretary seriously considered the research showing that work requirements are ineffective. As a result, his conclusory

[22] Arkansas argues there is evidence in the record supporting the success of work requirement. *See* Ark. Br. at 26, 30& n.8 (citing AR 1269). They mischaracterize a study by LaDonna Pavetti, which nowhere states that work requirements "have been a huge success." *See* LaDonna Pavetti, *Work Requirements Don't Cut Poverty, Evidence Shows*, Ctr. on Budget and Pol'y Priorities (2016), https://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf. While the study acknowledges that some people have argued TANF was successful, it immediately debunks those assertions and concludes "[t]he evidence from an array of rigorous evaluations . . . does not support the view that work requirements are highly effective, as their proponents often claim." Arkansas's citation to a MACPAC paper is no more persuasive. The Medicaid and CHIP Payment and Access Commission is a non-partisan legislative branch agency of health policy experts. *See* 42 U.S.C. § 1396. The MACPAC report largely tracks Pavetti's conclusion noting that any small employment gains diminished over time and that the small employment gains did not result in large growth in incomes. AR 1404. It also notes that individuals may not be able to replace Medicaid coverage with private insurance. MACPAC Report, at 1. (A subsequent MACPAC report has called on the Secretary to order Arkansas to stop terminations due to the magnitude of the coverage losses. *See* Letter from Penny Thompson, Chair, MACPAC to Alex Azar II, Secretary, HHS (Nov. 8, 2018), https://www.macpac.gov/wp-content/uploads/2018/11/MACPAC-letter-to-HHS-Secretary-Regarding-Work-Requirements-Implementation.pdf.)

statement that the work requirements create "appropriate" and "adequate" incentives is hollow. *See* Ark. Br. at 25. In fact, the Secretary argues that he was free to ignore that evidence, without explanation, because the Arkansas Works Amendment is a "demonstration." Fed. Br. at 20-21. Regardless of whether or not the Amendment is a true experiment, *see* Section III.B.1. above, "an agency cannot ignore evidence that undercuts its judgment; and it may not minimize such evidence without adequate explanation." *Genuine Parts Co.*, 890 F.3d at 312. The approval was, therefore, arbitrary and capricious.

C. The Secretary Lacks Statutory Authority to Approve the Arkansas Works Amendment.

Congress gave the Secretary limited power to "waive compliance with any of the requirements of" Section 1396(a) when necessary to allow a state to carry out an experimental project that is likely to promote the objectives of the Medicaid Act. 42 U.S.C. § 1315(a)(1). This Court should not interpret that waiver authority any more broadly than what the text permits. Section 1115 does not, as Defendants contend, give the Secretary unbridled authority to experiment at will with any facet of the Medicaid program, without regard to what Congress intended the purpose of the program to be, and without regard to which requirements Congress determined the Secretary can (and cannot) touch.

As the Supreme Court has noted, "Congress does not 'hide elephants in mouseholes.'" *Cyan, Inc. v. Beaver Cty. Empls. Ret. Fund.*, 138 S. Ct. 1061, 1072 (2018) (quoting *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001)). It is for Congress, not the executive through a narrowly circumscribed waiver power, to weigh the important public policy interests and adjust statutory programs like Medicaid accordingly. *See Chamber of Commerce of the U.S.A v. U.S. Dep't of Labor*, 885 F.3d 360, 387 (5th Cir. 2018) (summarizing cases and noting that "Congress enacts laws that define and, equally important, circumscribe the power of the Executive to control

the lives of the citizens."). In approving the Arkansas Works Amendment, the Secretary has incorrectly presumed that it does, and as a result, vastly exceeded his authority.

1. The Secretary Lacks Statutory Authority to Approve Work Requirements, which are Contrary to the Objectives of the Medicaid Act.

Section 1115 does not allow Defendants to transform Medicaid from a health coverage program into a program that uses health coverage as a carrot to promote work. *See* Pls.' Br. at 29-34. In attempting to do so now, the Secretary not only has exceeded his statutory authority but also reversed, without sufficient explanation, the agency conclusion that he lacks the authority to impose work requirements because they run counter to the objectives of the program. *See id.* at 34. Defendants' attempt to lump together public welfare programs, blurring the lines between Medicaid and SNAP, AFDC, and TANF, fails because of the fundamental differences in those programs, as described in Section II.B.5., above. *See* Ark. Br. at 33; Fed. Br. at 19-23.

Nor can Arkansas be correct in claiming that the approval of any project that reduces the number of beneficiaries is merely a routine "waiver" of the Section 1396a requirement for states to cover all members of a coverage population. *See* Ark. Br. At 32. The narrow waiver authority in Section 1115 cannot mean the Secretary may approve the implementation of wholly new classes of conditions or requirements that are untethered to any specific clause of Section 1396a, so long as they reduce the number of beneficiaries. Such a broad interpretation would give the Secretary the functional authority to write new statutory sections and fundamentally restructure Medicaid in a way the term "waive" cannot encompass.

In making this claim, Arkansas seeks to evade the clear import of *MCI Telecommunications Corp. v. AT&T,* 512 U.S. 218 (1994) by trying to distinguish between Section 1115 and the statutory provision at issue there based on the fact that the words "waive" and "modify" are different. Ark. Br. at 33. This is undoubtedly true. But the Court in *MCI Telecommunications* did

not merely address what "modify" meant. In *MCI Telecommunications*, the Court re-emphasized the common-sense principle that an agency's authority is defined—and limited—by what words mean. There, the FCC's authority to "modify any requirement" in a particular statute only permitted the FCC to modify the requirement "moderately or in minor fashion." 512 U.S. at 225. Here, the Secretary's authority to "waive compliance" with Section 1396a means narrowly that the Secretary may *waive* an existing requirement. But waiver authority does not give the Secretary any more fulsome power, like Defendants' alleged "demonstration-project-approval power," to impose new types of requirements untethered to Section 1396a. Ark. Br. at 32.

Finally, Arkansas seeks to equate the Arkansas Works Amendment with prior Section 1115 projects "under which Medicaid expansion beneficiaries would be disenrolled if they failed to pay premiums." Ark. Br. at 32. As the Court is aware, the Secretary's authority to waive the substantive limits on premiums is the subject of ongoing litigation. And, the lack of challenge to previous approvals of waivers allowing states to charge premiums to members of the expansion population does not mean those approvals were valid or that Plaintiffs' theories would not apply to those waivers. In fact, Defendants' cited source, a law review article, Ark. Br. at 32, references these approvals to argue that they are beyond the scope of the Secretary's authority. Sidney D. Watson, *Premiums and Section 1115 Waivers: What Cost Medicaid Expansion?*, 9 St. Louis U. J. Health L. & Pol'y 265, 289-94 (2016) (explaining the Secretary does not have the authority under Section 1115 to waive the statutory protections regarding premiums for the expansion population).

The Secretary simply does not have the authority to authorize work requirements as a condition of eligibility in Medicaid under Section 1115. Although Congress has amended the Medicaid Act numerous times, it has not implemented work requirements nor changed the language of the Medicaid Act to support the implementation of work requirements.

2. The Secretary Lacks Authority to Require Online Reporting.

The Secretary argues that Section 1115 gives him the authority to allow Arkansas to require online-only reporting and thus not adhere to 42 U.S.C. § 1396w-3, a provision outside of Section 1396a. Fed. Br. at 27. As Plaintiffs explained in their opening briefing, Section 1115 must be read as a whole and does not contain an independent authority that permits the Secretary to "authorize[] non-compliance" with any requirement of the Medicaid Act. *See* Pls.' Br., at 34-36. The Secretary cannot pull apart Section 1115 to create this authority – the text itself unambiguously precludes that reading. *Id.*

The Supreme Court has made clear that statutory interpretation follows "one, cardinal canon before all others … courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Conn. Nat'l Bank v. Germain,* 503 U.S. 249, 253-54 (1992) (citations omitted). Interpreting Section 1115 to include a separate expenditure authority would violate several established rules of statutory construction. Such a reading would ignore the plain meaning of the words Congress used—reading the "and" in Section 1115 as "or." *See* Pls.' Br. at 36. It would also add words to a statute that are not contained there—reading a delegation of authority into Section 1115(a)(2) when the subsection contains no such delegation. *See Mistretta v. United States.,* 488 U.S. 371, 373 (1989) (nondelegation doctrine). Such a reading of Section 1115 would also give parts of the statute no meaning—reading Section 1115(a)(1) out of the law because the authority the Secretary claims in (a)(2) would make use of (a)(1) unnecessary. *South Carolina v. Catawba Indian Tribe, Inc.*, 476 U.S. 498, 510 n.22 (1986) (statute should be interpreted so as not to render one part inoperative); *Children's Hosp. Ass'n. of Texas v. Azar,* 300 F. Supp. 3d 190, 207 (D.D.C. 2018) (courts must give meaning to every clause and word of a statute). Reading a separate expenditure authority into the statute would also disregard the doctrine

of last antecedent, as it would require a leapfrog interpretation, reading the qualifying phrase of "such project" when used in Section 1115(a)(2)(A) to refer back to Section 1115(a) rather than the immediately preceding clause of Section 1115(a)(1). *See Barnhart v. Thomas*, 540 U.S. 20, 26 (2003) (doctrine of last antecedent). In sum, there simply can be no question that the text of Section 1115 conflicts with the Secretary's interpretation.

3. The Secretary Had No Authority to Approve the Waiver of Retroactive Coverage.

In response to Plaintiffs' argument that the Secretary improperly approved Arkansas's waiver of retroactive coverage, the Defendants admit, as they must, that the Secretary did not waive retroactivity under 42 U.S.C. § 1396a(a)(10) and § 1396d(a). Fed. Br. at 27-28; Ark. Br. at 35-26 to 33; Doc. 39-1 at 35 to 36. They say this does not matter because the Secretary did waive retroactivity under Section 1396a(a)(34), and his non-action as to a(a)(10) and d(a) was a "harmless," "inadvertent" "technicality." Fed. Br. at 27-28; Ark. Br. at 35-36.

Defendants go too far. As Plaintiffs set forth in their opening brief, the Secretary does not have the authority to waive Section 1396d. Moreover, to treat the Secretary's non-waiver of a(a)(10) and d(a) as a mere technicality would require the Court to ignore two cardinal principles of construction. First, "the Court must 'give effect, if possible, to every clause and word of a statute,'" *Children's Hosp. Ass'n*, 300 F. Supp. 3d at 207 (quoting *United States v. Menasche*, 348 U.S. 528, 538–39 (1955)), but Defendants ask the Court to simply ignore a(a)(10) and d(a) by insisting that a waiver of a(a)(34) constitutes a waiver of all retroactive coverage, when it does not.

Second, the Court's interpretation of the approval letter and STCs "must begin with the plain meaning of the language," and where that "language provides a clear answer, it ends there as well." *See Am. Fed'n of Gov't Emps., Local 2924 v. Fed. Labor Relations Auth.*, 470 F.3d 375, 381 (D.C. Cir. 2006) (citations and quote omitted). But here, Defendants ask the Court to not

simply evaluate what the Secretary wrote—waiving a(a)(34) but not a(a)(10) and d(a)—but rather to engage in an exercise of inferring what they now claim the Secretary *intended* to write. *See Farrell v. Tillerson*, 315 F. Supp. 3d 47, 60 (D.D.C. 2018) (finding that "plain language meaning" of words used in agency correspondence demonstrated agency's intent). Following these bedrock principles of construction, it is clear that the separate mandate to provide retroactive coverage to Medicaid recipients under Sections 1396a(a)(10) and d(a) is still in effect—*irrespective* of subsection a(a)(34)'s waiver. Therefore, the Secretary has not permissibly waived retroactive coverage.

IV. The Appropriate Remedy is Vacatur

"When a court concludes that agency action is unlawful, 'the practice of the court is ordinarily to vacate the rule.'" *Stewart*, 313 F. Supp. 3d at 272 (quoting *Ill. Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693 (D.C. Cir. 1997)); *see also Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110 (D.C. Cir. 2014) ("[V]acatur is the normal remedy."). Nothing about this case warrants a departure from the ordinary rule favoring vacatur.

To determine whether remand without vacatur is justified, the court must consider two factors: "the seriousness of the . . . deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed." *Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993); *see also Stewart*, 313 F. Supp. 3d at 273. "Put otherwise, this Court must determine whether there is 'at least a serious possibility that the [agency] will be able to substantiate its decision on remand,' and whether vacatur will lead to impermissibly disruptive consequences in the interim." *Standing Rock Sioux Tribe v. U.S. Army Corps of Engineers*, 282 F. Supp. 3d 91, 97 (D.D.C. 2017) (citation omitted). Both factors counsel in favor of vacatur.

As to the first factor, courts "have not hesitated to vacate a rule when the agency has not responded to empirical data or to an argument inconsistent with its conclusion." *Comcast Corp. v. FCC*, 579 F.3d 1, 8 (D.C. Cir. 2009). As explained above, the Secretary's approval of the Arkansas Works Amendment suffers from "major shortcomings," including his failure to address the important effects of the program and his decision to "turn[][his] back on the implications" of the program. *Humane Soc'y of the U.S. v. Zinke*, 865 F.3d 585, 614-15 (D.C. Cir. 2017). Despite Defendants' claim to the contrary, the fact that the Secretary has now re-approved Kentucky HEALTH does not alter that fact. *See* Section III.A., above. The error in the Secretary's waiver approval "is not merely procedural; rather . . . the agency acted outside of the scope of its statutory authority." *Children's Hosp. Ass'n of Texas v. Azar*, 300 F. Supp. 3d 190, 211 (D.D.C. 2018). Put simply, the Secretary "cannot arrive at the same conclusions reached in the [approval] because the actions taken were not statutorily authorized." *Humane Soc'y of the United States v. Jewell*, 76 F. Supp. 3d 69, 137 (D.D.C. 2014). Vacatur is therefore appropriate.

"[T]he second *Allied-Signal* factor [disruptive consequences of vacatur] is weighty only insofar as the agency may be able to rehabilitate its rationale for the regulation." *Comcast*, 579 F.3d at 9. Here, for the reasons Plaintiffs have described, the approval cannot be rehabilitated, and therefore the Court need not reach the second factor. However, even if the Court evaluates this prong, it weighs in favor of vacatur. Defendants argument on this factor consists solely of the claim that vacatur would be impermissibly disruptive because it "would interrupt [the State's] data collection effort and cause confusion among beneficiaries."[23] Fed. Br. at 29; *see* Ark. Br. at 38.

[23] Significantly, many beneficiaries do not currently "understand the new work or reporting requirements or the consequences of failure to comply." *See* MaryBeth Musumeci et al., Kaiser Family Found., *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees* 6 (2018), https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/#A1. Thus, the State's concern that vacatur –

But, Defendants simply are wrong about the difficulty of unwinding the Amendment. There is an easy way to restore the status quo ante: Arkansas can permit individuals who had been dis-enrolled to re-apply for Medicaid, in the same manner as an initial enrollee, and can choose not to take the extra step of dis-enrolling individuals who fail to meet the work requirements.[24] It also can retain or re-open the very processes it had a few months ago for managing retroactive coverage.

Yet even if some disruption were inevitable as a result of vacating the Secretary's approval, that disruption cannot outweigh the far more onerous disruption that will occur to beneficiaries if Arkansas Works remains in place in the interim. *See Citizens for Responsibility & Ethics in Wash. v. FEC*, 316 F. Supp. 3d 349, 413-14 (D.D.C. 2018), *appeal filed*, No. 18-5261 (filed Aug. 30, 2018) (vacating challenged rule after balancing the disruption to non-political committees, who would have to make greater disclosures regarding donors if challenged rule were vacated, with the harm to the electorate who were denied donor information that should have been disclosed). Balanced against whatever impact on data collection Arkansas claims would occur—although it is not clear what data collection Arkansas is conducting or even whether it already has begun[25]—is the fact that, already, Arkansas has terminated over 16,900 individuals for failure to meet the work requirement. The monthly termination of Medicaid beneficiaries will continue if the Amendment remains in place, making needed medical care—surgeries, prescriptions, and chronic disease

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which would relieve beneficiaries of their obligation to meet the complicated work requirements that are the source of their confusion – would sow harmful confusion is meritless.

[24] This would be particularly simple given that as of January 1, 2019, no one will be subject to termination for failure to complete work requirements until March 31, 2019.

[25] *See* Letter from Andrea J. Casart, Dir., CMS Div. of Medicaid Expansion Demonstrations, to Dawn Stehle, Medicaid Dir., Ark. Dep't of Human Servs. (Nov. 1, 2018) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-feedback-eval-dsgn-20181101.pdf (directing Arkansas to revise evaluation design for the work requirements).

management—inaccessible to increasing numbers of the Medicaid-eligible population. Nor can the State even estimate the negative health and financial impact these individuals will endure if the Amendment remains in place during remand. These negative effects are both devastating to the individuals Medicaid is meant to assist and irreversible. This Court should vacate the Secretary's waiver approval upon remand.

V. The State Medicaid Director Letter is a Final Agency Action and Violates the APA.

In their opening brief, Plaintiffs explained that the SMD Letter not only was arbitrary and capricious but also forbidden by the APA as an improperly implemented substantive rule. Pls.' Br. at 38-45. In response, the Secretary insists that Plaintiffs cannot challenge the SMD Letter because it is not a "final agency action." Fed. Br. at 29-32; *see also* Ark. Br. at 36 n.10. The argument is meritless. Agency action is "final," and therefore subject to judicial review under the APA, if two factors are present. "'First, the action must mark the consummation of the agency's decisionmaking process—it must not be of a merely tentative or interlocutory nature.'" *U.S. Army Corps of Eng'rs v. Hawkes Co.*, 136 S. Ct. 1807, 1813 (2016) (quoting *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997)). "'[S]econd, the action must be one by which rights or obligations have been determined, or from which legal consequences will flow.'" *Id*. Both are true of the SMD Letter.

First, the SMD Letter is neither tentative nor interlocutory. It makes clear that CMS has concluded its evaluation of its position regarding state efforts to impose work requirements in Medicaid through the use of Section waivers. Indeed, the Letter "announc[es] a new policy" and it does so without equivocation—"CMS will support [such] efforts." AR 0074. The Letter emphatically declares that "CMS is *committing* to support state demonstrations that require eligible adult beneficiaries to engage in work or community engagement activities," and that "[t]his is a shift from prior agency policy." AR 0076 (emphasis added). The Letter thus reflects the "agency's

settled position, a position it plans to follow in reviewing State-issued [Section 1115 proposals]." *See Appalachian Power Co. v. EPA*, 208 F.3d 1015, 1022–23 (D.C. Cir. 2000) (finding EPA guidance document constituted "final agency action," where the document "consisted of requir[ements] State [] authorities" must satisfy in order to receive EPA approval of proposed regulatory permits), and thus marks the consummation of the agency's decision-making process).

Second, contrary to the Secretary's insistence that the SMD Letter is nothing more than "nonbinding guidance," Fed. Br. at 31, the SMD Letter has real legal consequences. Initially, the Secretary's retort is non-responsive; "[t]hat the issuance of a guideline or guidance may constitute final agency action has been settled in this circuit for many years." *Barrick Goldstrike Mines Inc. v. Browner*, 215 F.3d 45, 48 (D.C. Cir. 2000); *see, e.g.*, *Mendoza v. Perez*, 754 F.3d 1002, 1008 (D.C. Cir. 2014) (finding guidance letters that "update[d] special procedures" for "seeking [] certification in [certain] occupations" constituted final agency action). More fundamentally, the impact of the SMD Letter cannot be casually disregarded. It sets forth numerous requirements that "States *must* comply with" to receive CMS approval for a demonstration project imposing work requirements. AR 0078–82 (emphasis added). And the Secretary has consistently cited states' compliance with the terms of the SMD Letter as a basis for approving Section 1115 projects involving work requirements, including the Arkansas Works Amendment. *See* AR 0003; *see also* Pls.' Br. at 44 (discussing CMS's reliance on SMD Letter for approval of Kentucky and Indiana waivers). Accordingly, it is plain that the SMD Letter has direct legal consequences for any state seeking to implement work requirements: failure to comply with the Letter's requirements will result in a denial, while meeting the Letter's requirements makes a proposal eligible for approval.

For this reason, the D.C. Circuit's decision in *Appalachian Power* is instructive. There, the Court found an EPA guidance document constituted final agency action where the EPA "le[d] . . .

State permitting authorities to believe that it will declare permits invalid unless they comply with the terms of the document," and based future agency "actions on the policies or interpretations formulated in the document." 208 F.3d at 1021; *see also id.* at 1023 ("[The guidance document] . . . reads like a ukase. It commands, it requires, it orders, it dictates."). As in *Appalachian Power*, "[t]hrough the Guidance, [CMS] has given the States their 'marching orders' and [CMS] expects the States to fall in line. . . ." *Id.* at 1023; *see also Texas v. United States*, 300 F. Supp. 3d 810, 839 (N.D. Tex. 2018) (holding that HHS "guidance document" outlining information states must include "in their capitation rate proposals to CMS" to obtain approval was final agency action); *Ala. v. Ctrs. for Medicare & Medicaid Servs.*, 780 F. Supp. 2d 1219, 1227 (M.D. Ala. 2011), *aff'd*, 674 F.3d 1241 (11th Cir. 2012) (holding that CMS "Dear State Health Official" letter establishing "obligations of states who seek recovery from fraud-and-abuse defendants" was final agency action and that "agency action is not required to be specifically applied to an entity within the agency's purview before the action is considered final[,] [s]o long as the action is one from which 'legal consequences *will* flow'" (quoting *Bennett*, 520 U.S. at 178)).

Because the SMD Letter thus is a consummated, definitive pronouncement from which legal consequences will flow, it is a final agency action subject to judicial review under the APA. The Secretary offers only a cursory, one paragraph defense to the merits of that challenge. *See* Fed. Br. at 32. In response to Plaintiffs' claim that the SMD Letter is invalid because it was not promulgated pursuant to the notice and comment procedures required for a substantive rule, the Secretary argues that the Letter is exempt from notice and comment because it is a "general statement[] of policy." *See Id*. at 32 (citing 5 U.S.C. § 553(b)(3)(A)). The *only* reason the Secretary provides as to why the SMD Letter is a general statement of policy (rather than a substantive rule) is that "[t]he letter 'compels action by neither the recipient nor the agency.'" *Id.* (quoting *Holistic*

Candlers & Consumers Ass'n v. FDA, 664 F.3d 940, 944 (D.C. Cir. 2012)). But this is not the test.[26]

The correct test is well established: "If an agency pronouncement "substantially curtails [the agency's] discretion," then the pronouncement "meets . . . [the] affirmative definition of a legislative rule" and must be promulgated pursuant to notice and comment procedures. *McLouth Steel Prod. Corp. v. Thomas*, 838 F.2d 1317, 1322 (D.C. Cir. 1988). To make this determination, courts look at whether the "language" in the agency's statement "strongly suggests that [the agency] will treat the [statement] as a binding norm," and, even "[m]ore critically," whether the agency's "later conduct applying [the statement] confirms its binding character." *Id.* at 1320–21.

Here, both the language of the SMD Letter and CMS's conduct applying the Letter indicate that it is a substantive rule, not a mere policy statement. *See* Pls.' Br. at 42-44. In short, by announcing what is necessary to win CMS approval to impose work requirements, the SMD Letter "constrains the agency's discretion" over its Section 1115 decision-making. *McLouth*, 838 F.2d at 1320; *see also Sprint Corp. v. F.C.C.*, 315 F.3d 369, 373 (D.C. Cir. 2003).

VI. Plaintiffs Have Pleaded a Justiciable Claim Under the Constitution's Take Care Clause.

Plaintiffs allege that the Executive Branch's approval of the Arkansas Works Amendment usurps legislative power by unilaterally rewriting the Medicaid statute with the explicit intent of undermining the ACA's Medicaid expansion. Am. Compl., ECF. No. 26, ¶¶ 6, 106-12, 131-33,

[26] The one decision the Secretary cites—*Holistic Candlers* & *Consumers Ass'n*—does not even address the issue of whether an agency action is a general policy statement or a substantive rule triggering notice and comment. In any event, "compel[ling] action" is not necessary for finality either; *Holistic Candlers* merely mentions it as one relevant fact. 664 F.3d 940, 944. As the D.C. Circuit held in *Rhea Lana, Inc. v. Dep't of Labor*, 824 F.3d 1023, 1027–32 (D.C. Cir. 2016), a consummated agency decision is final if it "either" "determines obligations" *or* "creates legal consequences." *Id.* at 1027.

256. In response, Defendants ask the Court to dismiss that claim by effectively holding that the Take Care Clause is categorically unenforceable. Fed. Br. at 38. The Court should reject that sweeping argument, which cannot be squared with fundamental notions of separation of powers.

Under the Take Care Clause, when legislation is enacted, the Executive has a duty to ensure that the laws are "faithfully executed." *Util. Air Regulatory Grp.*, 134 S. Ct. at 2446; *Clinton v. City of New York*, 524 U.S. 417, 438 (1998); *Angelus Milling Co. v. Comm'r*, 325 U.S. 293, 296 (1945); *Kendall v. United States ex rel. Stokes*, 37 U.S. (12 Pet.) 524, 612-13 (1838). That obligation applies to "the President . . . personally and through officers whom he appoints." *Printz v. United States*, 521 U.S. 898, 922 (1997) (citing U.S. Const. art. II, § 2). Thus, when officers—such as the Secretary—exercise the President's Article II *power* to "execute" the laws, they are bound by the Article II *duty* to do so "faithfully." *Util. Air Regulatory Grp.*, 134 S. Ct. at 2446.

Defendants' citation to *Mississippi v. Johnson*, 71 U.S. (4 Wall.) 475, 499 (1866) does not change this conclusion. That case stands for the narrow principle that the Court may not enjoin the President, personally, to affirmatively take an official action that was committed to his discretion. *Id.* That the courts are, however, empowered to enjoin executive officials whose actions exceed the limits of their constitutional authority is beyond debate. *See, e.g.*, *Bowen v. Michigan Acad. of Family Physicians*, 476 U.S. 667, 681 (1986) (courts will "ordinarily presume that Congress intends the executive to obey its statutory commands and, accordingly, that it expects the courts to grant relief when an executive agency violates such a command."); *Chamber of Commerce of U.S. v. Reich*, 74 F.3d 1322, 1328 (D.C. Cir. 1996) ("When an executive acts *ultra vires*, courts are normally available to reestablish the limits on his authority." (quoting *Dart v. United States*, 848 F.2d 217, 224 (D.C. Cir. 1988)). And Defendants' passing assertion that the Clause is not privately enforceable runs counter to the long history of courts permitting private plaintiffs to hold executive

officials accountable for *ultra vires* actions. *See, e.g.*, *Util. Air Regulatory Grp*., 134 S. Ct. at 2446; *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 587 (1952); *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495 (1935); *Angelus Milling Co.*, 325 U.S. at 296; *Kendall*, 37 U.S. at 612-13.

The Take Care Clause, therefore, provides an important means for courts to review the actions of subordinate executive officials when, as here, they act as lawmakers and infringe on the legislative power vested exclusively in Congress. *See Youngstown Sheet & Tube Co.*, 343 U.S. at 587 (1952). In the administrative realm, courts have explained the relationship between the Legislative and Executive powers as requiring that "Congress must lay down by legislative act an intelligible principle, and the agency must follow it." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 536 (2009) (Kennedy, J. concurring) (internal quotations omitted); *see also Whitman*, 531 U.S. at 472. The Take Care Clause and non-delegation principles, therefore, form two sides of the same coin: Congress may not delegate its legislative authority to define a law's intelligible principle, and the Executive, in "faithfully execut[ing]" that law, may not exercise that core legislative power. *See Clinton*, 524 U.S. at 445-47 (line item veto unconstitutional although "Congress intended such a result," because it gave "the President the unilateral power to change the text of duly enacted statutes"). If Congress may not give away its legislative power, it is certainly unconstitutional for the Executive to take it without permission. *See Util. Air Regulatory Grp*., 134 S. Ct. at 2446.

That is precisely what the Secretary has done here. Because Plaintiffs have clearly stated a claim that the Secretary has overstepped and disregarded his constitutional obligation to take care that the laws are faithfully executed, the Court should deny Defendants' motion to dismiss.

CONCLUSION

For the reasons stated above, Plaintiffs respectfully ask that the Court grant their Motion for Summary Judgment, vacate the approval of the Arkansas Works Amendment, as well as the Dear State Medicaid Letter, and deny Defendants' Motions.

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CERTIFICATE OF SERVICE

I hereby certify that on December 21, 2018, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to the authorized CM/ECF filer listed below:

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