UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SAMUEL PHILBRICK, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 1:19-cv-00773 (JEB)
	)	
ALEX M. AZAR II, et al.,	)	
	)	
Defendants.	)	

PLAINTIFFS' MEMORANDUM IN SUPPORT OF
MOTION FOR PARTIAL SUMMARY JUDGMENT

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INTRODUCTION

This case challenges New Hampshire Granite Advantage, another cookie-cutter, Section 1115 waiver approved by the Secretary of Health and Human Services after the Administration announced its intent to explode the Affordable Care Act's Medicaid expansion and, as part of that effort, published guidelines encouraging states to condition Medicaid eligibility on mandatory work requirements. Essentially a carbon copy of the Kentucky and Arkansas approvals previously rejected by this Court, this case is "déjà vu all over again." *Gresham v. Azar*, 363 F. Supp. 3d 165, 175 (D.D.C. 2019); *see also Stewart v. Azar*, 366 F. Supp. 3d 125, 131 (D.D.C. 2019) (*Stewart II*); *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (*Stewart I*). As with Kentucky and Arkansas, the Granite Advantage approval fails to adequately consider the project against Medicaid's core purpose of furnishing medical assistance to low-income people. Consistent with his ongoing crusade to reinvent the Medicaid program, the Secretary instead based the New Hampshire approval on the same broad objectives that the Court has rejected because they are not objectives of the Medicaid statute. And, as with his previous approvals, the Secretary has ignored evidence in the administrative record that Granite Advantage's requirements will not promote coverage but will cause significant coverage losses.

In the end, Defendants' actions here reflect not a reasoned agency effort to effectuate the text and purpose of the statute Congress enacted, but instead an effort by an Executive to take by regulatory fiat what it could not accomplish in Congress and to "fundamentally transform Medicaid." But transformation of the social safety net is manifestly a job for Congress, not the Executive. Because Defendants broadly overstepped their authority under the Social Security Act and failed to adequately support or explain their conclusions, the Court should grant summary judgment on Plaintiffs' Administrative Procedure Act (APA) claims and vacate the waiver

approval and related State Medicaid Director letter.[1]

STANDARD OF REVIEW

The APA is the principal safeguard against irrational, incoherent, or unexplained agency decision making. Under the APA standard of review, *see* 5 U.S.C. § 706, the court must ensure that any agency action constitutes "reasoned decisionmaking." *Stewart I*, 313 F. Supp. 3d at 259 (quoting *Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015)). The agency must "examine all relevant factors and record evidence," *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 923 (D.C. Cir. 2017) (quote omitted), weigh "reasonably obvious alternative[s]" to its chosen course, *Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 797 (D.C. Cir. 1984), and furnish "a satisfactory explanation for its action"—one that draws a "rational connection between the facts found and the choice made" and that supplies "a reasoned analysis for [any] change," *Stewart II*, 366 F. Supp. 3d at 135 (quoting *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983)) (internal quotation marks omitted). Courts "do not defer to the agency's conclusory or unsupported suppositions," *Id.* at 135 (quoting *United Techs. Corp. v. U.S. Dep't of Def.*, 601 F.3d 557, 562 (D.C. Cir. 2010) (internal quotation marks and citation omitted), and merely "[s]tating that a factor was considered . . . is not a substitute for considering it," *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986). "Summary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [APA] standard of review." *Stewart I*, 313 F. Supp. 3d at 249 (citations omitted).

[1] Plaintiffs do not seek summary judgment on their constitutional claim, which they believe is more than sufficient to overcome a motion to dismiss. In addition, because summary judgment on Plaintiffs' individual claims will provide complete relief—through vacatur—there is no need to consider the class allegations at this time.

STATEMENT OF FACTS

I. The Federal Medicaid Program.

The Social Security Act establishes safety net programs to support low-income people. *See* 42 U.S.C. §§ 301-1397mm. The programs address a range of needs from cash and nutritional assistance to housing and health care. Title XIX of the Social Security Act addresses health care by establishing Medicaid. *See id.* §§ 1396-1396w-5. Congress enacted Medicaid "[f]or the purpose of enabling each State, as far as practicable . . . to furnish (1) medical assistance" on behalf of families and 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." *Id.* § 1396-1.

States do not have to participate in Medicaid, but all do. To receive federal funding, a state must operate its program according to a state plan approved by the Secretary. *Id*. § 1396a. The plan must describe the state's program and affirm its commitment to comply with requirements imposed by the Medicaid Act and implementing regulations. *Id*. §§ 1396a, 1316(a)(1); 42 C.F.R. § 430.10. The federal government reimburses states for a portion of "the total amount expended . . . as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1), (b) (establishing reimbursement formulas).

The Medicaid Act describes the population groups that are eligible to receive medical assistance. *See* 42 U.S.C. § 1396a(a)(10)(A), (C). States *must* cover individuals described in Section 1396a(a)(10)(A)(i) (the "mandatory categorically needy") and *may* cover individuals described in Sections 1396a(a)(10)(A)(ii) (the "optional categorically needy") and 1396a(a)(10)(C) (the "medically needy"). Prior to the Affordable Care Act ("ACA"), covered population groups included children, pregnant women, parents and other caretaker relatives, and

individuals who were aged, blind, or disabled. The ACA added a mandatory group to that list—adults who are under age 65, not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household incomes below 133% of the federal poverty level ("FPL") (the "expansion population"). *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14)) (eff. Jan. 1, 2014). With the addition, Congress expanded Medicaid "into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012) (*NFIB*). And although the Supreme Court in *NFIB* prohibited the Secretary from terminating federal funding to states that do not implement the Medicaid expansion, *id*. at 585, the population group nevertheless continues to be described as a mandatory coverage group in the Medicaid Act itself. The majority of states, including New Hampshire, have approved state plans to cover the expansion population. *See* Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision*, Apr. 9, 2019, https://bit.ly/2RbKzYY.

The Medicaid Act requires states to cover all members of a covered population group, not just subsets of a group. *See* 42 U.S.C. § 1396a(a)(10)(B). States may not impose eligibility requirements that are not explicitly allowed. *Id*. § 1396a(a)(10)(A); *see, e.g.*, *Jones v. T.H.*, 425 U.S. 986 (1976) (affirming ruling that Utah regulation violated Title XIX by adding requirement for obtaining medical assistance).

Since its enactment, the Medicaid Act has required states to determine eligibility and provide medical assistance to all eligible individuals with "reasonable promptness," 42 U.S.C. § 1396a(a)(8), and to provide retroactive eligibility for care provided in or after the third month before an enrollee's application if the enrollee would have been eligible for Medicaid at the time

the services were received, *id.* §§ 1396a(a)(34), 1396a(a)(10)(A), 1396d(a). Also, states must "provide such safeguards as may be necessary to assure" that eligibility and services "will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." *Id*. § 1396a(a)(19).

II. Section 1115 of the Social Security Act.

Section 1115 of the Social Security Act gives the Secretary limited authority to "waive compliance" with certain Medicaid Act requirements. 42 U.S.C. § 1315(a). The waiver must be limited to an "experimental, pilot, or demonstration" project. *Id*.; *see*. S. Rep. No. 87-1589, at 19-20 (1962) *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (stating congressional intent that projects "test out new ideas and ways of dealing with the problems of public welfare recipients," "be selectively approved," and "designed to improve the techniques of administering assistance and . . . related rehabilitative services"); H.R. Rep. No. 97-3982, pt. 2, at 307-08 (1981).

Congress also provided that the Secretary can only approve an experiment that is "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). In that circumstance, the Secretary can only waive a state's compliance with requirements of Section 1396a of the Medicaid Act. *Id.* Finally, the Secretary may only grant the waiver to the extent and for the period necessary to enable the state to carry out the experiment. *Id*. § 1315(a)(1). The costs of such an approved Section 1115 project are then regarded as Medicaid expenditures under the state plan. *Id*. § 1315(a)(2).

III. Medicaid Expansion in New Hampshire.

A. The 2014 Medicaid Expansion.

Effective July 1, 2014, New Hampshire amended its state Medicaid plan to include the expansion population through the "New Hampshire Health Protection Program" (NHHPP). *See*

New Hampshire State Plan Amendment 14-0004, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NH/NH-14-0004.pdf (last visited May 16, 2019). Over 130,000 individuals have been enrolled in Medicaid through the New Hampshire expansion at some point in time. New Hampshire Fiscal Pol'y Inst., *Medicaid Expansion in New Hampshire and the State Senate's Proposed Changes* 3 (May 12, 2018), http://nhfpi.org/wp-content/uploads/2018/03/Issue-Brief-Medicaid-Expansion-in-New-Hampshire-and-the-State-Senates-Proposed-Changes.pdf. Currently, in any given month, over 50,000 people receive coverage through the expansion. *See* N.H. Dep't of Health & Human Servs., *New Hampshire Medicaid Enrollment Demographic Trends and Geography (January 2019)*, 2 (Feb. 4, 2019), https://www.dhhs.nh.gov/ombp/medicaid/documents/nhhpp-enroll-demo-013119.pdf (reporting enrollment for "NHHPP Eligibility Group").

After implementing the Medicaid expansion, New Hampshire's uninsured rate fell from 10.7% in 2013 to 5.8% in 2017. New Hampshire Insurance Dep't, *2017 Final Report of the Health Care Premium and Claim Cost Drivers* 4 (Dec. 1, 2017), https://www.nh.gov/insurance/reports/documents/2018-nhid-annual-hearing-final-report.pdf. Individuals enrolled in the expansion have used their coverage to access critical health services. Between July 2014 and September 2017, 25,800 individuals obtained preventive care, 10,500 received screening for cervical cancer, 6,600 for breast cancer, and 4,700 for colorectal cancer. N.H. Dep't of Health & Human Servs., *New Hampshire Health Protection Program*, 3-4 (Sept. 27, 2017), https://www.dhhs.nh.gov/ombp/pap/documents/dhhs-pap.pdf. Moreover, 41,600 people received mental health services, 23,400 received cardiovascular treatment, 16,000 received services for asthma or chronic obstructive pulmonary disease, 11,000 received substance use disorder services, 6,100 received diabetes treatment, and 1,300 received cancer treatment services. *Id.*

In 2015, New Hampshire applied for a Section 1115 waiver called "New Hampshire Health Protection Program (NHHPP) Premium Assistance" ("Premium Assistance Program") to change the way it provided coverage to the expansion group. Through this Premium Assistance Program, the State sought to enroll most of the expansion population in private health plans and pay their premiums. *See* Letter from Andrew Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Nicholas A. Toumpas, Comm'r, N.H. Dep't of Health & Human Servs., 1, 16-17 (Mar. 4, 2015), ECF 1-1. The State's Premium Assistance application also sought to waive retroactive coverage. *Id.* at 2, 13. The Secretary approved a two-year waiver, from January 1, 2016 through December 31, 2018. *Id.* at 1. However, the Secretary imposed conditions on the State before allowing it to terminate retroactive coverage, permitting the State to terminate that coverage only if: (1) the State submitted data establishing that "there is seamless coverage that does not result in gaps in coverage prior to the time that a Medicaid application is filed, for individuals in the populations affected by the demonstration" and provided "a description of its renewal process and data related to that process, as well as any relevant data related to coverage continuity to evaluate whether individuals are losing coverage upon renewal"; and (2) CMS determined "that sufficient data has been provided to establish that retroactive coverage prior to the date of application is not necessary to fill gaps in coverage." *Id.* at 13.

In April 2016, the State passed legislation directing the State Medicaid agency to submit a waiver application seeking to impose work requirements on the expansion population. Accordingly, in August 2016, New Hampshire submitted a request to amend the Premium Assistance Program to, among other things, include a work requirement as a condition of eligibility in order to "increase personal responsibility." Letter from Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Human Servs., to Jennifer Kostesich, Project Officer, Div. of Medicaid Expansion

Demonstrations, Ctrs. for Medicare & Medicaid Servs., 1, 6-7 (Aug. 10, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-state-application-081016.pdf.

CMS denied New Hampshire's request, finding that the proposal "could undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do[es] not support the objectives of the Medicaid program." AR 99. Moreover, CMS never made a determination that New Hampshire provided sufficient data to "establish that retroactive coverage prior to the date of application is not necessary to fill gaps in coverage." Thus, CMS did not permit New Hampshire to implement the retroactive coverage waiver prior to the expiration of the Premium Assistance Program on December 31, 2018.

B. The Administration's Efforts to Explode Medicaid Expansion and New Hampshire's Restrictions on the Expansion

In 2017, the Trump administration began efforts to, in its own words, transform Medicaid and "explode" the ACA, including the Medicaid expansion. Amy Goldstein & Juliet Eilperin, *Affordable Care Act Remains "Law of the Land," but Trump Vows to Explode It*, Wash. Post (Mar. 24, 2017), https://wapo.st/2DirehA. President Trump signed an Executive Order calling on federal agencies to unravel the ACA. Exec. Order No. 13765, Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 82 Fed. Reg. 8351 (Jan. 20, 2017).

Shortly thereafter, the former HHS Secretary and Defendant Verma sent a letter to state Governors announcing the Centers for Medicare & Medicaid Services' ("CMS") disagreement with the purpose and objectives of the ACA. *See* Tom Price, Sec'y U.S. Dep't Health & Human Servs., Dear Governor Letter, AR 68. Despite Congress's clear directive in passing the ACA, Defendant Verma stated that "[t]he expansion of Medicaid through the Affordable Care Act (ACA)

to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program." AR 68. Subsequently, Defendant Verma repeatedly criticized the expansion of Medicaid to "able-bodied individual[s]," advocating for lower Medicaid enrollment and outlining plans to "reform" Medicaid through agency action.[2]

In June 2017, the New Hampshire Legislature passed legislation directing the state Medicaid agency to submit another request to impose work requirements on the expansion group. 2017 N.H. Laws, ch. 156, § 219 *available at* http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=744&txtFormat=html. The legislation threatened that if the State did not receive approval prior to April 30, 2018—later amended to June 30, 2018—the state Medicaid agency "shall . . . notify all program participants that the program has not been reauthorized beyond December 31, 2018." *Id.*; 2018 N.H. Laws, ch. 8, § 2 *available at* http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1751&txtFormat=html. Thereafter, Governor Sununu submitted the Premium Assistance Amendment waiver application to the Secretary in October 2017, stating that the work requirements were intended to "encourage unemployed and underemployed adults to proceed to full employment" so that "residents graduate from safety net programs and attain or return [to] a financially stable life." Letter from Christopher T. Sununu, Gov. of N.H., to Eric D. Hargan, Acting Sec'y, U.S. Dep't of Health & Human Servs. at 12 (Oct.

[2] *See* Casey Ross, *Trump health official Seema Verma has a plan to slash Medicaid rolls. Here's how*, Stat (Oct. 26, 2017), https://www.statnews.com/2017/10/26/seema-verma-medicaid-plan/; *see also, e.g.*, Remarks by Adm'r Seema Verma at the Nat'l Ass'n of Medicaid Dirs. (NAMD), 2017 Fall Conference, CMS.gov (Nov. 7, 2017), https://go.cms.gov/2SFu1ph (declaring that the ACA's decision to "move[] millions of working-age, non-disabled adults into" Medicaid "does not make sense," and announcing that CMS would resist that change through approval of state waiver projects that contain work requirements); *The Future Of: Healthcare*, Wall St. J. (Nov. 10, 2017), https://on.wsj.com/2AI1vMI (declaring Medicaid expansion a "major, fundamental flaw[]" and announcing CMS's efforts to "fundamentally transform Medicaid" and "restructure the Medicaid program"); Seema Verma, *Lawmakers have a rare chance to transform Medicaid. They should take it*, Wash. Post (June 27, 2017), https://wapo.st/2AJeZbg.

24, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa3.pdf ("Premium Assistance Amendment"). The State did not provide an estimate of the number of individuals who would lose coverage as a result of the work requirement. *See generally id.*

On January 11, 2018, more than a month after the federal comment period for the Premium Assistance Amendment had closed, CMS issued a State Medicaid Director letter ("SMD Letter") announcing a "new policy" to "Promote Work and Community Engagement Among Medicaid Beneficiaries." AR 57. The policy established guidelines for states wanting to "make participation in work or other community engagement a requirement for continued Medicaid eligibility." *Id*. It established the program features that states have since adhered to and HHS has used as the checklist for waiver approval.

On May 7, 2018, the Secretary approved the Premium Assistance Amendment effective through the end of 2018. AR 101-06. However, the State was not authorized to implement work requirements until after January 1, 2019. AR 101.

In June 2018, the New Hampshire Legislature authorized funding for the Medicaid expansion for five years and renamed the program "Granite Advantage." N.H. Rev. Stat. Ann. § 126-AA:2. The legislation did not direct the Medicaid agency to extend the waivers necessary for the Premium Assistance model and instead requires the Medicaid expansion population to enroll in managed care plans. *Id.* Accordingly, on August 6, 2018, New Hampshire submitted a State Plan Amendment to permit the State to enroll the expansion population in such plans starting January 1, 2019. *See* New Hampshire State Plan Amendment 18-0009, Managed Care - Addition of Granite Advantage Program, https://www.medicaid.gov/State-resource-center/Medicaid-State-

Plan-Amendments/Downloads/NH/NH-18-0009.pdf (last visited May 16, 2019). The Secretary approved the State Plan Amendment on September 13, 2018. *Id.*

The New Hampshire Legislature also directed the state Medicaid agency to apply for the necessary waivers to impose work requirements as a condition of eligibility, terminate retroactive coverage, impose an asset test, and require additional documentation of citizenship information. N.H. Rev. Stat. Ann. § 126-AA.2. Once again the Legislature threatened that "[i]f all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions." *Id.* The Legislature further explained that if the terms of the approved waiver differed from the terms of the statute with respect to the work requirements, the state Medicaid agency "shall provide written notification to the governor, the speaker of the house of representatives, and the president of the senate, informing them of the differences between the terms of this chapter and the approved waiver." *Id.*

On July 23, 2018, Governor Sununu requested permission from CMS to extend and amend the existing waiver project to extend the work requirements for a five-year period, eliminate retroactive coverage, impose an asset test, and require additional documentation of citizenship. AR 4377. Governor Sununu stated that the goal of the work requirements was to "lift thousands of Granite Staters towards independence and self-sufficiency." *Id*. Once again, the State did not provide an estimate of the number of individuals who would lose coverage as a result of the project.

On November 30, 2018, the Secretary approved the Granite Advantage application, effective January 1, 2019 through 2023. AR 1. The approval authorizes New Hampshire to require enrollees in Granite Advantage, ages 19 to 64, to engage in 100 hours of specified employment or community engagement activities every month to maintain their Medicaid coverage. AR 24-26.

The approval also authorized New Hampshire to eliminate retroactive coverage. AR 23-24. The State has implemented the waiver of retroactive eligibility and individuals must begin to complete the required 100 hours of work activities on June 1, 2019. The approval letter does not discuss the State's request to impose an asset test or citizenship requirements.

The Secretary's approval of New Hampshire's waiver continued the Administration's broader goal of transforming the Medicaid program. Work requirements have been approved in nine states in addition to New Hampshire— Utah, Ohio, Arizona, Michigan, Maine, Wisconsin, Indiana, Arkansas, and Kentucky—and more requests are pending. *See* CMS, *State Waivers List*, https://bit.ly/2BYzfms (last visited May 16, 2019). Medicaid beneficiaries in Kentucky and Arkansas have filed successful challenges against Defendants for approving similar Section 1115 waivers that included work requirements. In *Stewart v. Azar*, this Court found the approval of the Kentucky HEALTH project arbitrary and capricious because "[t]he Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." *Stewart I*, 313 F. Supp. 3d at 243.

After that decision, Defendant Verma reiterated that CMS is "very committed" to work requirements and wants "to push ahead with our policy initiatives and goals." Dan Goldberg, *Verma: Court ruling won't close door on other Medicaid Work requests*, Politico, July 17, 2018, https://politi.co/2RsJhIF. Defendant Azar similarly declared that "[the Federal Defendants] are undeterred . . . [and a]re proceeding forward [with] . . . work requirements . . . in the Medicaid program." Colby Itkowitz, *The Health 202: Trump administration 'undeterred' by court ruling against Medicaid work requirements*, Wash. Post (July 25, 2018), https://wapo.st/2QUKyss; *see also* Alex M. Azar II, Sec'y, U.S. Dep't of Health & Human Servs., Remarks on State Healthcare Innovation at the Am. Legis. Exchange Council Annual Mtg. (Aug. 8, 2018) ("[Defendant

Verma] is now overseeing the next great generation of transformation in Medicaid, through our efforts to encourage work and other forms of community engagement.").

Following the *Stewart I* decision, CMS re-approved Kentucky HEALTH. After reviewing the revised approval letter, the Court concluded that "[r]ather than adequately addressing Kentucky HEALTH's potential to cause loss of medical coverage, the Secretary continues to press his contention that the program promotes his alternative proposed objectives of beneficiary health, financial independence, and the fiscal sustainability of Medicaid." *Stewart II*, 366 F. Supp. 3d at 138. The Court held that beneficiary health and financial independence are not standalone objectives of the Medicaid program, and while fiscal sustainability could be an program objective, the Secretary did not undertake a reasoned analysis of "the fiscal-sustainability concern, both alone and relative to the issue of coverage loss." *Id*. at 152. The Court found that his "failure once again to adequately consider the effects of Kentucky HEALTH on coverage is alone – as it was in *Stewart I* – fatal to the approval." *Id.* at 138.

Meanwhile, this Court considered a similar challenge to Defendants' approval of an amendment to Arkansas's existing Section 1115 project, which allowed the State to impose work requirements and limit retroactive eligibility. In *Gresham v. Azar,* this Court vacated the approval holding that it was arbitrary and capricious because it failed to address whether and how the amendment would impact Medicaid's "core" objective of furnishing medical coverage to the needy. 363 F. Supp. 3d at 181.

After these decisions were announced, Defendant Verma confirmed that CMS "will continue to defend our efforts to give states greater flexibility to help low income Americans rise out of poverty." Rachana Pradhan, *Judge strikes down Medicaid work rules in Arkansas, Kentucky*, Politico, Mar. 27, 2019, https://www.politico.com/story/2019/03/27/work-

requirements-medicaid-1240074. The Administration subsequently announced its 2020 budget, which would immediately impose mandatory work requirements in the Medicaid program, nationwide, projecting it would save $130 billion over ten years. *See* Dep't of Health & Human Servs., *FY 2020 Budget in Brief*, 100 (Mar. 11, 2019), https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf.

The work requirements and retroactive coverage waiver will harm Plaintiffs and thousands of others enrolled in Granite Advantage. They are at risk of losing coverage when they cannot meet the work requirements or successfully report compliance. *See* Exh. A, Philbrick Decl. at ¶¶ 4-5, 12-13 (will struggle to comply with work requirements and reporting compliance, lacks transportation to other activities); Exh. B, Ludders Decl. at ¶¶ 5-8, 13, 16 (has no work lined up after August 2019 and relies on time between jobs to complete subsistence activities, making compliance with work requirements difficult); Exh. C, K. Vlk Decl. at ¶¶ 3, 9-14, 19-20, 23 (exemption based on child under six ends on July 31, 2019, unable to work or complete other activities, and faces significant barriers to reporting compliance, including lack of reliable vehicle). Without coverage, their health will suffer or they will incur bills they cannot pay. *See* Exh. A, Philbrick Decl. at ¶¶ 7-8 (needs medication to sleep); Exh. D, J. Vlk Decl. at ¶¶ 8-11, 14 (struggles with chronic hernia pain requiring surgery, needs counseling, and suboxone to treat addiction); Exh. C, K. Vlk Decl. at ¶¶ 15-16 (suffers chronic pain and fatigue requiring surgery and medication as well as medication and counseling for mental health disorders). Their efforts to comply with the new requirements will also impose burdens on the Plaintiffs. Exh. B, Ludders Decl. at ¶¶ 8, 15 (compliance with work requirements will prevent subsistence activities, increasing food and heating expenses); Exh. C, K. Vlk. Decl. at ¶¶ 4, 19-20 (reporting to state agency requires driving, which is painful and time consuming). Moreover, if a Plaintiff loses

coverage due to the work requirements, he will not have retroactive coverage for health services received during the gap in coverage.

ARGUMENT

I. The Secretary's Approval of New Hampshire Granite Advantage Promotes His Own Agenda at the Expense of the Medicaid Act's Objectives.

The Secretary may grant a Section 1115 waiver only for an experiment that is "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). As this Court has already held, Section 1396-1 "provides a central objective of the Medicaid Act: to furnish medical assistance to the populations covered by the Act," including the expansion population, which the ACA placed "on equal footing" with other Medicaid populations. *Stewart II*, 366 F. Supp. 3d at 139. In approving New Hampshire Granite Advantage, however, the Secretary sought to advance a different slate of objectives: "advanc[ing] the health and wellness needs of its beneficiaries, increasing financial independence" which purportedly would transition low-income adults from Medicaid to commercial coverage, and improving the fiscal sustainability of the safety net. AR 1-2. But Congress did not authorize these objectives, and it is not for the Secretary to redefine Medicaid's purpose.

First, this Court has repeatedly concluded that "[t]reating health—rather than the furnishing of medical services—as the Act's ultimate goal is nothing more than a sleight of hand," because it impermissibly "extrapolate[s] the objectives of the statute to a higher level of generality." *Stewart II*, 366 F. Supp. 3d at 144 (internal quote omitted). "Promoting health" might be a desirable *result* of the Medicaid program, but the Secretary has no authority to "choose his own means to that end." *Stewart I*, 313 F. Supp. 3d at 266 (citing *Waterkeeper Alliance v. EPA*, 853 F.3d 527, 535 (D.C. Cir. 2017)). The text and the structure of the Act show that Congress "designed a scheme to address not health generally but the provision of care to needy populations." *Stewart II*, 366 F. Supp. 2d at

144. Were it otherwise, the Secretary could approve *any* policy he subjectively concludes might improve health outcomes, including "conditioning coverage on a special diet or exercise regime." *Id.* at 145. Because "health is not a freestanding objective of the statute . . . the Secretary's consideration of it cannot support his § 1115 analysis." *Id.*

Second, the Secretary's goals of promoting individuals' "financial independence" and transitioning low-income adults from Medicaid to commercial coverage, *see* AR 2, 6, are not goals of the Medicaid Act. Congress created the program to provide coverage to people "whose income and resources *are* insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1 (emphasis added). While reducing the number of low-income people in general might be a laudable goal, it is external to Medicaid, which seeks to ensure that people have access to care at the point in time when their incomes are too low, full stop. If Congress had wanted reducing dependency on public assistance to be a goal of Medicaid, it would have said so. *Cf.* 42 U.S.C. § 601 (stating purpose of Temporary Assistance for Needy Families program ("TANF") to "end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage"). Instead, the text Congress enacted in § 1396-1 "quite clearly limits [the Act's] objectives to helping States furnish *rehabilitation and other services* that might promote self-care and independence." *Stewart II*, 366 F. Supp. 3d at 146 (quoting *Stewart I*, 313 F. Supp. 3d at 271). In this context, "independence" refers to functional (not financial) independence—*i.e.*, the capacity to accomplish the activities of daily living, such as feeding, dressing, and bathing. *See, e.g.*, 42 U.S.C. § 1396d(a)(13)(C) (defining rehabilitation services as "any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or practitioner of the health arts . . . for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level"). As this Court has acknowledged, the Secretary's

interpretation untethers the term from its context and cannot be squared with the sentence in which it is used. *Stewart II*, 366 F. Supp. 3d at 146. Because "financial self-sufficiency is not an independent objective of the Act," it "cannot undergird the Secretary's finding under § 1115 that the project promotes the Act's goals." *Id.* at 145.

Third, as with the Arkansas and Kentucky approvals, the Secretary relies on a generally undefined goal of ensuring fiscal sustainability. *See* AR 2, 6-7, 11. But, as other courts have held, if the "purpose of [a Section 1115] waiver application [i]s to save money," the application does not satisfy Section 1115. *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011). Section 1115 "was not enacted to enable states to save money or to evade federal requirements but to test out new ideas . . . ." *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). What is more, as discussed in Section II.B below, the Secretary did not make any findings at all about the fiscal effects of Granite Advantage or show that he weighed the purported fiscal benefits against the substantial risk of coverage loss.

And even if fiscal sustainability is an appropriate consideration, the Secretary cannot treat it as the prime objective of the Medicaid Act. That interpretation transforms fiscal sustainability from a "qualifier" on the primary goal of furnishing coverage, *see Stewart II*, 366 F. Supp. 3d at 149, into its own central goal that may directly compete with, or even supersede, the goal of coverage. The "as far as practicable" language on which the Secretary relies, *see* AR 2, appears as a dependent clause in the sentence enumerating the specific goal of furnishing medical assistance. Ordinary rules of grammar require the dependent clause to be interpreted in relationship to the remainder of the sentence, not in isolation. *Cf. Yates v. United States*, 135 S. Ct. 1074, 1081-82 (2015) (noting that words must be read in context). The Secretary did just the opposite, plucking

the clause from its context and imbuing it with meaning divorced from the remainder of the sentence in which it appears.

Thus, even if the Secretary may consider fiscal sustainability in some fashion as a part of the Section 1115 analysis, the text of Section 1396-1 and rules of statutory construction demand that it remain, at best, a subordinate consideration to the guiding principle of furnishing coverage. *Cf. Stewart II* at 152 ("[A] project that enhances financial sustainability may not advance the objectives of Medicaid if it significantly impedes or curtails Medicaid services or coverage.").

Next, and just as he did in re-approving Kentucky HEALTH, the Secretary presented fiscal sustainability as a way to promote coverage. In the Granite Advantage approval, he again contended that saving money would allow the State to continue to cover the expansion population and, perhaps, other optional populations and services, and that without the waiver New Hampshire would terminate coverage for the expansion population. AR 6, 10. Notably, this reasoning is based on a false premise—that given the decision in *NFIB*, New Hampshire may simply terminate coverage for the mandatory expansion population. In *NFIB*, the Court decided a constitutional question: whether it was unduly coercive for Congress to compel a Medicaid-participating state to cover the Medicaid expansion population under the threat of losing all federal Medicaid funding. The Court held that it was coercive because, prior to 2010, states did not understand they would have to cover this group as part of the Medicaid bargain. And "though Congress' power to legislate under the spending power is broad, it does not include surprising participating States with post-acceptance or 'retroactive' conditions." 567 U.S. at 584 (citation omitted and alteration adopted). As the full remedy for the unconstitutional violation, the Court prohibited the Secretary from withdrawing existing federal funds from a state that refused to expand, *id.* at 586, and otherwise left the Medicaid statutory scheme intact, *id*. at 585. *NFIB* established only whether requiring

coverage of the expansion population *without a state's opt-in* was coercive. But it did not deem the expansion population an optional coverage population. And following enactment of the ACA in 2010 and the Supreme Court's *NFIB* decision in 2012, states, such as New Hampshire, that opted-in to the Medicaid expansion understood the bargain.

Moreover, the fiscal sustainability rationale "is not subject to any kind of limiting principle." *Stewart II*, 366 F. Supp. 3d at 154. Taken to its logical conclusion, it would mean that whenever a state threaten to de-expand, as New Hampshire has here, "or indeed do away with all of Medicaid—for fiscal reasons or no reason at all—if the Secretary does not approve whatever waiver of whatever Medicaid requirements they wish to obtain," the Secretary could approve those requests "no matter how few people remain on Medicaid thereafter because *any* waiver would be coverage promoting compared to a world in which the state offers no coverage at all." *Id*. at 154 (emphasis in original). Congress did not, and could not, grant the Secretary such unbridled authority. *See id.*; *see also A.L.A. Schechter Poultry, Corp. v. United States*, 295 U.S. 495, 538-39 (1935) (finding delegation unconstitutional where President had authority to "impose his own conditions, adding to or taking from what is proposed, as 'in his discretion' he thinks necessary 'to effectuate the policy' declared by the act"); *Clinton v. City of New York*, 524 U.S. 417, 444 (1998). In fact, as this Court determined, the text of Section 1115 makes clear that "the relevant baseline is whether the waiver will still promote the objectives of the Act as compared to compliance with the statute's requirements, not as compared with a hypothetical future universe where there is no Act." *Stewart II*, 366 F. Supp. 3d at 154. Any interpretation to the contrary "constitutes 'an impermissible construction of the statute . . . because [it] is utterly unreasonable in its breadth.'" *Id.* (quote omitted).

In short, the State remains obligated to cover the entire expansion population as described in the Act, and even if it did not, the Secretary may not use his Section 1115 power to "turn the comprehensive Medicaid program that Congress designed into a buffet for states." *Stewart II*, 366 F. Sup. 3d at 154. By continuing to focus on the unbridled objectives of promoting health, financial independence, and fiscal sustainability, the Secretary impermissibly prioritized his own objectives to impose work requirements on the "able-bodied" expansion population at the expense of the statute's "clear emphasis on promoting medical . . . assistance." *Stewart I*, 313 F. Supp. 3d at 268 (internal quotes omitted). Because the Secretary continues to "exercise[] discretion using the wrong legal standard, [his] action cannot survive." *Id.* at 272 (citing *SEC v. Chenery Corp*., 318 U.S. 80, 94 (1943)).

II. The Secretary's Approval is Arbitrary and Capricious Because He Failed to Adequately Examine if Granite Advantage Met the Section 1115 Conditions.

The Secretary did not reasonably conclude that his approval of Granite Advantage is a valid experiment likely to promote the objectives of the Medicaid Act. 42 U.S.C. § 1315(a); *Stewart I*, 313 F. Supp. 3d at 254 (citing *Newton-Nations*, 660 F.3d at 379-80). The central objective of the Act is to furnish medical assistance to low-income people. The Secretary, thus, had an affirmative obligation to examine whether Granite Advantage "would cause recipients to *lose* coverage [and] whether the project would help *promote* coverage." *Stewart I*, 313 F. Supp. 3d at 262; *Gresham* 363 F. Supp. 3d at 177; *see also Newton Nations*, 660 F.3d at 381.

"The Secretary . . . neglected both." *Stewart I*, 313 F. Supp. 3d at 262. His central argument regarding coverage mirrors the reasoning he used to re-approve Kentucky HEALTH: that without Granite Advantage, the State would terminate coverage for the entire expansion population and perhaps (some undisclosed) optional coverage groups as well. *Compare* AR 10 (noting that absent the waiver, New Hampshire "could respond by seeking to scale back or even end coverage for the

ACA expansion population, or other optional populations and services currently covered under the state plan.") *with Stewart II*, 366 F. Supp. 3d at 131 (rejecting argument that the Secretary "need not grapple with the coverage-loss implications of a state's proposed project as long as it is accompanied by a threat that the state will de-expand[.]"). For the reasons described above, that flawed logic cannot carry the day. The Secretary needed to consider "whether the waiver will still promote the objectives of the Act as compared to compliance with the statute's requirements," *Stewart II*, 366 F. Supp. 3d at 154, and he did not do so here. In fact, he ignored evidence submitted by commenters confirming that Granite Advantage will significantly reduce Medicaid coverage for low-income individuals. This failure to "adequately analyze" the impact on coverage "is alone—as it was in *Stewart I* [and *Stewart II*]—fatal to the approval." *Id.* at 138.

But even assuming the Secretary could properly consider his preferred alternative objectives—promoting health, financial independence, and fiscal sustainability—his reasoning here is nearly identical to that in the Kentucky re-approval and fails for the same reasons: he ignored substantial evidence undermining his conclusions and failed to weigh the purported benefits against the risks of coverage loss.

A. The Secretary Failed to Consider Whether the Project Would Cause Medicaid Coverage Loss or Promote Medicaid Coverage.

The record contains dozens of comments warning that many thousands of people will lose Medicaid coverage due to Granite Advantage and citing research from health policy experts. *See, e.g.*, AR 2206-07, 2585-87, 2694-96, 2960, 2974-75, 3644-45, 3656.[3] Comments also

[3] Commenters cited numerous studies, including: Aviva Aron-Dine, Ctr. on Budget & Policy Priorities, *Eligibility Restrictions in Recent Medicaid Waivers Would Cause Many Thousands of People to Become Uninsured* (2018), https://www.cbpp.org/research/health/eligibility-restrictions-in-recent-medicaid-waivers-would-cause-many-thousands-of; Rachel Garfield et al., Kaiser Family Found., *Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses* (2018), AR 2530; Jennifer Wagner, Ctr. on Budget & Policy Priorities,

highlighted data from Arkansas showing that, during the first two months of Arkansas's work requirement, more than a quarter of enrollees required to report work hours or seek an exemption did not. *See, e.g.*, AR 1489-90, 2208-09, 2563, 2596-97, 2612-13, 2731-47. By the time he approved Granite Advantage, the Secretary also had access to five months of data from Arkansas showing that over 12,200 people had been terminated for failure to comply with the work requirements. *See* Exh. E, Ark. Dep't of Human Servs., Arkansas Works Program August–October 2018 Reports. New Hampshire's work requirements closely resemble those implemented in Arkansas, and there is nothing in the record to project a better result in New Hampshire. Indeed, the record suggests rates of coverage loss in New Hampshire will likely be higher. *Cf.* AR 2209, 2542, 2696.

Commenters also supplied numerous comments stating the obvious—waiving retroactive coverage will create gaps in coverage and reduce access to Medicaid services by weakening the network of providers serving enrollees. *See, e.g.*, AR 1492, 2214-16, 2224, 2246-47, 2596, 2714-16, 3658-60.[4] *See also Stewart I*, 313 F. Supp. 3d at 265 ("restricting retroactive eligibility will, by definition, *reduce* coverage for those not currently on Medicaid rolls.").

The Secretary did not adequately grapple with the well-founded concerns regarding the work requirements and retroactive coverage. The Secretary agreed that some individuals "may lose coverage," AR 11, but this aside does not show that he reasonably examined the problem or explained how the waiver would deal with that issue. *See Stewart I*, 313 F. Supp. 3d at 259 (agency

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Commentary: As Predicted, Eligible Arkansas Medicaid Beneficiaries Struggling to Meet Rigid Work Requirements (2018) AR 2540; Anuj Gangopadhyaya et al., Urban Institute, *Medicaid Work Requirements in Arkansas* (2018), https://www.urban.org/research/publication/medicaid-work-requirements-arkansas/view/full_report.

[4] Comments cited an evaluation of a similar proposal in Ohio that estimated that ending retroactive coverage "could cost hospitals as much as $2.5 billion" over five years. Virgil Dickson, *Ohio Medicaid waiver could cost hospitals $2.5 billion*, Modern Healthcare. (Apr. 22, 2016), AR 2600.

"must provide more than 'conclusory statements'") (citing *Getty*, 805 F.2d at 1057). The Secretary also did not provide a "bottom-line estimate of how many people would lose Medicaid with [Granite Advantage] in place." *Id.* at 262. Nor did he calculate how many of these individuals would, as he claims, transition to commercial coverage.[5] *See* AR 11; *see also Stewart II*, 366 F. Supp. 3d at 142. This, too, was reversible error because "the Secretary unquestionably ha[d] a duty to consider that issue where multiple commenters provide[d] credible forecasts that it will occur." *Gresham*, 363 F. Supp. 3d at 178. He thus "failed to consider an important aspect of the problem." *Id.* at 264 (citing *State Farm*, 463 U.S. at 43). This "failure to consider the effects of the project on coverage alone renders his decision arbitrary and capricious." *Id.* at 180.

Instead of addressing coverage loss, the Secretary maintained that any loss would be minimal. The record contradicts his assertions. For instance, the Secretary argued that enrollees can satisfy the work requirements through "an array of activities" other than work. AR 8. As commenters carefully explained, however, extensive research shows that the requirement—however it is described—will cause massive coverage loss. *See, e.g.*, AR 1950, 2242, 2964-65, 2698-99, 3588, 3651-52 (highlighting barriers to working, volunteering, or completing other activities, including nature of low-wage labor market and lack of internet access and affordable

[5] Commenters explained that, due to the nature of the labor market, individuals who fulfill the work requirement are not likely to access employer-sponsored or other commercial insurance, particularly if they rely on activities such as job training or community service that do not come with commercial insurance. *E.g.*, AR 2209-10, 2707-09, 3370, 3644-45, 3651-52. Commenters included numerous studies, *e.g.*: Michelle Long et al., Kaiser Family Found. *Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014* (Mar. 21, 2016), https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/; Josh Bivens & Shawn Fremstad, Econ. Policy Inst., *Why Punitive Work-Hours Tests In SNAP And Medicaid Would Harm Workers And Do Nothing To Raise Employment* (2018), https://www.epi.org/publication/why-punitive-work-hours-tests-in-snap-and-medicaid-would-harm-workers-and-do-nothing-to-raise-employment/; Kids Forward, *The Wisconsin Approach to Medicaid Expansion* (2017), http://kidsforward.net/assets/Medicaid-Approach.pdf.

transportation). The Secretary also did not address the substantial evidence detailing how the administrative reporting requirements will reduce enrollment in Medicaid. AR 2207, 2244, 2596, 2720-22, 3588-89 (describing research that even minimal reporting requirements reduce enrollment in Medicaid and other programs).

As he did in Kentucky and Arkansas, the Secretary again contended that exemptions to the work requirements—the good cause exceptions and the opportunities to re-enroll in Granite Advantage through the "cure" option—will minimize any coverage loss. AR 7-8 (in general). However, with respect to the exemptions, the Secretary "cannot limit his review to only 'vulnerable individuals' . . . [h]e must consider coverage to all groups enrolled in the project."[6] *Stewart I*, 313 F. Supp. 3d at 263-64. Equally important, nearly identical features were included in the work requirements approved in New Hampshire's Premium Assistance Amendment, *see* AR 103-05, 124-25, 127, and the State described those features in its Granite Advantage application. *See* AR 4389-90. Commenters, therefore, expressed their concerns about coverage loss despite those features. *See, e.g.*, AR 1488-90, 2702, 3589, 3649-50 (raising concerns about the exemptions, good cause exceptions, and opportunity to cure). In addition, commenters cited research from the Supplemental Nutrition Assistance Program ("SNAP") and TANF demonstrating that these kinds of safeguards do not avoid coverage loss. *See, e.g.*, AR 2207, 2586-87, 2700-01, 3741, 4564. Highlighting these so-called protections is, therefore, "no answer at all" to the concerns commenters raised. *Stewart I*, 313 F. Supp. 3d. at 263. In fact, when approving Granite Advantage, the Secretary made several changes that actually narrowed or limited these

[6] The Secretary claimed that only individuals who willfully ignore the work and other requirements will lose coverage. *See, e.g.*, AR 6, 11. But commenters made clear that many individuals who are working or fall within an exemption will nonetheless lose coverage due to the added burden of reporting work hours or seeking an exemption. *See, e.g.*, AR 1484, 2207, 2241-42, 3649-50.

"safeguards." For instance, he narrowed the opportunity to "cure" deficient hours. While the opportunity to cure contained no limitation in the Premium Assistance Amendment, *see* AR 127, Granite Advantage prohibits "repeated consecutive use of the opportunity to cure . . . for an entire one-year eligibility period." AR 28. The Secretary likewise narrowed certain exemptions, for instance, limiting the exemption for parents of a child with a disability, so that it "only applies to one parent or caretaker in the case of a 2-parent household. *Compare* AR 125 (Premium Assistance Amendment) with AR 24 (Granite Advantage).[7]

As he did in the Kentucky approval letters, the Secretary points to other "guardrails" he contends will "protect beneficiaries," including requiring the State to provide: (1) reasonable modifications to the work requirement for people with disabilities; (2) appeal rights prior to termination; and (3) a 75-day notice period before individuals must comply with the work requirements. AR 8-9. Again, each of these features was included in the Premium Assistance Amendment, meaning commenters were aware of them. AR 126-27. In addition, existing federal law, not the Special Terms and Conditions (STCs), requires the first two of these features. *See* 42 U.S.C. § 12132; 29 U.S.C. § 794; 42 U.S.C. § 18116 (prohibiting discrimination and requiring modifications for individuals with disabilities); *Goldberg v Kelly*, 397 U.S. 254 (1970) (holding that the Constitution's Due Process Clause requires opportunity for impartial review prior to termination of public benefits). Moreover, the appeal process will only help individuals who were terminated erroneously or who belatedly realize they may qualify for a narrow good cause exception. And, the 75-day introductory period does nothing to allay the extensive concerns raised

[7] The Secretary added one exemption: a good cause exemption for parents with children ages 6-12 who are unable to secure child care. *Compare* AR 126-7 *with* AR 26-27. The Secretary also made small changes in wording and organization of some STCs. *Compare* AR 125-26, 128-30 *with* AR 25, 29-33. These changes are insufficient to address coverage loss, and the Secretary did not calculate how, if at all, they could reduce coverage loss. *See Stewart I*, 313 F. Supp. 3d at 264.

by commenters that monthly reporting will prove too burdensome, including after the initial 75-day period ends. *See, e.g.*, AR 1484, 2207, 2241-42, 3588-89, 3649-50. In short, the Secretary did nothing "more than acknowledge—in a conclusory manner no less—that commenters forecast a loss in Medicaid coverage." *Gresham*, 363 F. Supp. 3d at 177. But "the agency did not engage with that possibility." *Id.*

Unable to credibly address the substantial record evidence showing Granite Advantage would be disastrous to medical coverage, the Secretary attempts to justify his approval of the program by emphasizing that Granite Advantage is just an experiment, the exact outcome of which is uncertain. AR 12. But "the experimental nature of the project cannot relieve the Secretary of the obligation to do the analysis that § 1115 itself demands –*viz.*, whether a demonstration project promotes the objectives of the Act."[8] *Stewart II*, 366 F. Supp. 3d at 141. The approval letter shows that the Secretary disregarded that obligation. AR 12 ("*Regardless of the degree to which [the] project succeeds in achieving the desired results*, the information it yields will provide policymakers real-world data on the efficacy of such policies. That in itself promotes the objectives of the Medicaid statute.") (emphasis added).

Promote Coverage: The Secretary did not reasonably explain how the project would promote coverage. With respect to work requirements, the Secretary asserts—without support—that work requirements could promote private health insurance coverage if "individuals achieve financial independence and transition to commercial coverage." AR 6. But he ignored evidence

[8] In any event, the work requirement is not actually "experimental." *See Beno*, 30 F.3d at 1069. Work requirements have been a condition of eligibility in other safety net programs (under those programs' governing statutes), and the subject of a large body of research with consistent findings regarding their efficacy. In fact, the Secretary approved Granite Advantage without an assessment plan in place to evaluate whether the requirements actually improve employment or health—ostensibly the purpose of the waiver. AR 39-40 (initial draft evaluation not due until 180 days after approval, and subsequent drafts not due until 60 days after CMS comments); *see also* AR 2964.

showing that such a result is unlikely to occur. *See* n.7 *supra*, Section II.B, *infra* (discussing financial independence). Even assuming that imposing a work requirement would cause Medicaid enrollees to transition to commercial coverage (and that such an objective is proper), the Secretary did nothing to balance the number of individuals who might gain commercial coverage against the number of individuals who will lose health coverage due to the work requirement. *See* AR 6.

The Secretary's rationale regarding the waiver of retroactive coverage fares no better. He repeated several times that eliminating retroactive eligibility will "encourage beneficiaries to enroll earlier, to maintain health insurance coverage even while healthy." AR 3; *see also* AR 5, 12, 13. But this "conclusory reference cannot suffice, especially when viewed in light of an obvious counterargument." *Stewart I*, 313 F. Supp. 3d at 265 (internal quotations omitted); *Stewart II*, 366 F. Supp. 3d at 143. There is no evidence in the record showing that low-income individuals decide not to enroll in Medicaid because they are healthy (thereby showing that eliminating retroactive coverage will promote coverage). The administrative record does contain the evidence-based counterarguments noted above: waiving retroactive eligibility will create coverage gaps, harm providers, diminish enrollees' access to care, and put low-income individuals at risk of negative health outcomes and crushing medical debt. AR 1492, 2238-39, 2246, 2714-17, 2975, 3659-60. The idea that *withholding* coverage and services through eliminating retroactive coverage will somehow *promote* the furnishing of coverage and services remains nonsensical.

Not only did the Secretary neglect to explain how Granite Advantage would promote coverage, but he also did not acknowledge—let alone explain—the decision to reverse course on both the work requirements and retroactive coverage. With respect to the work requirements, the Secretary's approval ignores the fact that in 2016, HHS had rejected New Hampshire's nearly identical proposal as inconsistent with the Act's objectives. *See supra* at 8. In fact, as the Court

has recognized, "during the 50-plus years of Medicaid," CMS had *never* "approved a community-engagement or work requirement as a condition of Medicaid eligibility. Instead, the agency [] consistently denied these requests, finding that work requirements could undermine access to care and were thus inconsistent with the purposes of Medicaid." *Stewart I*, 313 F. Supp. 3d at 245 (internal quotation marks omitted). Nor did the Secretary acknowledge or justify his decision to reverse course on the conditions HHS previously imposed on the waiver of retroactive coverage. *See* AR 3, 5-6 (failing to mention prior condition); *see also* AR 2716-17. In 2015, CMS refused to permit New Hampshire to waive retroactive coverage unless and until it supplied data establishing seamless coverage for beneficiaries, a precaution imposed to ensure individuals would not experience gaps in coverage as a result of the waiver. ECF 1-1 at 2, 13. The Secretary made no mention whatsoever of these prior conditions in the approval letter, nor did he attempt to explain why such a protection was no longer necessary for beneficiaries. This "unexplained inconsistency" in agency position with respect to a waiver of retroactive coverage in New Hampshire was arbitrary and capricious. *Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005); *see also Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (finding agency "fell short of [its] duty to explain why it deemed it necessary to overrule its previous position" when it "offered barely any explanation").

B. Even Assuming the Secretary Could Properly Consider His Preferred Alternative Objectives – Promoting Health, Financial Independence, and Fiscal Sustainability – He Could Not Have Reasonably Concluded That Granite Advantage Was Likely to Promote Them.

As discussed above, health, financial independence, and fiscal sustainability are not standalone objectives of the Medicaid Act. But even if the Secretary could have pursued these alternative objectives, he did not reasonably determine that Granite Advantage was likely, on balance, to achieve them. And, in evaluating each of these impermissible goals, he entirely failed

to weigh the purported benefits "against the consequences of lost coverage, rendering his determination arbitrary and capricious." *Stewart II*, 366 F. Supp. 3d at 149.

Health. The Secretary did not reasonably conclude that Granite Advantage will improve the health of individuals who satisfy the new eligibility requirements. With respect to work requirements, the Secretary provides a simple causal argument: forcing people to work or volunteer "may lead to improved health and wellness." AR 4. The Secretary cited no research to support this assertion in the approval letter, *id.*, though, he included various studies in the administrative record. *See Coburn v. McHugh*, 679 F.3d 924, 934 (D.C. Cir. 2012) ("At the very least, the [agency] must provide an explanation that will enable the court to evaluate the agency's rationale at the time of decision.") (internal quote omitted).

But even if the Court were to connect the dots for the Secretary, the studies that appear in the record contain critical qualifications that undermine any simple causal relationship between work and health; and those qualifications were identified by commenters. *See, e.g.*, AR 2211, 2712-13, 2728-29, 3582-85. The research shows that job quality matters—unstable, low-wage work (often the only work Medicaid recipients can get) is associated with similar or even poorer health outcomes than no work at all. *See, e.g.*, AR 2211, 3357, 3372, 3583, 3601-02, 3654. Also, several studies discuss health selection effects—*i.e.*, healthier people are more likely to find work or volunteer. *See* AR 4011, 4531-4368, 4013-19, 4345-50. Lastly, several commenters directed the Secretary to a new, comprehensive literature review noting these and other complications that undermine any claim of a simple causal relationship between work and health. *See, e.g.*, AR 2211, 2576, 2588, 2713, 2964, 3357 (citing Larisa Antonisse & Rachel Garfield, Kaiser Family Found., *The Relationship Between Work and Health: Findings from a Literature Review* (Aug. 2018), AR 3365). The Secretary did not acknowledge this evidence or the comments raising these criticisms.

Further, the research the Secretary included in the administrative record does not, and could not, account for the harms that stem from the *penalty* the Secretary approved. That research derives primarily from European countries and Australia, where access to health coverage is nearly universal and thus excludes consideration of the harm from health coverage loss. *See* AR 3786, 4071, 4345. In fact, one report cautions that "interventions which simply force claimants off benefits are more likely to harm their health and well-being." AR 4111. While comments alerted the Secretary to these and other warnings, *see, e.g.*, AR 2588, 2712-13, 3601, he ignored them.

The Secretary also suggests that eliminating retroactive coverage will encourage people to enroll in Medicaid even when they are healthy, thereby encouraging them to seek preventive services and improving health outcomes. AR 3, 5, 12. For the reasons discussed in Section II.A., *supra*, that implausible claim is not supported by the record. There is no conceivable way that making it more difficult to obtain necessary health services will promote health.

Finally, the Secretary entirely failed to weigh the purported health benefits against the serious health harms from coverage loss. As established above, the record confirms that many thousands of individuals will lose Medicaid coverage due to Granite Advantage. This coverage loss will significantly harm the health of those individuals. AR 2131-32, 2223-24, 2242-43, 2723, 2973-74. Moreover, without estimating the number of individuals who would lose coverage for failure to comply with the new eligibility requirements, the Secretary could not have adequately analyzed the magnitude of the health harm those individuals would suffer or weighed that harm against health benefits. *See Stewart II*, 366 F. Supp. 3d at 145. His failure to do so is especially problematic here, as in *Stewart II*, because "the Secretary himself acknowledged that there is a conflict between his reasoning for why the program promotes health and the possibility that it will cause widespread coverage deprivation." *Id.* at 145; *see* AR 10 ("To create an effective incentive

for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures," which "may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily."). Even if the Secretary could properly consider health when evaluating Granite Advantage, the Secretary failed to adequately analyze the health effects, rendering his decision arbitrary and capricious.

Financial Independence. As with health, the Secretary did not reasonably determine that Granite Advantage would promote financial independence. Substantial evidence in the record, ignored by the Secretary, shows that work requirements do not meaningfully increase work and income. For instance, the record includes substantial longitudinal research from SNAP and TANF indicating that work requirements have failed to effectively promote work, while increasing poverty, financial insecurity, and even mortality. *See, e.g.*, AR 2209-10, 2703-05, 3585-86, 3656 (describing and citing research). The Secretary likewise ignored evidence that voluntary employment support programs, which do not threaten coverage loss, on the other hand, have been effective at increasing employment for the small subset of Medicaid recipients who are not already working. *See* AR 2709, 3367.[9] Instead of addressing any of that research, the Secretary made the conclusory statement that the work requirement will promote financial independence. Tellingly, however, he once again made no "attempt to estimate the number of people who will gain employment and move onto commercial coverage or otherwise attain financial independence." *Stewart II*, 366 F. Supp. 3d at 147.

[9] Commenters cited numerous studies: Bureau of Business and Econ. Research, Univ. of Montana, *The Economic Impact of Medicaid Expansion in Montana*, 3 (2018), https://bit.ly/2HtvBW9; Hannah Katch, Ctr. On Budget & Policy Priorities, *Promising Montana Program Offers Services to Help Medicaid Enrollees Succeed in the Workforce* (2018), https://www.cbpp.org/research/health/promising-montana-program-offers-services-to-help-medicaid-enrollees-succeed-in-the; Montana Dep't of Labor & Industry, *HELP-Link Program Update* (2018), https://bit.ly/2TRzKZd.

The Secretary also failed to contend with comments explaining that coverage loss significantly harms financial security. *See, e.g.*, AR 2578, 2723-25, 2482, 3646 (describing and citing research). He likewise ignored comments highlighting that without retroactive coverage, medical debt and resulting bankruptcies will increase and damage the already tenuous financial situation of many low-income New Hampshire citizens. *See, e.g.*, AR 2215, 2246, 2714-15. Finally, the Secretary once again failed to weigh the purported financial benefits to beneficiaries who manage to comply with the work requirements against the financial harms of coverage loss. *See Stewart II*, 366 F. Supp. 3d at 148. Thus, even assuming the Secretary properly determined the objectives of the Medicaid Act (and he did not), these failures render his decision arbitrary and capricious. *Id.*

Fiscal Sustainability. The Secretary failed to make any findings about the fiscal effects of Granite Advantage, let alone adequately analyze the record evidence. First, the Secretary did not find that Granite Advantage would save the State "any amount of money or otherwise make the program more sustainable in some way." *Stewart II*, 366 F. Supp. 3d. at 149. This is especially problematic, given that commenters explained how the project, through administrative costs and costs resulting from gaps in coverage, could actually *increase* state expenditures. AR 1480, 2710-11, 2242-43, 2492-95, 2597, 2710-11, 3656-58.[10] "[W]ithout a finding about the savings that [Granite Advantage] could be expected to yield[,] the Secretary could not make a reasoned

[10] Commenters cited studies including, Jennifer Wagner & Judith Solomon, Ctr. On Budget & Pol. Priorities, *States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries* (2018) https://www.cbpp.org/sites/default/files/atoms/files/5-23-18health2.pdf; Leighton Ku et al., Association of Community Affiliated Plans *Improving Medicaid's Continuity of Coverage and Quality of Care* (2009), *available at* http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf.

decision that it would promote fiscal sustainability," particularly in light of contrary evidence in the record. *Stewart II*, 366 F. Sup. 3d at 149.

Second, there is no evidence in the record that New Hampshire in fact lacks the funding to maintain coverage of the expansion population (or other optional groups or services) without Granite Advantage. *See Stewart I*, 313 F. Supp. 3d at 270-71. Nothing in the record suggest that the New Hampshire Medicaid program is "actually at risk" of financial collapse. *Id*. In fact, commenters explained that the Medicaid expansion has significantly reduced uncompensated care costs for hospitals and other providers in the State. AR 2206, 2585, 3653. Moreover, the Secretary did not explain why "cuts to the expansion population would be the best remedy for any budget woes." *Id*. at 271. As the Court noted in *Stewart I*, without data on New Hampshire's financial position, "the Secretary could not make a reasoned decision that [New Hampshire] would truly be 'unable to maintain access for currently enrolled populations.'" *Stewart I*, 313 F. Supp. 3d at 271.

Finally, "the Secretary's reliance on fiscal sustainability was arbitrary and capricious because he did not compare the benefit of savings to the consequences for coverage." *Stewart II*, 366 F. Supp. 3d at 150. While the Secretary acknowledges that he must make this comparison—*see* AR 11—he did not undertake that analysis. His reasoning in the Granite Advantage approval is nearly identical to the reasoning he used to re-approve Kentucky, which this Court found unlawful. "In failing to analyze the nature of the expected savings, whether the burden on Medicaid recipients was minimal, and how the savings should be balanced against the burdens, the Secretary acted arbitrarily and capriciously." *Stewart II*, 366 F. Sup. 3d at 152 (citations omitted).

III. The Secretary Lacks the Authority to Approve the Granite Advantage Work Requirements.

In Section 1115 Congress only gave the Secretary the narrow authority to "waive compliance" with certain provisions of the Medicaid Act. 42 U.S.C. § 1315(a). The term "waive"

means "[t]o refrain from insisting on (a strict rule, formality, etc.); to forgo." *Black's Law Dictionary* (10th ed. 2014). It does not confer the authority to fundamentally modify, amend, or "transform" statutory provisions. Authorizing a state to comprehensively transform Medicaid by *creating* new, mandatory work requirements cannot be understood as a *waiver* of compliance with an existing condition or requirement of coverage under the Medicaid Act. *See Syed v. M-I, LLC*, 853 F.3d 492, 502 (9th Cir. 2017) ("To authorize is to 'grant authority or power to.' *American Heritage Dictionary* 120. To waive is to 'give up . . . voluntarily' or 'relinquish.' *Id.* at 1947. Authorization bestows, whereas waiver abdicates."), *cert. denied*, 138 S. Ct. 447 (2017).

Further, Section 1115 permits the Secretary to "waive compliance" only for a time-limited experiment that is "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). Again, the central purpose of the statute is to provide medical assistance to low-income individuals; withholding that assistance from otherwise eligible people who do not meet a work requirement is directly contrary to that purpose. The difference between the statutes governing the various safety net programs illustrates this point. TANF and SNAP expressly authorize work requirements; the Medicaid Act does not. *Compare* 42 U.S.C. § 607 (requiring states to ensure that most TANF recipients engage in "work activities" and to reduce or terminate TANF benefits be if an individual does not) *and* 7 U.S.C. § 2015(d), (o) (requiring individuals to meet work requirements as a condition of participation in SNAP), *with* 42 U.S.C. § 1396a(a)(10) (requiring states to provide medical assistance to individuals who meet the criteria listed. Congress knows how to include work requirements when it wants to, and it chose not to include them in Medicaid. *See Digital Realty Tr., Inc. v. Somers*, 138 S. Ct. 767, 777 (2018) (presuming a difference in meaning when Congress includes particular language in one statute but omits in another).

Moreover, Congress did not just include work requirements in SNAP and TANF—it prescribed detailed regimes outlining the nature of the requirements, including how they would balance against other congressional policy priorities, such as minimum wage and nondiscrimination protections. *See, e.g.*, 42 U.S.C. § 607 (detailing TANF work requirements, exemptions, and penalties for beneficiaries, and creating non-displacement protections for other workers); *id.* § 604a (addressing role of religious organizations and establishing nondiscrimination protections for contracting organizations and beneficiaries); 7 U.S.C. § 2029(a)(1) (directing SNAP benefit amounts to account for minimum wage laws). These detailed regimes demonstrate that the nature and scope of any work requirement is a decision left to Congress in the first instance.

Congress has had several opportunities to import work requirements into Medicaid but has not done so. *See* American Health Care Act, H.R. 1628, 115th Cong., § 117 (2017); Medicaid Reform and Personal Responsibility Act of 2017, S. 1150, 115th Cong. (2017). In addition, when Congress repealed AFDC in favor of TANF in 1996, it amended Medicaid's Section 1396u to maintain consistency for certain joint TANF/Medicaid recipients, including by allowing states to terminate the Medicaid benefits of individuals—and only those individuals—who had their TANF benefits terminated for failure to comply with TANF's work requirements. *See* 42 U.S.C. § 1396u-1(b)(3)(A). At that time, Congress could have amended the Medicaid Act to permit work requirements generally, but it did not. That is revealing. Where a statute "expressly describes a particular situation to which it shall apply, what was omitted or excluded was intended to be omitted or excluded." *Teles AG v. Kappos*, 846 F. Supp. 2d 102, 111 (D.D.C. 2012) (cite omitted).

In sum, Section 1115 does not permit the Secretary to circumvent the will of Congress and transform Medicaid into a program designed to "incentivize" work. Nothing in Section 1115 suggests a broad agency authority for such a rewrite. "[H]ad Congress wished to assign that

[authority] to [the] agency, it surely would have done so expressly." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (quoting *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444 (2014)). *See MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 (1994) (finding that "[i]t is highly unlikely that Congress would leave" an "essential characteristic" of the statutory scheme "to agency discretion—and even more unlikely that it would achieve that through such a subtle device as permission to 'modify' [statutory] requirements"); *Cyan, Inc. v. Beaver Cty. Emps. Ret. Fund.*, 138 S. Ct. 1061, 1071 (2018) ("Congress does not hide elephants in mouseholes.") (internal quotation marks and citations omitted).

For these reasons, the Secretary lacks statutory authority to allow New Hampshire to condition eligibility for Medicaid on work or the completion of work-related or community engagement activities.

IV. The Dear State Medicaid Director Letter Violates the Administrative Procedure Act.

On January 11, 2018, the agency released a Dear State Medicaid Director Letter (the "SMD Letter") announcing a new policy of allowing states to condition Medicaid coverage on work or community engagement. AR 90-99. Not only is the new policy arbitrary and capricious, CMS failed to follow the notice-and-comment procedures required under the APA for a substantive rule, which is what the SMD Letter implements. *See* 5 U.S.C. § 553(b), (c). The SMD Letter separately violates the APA and must be vacated.

A. The SMD Letter's Authorization of Work Requirements is Arbitrary and Capricious and Exceeds Statutory Authority.

The SMD Letter violates the APA's ban on arbitrary and capricious action because it did not provide any logical reasoning to conclude that work requirements advance the objectives of Medicaid, failed to discuss alternatives to work requirements for achieving its objectives, and insufficiently explained its about-face from its longstanding stance against work requirements.

First, the SMD Letter ignores the central purpose of Medicaid—the provision of medical assistance to low-income people—in pursuit of the administration's preferred goals of promoting health and financial independence. *See* Section I, *supra*. What is more, the Letter provides inadequate support for the conclusion that work requirements promote those alternative objectives. Like the Granite Advantage approval letter, the SMD Letter focuses on the possible health benefits of work, while ignoring the obvious health consequences associated with withholding or terminating health insurance coverage for low-income individuals who do not work enough. AR 58-59. Indeed, for the reasons described in Section II.B, *supra*, none of the "authorities" cited in the SMD Letter addresses work *requirements* or come close to supporting them.

Second, CMS failed to mention even a single alternative course of action the agency considered. "[F]ail[ure] to provide any explanation for [the agency's] implicit rejection of alternatives . . . or to consider such alternatives" is arbitrary and capricious. *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 815 (D.C. Cir. 1983). Although the SMD Letter acknowledges that, in the past, the agency sought to capture any salutary effects from work and community engagement by supporting state programs like "job training and work referral," it does not explain why that approach was ineffective. AR 91. To be sure, an agency need not consider and explain "every alternative device and thought conceivable by the mind of man." *State Farm*, 463 U.S. at 51 (internal quotation marks omitted). But nowhere in the SMD Letter does CMS weigh any of the many obvious and compelling alternatives to mandatory work requirements. *See Donovan*, 722 F.2d at 817 (finding agency action arbitrary and capricious where agency failed to consider options "specifically mentioned" to the agency or that were "an obvious response"). "[S]uch an artificial narrowing of options is antithetical to reasoned decisionmaking and cannot be upheld." *Id.* (internal quotation marks omitted).

Third, CMS failed to discharge its "duty to explain why it deemed it necessary to overrule its previous position" on work requirements. *Navarro*, 136 S. Ct. at 2126. The SMD Letter reverses HHS's prior position that "the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work." Sylvia Burwell, Sec'y of Health & Human Servs., Hearing on The President's Fiscal Year 2017 Budget, Attachment—Additional Questions for the Record, U.S. House of Rep. Energy & Commerce Health Subcomm. at 13 (Feb. 24, 2016), http://bit.ly/2QcKnEi; *see also* n. 3, *supra*. Although the APA does not bar an agency from reversing course, *see Nat'l Ass'n of Home Builders v. EPA*, 682 F.3d 1032, 1043 (D.C. Cir. 2012), when an agency does so it must candidly weigh the relevant factors, including the "facts and circumstances that underlay or were engendered by the prior policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009). The agency must also "set forth with such clarity as to be understandable" why it is changing course. *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947).

CMS did not adequately explain its about-face here. The Letter offers only the vague and unsupported claim that imposing work requirements "is anchored in historic CMS principles that emphasize work to promote health and well-being." AR 92. Defendants do not identify those principles or explain why they support *conditioning* health coverage on satisfying work requirements. Moreover, the studies cited in the SMD Letter all predate agency decisions to reject work requirements as fundamentally incompatible with the Medicaid Act, so Defendants cannot contend that new information supported the change in position. *Compare* AR 58 nn.3-9 *with supra* at 28 (noting prior CMS decisions and citing *Stewart I*, 313 F. Supp. 3d at 245). Likewise, the fact that CMS "has long assisted state efforts to promote work and community engagement and provide incentives" for individuals to work, AR 58, does not explain the agency's decision to convert policies that support and incentivize Medicaid enrollees to work into policies that withhold

Medicaid coverage if individuals are not working sufficient hours. Defendants' decision to "simply disregard" the agency's earlier, long-held rationale confirms they did not undertake a reasoned analysis of the complex issues at stake or consider the impact of the policy reversal. *Fox*, 556 U.S. at 515. Thus, CMS's decision to authorize work requirements in the SMD Letter, was arbitrary and capricious.

B. The SMD Letter Imposes a Substantive Rule Without the Requisite Notice and Comment Procedures.

Because the Letter announces a substantive rule that cabins CMS's discretion, drives its outcomes, and alters the regulatory framework, the lack of notice and comment rule-making independently invalidates the Letter. *See* 5 U.S.C. § 553(b), (c); *Chamber of Commerce of U.S. v. OSHA*, 636 F.2d 464, 470-71 (D.C. Cir. 1980).

An agency's statement qualifies as a substantive rule, and thereby requires notice-and-comment rulemaking, if the "statement is a rule of present binding effect"—meaning that "the statement constrains the agency's discretion." *McLouth Steel Prods. Corp. v. Thomas*, 838 F.2d 1317, 1320 (D.C. Cir. 1988). To make this determination, courts look at whether the "language" in the agency's statement "strongly suggests that [the agency] will treat the [statement] as a binding norm," and, even "[m]ore critically," whether the agency's "later conduct applying [the statement] confirms its binding character." *Id.* at 1320-21. The key inquiry is "whether the substantive effect is sufficiently grave so that notice and comment are needed to safeguard the policies underlying the APA." *Elec. Privacy Info. Ctr. v. U.S. Dep't of Homeland Sec. (EPIC)*, 653 F.3d 1, 5-6 (D.C. Cir. 2011). The SMD Letter clearly meets this test.

First, the language of the Letter shows that it "constrains the agency's discretion" and is thus a rule of present, binding effect. *McLouth*, 838 F.2d at 1320. The Letter "announc[es] a new policy"—"support [for] state efforts" to add work requirements to their Medicaid programs—and

sets out numerous conditions that states must meet to obtain CMS approval. AR 57. The Letter phrases these conditions in binding terms, stating that state applicants "will be required" to make various showings to win agency approval and "will not be permitted" approval unless they meet certain standards. AR 60, 63-65. For example, the SMD Letter says "States must also create exemptions for individuals determined by the state to be medically frail[.]" AR 61. This kind of "mandatory, definitive language" is a "powerful, even potentially dispositive, factor" in identifying a substantive rule. *Community Nutrition Instit. v. Young*, 818 F.2d 947 (D.C. Cir.1987); *see also Gen. Elec. Co. v. EPA*, 290 F.3d 377, 385 (D.C. Cir. 2002) (holding "Guidance Document" a substantive rule because it imposed "obligations upon applicants to submit applications that conform to the Document"); *McLouth*, 838 F.2d at 1320-21 ("The use of the word 'will' suggests the rigor of a rule, not the pliancy of a policy.").

Second, the agency has confirmed in its application of the SMD Letter that the Letter has binding effect. *See McLouth*, 838 F.2d at 1320-21; *see also Texas v. United States*, 809 F.3d 134, 173 (5th Cir. 2015) ("[A] rule can be binding if it is 'applied by the agency in a way that indicates it is binding.'" (quoting *Gen Elec.*, 290 F.3d at 383)), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016). In CMS's initial approval of Granite Advantage, the May 7, 2018 approval letter expressly relied on the evidence presented in the SMD Letter. AR 103. The November 30, 2018 Granite Advantage approval letter again relies on the parameters set out in the SMD Letter, simply choosing not to explicitly refer to the Letter this time around. The approval letter discusses various components of the project that the agency deems mandatory in the SMD Letter. For example, the approval letter emphasizes that the requirements may be met through a range of allowable activities, *see* AR 8, as required in the Letter. AR 60, 63. Likewise, the Granite Advantage approval highlights the ability for the State to exempt areas with high rates of unemployment, *see* AR 8, as

required in the Letter. AR 61, 63. Thus, Defendants have deemed the SMD Letter controlling by invoking it or its requirements in their decisions to approve.

Moreover, Defendants' implicit reliance on the SMD Letter in this case is not an isolated occurrence. Since its issuance, the policies established in the Letter have driven each outcome the agency has reached on a request to impose work requirements. In approving work requirements in Arkansas, the agency explained, "CMS is approving the community engagement program based on our determination that it is likely to assist in promoting the objectives of the Medicaid program" because its terms and conditions "are consistent with the guidance provided to states through [the SMD Letter]." Letter from Seema Verma to Asa Hutchinson, Governor of Arkansas (Mar. 5, 2018), https://bit.ly/2FFkcnT. The approval of Indiana's application was even more explicit. It justified the work requirements based on the fact that the "terms and conditions of Indiana's community engagement requirement that accompany this approval are aligned with the guidance provided to states through [the SMD Letter]." Letter from Demetrios Kouzoukas, Principal Dep. Admin., Ctrs. For Medicare & Medicaid Servs., HHS, to Allison Taylor, Medicaid Dir., Ind. Family & Soc. Servs. Admin. (Feb. 1, 2018), http://bit.ly/2EZcMfO; *see also* Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (@Seema CMS), Twitter (Mar. 5, 2018, 9:45 AM), https://twitter.com/SeemaCMS/status/1076221399390478336 ("Maine marks the 7th community engagement demonstration we have approved since announcing this important opportunity earlier this year.").

Recently, on March 14, 2019, CMS issued new guidance, further implementing the policies announced in the SMD Letter. In that guidance, CMS explained that the SMD Letter communicates "CMS's expectation that states test the effects of community engagement requirements on health, well-being, independence, and the sustainability of the Medicaid

program." Ctrs. for Medicare & Medicaid Servs., Evaluation Design Guidance for Section 1115 Eligibility and Coverage Demonstrations 2 https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ce-evaluation-design-guidance.pdf (last visited May 16, 2019); Ctrs. for Medicare & Medicaid Servs., Appendix to Evaluation Design Guidance for Section 1115 Eligibility & Coverage Demonstrations: Community Engagement 1, https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ce-evaluation-design-guidance-appendix.pdf (last visited May 16, 2019) (SMD Letter "signaled [CMS's] expectation that states will test hypotheses that such policies lead to increased employment and community engagement rates and that increased employment will promote health and wellbeing."). This language communicates CMS's view that the SMD letter has binding effect.

As this Court has explained, the SMD Letter replaces a decades-old policy against work requirements with "a new commitment" to support state efforts to implement work requirements and promulgates criteria to reach that result. *Stewart I*, 313 F. Supp. 3d at 245-46. Through the SMD Letter, and under the guise of "guidance," the Secretary has transformed Medicaid from medical coverage for the poorest among us to a work program with health coverage on the side—all without Congressional action or authorization. This action has undermined the very purposes of the Medicaid program, affecting tens of thousands of New Hampshire citizens and millions of Medicaid recipients across the nation. The SMD Letter plainly does more than "clarify a statutory or regulatory term, remind parties of existing statutory or regulatory duties, or 'merely track[]' preexisting requirements and explain something the statute or regulation already required." *Mendoza v. Perez*, 754 F.3d 1002, 1021 (D.C. Cir. 2014) (citation omitted). It "effects a substantive regulatory change to the statutory or regulatory regime." *EPIC*, 653 F.3d at 6-7 (internal quotation

marks omitted). Because the APA requires notice and comment before promulgating such substantive changes, the SMD Letter must be vacated.

V. The Secretary's Approval of the New Hampshire Granite Advantage Waiver and the SMD Letter Should Be Vacated.

The Granite Advantage approval and SMD Letter should be vacated. "When a court concludes the agency action violates the APA, 'the practice of the court is ordinarily to vacate the rule.'" *Stewart I*, 313 F. Supp. 3d at 272 (quoting *Ill. Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693 (D.C. Cir. 1997)); *see also Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110 (D.C. Cir. 2014) ("[V]acatur is the normal remedy."). Nothing about this case warrants a departure from the default rule favoring vacatur. *See Gresham*, 363 F. Supp. 3d at 182-84; *Stewart I*, 313 F. Supp. 3d at 273-74. For remand without vacatur to be justified, the Court must consider "the seriousness of the deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed." *Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993). Here, neither of those factors weighs against vacatur.

With respect to the first factor, courts "have not hesitated to vacate a rule when the agency has not responded to empirical data or to an argument inconsistent with its conclusion." *Comcast Corp. v. FCC*, 579 F.3d 1, 8 (D.C. Cir. 2009). As explained above, the Secretary's approval of Granite Advantage suffers from "major shortcomings," including his failure to address the important effects of the project and his decision to "turn[his] back on the implications" of the project. *Humane Soc'y of the U.S. v. Zinke*, 865 F.3d 585, 614-15 (D.C. Cir. 2017). The deficiencies in the Secretary's approval thus are serious, substantive, and cannot be explained away. Moreover, the deficiencies in the Secretary's waiver approval are "not merely procedural; rather . . . the agency acted outside of the scope of its statutory authority." *Children's Hosp. Ass'n*

of Tex. v. Azar, 300 F. Supp. 3d 190, 211 (D.D.C. 2018). Where the Secretary has misinterpreted the statute, including the scope of his waiver authority, or "neglected to consider one of Medicaid's central objectives," "vacatur [is] appropriate." *Stewart I*, 313 F. Supp. 3d at 273.

As for the second factor—the disruptive consequences of vacatur—that consideration is "weighty only insofar as the agency may be able to rehabilitate its rationale for the regulation." *Comcast*, 579 F.3d at 9. For reasons Plaintiffs have described, the approval cannot be rehabilitated and, therefore, the Court need not reach the second factor. *See Standing Rock Sioux Tribe v. U.S. Army Corps of Eng'rs*, 282 F. Supp. 3d 91, 97 (D.D.C. 2017). But even if the Court were to consider this factor, it plainly weighs in favor of vacatur. Allowing the approval to remain in effect will indisputably disrupt access to health insurance coverage and medically necessary care for tens of thousands of Medicaid enrollees. *See Gresham*, 363 F. Supp. 3d. at 184-85.

Finally, the SMD Letter should be vacated because the agency failed to comply with the APA's notice-and-comment requirements. "[D]eficient notice is a 'fundamental flaw' that almost always requires a vacatur." *Nat'l Venture Capital Ass'n v. Duke*, 291 F. Supp. 3d 5, 20 (D.D.C. 2017); *id.* ("When notice-and-comment is absent, the Circuit has regularly opted for vacatur."); *see also Daimler Trucks N. Am. LLC v. EPA*, 737 F.3d 95, 103 (D.C. Cir. 2013). Nothing about the circumstances of this case warrants departure from that established practice.

CONCLUSION

For the reasons above, Plaintiffs respectfully ask the Court to vacate the approval. Plaintiffs also ask the Court to enjoin the SMD Letter as a rule that was not properly promulgated under the APA.

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Respectfully submitted,

By: /s/ Jane Perkins
Jane Perkins
Sarah Somers
Sarah Grusin
Catherine McKee
National Health Law Program
200 N. Greensboro Street, Suite D-13
Carrboro, NC 27510
Phone: 919-968-6308 (x101)
perkins@healthlaw.org
somers@healthlaw.org
grusin@healthlaw.org
mckee@healthlaw.org

Kay E. Drought
New Hampshire Legal Assistance
154 High Street
Portsmouth, NH 03801
603-206-2253
kdrought@nhla.org

Raymond Burke
New Hampshire Legal Assistance
117 N. State Street
Concord, NH 03301
603-206-2214
rburke@nhla.org

Travis W. England
Jen Samantha D. Rasay
National Center for Law and Economic Justice
275 Seventh Avenue, Suite 1506 New York,
NY 10001
212-633-6967
england@nclej.org
rasay@nclej.org

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on May 16, 2019, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to all authorized CM/ECF filers.

By: /s/ Jane Perkins
Jane Perkins