[ORAL ARGUMENT NOT SCHEDULED]

19-5905 & 19-5097
UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

RONNIE MAURICE STEWART, et al.,
Appellees

v.

ALEX MICHAEL AZAR II, in his official capacity
as Secretary of the United States
Department of Health and Human Services, et al.,

THE COMMONWEALTH OF KENTUCKY
Appellants.

*** *** *** ***
On appeal from the
United States District Court
for the District of Columbia
Case No. 1:18-cv-152
*** *** *** ***

BRIEF FOR THE COMMONWEALTH OF KENTUCKY

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

A. Parties, Intervenors, Amici

The Plaintiffs-Appellees are Ronnie Maurice Stewart, Shawna Nicole McComas, David Roode, Sheila Marlene Penney, Hunter Malone, Sarah Martin, Althea Humber, Melissa Spears-Lojek, Linda Keith, Kimberly Kobersmith, Debra Wittig, Randall Yates, Rodney Lee, Teri Blanton, Robin Ritter, and Diika:Nèhi Segovia.

The federal Defendants-Appellants are Alex M. Azar II, in his official capacity as Secretary of the United States Department of Health and Human Services; Seema Verma, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; Paul Mango, in his official capacity as Chief Principal Deputy Administrator of the Centers for Medicare & Medicaid Services; Demetrios L. Kouzoukas, in his official capacity as Principal Deputy Administrator of the Centers for Medicare & Medicaid Services; the United States Department of Health and Human Services; and the Centers for Medicare & Medicaid Services.

The Commonwealth of Kentucky is Intervenor-Defendant-Appellant.

The following organizations participated as amici before the district court: Deans, Chairs and Scholars; AARP; AARP Foundation; Justice in Aging; National Academy of Elder Law Attorneys; Disability Rights Education and Defense Fund; American Academy of Pediatrics; American College of Physicians; American Medical Association; American Psychiatric Association; Catholic Health Association of the

United States; March of Dimes; and National Alliance on Mental Illness. The Commonwealth of Kentucky also filed an amicus brief before it was granted leave to intervene.

B. Rulings under review

The rulings under review are the memorandum opinion and order entered on March 27, 2019 (Dkt. Nos. 131, 132); the order entering judgment on April 4, 2019 (Dkt. No. 134); and all prior orders and decisions that merge into those, including the memorandum opinion and order entered on June 29, 2018 (Dkt. Nos. 73, 74). The Honorable James E. Boasberg issued these rulings in Case No. 1:18-cv-152 (D.D.C.). They are reported at 313 F. Supp. 3d 237 (D.D.C. 2018), and 366 F. Supp. 3d 125 (D.D.C. 2019).

C. Related cases

This case was not previously before this Court. Substantially the same issues are presented in *Gresham v. Azar*, 19-5094, 19-5096 (D.C. Cir.), and *Philbrick v. Azar*, Case No. 1:19-cv-773 (D.D.C.) (Boasberg, J.).

/s/ Matthew F. Kuhn
Matthew F. Kuhn

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TABLE OF AUTHORITIES[1]

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GLOSSARY

ACA	Patient Protection and Affordable Care Act
AFDC	Aid to Families with Dependent Children
APA	Administrative Procedure Act
FPL	Federal poverty level
Secretary	Secretary of the United States Department of Health and Human Services
SNAP	Supplemental Nutrition Assistance Program
SUD	Substance use disorder
TANF	Temporary Assistance for Needy Families

INTRODUCTION

In this lawsuit, 16 Kentuckians challenge Kentucky HEALTH, a waiver of certain Medicaid provisions granted to the Commonwealth of Kentucky by the Secretary of the United States Department of Health and Human Services (Secretary) under Section 1115 of the Social Security Act. For this lawsuit to succeed in invalidating Kentucky HEALTH, the Court must take a series of untenable positions *en route* to substituting its judgment for that of the Secretary.

The district court went down that road, holding that the Medicaid statute is almost solely concerned with paying for health care for as many people as possible. In the district court's view, the Medicaid program does not care about whether Medicaid actually improves the health and wellness of recipients. Nor, according to the district court, is the Medicaid program concerned with promoting the financial independence of recipients. These conclusions, which are irreconcilable with the Medicaid program, not to mention the Secretary's entitlement to deference in defining Medicaid's objectives, cannot stand.

Kentucky HEALTH is within the heartland of the Secretary's judgment to approve, and his reasoning explaining that judgment is the definition of rational. The Secretary rationally concluded that Kentucky HEALTH likely will promote recipients' health and wellness through measures like a community-engagement program, which, generally speaking, requires able-bodied, working-age adults to work or become involved in their communities in order to remain eligible for Medicaid. The Secretary

also rationally determined that Kentucky HEALTH likely will make Medicaid in Kentucky more sustainable. The district court overruled that judgment, even though Kentucky HEALTH will allow the Commonwealth to provide optional Medicaid benefits and even non-Medicaid benefits to Kentuckians. Kentucky HEALTH, more importantly, is how the Commonwealth can continue to afford expanded Medicaid.

The Secretary also gave ample consideration to any coverage loss that Kentucky HEALTH may cause. The Secretary is not required to show that no coverage loss will occur; in fact, Section 1115's text envisions that coverage loss can happen as a result of a Section 1115 waiver. It was more than rational for the Secretary to conclude that any potential for coverage loss is sufficiently addressed through Kentucky HEALTH's guardrails against coverage loss, on-ramps for recipients to regain coverage, and its targeted exclusions from program requirements. Also, as the Secretary noted, Kentucky HEALTH is designed to test the extent to which any coverage loss will be the result of enrollees moving off of public assistance and onto other health coverage.

STATEMENT OF JURISDICTION

Plaintiffs-Appellees invoked the district court's jurisdiction under 28 U.S.C. § 1331. The district court entered final judgment on Count VIII of Plaintiffs'-Appellees' Amended Complaint under Federal Rule of Civil Procedure 54(b) on April 4, 2019. Defendants-Appellants filed notices of appeal on April 10 and 11, 2019. This Court has appellate jurisdiction under 28 U.S.C. § 1291.

ISSUES PRESENTED[2]

1. Whether the district court correctly vacated and remanded the Secretary's judgment that Kentucky HEALTH as a whole is likely to assist in promoting the objectives of Medicaid.

2. Whether the Secretary correctly or reasonably determined that improving health and wellness and promoting financial independence are permissible objectives of the Medicaid statute.

PERTINENT STATUTES & REGULATIONS

Pertinent provisions are reproduced in the addendum.

STATEMENT OF THE CASE

Effective January 1, 2014, the Commonwealth amended its state Medicaid plan to cover the expansion population created by the Patient Protection and Affordable Care Act (ACA). AR6720 [JA__]. Although many more Kentuckians than expected have enrolled in expanded Medicaid, AR5440 [JA__], the program has not been a panacea for the health problems facing many Kentuckians. Even after expanding Medicaid, Kentucky has reported the highest number of cancer deaths in the nation, as well as the 12th highest rate of adult obesity. AR5439 [JA__]. Post-Medicaid expansion, the Commonwealth also has ranked 45th and 47th worst in the country in the occurrence of diabetes and heart disease, respectively. *Id.* And during Kentucky's first

[2] The Commonwealth incorporates by reference the federal government's argument about the overbreadth of the relief granted by the district court.

year of expanded Medicaid, less than ten percent of enrollees received an annual wellness or physical exam, AR6724 [JA__]—a key indicator of whether Medicaid expansion was changing behaviors that would lead to better health outcomes.

Nearly three years ago, Governor Matthew Bevin set out to try to address these and other problems through a Section 1115 waiver. AR5432 [JA__]. Generally speaking, Section 1115 of the Social Security Act allows the Secretary to "waive compliance" with "any" of Medicaid's requirements in 42 U.S.C. § 1396a if, in the Secretary's "judgment," the project is "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a). The Secretary can use Section 1115 to approve "any experimental, pilot, or demonstration project." *Id.*

Under Section 1115, Governor Bevin sought approval of a waiver known as Kentucky HEALTH. In Kentucky's waiver application, Governor Bevin explained that "Kentucky HEALTH is a transformative program designed not only to stabilize the [Medicaid] program financially, but to improve health outcomes and overall quality of life for its members." AR5432 [JA__]. With these goals in mind, the Commonwealth proposed a number of complementary features, one of which was a community-engagement program. Generally speaking, this program would require enrollees who are able-bodied, working age adults to participate in their communities for a set number of hours each month. AR5445–46 [JA__–__]. Enrollees could meet this requirement by any one of many routes, including by employment, volunteering, caretaking, job training, or job-search activities. *Id.* The Commonwealth proposed to exempt many

groups from the community-engagement requirement, including children, pregnant women, individuals deemed medically frail, and adults who are the primary caregiver of a dependent. AR5446 [JA__]. Kentucky's original waiver application also sought to cover Medicaid recipients' use of substance use disorder (SUD) treatment at an institution for mental disease. AR5469 [JA__].

Kentucky's waiver application also made clear that, in addition to improving health outcomes, Kentucky HEALTH was the Commonwealth's "good faith effort" to keep expanded Medicaid, which "is expected to cost Kentucky taxpayers approximately $1.2 billion in new spending for fiscal years 2017 through 2021." AR5432–33 [JA__–__]. As Governor Bevin explained, "[t]his is an expense Kentucky *cannot afford* without jeopardizing funding for education, pension obligations, public safety and the traditional Medicaid program for our most vulnerable individuals." AR5432 [JA__] (emphasis added).

On January 12, 2018, the Secretary approved Kentucky HEALTH as part of a broader KY HEALTH project for a five-year period. AR2 [JA__]. That same day, Governor Bevin issued an executive order, stating:

> [T]he Commonwealth will not be able to afford to continue to operate its Medicaid expansion program as currently designed in the event any one or more of the components of Kentucky's Section 1115 Waiver and the accompanying Special Terms and Conditions are prevented by judicial action from being implemented within the demonstration period set forth in the Special Terms and Conditions.

Dkt. No. 25-1 at 3 [JA__]. Governor Bevin thus ordered that if any aspect of Kentucky's waiver is ultimately enjoined, the applicable state officials are "directed to take the necessary actions to terminate Kentucky's Medicaid expansion program." *Id.* This executive order remains the law of Kentucky.

Nevertheless, 16 Kentuckians promptly filed this litigation challenging Kentucky HEALTH. Dkt. No. 1 [JA__-__]. After Kentucky intervened in this matter, the district court vacated the approval of Kentucky HEALTH and remanded to the Secretary because, in the district court's view, the Secretary "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (*Stewart I*). In reaching this conclusion, the district court latched onto part of Kentucky's amended waiver application, which the district court interpreted to mean that "Kentucky estimated that the project would cause more than 95,000 people to leave its Medicaid rolls by the fifth year." *Id.* at 262.

On remand, the Secretary opened a new comment period on the Commonwealth's waiver application. AR25,499 [JA__]. On November 20, 2018, the Secretary again approved Kentucky HEALTH as part of KY HEALTH for a five-year period. AR6718 [JA__]. The Secretary's approval letter carefully defined the "objectives" of Medicaid for purposes of Section 1115, identifying at least four objectives relevant to his approval of Kentucky HEALTH.

First, the Secretary stated that an "important" Medicaid objective is "furnish[ing] medical assistance and other services to vulnerable populations." AR6719 [JA__]. But paying for health care, the Secretary explained, is not the only objective of Medicaid. He reasoned that "there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence." *Id.* The Secretary therefore concluded that "advanc[ing] the health and wellness needs of . . . beneficiaries" is a second permissible objective of Medicaid. *Id.*

Third, the Secretary reasoned that Section 1115 demonstration projects "provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program." *Id.* Fourth, the Secretary determined that improving enrollees' financial independence promotes the objectives of Medicaid primarily because "measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance from the state." AR6719–20 [JA__–__].

With these objectives in mind, the Secretary approved the following components of Kentucky HEALTH:

1. Community Engagement

Kentucky HEALTH's community-engagement program requires that, as a condition of Medicaid eligibility, adult enrollees (age 19-64) participate in their

community for 80 hours each month. AR6774–75 [JA__–__]. Although employment will satisfy the community-engagement requirement, so will participating in job-skills training, job-search activities, education, self-employment, community service, caregiving, or even SUD treatment. AR6774 [JA__]. The community-engagement requirement is narrowly drawn to apply only to those most able to meet it. It exempts, for example, pregnant women, primary caregivers of a dependent, medically frail beneficiaries, beneficiaries diagnosed with an acute medical condition, and full-time students. *Id.* Certain enrollees also are deemed to automatically meet the community-engagement requirement, including those who are enrolled in the Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) but are exempt from the program's work-oriented initiative. *Id.* This is a meaningful carve-out. SNAP's employment initiative exempts those who are over 50 years of age, as well as a parent or other member of a household who merely has responsibility for a dependent child. 7 U.S.C. § 2015(o)(3)(A) & (C).

If an enrollee subject to the community-engagement program fails to complete 80 hours of community engagement in a given month, her Medicaid eligibility eventually will be suspended after receiving a one-month opportunity to cure, unless she can demonstrate good cause. AR6775–77 [JA__–__]. Even if Medicaid coverage is suspended for non-compliance, it is by no means a permanent, or even long-term, suspension of Medicaid benefits. A suspended beneficiary has two options to regain coverage: (i) she can complete 80 hours of community engagement in a 30-day period,

or (ii) once each year, she can complete a state-provided course focused on health or financial literacy. AR6777 [JA__].

In addition, beneficiaries cannot be unknowingly suspended for failure to complete the community-engagement requirement. Under Kentucky HEALTH, Kentucky must "[p]rovide full appeal rights . . . prior to suspension and observe all requirements for due process for beneficiaries whose eligibility will be suspended, denied, or terminated for failing to meet the community engagement requirement . . . ." AR6779 [JA__].

2. *My Rewards Account* and *Deductible Account*

Kentucky HEALTH also contains two consumer-driven tools known as a *My Rewards Account* and a *Deductible Account*. Taking each in turn, an enrollee in Kentucky HEALTH will receive a *My Rewards Account* that rewards healthy behaviors by unlocking additional benefits. AR6721 [JA__]. By way of example, if an enrollee performs community service, attends prenatal care visits, passes the GED, completes a wellness course, participates in smoking-cessation activities, or participates in drug-addition counseling, she receives virtual dollars in a *My Rewards Account*. *See* AR5462 [JA__]. These virtual dollars can be used on enhanced health benefits that otherwise are not covered by Kentucky HEALTH, which include vision and dental services, over-the-counter medications, and even a gym membership. AR6764 [JA__]. Even though the

My Rewards Account program has yet to take effect, future enrollees have already earned over 70 million virtual dollars to use once the program goes live.[3]

The Secretary found that the *My Rewards Account* is designed to test whether Kentucky will "strengthen beneficiary engagement in their personal health and provide an incentive structure to support responsible consumer decision-making about maintaining health and accessing care and services." AR6724 [JA__]. The *My Rewards Account* also is an example of Kentucky extending *optional Medicaid benefits* to enrollees that they otherwise are not required to receive. The Secretary correctly summarized: "Kentucky is not required to offer these . . . [benefits] available through the *My Rewards Account*; in fact, the fitness services available through the account are covered only *because* of CMS approval of the demonstration." AR6735 [JA__].

The *My Rewards Account* works hand in hand with the *Deductible Account*. At the start of each benefit year, an enrollee's *Deductible Account* has a dollar-value equivalent of $1,000. AR6722 [JA__]. The *Deductible Account* covers "all non-preventive healthcare services" up to $1,000. *Id.* However, "[i]f funds in the deductible account are exhausted before the end of a beneficiary's 12-month benefit period, the beneficiary still will be able to receive covered services just as services would be covered after satisfaction of a deductible under commercial coverage." *Id.* If a beneficiary has funds remaining in his

[3] "Cabinet Releases Updated Medicaid Budget Predictions & Kentucky HEALTH Implementation Timeline" (Jan. 31, 2019), *available at* https://www.lanereport.com/110137/2019/01/cabinet-releases-updated-medicaid-budget-predictions-and-kentucky-health-implementation-timeline/ (last visited May 13, 2019).

Deductible Account at the end of the applicable benefit period, he may transfer up to 50 percent of the prorated balance to his *My Rewards Account*. *Id.*; *see also* AR6763 [JA__]. In this way, the *Deductible Account* "encourage[s] appropriate healthcare utilization." AR6722 [JA__].

3. Premiums

Kentucky HEALTH also requires certain beneficiaries to pay modest monthly premiums in lieu of the copayments they are required to pay under Kentucky's existing state plan. *Id.* The Secretary has previously approved some version of premiums for the expansion population in Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Mexico.[4] The premiums approved as part of Kentucky HEALTH can be as low as $1.00 per month but cannot exceed four percent of a beneficiary's household income. *Id.* Several groups are exempt from the premium requirement, including pregnant women, survivors of domestic violence, and those deemed medically frail. *Id.*

If an enrollee fails to pay the applicable premium after 60 days, he is subject to disenrollment from Kentucky HEALTH for six months. Disenrollment, however, can only occur if the enrollee has an income above 100 percent of the federal poverty level (FPL). AR6770 [JA__]. However, a beneficiary can resume coverage by establishing good cause for his failure to pay his premium. AR6771 [JA__]. Moreover, even if a

[4] "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State" (Apr. 18, 2019), *available at* https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/ (last visited May 13, 2019).

beneficiary is disenrolled, he can immediately reenroll once each year merely by paying the premium for the first month of coverage and attending a state-provided course. AR6773 [JA__]. In these ways, Kentucky HEALTH seeks to minimize disenrollment for premium nonpayment.

Enrollees with incomes under 100 percent of FPL who fail to pay their premiums are not subject to disenrollment. AR6771 [JA__]. In other words, premiums for those in this income bracket are optional. If an enrollee with an income below this threshold fails to pay her premium, she keeps her Medicaid coverage, but will lose her *My Rewards Account* and be required to make the copayments required by Kentucky's state plan. *Id.*

In approving premiums, the Secretary noted that "interim evaluation findings regarding premiums in one state [Indiana] found that beneficiaries who paid premiums are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not." AR6734–35 [JA__–__]. The Secretary thus approved premiums to test whether, in conjunction with the remainder of Kentucky HEALTH, paying modest premiums will "encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans." AR6735 [JA__].

4. Waiver of retroactive eligibility

Under Medicaid, a state plan must provide coverage to an eligible individual for applicable "care and services . . . furnished in or after the third month before the month in which he made application." 42 U.S.C. § 1396a(a)(34). The Secretary waived this

provision for Kentucky HEALTH, except as to pregnant women and former foster care youth. AR6722 [JA__]. The Secretary has approved similar waivers in Arizona, Arkansas, Indiana, Iowa, New Hampshire, and New Mexico. *See* Medicaid Waiver Tracker, *supra* note 3.

The waiver of retroactive coverage for Kentucky HEALTH, the Secretary explained, will not only likely enable Kentucky "to better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health care," AR6727 [JA__], but also "may improve uptake of preventive services and thus improve beneficiary health," AR6736 [JA__]. As to the latter goal, the Secretary explained that the waiver of retroactive eligibility is "designed to test whether [] beneficiaries will be encouraged to obtain and maintain health coverage, even when healthy, and whether there will be a reduction in gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick." AR6724 [JA__].

5. Other components of Kentucky HEALTH

Kentucky HEALTH has several other features that Plaintiffs-Appellees have challenged in this lawsuit. First, Kentucky HEALTH imposes a six-month period of Medicaid non-eligibility for beneficiaries who fail to follow the longstanding Medicaid requirements of completing the annual redetermination process or reporting a change in circumstances that affects Medicaid eligibility. AR6722, 6727 [JA__, __]. Kentucky HEALTH exempts various individuals from this ineligibility period, including medically frail individuals, pregnant women, and survivors of domestic violence. AR6722 [JA__].

And Kentucky HEALTH provides procedural protections for those subject to the ineligibility period, such as a good-cause exemption and appeal rights. AR6722, 6758–61 [JA__, __–__]. Kentucky HEALTH also provides an early reenrollment option for those who are disenrolled. AR6757, 6761 [JA__, __].

Second, Kentucky HEALTH waives the Medicaid requirement that Kentucky provide non-emergency medical transportation for individuals enrolled in expanded Medicaid. AR6723 [JA__]. This aspect of Kentucky HEALTH does not apply to medically frail beneficiaries, pregnant women, certain 19- and 20-year old beneficiaries, former foster care youth, and survivors of domestic violence. *Id.* Similar waivers have been approved in Iowa and Indiana. *See* Medicaid Waiver Tracker, *supra* note 3.

And third, Kentucky HEALTH reduces a beneficiary's *My Rewards Account* balance for each non-emergency visit to the emergency room. AR6765 [JA__]. This reduction is waived if the beneficiary merely contacts a provided nurse hotline before using the emergency room. *Id.* Kentucky HEALTH has various guardrails that limit the scope of this requirement—namely, an enrollee must receive an appropriate medical screening before a *My Rewards Account* can be reduced and hospitals must educate enrollees about non-emergency use of the emergency room before a *My Rewards Account* can be reduced. *Id.*

6. The broader KY HEALTH waiver

As discussed above, the Secretary approved Kentucky HEALTH as part of the broader KY HEALTH waiver. As relevant here, KY HEALTH allows the

Commonwealth, which is in the grips of the opioid epidemic, to cover needed SUD treatment through Medicaid. AR6723 [JA__]. In reapproving Kentucky HEALTH last November, the Secretary clearly linked it to KY HEALTH, explaining that "Kentucky HEALTH, working within the larger KY HEALTH demonstration program, is likely to assist in promoting the objectives of the Medicaid program." *Id.*

After the Secretary reapproved Kentucky HEALTH on November 20, 2018, Plaintiffs-Appellees filed an Amended Complaint, raising essentially the same claims as before. Dkt. No. 88 [JA__–__]. After merits briefing, the district court again vacated and remanded the Secretary's approval of Kentucky HEALTH by granting summary judgment to Plaintiffs-Appellees on Count VIII of their Amended Complaint, which challenged Kentucky HEALTH "as a whole" under the Administrative Procedure Act (APA). *Stewart v. Azar*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019) (*Stewart II*). The court then entered a Rule 54(b) judgment as to Count VIII. Dkt. No. 134 [JA__]. This appeal and the federal government's appeal follow.

SUMMARY OF ARGUMENT

Section 1115 vests the Secretary with the judgment to approve Kentucky HEALTH. Under Section 1115, a demonstration project, in the Secretary's judgment, must be likely to assist in promoting the objectives of Medicaid. By its terms, Section 1115 grants considerable deference to the Secretary, and courts must be careful not to intrude on the Secretary's judgment.

Section 1115 is a valuable way for testing new ideas for improving Medicaid on a temporary, limited basis. It allows states to try to improve or restructure Medicaid in ways that are tailored to the problems that they are facing in real-time. And it provides policymakers with real-world data before they permanently alter a public-assistance program.

The Secretary's rationale for approving Kentucky HEALTH is careful and well-reasoned. Kentucky HEALTH, as found by the Secretary, is likely to assist in promoting the health and wellness of recipients—an intrinsic Medicaid objective. To conclude otherwise, as the district court did, requires concluding that Medicaid—*a health care program*—is unconcerned with whether it actually makes enrollees healthier. To state that contention is to reject it. Kentucky HEALTH promotes health and wellness through, among other things, its community-engagement program, its modest premium requirements, and its beneficiary-engagement provisions.

Kentucky HEALTH, in the Secretary's judgment, also is likely to help sustain the Commonwealth's Medicaid program. This Medicaid objective is clearly stated in the Medicaid statute, and it is consistent with applicable precedent. The Secretary's judgment about making Kentucky's Medicaid program more sustainable rationally relies on Kentucky HEALTH's optional Medicaid benefits and optional non-Medicaid benefits and the fact that Kentucky HEALTH preserves optional coverage for the new adult group.

Section 1115 plainly envisions that demonstration projects can cause coverage loss. And after the initial remand, the Secretary amply considered this issue. As found by the Secretary, Section 1115 minimizes any coverage loss caused by Kentucky HEALTH by excluding those most unable to meet its requirements, providing meaningful guardrails to temper coverage loss, and offering on-ramps for those who nevertheless lose coverage. Moreover, Kentucky HEALTH is specifically designed to enable enrollees to move off of public assistance. It therefore tests whether some, or hopefully much, of any coverage loss caused by Kentucky HEALTH will be because enrollees are able to gain coverage elsewhere.

The Secretary also rationally concluded that Kentucky HEALTH will promote the financial independence of enrollees. The district court's determination that financial independence is not an objective of Medicaid is irreconcilable with case law and Medicaid's appropriations provision, which lists attaining or retaining "independence" as a purpose of Medicaid appropriations.

STANDARD OF REVIEW

This appeal from a district court ruling in an APA case is reviewed *de novo*. *See Gerber v. Norton*, 294 F.3d 173, 178 (D.C. Cir. 2002).

ARGUMENT

I. Section 1115 gives the Secretary significant discretion to test ideas related to Medicaid.

Section 1115 of the Social Security Act empowers the Secretary to "waive compliance with any of the requirements of section . . . . 1396a" for "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid statute. 42 U.S.C. § 1315(a). Put more directly, Section 1115 allows the Secretary to "test out new ideas and ways of dealing with the problems of public welfare recipients." *See* S. Rep. No. 87-1589, at 1961 (1962).

As relevant to this appeal, the key component of Section 1115 is that it vests the Secretary, and no one else, with the "judgment" to determine whether a project is "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a). Relying on this language, Judge Friendly concluded for the Second Circuit that Section 1115 "speak[s] in terms of an otherwise unfettered 'judgment'" for the Secretary and "does not require that, before the Secretary approves an experiment, every i must be dotted and t crossed." *Aguayo v. Richardson*, 473 F.2d 1090, 1107 (2d Cir. 1973). More to the point, by its terms, Section 1115 only requires that, in the Secretary's judgment, it be "likely"—as opposed to certain—that a proposed project "assist[s] in promoting"—not that the project itself promotes—the objectives of Medicaid.

This is a predictive exercise by the Secretary. Section 1115 does not require that the Secretary prove his judgment to be correct in advance. The "likely" qualifier in

Section 1115 makes this clear, as does the statute's reference to the Secretary's "judgment." Also, Section 1115 unambiguously speaks of an "*experimental*, pilot, or demonstration project," 42 U.S.C. § 1315(a) (emphasis added), thus conveying that a Section 1115 project, by design, can be an experiment to test a hypothesis. As one court has summarized, "[t]he requirements of § 1115 do not require certainty much less prescience, on the Secretary's part as to the results." *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 497 (N.D. Cal. 1972). Indeed, "the experimental project which 'fails' may well assist in promoting the objectives [of Medicaid] precisely by demonstrating what will not work, and what should therefore, be avoided in formulating the requirements for state plans." *Id.*

Section 1115 waivers are an important way to test ideas on a temporary, limited basis. Policymakers can then review the results of the Section 1115 experiment to determine whether to adopt the project as a permanent, nationwide change to Medicaid. This gives policymakers key insights about the efficacy (or not) of potential legislative changes that they otherwise would lack. In this respect, Section 1115 affirms that:

> The only thing more serious than an experimental program that does not produce beneficial results, is the non-experimental, standard program, statutorily mandated which so fails. Certainly one purpose of the § 1115 program is to discover what may work on a limited scale before it is incorporated into the mandatory requirements for all state plans.

Id.

One example suffices to make this point: SNAP and TANF have long contained work-oriented programs. *See* 7 U.S.C. § 2015(o); 42 U.S.C. § 607(c), (d). The current

iterations of these programs, however, are not original to SNAP and TANF. The present versions trace to the welfare-reform legislation that President Clinton signed in 1996. *See* Personal Responsibility & Work Opportunity Reconciliation Act, Pub. L. No. 104-193, §§ 407, 824, 110 Stat. 2105, 2323, 2131–33 (1996). Important for present purposes, prior to 1996, many states had received Section 1115 waivers to test work-related requirements in TANF's predecessor program, Aid to Families with Dependent Children (AFDC). These pre-1996 waivers were an impetus for adopting work-oriented requirements as permanent welfare reform in 1996:

> Growing dissatisfaction with AFDC . . . led an increasing number of states to seek waivers from the AFDC rules. These waivers were mostly designed to allow states to more stringently enforce work requirements for welfare recipients. Such waivers had started under President Ronald Reagan, but the Clinton Administration actively encouraged more expansive statewide waiver programs. As a result, by the time [that the 1996 welfare reform law] passed, 27 states had major state-wide waivers in place.

Blank, Evaluating Welfare Reform in the United States, *Journal of Economic Literature*, Vol. 40, No. 4, at 1106 (Dec. 2002). These pre-1996 waivers "were a major reason why policymakers supported work-oriented welfare reforms in the 1990s." *Id.* at 1122. This is a critical point. Section 1115 waivers have already been used to evaluate whether to extend work-related requirements into SNAP and TANF, and they convinced lawmakers to do so.

There is no reason why a Section 1115 waiver cannot test a community-engagement program in Medicaid, given that SNAP and TANF already have work-

oriented programs. Surely Section 1115 allows the Secretary to test whether longstanding work-oriented programs from other public-assistance programs will work in Medicaid. In addition, the 1996 welfare reforms *already incorporated* a work-related component into Medicaid, allowing a state to terminate Medicaid benefits if a participant's TANF benefits are terminated because of a "refus[al] to work." 42 U.S.C. § 1396u-1(b)(3)(A) (adopted by Pub. L. No. 104-193, § 114(a)(2), 110 Stat. 2105, 2178). This means that Kentucky HEALTH merely extends to Medicaid, on a temporary and limited basis, a program (i) that is similar to SNAP's and TANF's work-oriented programs and (ii) that is already part of Medicaid in certain respects.

Before the district court, Plaintiffs-Appellees responded by arguing that SNAP and TANF have standalone work-oriented programs, whereas Medicaid does not. That argument ignores 42 U.S.C. § 1396u-1(b)(3)(A). Regardless, this argument proves the Secretary's point in approving Kentucky HEALTH: Section 1115 allows a willing state to test a concept that is not part of Medicaid on a limited, temporary basis so that lawmakers are not left to guess about whether such a proposal is good policy.

Now is a particularly appropriate time to test a community-engagement program as part of Medicaid. In recent years, Congress has considered whether to add a work-oriented program to Medicaid. American Health Care Act, H.R. 1628, 115th Cong., § 117 (2017); Medicaid Reform & Personal Responsibility Act, S. 1150, 115th Cong. (2017). Although neither of these bills ultimately became law, these failed legislative efforts show that at least some legislators have recently considered whether a work-

oriented program specific to Medicaid should be enacted. These lawmakers would doubtless benefit from the real-world data that Kentucky HEALTH will provide.

This leads to the question of what role, if any, Article III courts play with respect to Section 1115 waivers.[5] Under the APA, the Court "is not empowered to substitute its judgment for that of the [Secretary]." *Aguayo*, 473 F.2d at 1107 (quoting *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971)). Both the Second and Third Circuits have correctly taken a decidedly deferential approach to judicial review of Section 1115 projects under the APA. As Judge Friendly explained in distinguishing the Supreme Court's *Overton Park* decision, which concerns more typical judicial review of agency action:

> [I]t is legitimate for an administrator to set a lower threshold for persuasion when he is asked to approve a program that is avowedly experimental and has a fixed termination date than a proposal, like that in *Overton Park*, which is irreversible. Moreover, *Overton Park* dealt with a situation where an administrator was required to make two highly specific determinations on the basis of explicit, legislatively prescribed considerations, rather than reach an over-all "judgment."

See id. at 1103 (footnote omitted); *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 183 (3d Cir. 1996) (agreeing "generally" with *Aguayo*'s analysis). For this reason, both the Second and Third Circuits have reviewed the Secretary's Section 1115 judgment under something akin to a mere rationality standard. *Aguayo*, 473 F.2d at 1105

[5] The federal government argues that the Secretary's judgment under Section 1115 is judicially unreviewable as a matter committed to the Secretary's discretion. The Commonwealth agrees, but leaves this argument to the federal government to press.

("This bring[s] us to the question whether the Secretary had a rational basis for determining that the programs were 'likely to assist in promoting the objectives'" of AFDC); *C.K.*, 92 F.3d at 183 ("[T]he central question before us is whether the record disclosed that the Secretary rationally could have determined that . . . New Jersey's program was 'likely to assist in promoting the objectives' of AFDC.").

This Court's case law also points to an unusually deferential standard for reviewing the Secretary's judgment. For example, in *Kreis v. Secretary of Air Force*, 866 F.2d 1508 (D.C. Cir. 1989), the Court considered a statute that, similar to Section 1115, allowed an official to take action "when *he considers* it necessary to correct an error or remove an injustice." *Id.* at 1513 (emphasis added) (quoting 10 U.S.C. § 1552(a)). This statute, the Court emphasized, "draw[s] a distinction between the objective existence of certain conditions and the Secretary's determination that such conditions are present." *Id.* This led the Court to conclude that "the way in which the statute frames the issue for review *does substantially restrict* the authority of the reviewing court to upset the Secretary's determination." *Id.* at 1514 (emphasis added). The Court therefore concluded that "balancing of considerations is to be done by the Secretary, free of judicial second-guessing" and even that "[p]erhaps only the most egregious decisions may be prevented under such a deferential standard of review." *Id.* at 1514–15.

So too here. Section 1115 does not say that, as a matter of fact, a waiver must be likely to assist in promoting Medicaid's objectives. Rather, Section 1115 provides that a waiver must do so in the Secretary's "judgment." Similar to the statute in *Kreis*, Section

1115 distinguishes between the objective existence of a condition, on the one hand, and the Secretary exercising his judgment to conclude that such a condition likely will occur, on the other hand. Section 1115, moreover, does not require that it be certain that a given program will assist in promoting the objectives of Medicaid; it must only be "likely." Projects, moreover, can be "experimental." Under *Kreis*, and consistent with *Aguayo* and *C.K.*, the Court therefore should give unusually strong deference to the Secretary's judgment under Section 1115.

II. The Secretary rationally concluded that Kentucky HEALTH is likely to assist in promoting the objectives of Medicaid.

The Secretary's rationale for approving Kentucky HEALTH is contained in a careful and exhaustive 20-page letter, followed by almost 80 pages of special terms and conditions. AR6718–816 [JA__–__]. If the district court's judgment invalidating Kentucky HEALTH stands, for the reasons that follow, the Court will call all manner of Section 1115 waivers into question and greatly circumscribe the Secretary's waiver authority going forward.

The Social Security Act does not list Medicaid's objectives for purposes of Section 1115. This undisputed omission introduces an ambiguity into the Secretary's job of ascertaining Medicaid's objectives. This means that the Secretary's interpretation of Medicaid's objectives receives *Chevron* deference. *See Pharm. Res. & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 821–22 (D.C. Cir. 2004) (applying *Chevron* deference where

"Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments").

Chevron deference to the Secretary's interpretation of Medicaid's objectives is independently justified for the further reason that Kentucky HEALTH, by design, primarily affects the expansion population that the ACA added to the Medicaid program. As Chief Justice Roberts summarized in *NFIB v. Sebelius*, 567 U.S. 519 (2012):

> The original [Medicaid] program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the [ACA], Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the federal poverty level.

Id. at 583 (internal citation omitted). As Chief Justice Roberts acknowledged, the expansion population is obviously different in many ways from the populations that Medicaid traditionally served. It stands to reason that the objectives of Medicaid for the able-bodied population subject to Kentucky HEALTH are different in certain respects from the objectives with respect to traditional Medicaid populations. *See id.* ("The Medicaid expansion . . . accomplishes a shift in kind, not merely degree."). Thus, Kentucky HEALTH's focus on the expansion population introduces another layer of ambiguity into the Secretary's job of determining Medicaid's objectives.

As summarized above, the Secretary ascertained at least four Medicaid objectives: (i) improving health and wellness; (ii) ensuring the fiscal sustainability of Medicaid; (iii)

providing coverage; and (iv) promoting financial independence. Each objective is discussed in turn.

A. Improving health and wellness

The Secretary concluded that an objective of Medicaid is "to advance the health and wellness needs of . . . beneficiaries." AR6719 [JA__]. In reaching this conclusion, the Secretary relied upon Medicaid's appropriations provision, 42 U.S.C. § 1396-1, to conclude that "an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations." AR6719 [JA__]. From this conclusion, the Secretary reasoned that "there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them." *Id.* The Secretary's easy-to-follow reasoning is demonstrably correct and, at the very least, reasonable. By definition, a health-care program like Medicaid must be intended to improve recipients' health and wellness. Medicaid cannot be solely concerned with paying for health care without any consideration of whether that health care actually makes recipients healthier.

This reasoning is firmly grounded in the text of the Medicaid statute. In discussing this issue, the Secretary cited Section 1396-1's language about "furnish[ing] . . . medical assistance." *Id.* The term "medical assistance" is a term of art. In defining this term, the district court cited this Court's decision in *Adena Regional Medical Center v. Leavitt*, 527 F.3d 176, 180 (D.C. Cir. 2008), which in turn relied on 42 U.S.C. § 1396d(a), as it then existed, to define "medical assistance" as ""payment of part

or all of the cost' of medical 'care and services' for a defined set of individuals," *Stewart II*, 366 F. Supp. 3d at 138; *Stewart I*, 313 F. Supp. 3d at 260 (supplying an identical definition). But this is an outdated definition of "medical assistance."

At all times relevant to this matter, the Medicaid statute defined "medical assistance" as not only paying for the costs of medical care, but also the medical care itself. 42 U.S.C. § 1396d(a) ("The term 'medical assistance' means payment of part or all of the cost of the following care and services *or the care and services themselves*, or both . . . ." (emphasis added)). The ACA amended the term "medical assistance" in this respect. *See* ACA, Pub. L. No. 111-148, § 2304, 124 Stat. 119, 296 (2010). Some legislative history suggests that this amendment was a response to judicial opinions that had narrowly and incorrectly interpreted medical assistance "to refer only to payment" for medical care (as the district court did), which created problems in interpreting the Medicaid statute. *See* H.R. Rep. 111-299, at 649–50 (2009). Consequently, when Congress expanded Medicaid, it also reaffirmed that "medical assistance" encompasses paying for health care as well as the health care itself.

This is a crucial point. The broadened definition of "medical assistance" confirms that the Medicaid program is not just about ensuring that covered populations do not have to pay for medical care. Medicaid is *equally concerned with the medical care itself*—and by necessary extension, associated health outcomes. The definition of "medical assistance" does not prioritize paying for health care over the health care itself. Because Medicaid is unambiguously directed toward medical care, it follows that Medicaid is

concerned with promoting health and wellness. To be concerned about medical care, as the Medicaid statute is, is to be concerned about health and wellness.

The district court rejected this line of thinking, finding that the Secretary's focus on improving health and wellness is "nothing 'more than a sleight of hand'" that substitutes a focus on health and wellness for a focus on paying for health care. *Stewart II*, 366 F. Supp. 3d at 144 (quoting *Stewart I*, 313 F. Supp. 3d at 266). The court also determined that any conclusion to the contrary is unreasonable and therefore fails at *Chevron* step two. *Id.* According to the district court, Medicaid is targeted at avoiding "medical bankruptcies." *See id.* The Medicaid statute, the district court essentially concluded, cares not one iota about whether billions of state and federal dollars move the needle at all in improving recipients' health and wellness.

The district court offered virtually no rebuttal to the undisputed point that the definition of "medical assistance" now includes both paying for health care and the health care itself. The sum-total of the district court's rejoinder was to conclude that the broadened definition of "medical assistance" does not "suggest[] that promoting health as a stand-alone objective has replaced furnishing medical assistance as the statute's primary aim." *Id.* at 144–45. Tellingly, the district court could not even reject this argument without using the term "medical assistance" in its outdated sense. Even putting that aside, the Commonwealth has not argued that promoting health and wellness has "replaced" the objective of paying for health care. Instead, the Commonwealth's position is that paying for health care and the health care itself are

co-equal parts of providing "medical assistance." Medicaid's definition of "medical assistance" does not rank one above the other.

Although the Court can, and should, reverse the district court's application of *Chevron* step two for this reason, it need not do so. The Secretary's conclusion that improving health and wellness is a permissible Medicaid objective is not only reasonable so as to satisfy *Chevron* step two, but it is the unambiguously correct reading of the Medicaid statute.

Other parts of the Medicaid statute reinforce this conclusion. The Medicaid program directs that "medical assistance" be provided with "reasonable promptness." 42 U.S.C. § 1396a(a)(8). Ensuring that medical assistance is timely provided is undeniably linked to health and wellness. Generally speaking, the longer one goes without medical care, the worse one's health becomes. In fact, according to the legislative history discussed above, Medicaid's requirement of "reasonabl[y] prompt[]" medical assistance was one of the main reasons that the ACA broadened the definition of "medical assistance" to include medical care. *See* H.R. Rep. 111-299, at 649–50. Considered in conjunction with the Medicaid statute's current definition of "medical assistance," there can be no doubt that Medicaid cares a great deal about improving health and wellness.

The district court also justified its holding that health and wellness is not a Medicaid objective by referencing the "bizarre results" that, in its view, would follow:

"[N]othing would prevent the Secretary from conditioning coverage on a special diet or certain exercise regime." *Stewart II*, 366 F. Supp. 3d at 145. Three points in response.

First, even if a "special diet" requirement were permissible under Section 1115, the district court presupposed that only an Article III court can stop it. The political process would almost certainly step in long before the "special diet" requirement made it to a courtroom. The judicial branch is not the only check on the Secretary's Section 1115 waiver authority. If Congress dislikes a Section 1115 waiver, it has the power to modify Section 1115 accordingly. And even if Congress does not step in, the People can respond by electing a new President with a new Secretary who will not approve a "special diet" requirement. The People also can choose to elect new state decisionmakers who will not request a "special diet" requirement from the Secretary.

Second, a judgment upholding Kentucky HEALTH will not necessarily pave the way to a "special diet" requirement. The district court's reasoning confirms as much. According to the district court, this hypothetical might arise if "the Secretary could exercise his waiver authority *solely to promote health*." *Stewart I*, 313 F. Supp. 3d at 267–68 (emphasis added). As the italicized language demonstrates, the "special diet" hypothetical only comes into play if the Secretary approves a Section 1115 waiver *solely* to promote health and wellness. Here, by contrast, the Secretary identified other objectives that also justify Kentucky HEALTH. Presumably, a "special diet" requirement would not advance the other Medicaid objectives relied upon by the Secretary.

Third, Kentucky HEALTH takes a much more nuanced approach to promoting health and wellness than does a simple "special diet" requirement. A "special diet" requirement only addresses physical health, and it would be next-to impossible for a state to operationalize. Kentucky HEALTH, by contrast, can be effectively implemented. And it approaches health and wellness from the more refined, research-based perspective of encouraging enrollees to participate in their communities, which the Secretary and Kentucky expect will lead to better mental and physical health and wellness and will give enrollees the tools and knowledge that they need to improve their circumstances. To compare Kentucky HEALTH's holistic approach to improving health and wellness with a simplistic "special diet" requirement is to equate a Bach concerto to a nursery rhyme. If the Court upholds Kentucky HEALTH based upon the Medicaid objective of improving health and wellness, a subsequent court will have ample latitude to reject a rudimentary "special diet" requirement, if the court so chooses, in the unlikely event that such a waiver makes it past the Secretary and survives the political process.

Turning to the Secretary's judgment that Kentucky HEALTH likely will assist in promoting health and wellness, the Secretary explained that the community-engagement program, in particular, is directed toward this end. AR6724 [JA__]. Although he was not required to do so, the Secretary marshaled research to support his thinking, explaining that community engagement "may reduce social isolation, which multiple studies have linked to higher rates of mortality," and that "research also shows

a positive link between community engagement and improved health outcomes." AR6733 [JA__] (collecting sources). This more than suffices to sustain the Secretary's judgment that Kentucky HEALTH's community-engagement program likely will assist in promoting the objective of improving health and wellness.

But the Secretary did not limit his health-and-wellness rationale to the community-engagement program, but instead extended it to cover Kentucky HEALTH as a whole. The Secretary also determined that Kentucky HEALTH is "designed to encourage more individuals to seek preventive care, which can help improve beneficiary health." AR6724 [JA__]. In this regard, the Secretary relied on the *My Rewards Account*, which provides "incentives for healthy behaviors [that] are intended to increase uptake of preventive services," *id.*, as well as the waiver of retroactive coverage, which is "designed to test whether [] beneficiaries will be encouraged to obtain and maintain coverage, even when healthy," *id.* The Secretary also found that Kentucky HEALTH's modest premiums likely would assist in promoting health and wellness by relying on "interim evaluation findings" from Indiana's Section 1115 waiver.[6] AR6734–35 [JA__–__].

The district court did not meaningfully contest the Secretary's judgment about health and wellness, other than to assert that the Secretary "did not weigh health gains against coverage losses in justifying the approval" and, more specifically, "did not

[6] Those findings are available at AR4850–961 [JA__–__].

consider the health benefits of the project relative to its harms to the health of those who might lose coverage." *Stewart II*, 366 F. Supp. 3d at 145. That conclusion cannot be squared with the Secretary's lengthy discussion of Kentucky HEALTH's potential effects on coverage (discussed below). *E.g.*, AR6730–32 [JA__–__]. Moreover, the Secretary specifically noted that he weighed health benefits against potential coverage loss. *E.g.*, AR6731 [JA__] ("[A]ny loss of coverage as the result of noncompliance must be weighed against the benefits Kentucky hopes to achieve through the demonstration project, including . . . improved health and independence of the beneficiaries . . . .").

More generally, the district court's criticism of the Secretary's alleged failure to "weigh" certain factors, which the district court levied about multiple aspects of the Secretary's approval, is an implicit usurpation of the Secretary's judgment. It is undisputed that the Secretary considered potential coverage loss in approving Kentucky HEALTH. The district court's assertion that he did not "weigh" coverage loss against other matters that the Secretary also expressly considered equates to disagreement with the Secretary's "weighing." It is well established that this is off limits. *See, e.g.*, *Kreis*, 866 F.2d at 1514 (holding that "balancing of considerations is to be done by the Secretary, free of judicial second-guessing").

B. Ensuring fiscal sustainability

The Secretary also concluded that Kentucky HEALTH likely would assist in promoting the objectives of Medicaid by "furnish[ing] medical assistance in a manner that improves the sustainability of the safety net." AR6726 [JA__]. As a cooperative

federal-state program, the sustainability of Medicaid vis-à-vis both state and federal actors is implicit to the program. The Secretary derived his sustainability rationale, in part, from the Medicaid statute, relying on 42 U.S.C. § 1396-1's statement that Medicaid appropriations are to "enabl[e] each State, as far as practicable under the conditions in such State" to furnish medical assistance, AR6719 [JA__]. This provision unmistakably conveys that "practicab[ility]" is a pertinent concern in providing "medical assistance," as are the "conditions" on the ground in the state. The district court perhaps understated this point but acknowledged that "[i]n context, practicability is at least a qualifier of the extent to which states must furnish medical assistance." *Stewart II*, 366 F. Supp. 3d at 149.

Sustainability as a Medicaid objective is firmly rooted in case law. In *Thompson*, this Court accepted as reasonable the Secretary's conclusion that a program was consistent with Medicaid's "goals and objectives" because "[i]ncreased Medicaid enrollments and expenditures for newly qualified Medicaid recipients will strain already scarce Medicaid resources in a time of State budgetary shortfalls." *See* 362 F.3d at 825. This decision built on the Supreme Court's holding in *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003) (plurality), that Medicaid eligibility is fluid and that a measure that reduces the likelihood of borderline groups becoming Medicaid eligible is consistent with the Medicaid program, *see id.* at 663–64; *see also id.* at 687 (O'Connor, J., concurring and dissenting in part) (discussing "stretching available resources to the greatest effect").

The Secretary framed his sustainability rationale in two main ways, approaching it from the perspectives of (i) extending benefits and (ii) preserving coverage. Taking each in turn, the Secretary cataloged the ways in which Kentucky HEALTH provides coverage for benefits *beyond* what the Medicaid statute requires. In this respect, the Secretary noted that a *My Rewards Account* gives an enrollee access to coverage for over-the-counter medications, vision services, dental services, and even a gym membership. AR6726 [JA__]. All of these services, the Secretary noted, are purely optional on the part of Kentucky. The same, the Secretary explained, goes for the broader KY HEALTH waiver, of which Kentucky HEALTH is a part, which provides "new, non-mandatory coverage" for needed SUD treatment. *Id.*

The Secretary also explained how Kentucky HEALTH likely assists in promoting the sustainability of Medicaid by preserving coverage. On this point, the Secretary noted that "Kentucky has repeatedly stated that if it is unable to move forward with its Kentucky HEALTH demonstration project, it will discontinue coverage for the ACA expansion population, a choice it is entitled to make." *Id.* The Secretary continued: "Any potential loss of coverage that may result from a demonstration is properly considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage for existing (but non-mandatory) populations, such as (in light of the Supreme Court's ruling in *NFIB v. Sebelius*) the ACA adult population." AR6731 [JA__].

The Secretary is correct that Kentucky can leave expanded Medicaid if it so chooses. Although the district court expressed skepticism about this conclusion in *Stewart I*, 313 F. Supp. 3d at 252, by *Stewart II*, the district court acknowledged that it "may well be correct" that Kentucky can "un-expand," 366 F. Supp. 3d at 153. *NFIB* leaves no doubt about this issue. The question in *NFIB* was whether Congress could compel states to participate in expanded Medicaid under the threat of losing all Medicaid funding. Chief Justice Roberts's decision held that Congress "cannot . . . withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion." *NFIB*, 567 U.S. at 585. It continued: "States may now choose to reject the expansion; that is the whole point . . . . Some states may indeed decline to participate . . . because they are unsure they will be able to afford their share of the new funding obligation . . . ." *Id.* at 587. The only logical takeaway is that a state's decision about whether to participate in expanded Medicaid must be separate from its decision to cover Medicaid's mandatory populations and benefits. *NFIB* therefore puts the expansion population on identical footing with the other optional populations that a state can choose not to cover without losing other Medicaid funding.

The district court did not meaningfully contest this reading of *NFIB*, but instead determined that the Secretary allegedly "made no finding, supported by substantial evidence, that Kentucky HEALTH would improve the sustainability of Kentucky's Medicaid program—either by accruing savings to the state or by any other mechanism." *Stewart II*, 366 F. Supp. 3d at 149. This is incorrect on several levels. For one thing, the

district court overlooked that Kentucky HEALTH is an experiment, the results of which need not be known in advance. For another, the sustainability of a given state's Medicaid program is not strictly a question for the Secretary, but for the duly elected or appointed state leaders. More to the point, whether a state wants to continue providing an optional benefit or providing Medicaid to an optional population is left to the state's discretion. *See Harris v. McRae*, 448 U.S. 297, 301 (1980) (describing participation in Medicaid as "entirely optional"). The applicable Medicaid provision leaves no doubt about this issue: it unambiguously states that the decision to provide coverage to an optional population is "at the option of the State." 42 U.S.C. § 1396a(10)(A)(ii). *NFIB* itself confirms this point by holding that states can choose not to have expanded Medicaid merely "because they are unsure they will be able to afford their share of the new funding obligations . . . ." 567 U.S. at 587.

The district court's contrary conclusion necessarily means that the Secretary will have to sift through state budgets and answer the questions that Kentuckians have elected their state policymakers to answer. The district court, for example, faulted the Secretary—an appointed official not elected by the people of Kentucky—for not answering questions like: "What are Kentucky's current state revenues? What is its budget generally? Is the state running a deficit?" *See Stewart I*, 313 F. Supp. 3d at 271. However, as Kentucky's waiver application makes clear, the sustainability of its Medicaid program turns on a careful balancing of policy priorities and budgetary realities, not (as the district court assumed) on mere dollars and cents. The expected

$1.2 billion that Kentucky taxpayers will pay for expanded Medicaid through 2021, the Commonwealth has explained, "is an expense Kentucky cannot afford without jeopardizing funding for education, pension obligations, public safety and the traditional Medicaid program for most of our vulnerable citizens." AR5432 [JA__]. Taken to its logical conclusion, the district court's holding would require the Secretary to opine about how Kentucky should order its policy priorities in order to adjudge the sustainability of its Medicaid program.

The Secretary has appropriately recognized that "states are given great latitude in making tradeoffs in how the state furnishes medical assistance 'as far as practicable under the conditions' in the state." AR6732 [JA__]. The Secretary also noted that Kentucky has "repeatedly stated that if it is unable to move forward with its Kentucky HEALTH demonstration project, it will discontinue coverage for the ACA expansion population . . . ." AR6726 [JA__]. Importantly, Kentucky's policy decision about whether to leave expanded Medicaid already carries the force of law. As noted above, Governor Bevin has issued an executive order that finds that Kentucky cannot afford the status quo of expanded Medicaid going forward. Governor Bevin therefore directed the applicable state officials to submit a Medicaid plan amendment removing Kentucky from expanded Medicaid if Kentucky HEALTH is ultimately enjoined. Dkt. No. 25-1 at 3 [JA__]. Surely an executive order establishing the law of Kentucky, as well as Kentucky's other "repeated[]" statements about the ACA expansion, suffice for substantial evidence about the sustainability of Medicaid in Kentucky, to the extent such

a showing is required. *See Biestek v. Berryhill*, 139 S. Ct. 1148, 1154 (2019) ("Substantial evidence . . . is 'more than a mere scintilla.' . . . It means—and means only—'such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" (internal citations omitted)). If more proof is needed, Kentucky at one time estimated that it will save more than $331 million—a substantial sum—because of Kentucky HEALTH, AR5513 [JA__], a number that now understates the Commonwealth's savings given that Kentucky HEALTH will be implemented beyond 2021 in more years with a higher state share, *see* 42 U.S.C. § 1396d(y)(1).

The district court also criticized the Secretary's sustainability rationale because "he did not compare the benefits of savings to the consequences for coverage." *Stewart II*, 366 F. Supp. 3d at 150. As already discussed, criticisms about the Secretary's balancing of interests implicitly tells the Secretary how he should exercise his judgment. Even so, the Secretary did exactly what the district court asked, explaining that "any loss of coverage as the result of noncompliance must be weighed against . . . the Commonwealth's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program." AR6731 [JA__].

The district court also concluded that Kentucky HEALTH is analogous to the waivers in *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011), and *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994). As framed by the district court, these cases stand for the proposition that a Section 1115 waiver cannot be used to accomplish "[a] simple benefits cut, which might save money, but has no research or experimental goal."

Betlach, 660 F.3d at 380 (quoting *Beno*, 30 F.3d at 1069). Even accepting this holding, Kentucky HEALTH has many "research or experimental goal[s]" supporting it, such as (to name only three) whether a community-engagement program increases health and wellness, whether modest premiums increase beneficiary engagement in their health care, and whether the waiver of retroactive coverage will prompt an increase in preventive care. Nor is Kentucky HEALTH "[a] simple benefits cut." Instead, as explained above, it expands benefits and preserves coverage beyond what Kentucky is required to provide and can otherwise provide.

The district court also concluded that Kentucky is impermissibly attempting to "implement the ACA expansion as an *à la carte* exercise, picking and choosing which of Congress's mandates it wishes to implement." *Stewart II*, 366 F. Supp. 3d at 153. That is a gross mischaracterization of Kentucky HEALTH. It is not an effort to whittle down expanded Medicaid as much as the Secretary will allow, but instead is, in the Secretary's judgment, a holistic, research-based program that likely will assist in promoting Medicaid's objectives. To conclude otherwise is to intrude on the Secretary's judgment. Also, characterizing Kentucky HEALTH as merely cutting benefits ignores, for example, its groundbreaking community-engagement program and *My Rewards Account* program. Also, if Kentucky HEALTH solely concerns cutting benefits, why does it provide access to optional benefits, like dental and vision care, over-the-counter drugs, and gym memberships? And why does the umbrella KY HEALTH waiver guarantee non-Medicaid benefits of needed SUD treatment to enrollees? In sum, if the Court

upholds Kentucky HEALTH under the Secretary's sustainability rationale, the Court will not be opening the door to any Section 1115 waiver that merely cuts benefits to preserve others.

The district court also posited several sky-is-falling scenarios: "Could a state decide it did not wish to cover pregnant women? The blind? All but 100 people currently on its Medicaid rolls?" *Id.* One obvious rebuttal to these concerns is the political process, which almost certainly would swiftly quash waivers of this sort. The district court also overlooked that, even if the Secretary can approve such waivers, he undeniably has the "judgment" to disapprove them. Before the district court, the Secretary made clear—without qualification—that a waiver that eliminated coverage for the blind, for example, would not be approved. *Stewart I*, 313 F. Supp. 3d at 255.

This argument, moreover, is a classic straw man. In approving Kentucky HEALTH, the Secretary has not claimed the authority to eliminate Medicaid coverage for mandatory groups so long as at least a few people maintain coverage. Nor has the Secretary applied this logic in the context of optional Medicaid coverage. To claim otherwise, as the district court did, overlooks the Secretary's careful explanation of why, in his judgment, Kentucky HEALTH as a whole is likely to assist in promoting the objectives of Medicaid, only one of which is improving the fiscal sustainability of Medicaid. It also overlooks that Kentucky HEALTH is a temporary program designed to test hypotheses.

In addition, the district court's parade of horribles incorrectly assumes that Kentucky is simply utilizing Section 1115 to eliminate or narrow coverage. This intrudes upon the Secretary's judgment. Virginia's recent experience with expanded Medicaid nicely illustrates this point. Virginia recently agreed to cover the new adult population, but as a condition of expansion, required the submission of a Section 1115 waiver application that, among other things, contains a community-engagement program.[7] 2018 Va. Acts 1st Sp. Sess. Ch. 2 (HB 5002), at 306-07 (2018); *see also* Virginia Waiver Application (Nov. 20, 2018), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-pa4.pdf (last visited May 12, 2019). Viewed through Virginia's lens, Section 1115 is a means for expanding medical assistance that otherwise would not exist. Kentucky's situation is the flip side of the same coin. Whereas Virginia very likely would not have expanded Medicaid without the possibility of a Section 1115 waiver, Kentucky cannot keep expanded Medicaid absent a Section 1115 waiver. In both states, making expanded Medicaid a reality equally justifies the respective Section 1115 waivers (assuming Virginia's application is granted).

[7] Virginia's approach to expanding Medicaid mirrors Idaho's in large measure. Norris, "Idaho and the ACA's Medicaid Expansion" (Apr. 10, 2019), *available at* https://www.healthinsurance.org/idaho-medicaid/ (last visited May 10, 2019).

C. Providing coverage

The Secretary went to great lengths to consider the effect that Kentucky HEALTH could have on Medicaid coverage. The district court in *Stewart II* correctly acknowledged that the Secretary considered concerns about coverage loss, but reasoned that the approval was "nevertheless legally inadequate because he 'failed to adequately analyze coverage.'" 366 F. Supp. 3d at 140 (citation omitted). As shown below, the district court's reasoning on this issue is irreconcilable with the unusually deferential approach applied by the Second and Third Circuits, as well as this Court in *Kreis*.

The Secretary's post-remand approval letter began with the premise that Section 1115 *specifically envisions that coverage loss may occur as a result of a waiver*. AR6719, 6730 [JA__, __] (citing 42 U.S.C. § 1315(d)(1), which states that a demonstration project may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing"). Because Section 1115 itself foresees coverage loss, it cannot be the case that a demonstration project only assists in promoting the objectives of Medicaid if it maintains or expands coverage or benefits. Thus, the question facing the Secretary about coverage loss was merely one of degree—something about which he is entitled to the utmost deference.

The Secretary confronted potential coverage loss head on. To begin with, the Secretary summarized the numerous, overlapping provisions of Kentucky HEALTH that are specifically designed to minimize any coverage loss. Kentucky HEALTH, the Secretary noted, does not easily disenroll recipients, nor does it make it impossible, or even difficult, for them to immediately regain coverage if they lose it. Instead, Kentucky

HEALTH has "substantial beneficiary protections in place," AR6732 [JA__], ranging from early-reenrollment provisions, AR6721, 6725 [JA__, __], to generous exclusions from program requirements for the medically frail and the primary caregiver of a dependent, among many others, AR6721–23 [JA__–__], and to good-cause exemptions from coverage loss as well as other procedural protections, *id.* All of these provisions led the Secretary to conclude that "CMS has incorporated safeguards into the [special terms and conditions] intended to minimize coverage loss due to noncompliance . . . ." AR6729 [JA__]. Plaintiffs-Appellees may believe that these guardrails, on-ramps, and exclusions are insufficient to alleviate potential coverage loss, but that is an issue vested in the Secretary's judgment.

The Secretary also addressed concerns about coverage loss from the perspective of the additional benefits and coverage that Kentucky HEALTH provides to enrollees. As discussed above, the Secretary framed this issue in terms of Kentucky's inability to continue to participate in expanded Medicaid without Kentucky HEALTH. *E.g.*, AR6732 [JA__]. Beyond that, the Secretary also explained how the Commonwealth will use Kentucky HEALTH to give optional benefits to enrollees, like over-the-counter medications, vision services, dental services, and a gym membership. AR6726 [JA__]. The same goes for the SUD program approved as part of the broader KY HEALTH waiver. *Id.* In short, the Secretary concluded that Kentucky HEALTH addressed coverage concerns by expanding benefits and preserving coverage. Here again, Plaintiffs-Appellees may disagree, but it is not their call to make.

The Secretary also addressed coverage concerns by noting that Kentucky HEALTH is designed to help enrollees successfully transition to other health coverage. AR6724–25, 6731 [JA__–__, __]. Kentucky's recent experience bears out the Secretary's judgment. From December 2017 until December 2018, which was, generally speaking, a time of economic progress in the Commonwealth, Kentucky's expansion population fluctuated significantly, going from 490,668 down to 450,008—a decrease of over 8 percent. Dkt. No. 110-2 [JA__–__]. These recent figures are consistent with the fact, which the Secretary specifically noted in his waiver approval, that "Kentucky's application noted the significant number of individuals in the Kentucky HEALTH program who are estimated to move between Medicaid eligibility and Exchange coverage." AR6725 [JA__]; *see also* AR5444 [JA__]. Consequently, the Secretary was well within his judgment to conclude that Kentucky HEALTH likely will assist enrollees in transitioning off of public assistance.

The district court also criticized the Secretary for failing to estimate the number of Medicaid recipients who will transition to other coverage because of Kentucky HEALTH's reforms. *Stewart II*, 366 F. Supp. 3d at 147–48. But the Secretary is not required to know the results of Kentucky HEALTH in advance. After all, "predictive calculations are a murky science in the best of circumstances." *Cablevision Sys. Corp. v. F.C.C.*, 597 F.3d 1306, 1314 (D.C. Cir. 2010). As the Supreme Court has emphasized, "[i]t is one thing to set aside agency action under the [APA] because of failure to adduce empirical data that can readily be obtained. It is something else to insist upon obtaining

the unobtainable." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009) (internal citation omitted). If the district court's conclusion about the lack of predictive data concerning enrollees transitioning to other coverage is upheld, the Secretary's Section 1115 authority will be reduced to testing ideas that have already been tested.

The district court disagreed with most of the above by latching onto the "95,000 projection" that allegedly was drawn from Kentucky's revised waiver application. *See Stewart II*, 366 F. Supp. 3d at 141–43. Most of the district court's objections can be written off as implicit disagreement with the Secretary's judgment as to the meaning and significance of the "95,000 projection." This estimate was not specifically created to approximate coverage loss, but instead for budget-neutrality purposes. AR 5421–22 [JA__–__]. That projection, in any event, cannot be proven or disproven until after Kentucky HEALTH has run its course. A single-minded focus on the "95,000 projection," therefore, is a distraction from the Secretary's proper and reasoned analysis of coverage loss. Rather than focusing solely on the "95,000 projection" to the exclusion of all else, the Secretary rationally focused on protecting the entirety of the Commonwealth's Medicaid population by ensuring that adequate guardrails and protections were in place to prevent inadvertent and inappropriate coverage loss.

In any event, the Secretary fully addressed the "95,000 projection," emphasizing that it does not actually "predict how many recipients will become uninsured under the demonstration project." AR6731 [JA__]. As the Secretary explained, "[t]he projected decrease in total member months is likely attributable to a number of factors, including

beneficiaries transitioning to commercial coverage, as well as the elimination of retroactive eligibility and beneficiaries who are temporarily suspended or otherwise lose eligibility for part of the year due to the noncompliance with program requirements." *Id.* The district court did not meaningfully challenge any of these conclusions. Most importantly, the district court did not contest that the "95,000 projection" includes individuals who transition off of Medicaid and receive other coverage.

The Secretary also noted that the "95,000 projection" was made "prior to the inclusion of changes made to the demonstration at approval, including additional beneficiary guardrails expected to help beneficiaries maintain enrollment." *Id.* The district court disagreed with the Secretary's description of when guardrails were added. *See Stewart II*, 366 F. Supp. 3d at 142. This conclusion is irreconcilable with the record in this matter. Several meaningful guardrails were added *after* the "95,000 projection" was made. After the "95,000 projection," for example, the Secretary added an additional way for beneficiaries to avoid disenrollment for failing to satisfy the community-engagement program—namely, the beneficiary can submit a statement from a physician that she has an "acute medical condition that would prevent [her] from complying with the requirements."[8] *Compare* AR6774 [JA__] (containing this guardrail), *with* AR1611, 5450 [JA__, __] (lacking this guardrail).

[8] In addition, after the "95,000 projection," Kentucky proposed utilizing a randomized control group that would include approximately 35,000–40,000 enrollees who would maintain their current benefit package without change. AR899 [JA __].

Perhaps the most meaningful guardrail added after the "95,000 projection" applies to Kentucky HEALTH participants who also are enrolled in SNAP or TANF but are exempt from either program's employment initiative. These enrollees in Kentucky HEALTH are deemed to automatically satisfy the community-engagement requirement. *Compare* AR6774 [JA__] (containing this exemption), *with* AR1611 [JA__] (lacking this exemption). This is a provision that the Commonwealth originally did not include in its application but that was added prior to the initial approval of Kentucky HEALTH. *See* AR2890, 2927 [JA__, __]. Indeed, CMS's January 11, 2018 letter to state Medicaid directors makes clear that including such a provision is a required condition for the Secretary to consider approving a community-engagement program. AR94 [JA__] (stating this must be "automatic[]").

A mere description of the two main exemptions from SNAP's employment initiative makes clear how big of a carve-out this is from Kentucky HEALTH's community-engagement program. As summarized above, SNAP excludes those over the age of 50 from its employment initiative. 7 U.S.C. § 2015(o)(3)(A). This is a meaningful expansion of Kentucky HEALTH's normal age cut-off for those "over the age of 64," which applies to enrollees who are not enrolled in SNAP. AR6774 [JA__]. SNAP's employment initiative also excludes "a parent or other member of a household with responsibility for a dependent child." 7 U.S.C. § 2015(o)(3)(C). Normally, Kentucky HEALTH only exempts the "primary caregivers of a dependent." AR6774 [JA__]. Thus, if a beneficiary is enrolled in SNAP, he must only have "responsibility for

a dependent child" in order to be exempt from Kentucky HEALTH's community-engagement program. In these two respects, the SNAP/TANF exclusion added after the "95,000 projection" almost certainly meaningfully lowers that projection.[9]

The district court, however, did not think this issue was properly before it because, in its view, the Secretary's reapproval letter did not "evince[] consideration" of this new exclusion. *Stewart II*, 366 F. Supp. 3d at 143 (citing *SEC v. Chenery Corp.*, 318 U.S. 80, 87 (1943)). The district court, however, clearly overlooked the Secretary's conclusion that the "95,000 projection" was "made prior to the inclusion of changes made to the demonstration at approval." AR6731 [JA__]. That more than suffices to raise the issue, as does the specific reference to it in the January 11, 2018 letter to state Medicaid directors, as well as the other places in the administrative record that discuss the SNAP/TANF exclusion.

D. Promoting financial independence

The Secretary also concluded that Kentucky HEALTH is "likely to promote the objective of helping beneficiaries attain or retain financial independence." *See* AR6724

[9] Although the Secretary did not estimate in advance how broad this SNAP/TANF exemption would be, during oral argument before the district court, the Commonwealth, which was in the process of running eligibility, noted that, based upon its "initial runs," the SNAP/TANF exemption would exclude approximately 60,000 recipients from the community-engagement program at that time. *Stewart II*, Oral Arg. Trans. at 24. As generally discussed above, the Secretary was not required to make predictions about such figures before approving Kentucky HEALTH, but the Commonwealth's experience is bearing out his judgment.

[JA__]. The Secretary's "attain or retain" language tracks that in Section 1396-1, which the Secretary identified as setting forth some of the purposes of Medicaid. AR6719 [JA__] (stating that, under Section 1396-1, Medicaid appropriations are to "enabl[e] each State . . . to furnish . . . rehabilitation or other services to help such families and individuals attain or retain capability for *independence* or self-care" (emphasis added)). The Secretary therefore drew his independence rationale, at least in part, from Section 1396-1.

The Secretary's independence rationale is tied to Kentucky HEALTH's "policies designed to prepare people for the commercial health insurance market, including to prepare them for the federally subsidized insurance that is available through the Exchanges." AR6725 [JA__]. In this regard, the Secretary noted that many of Kentucky HEALTH's components work "like insurance products sold on the commercial market," such as premiums, the *Deductible Account*, the *My Rewards Account*'s similarity to a health savings account, and the annual redetermination process, among others. *Id.* Educating enrollees about commercial coverage responds to a particular problem in Kentucky, as the Secretary noted: the "significant number of individuals in the Kentucky HEALTH program who are estimated to move between Medicaid eligibility and Exchange coverage." *Id.*; *see also* AR5444 [JA__].

The district court rejected this reasoning because, in its view, promoting financial independence is not a permissible objective of the Medicaid statute, even under *Chevron* step two. *Stewart II*, 366 F. Supp. 3d at 145–46. But the Supreme Court has already

concluded that states may "attempt to promote self-reliance and civic responsibility, to assure that limited state welfare funds be spent on behalf of those genuinely incapacitated and most in need, and to cope with the fiscal hardships enveloping many state and federal governments . . . ." *See Walsh*, 538 U.S. at 667 (quoting *N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 413 (1973)). The Second Circuit reached a similar conclusion in upholding a Section 1115 waiver of AFDC provisions. *See Aguayo*, 473 F.2d at 1103–04 (upholding a Section 1115 demonstration project that imposed employment requirements as a condition of AFDC eligibility because "Congress must have realized that extension of assistance to cases where parents, relatives or the child himself was capable of earning money would diminish the funds available for cases where they were not").

These commonsense holdings are fully consistent with Medicaid's appropriations provision, on which the Secretary relied. Section 1396-1 provides that Medicaid appropriations are to help furnish to "families with dependent children[,] [the] aged, [the] blind, or disabled individuals . . . rehabilitation and other services to help [them] attain or retain capability for independence or self-care." Unhelpfully, this provision was not updated in light of the ACA's enactment of expanded Medicaid, but it nevertheless specifies that even for the original Medicaid populations (the elderly, the disabled, the blind, and families with dependent children), Medicaid is to provide "rehabilitation and other services" so that these populations can "attain or retain capability for *independence* or self-care." *Id.* (emphasis added). Because even traditional

Medicaid is focused on attaining or retaining "capability for independence," it is reasonable to conclude that expanded Medicaid is as well.

The district court disagreed, reasoning that Section 1396-1 discusses a different type of "independence" than did the Secretary in approving Kentucky HEALTH. The district court reasoned that, in its view, Section 1396-1's text limits its discussion of independence to "furnish[ing] rehabilitation and other services," which Kentucky HEALTH does not do. *Stewart II*, 366 F. Supp. 3d at 145–46. But the district court overlooked that Kentucky HEALTH primarily applies to participants in expanded Medicaid, not to the four populations listed in Section 1396-1. At the very least, Congress's failure to update Section 1396-1 in light of the ACA's changes to the Medicaid program creates an ambiguity about the meaning of "independence" as applied to the new adult group, thus warranting *Chevron* deference. Importantly, the expansion population—the primary focus of Kentucky HEALTH—is altogether unlike the four populations mentioned in Section 1396-1. "Independence" for those four populations and what they need to attain or retain it is quite different from "independence" for the expanded Medicaid population and what that population needs to attain or retain it. *See NFIB*, 567 U.S. at 583 ("The Medicaid expansion . . . accomplishes a shift in kind, not merely degree."). For these reasons, the Secretary adopted not only a reasonable reading of the Medicaid statute, but also the correct one, in concluding that promoting financial independence is an objective of Medicaid as applied to participants in Kentucky HEALTH.

CONCLUSION

The Court should reverse the district court's judgment with respect to Count VIII of the Amended Complaint and enter summary judgment on that count in favor of Defendants-Appellants.

Respectfully submitted,

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May 14, 2019

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B)(i) because it contains 12,877 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)–(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Matthew F. Kuhn
Matthew F. Kuhn

CERTIFICATE OF SERVICE

I certify that on May 14, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Matthew F. Kuhn
Matthew F. Kuhn

ADDENDUM

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42 U.S.C. § 1315

(a) Waiver of State plan requirements; costs regarded as State plan expenditures; availability of appropriations

In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter I, X, XIV, XVI, or XIX, or part A or D of subchapter IV, in a State or States--

> (1) the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and
>
> (2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and
>
> (B) costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV and which are not included as part of the costs of projects under section 1310 of this title, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such subchapters for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such subchapters and is not included as part of the cost of projects for purposes of section 1310 of this title.

(b) Child support enforcement programs

> (1) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of part D of subchapter IV, the project--

(A) must be designed to improve the financial wellness of children or otherwise improve the operation of the child support program;

(B) may not permit modifications in the child support program which would have the effect of disadvantaging children in need of support; and

(C) must not result in increased cost to the Federal Government under part A of such subchapter.

(2) An Indian tribe or tribal organization operating a program under section 655(f) of this title shall be considered a State for purposes of authority to conduct an experimental, pilot, or demonstration project under subsection (a) to assist in promoting the objectives of part D of subchapter IV and receiving payments under the second sentence of that subsection. The Secretary may waive compliance with any requirements of section 655(f) of this title or regulations promulgated under that section to the extent and for the period the Secretary finds necessary for an Indian tribe or tribal organization to carry out such project. Costs of the project which would not otherwise be included as expenditures of a program operating under section 655(f) of this title and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under a tribal plan or plans approved under such section, or for the administration of such tribal plan or plans, as may be appropriate. An Indian tribe or tribal organization applying for or receiving start-up program development funding pursuant to section 309.16 of title 45, Code of Federal Regulations, shall not be considered to be an Indian tribe or tribal organization operating a program under section 655(f) of this title for purposes of this paragraph.

(c) Demonstration projects to test alternative definitions of unemployment

(1)(A) The Secretary shall enter into agreements with up to 8 States submitting applications under this subsection for the purpose of conducting demonstration projects in such States to test and evaluate the use, with respect to individuals who received aid under part A of subchapter IV in the preceding month (on the basis of the unemployment of the parent who is the principal earner), of a number greater than 100 for the number of hours per month that such individuals may work and still be considered to be unemployed for purposes of section 607 of this title. If any State submits an application under this subsection for the purpose of conducting a demonstration project to test and evaluate the

total elimination of the 100-hour rule, the Secretary shall approve at least one such application.

(B) If any State with an agreement under this subsection so requests, the demonstration project conducted pursuant to such agreement may test and evaluate the complete elimination of the 100-hour rule and of any other durational standard that might be applied in defining unemployment for purposes of determining eligibility under section 607 of this title.

(2) Notwithstanding section 602(a)(1) of this title, a demonstration project conducted under this subsection may be conducted in one or more political subdivisions of the State.

(3) An agreement under this subsection shall be entered into between the Secretary and the State agency designated under section 602(a)(3) of this title. Such agreement shall provide for the payment of aid under the applicable State plan under part A of subchapter IV as though section 607 of this title had been modified to reflect the definition of unemployment used in the demonstration project but shall also provide that such project shall otherwise be carried out in accordance with all of the requirements and conditions of section 607 of this title (and, except as provided in paragraph (2), any related requirements and conditions under part A of subchapter IV).

(4) A demonstration project under this subsection may be commenced any time after September 30, 1990, and shall be conducted for such period of time as the agreement with the Secretary may provide; except that, in no event may a demonstration project under this section be conducted after September 30, 1995.

(5)(A) Any State with an agreement under this subsection shall evaluate the comparative cost and employment effects of the use of the definition of unemployment in its demonstration project under this section by use of experimental and control groups comprised of a random sample of individuals receiving aid under section 607 of this title and shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of the project conducted by the State.

(B) The Secretary shall report the results of the demonstration projects conducted under this subsection to the Congress not later than 6 months after all such projects are completed.

(d) Regulations relating to applications for or renewals of demonstration projects

(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of subchapter XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under subchapter XIX or XXI (in this subsection referred to as a "demonstration project") shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

(2) Not later than 180 days after March 23, 2010, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for--

(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(B) requirements relating to--

(i) the goals of the program to be implemented or renewed under the demonstration project;

(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with subchapter XIX or XXI;

(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

(E) a process for the periodic evaluation by the Secretary of the demonstration project.

(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

(e) Extensions of State-wide comprehensive demonstration projects for which waivers granted

(1) The provisions of this subsection shall apply to the extension of any State-wide comprehensive demonstration project (in this subsection referred to as "waiver project") for which a waiver of compliance with requirements of subchapter XIX is granted under subsection (a).

(2) During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title), of the project.

(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waiver project would otherwise have expired.

(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.

(f) Application for extension of waiver project; submission; approval

An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) (in this subsection

referred to as the "waiver project") shall be submitted and approved or disapproved in accordance with the following:

(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends to review the terms and conditions of the waiver project. A failure to provide such notification shall be deemed to be an approval of the application.

(3) Not later than 45 days after the date a notification is made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed to by the chief executive officer of the State), the Secretary shall--

(i) approve the application subject to such modifications in the terms and conditions--

(I) as have been agreed to by the Secretary and the State; or

(II) in the absence of such agreement, as are determined by the Secretary to be reasonable, consistent with the overall objectives of the waiver project, and not in violation of applicable law; or

(ii) disapprove the application.

(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title).

(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e) (taking into account the extension under this subsection with respect to any timing requirements imposed under those paragraphs).

42 U.S.C. § 1396-1

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.