

Nos. 20-37, 20-38

In the Supreme Court of the United States

ALEX M. AZAR, II, SECRETARY OF HEALTH AND HUMAN
SERVICES, et al.,

Petitioners,

v.

CHARLES GRESHAM, et al.,

Respondents.

STATE OF ARKANSAS,

Petitioner,

v.

CHARLES GRESHAM, et al.,

Respondents.

**On Writ of Certiorari to the United States
Court of Appeals for the District of Columbia**

**BRIEF OF STATE OF NEBRASKA AS AMICUS
CURIAE IN SUPPORT OF PETITIONERS**

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INTEREST OF AMICUS CURIAE

The Secretary of Health and Human Services (HHS) recently approved a Medicaid demonstration project proposed by Amicus Curiae State of Nebraska. That project implements a set of wellness initiatives and personal-responsibility requirements (which include specific kinds of community engagement). In this case, the court of appeals invalidated Arkansas's and New Hampshire's demonstration projects that also included community-engagement requirements. That ruling threatens the future of Nebraska's program.

The Secretary has broad authority to approve demonstration projects and to consider fiscal-sustainability factors such as overall beneficiary health and financial independence. If the Court affirms this power and upholds the Secretary's right to exercise it, that would not only reinstate the Arkansas and New Hampshire projects, but also have the effect of affirming Nebraska's program. Nebraska thus has a direct interest in this case.

SUMMARY OF ARGUMENT

Demonstration projects provide great opportunities for States to experiment at the local level with diverse ways of improving their Medicaid programs. Many States, including Arkansas and New Hampshire, have done that by implementing community-engagement requirements in their Medicaid expansion programs. More recently, Nebraska has put a unique twist on community-engagement requirements. Rather than making those requirements a prerequisite to Medicaid eligibility, Nebraska has

adopted a model in which community engagement opens the door to additional benefits.

The Secretary has broad authority to approve these kinds of Medicaid demonstration projects. And when doing so, it is only natural for him to assess—and indeed nothing in the relevant statutes forbids him from considering—fiscal-sustainability factors such as beneficiary health and financial independence. The court of appeals erred in declaring these factors out of bounds and wholly inconsistent with the purposes of Medicaid.

A ruling affirming the court of appeals' decision will stifle ongoing Medicaid experiments. Arkansas's and New Hampshire's projects will be prohibited. And although Nebraska's model should still survive since it does not take away anyone's Medicaid eligibility, HHS and the States will not be able to compare the results of these differing approaches to determine which better serves Medicaid recipients.

But a decision that affirms the Secretary's broad discretion to approve Medicaid demonstration projects will have the effect of upholding Arkansas's, New Hampshire's, and Nebraska's projects. That will allow those States to complete their experiments, generate data to evaluate their real-world impacts, and compare the outcomes of their competing models. All this will inform Medicaid administrators nationwide and enable them to better serve the public.

ARGUMENT

I. Many States, including Arkansas, New Hampshire, and Nebraska, are implementing diverse projects to experiment with community-engagement requirements in Medicaid expansion.

Medicaid is a large governmental program that is jointly operated by the States and the federal government. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 541–42 (2012). Each State's involvement in Medicaid creates the opportunity for local experiments. *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 439 (2004) (there are “various ways that a State could implement the Medicaid Act”). Congress has explicitly authorized such localized testing by permitting HHS to approve “any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives” of Medicaid. 42 U.S.C. §1315(a).

These demonstration projects are vital to Medicaid's continued improvement. Indeed, they often “influence policy making at the State and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other States.” Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 77 Fed. Reg. 11,678, 11,680 (Feb. 27, 2012).

With the Secretary's blessing, some States like Arkansas and New Hampshire have chosen to add community-engagement requirements to their Medicaid-expansion programs. Arkansas's demonstration project, in particular, requires non-exempt expansion beneficiaries to log 80 hours of work, work-related

activities, education, or volunteering per month in order to maintain their Medicaid eligibility. More recently, on October 20, 2020, Nebraska received permission to implement its unique approach to community-engagement requirements. That program—under which community engagement is a pathway to additional benefits rather than a requirement for eligibility—provides relevant background information as this Court evaluates the demonstration waivers that Arkansas and New Hampshire have received.

“The goal of the [Nebraska] demonstration is to incentivize beneficiaries to engage in wellness, personal responsibility, and community engagement activities.” Nebraska Heritage Health Adult Demonstration, Centers for Medicare & Medicaid Servs. Expenditure Authority, No. 11-W-00337/7, at pg. 12, ¶ 21, <https://bit.ly/2KDBFRY> (hereinafter “Neb. Expend. Auth.”). Nebraska will “test[] whether engagement in these activities improves beneficiary health outcomes and thereby the fiscal sustainability of the Medicaid program in the state.” *Ibid.*

Nebraska’s demonstration project creates a two-tiered system for Medicaid-expansion beneficiaries. The first is known as Basic. It provides all “the mandatory Medicaid benefits, plus 35 optional Medicaid benefits,” but not “vision services, dental services, or OTC [over-the-counter] medication.” Letter from Seema Verma, Centers for Medicare & Medicaid Servs., to Jeremey Brunssen, Nebraska Dep’t of Health and Hum. Servs. Div. of Medicaid and Long-Term Care, at 4 (Oct. 20, 2020), <https://bit.ly/2KDBFRY> (hereinafter “Neb. Approval Letter”). The

second tier is called Prime. It “includes all Medicaid benefits that are available under the Nebraska state plan to other full-benefit populations” and adds “coverage of dental services, vision services, and OTC medications.” *Ibid.*

Automatic recipients of Prime include individuals “who are pregnant, medically frail, or 19 or 20 years old.” *Ibid.* All other Medicaid-expansion beneficiaries—those “who are aged 21 through 64 and who are not pregnant or medically frail”—may access Prime if they satisfy the project’s (1) wellness initiatives and (2) personal-responsibility requirements (which include certain kinds of community engagement). *Ibid.* Alternatively, expansion beneficiaries seeking Prime may show that they are exempt from the community-engagement requirements or that they are entitled to a good-cause exception from any or all personal-responsibility requirements. *Id.* at 6–7. All Medicaid-expansion beneficiaries who do not qualify for Prime receive Basic coverage. *Id.* at 4.

The project’s wellness initiatives place two requirements on beneficiaries. First, they must “participate in case and care management” by completing an initial “health risk screening.” Neb. Expend. Auth. at pg. 12, ¶ 22. Second, they must “attend an annual health visit” to ensure ongoing physician monitoring of their health. *Ibid.*

In addition, the personal-responsibility requirements impose four more obligations on beneficiaries. First, they must “not miss three or more scheduled medical appointments in a six month benefit period.” *Id.* at pg. 14, ¶ 23. Second, they need to “maintain employer-sponsored coverage that is available and

affordable.” *Ibid.* Third, they are obliged to “timely notify the state of any changes in status that may impact [their] eligibility” for Prime. *Ibid.* And fourth, beneficiaries must satisfy the community-engagement requirements, show that they are exempt from those requirements, or “demonstrate that they had a good cause not to engage in a qualifying community engagement activity.” *Id.* at pg. 17, ¶ 23.d.

Qualifying community-engagement activities focus on employment, volunteering, and education. They include (1) any form of employment “at least 80 hours per month,” (2) “volunteer activities with a public charity for at least 80 hours per month,” (3) at least half-time enrollment “in any accredited college, university, trade school, or post-secondary training program,” (4) participation “in a course of study leading to a Certificate of General Equivalence (GED) for at least 80 hours per month,” or (5) involvement in certain federally approved “job search activities for at least 20 hours per week.” *Id.* at pg. 18.

Many beneficiaries are exempt from these community-engagement requirements. Examples of exempt beneficiaries include, among others, (1) “[i]ndividuals participating in a substance use disorder or mental health treatment program,” (2) “[i]ndividuals receiving unemployment compensation[] or who have applied for unemployment compensation and are fulfilling weekly work search requirements while in the waiting period,” (3) “[m]embers of a federally recognized tribe,” (4) “[i]ndividuals aged 60 through 64,” (5) certain “[v]ictims of domestic violence,” (6) some “parent[s], caretaker relative[s], guardian[s], or con-

servator[s] of a dependent child” or “an elderly or disabled relative,” and (7) participants in various federal programs for low-income citizens. *Id.* at pg. 19.

When approving this project, the Secretary began by outlining some of Medicaid’s objectives. One purpose is “to enable states to ‘furnish . . . medical assistance’—i.e., healthcare services—to certain vulnerable populations.” Neb. Approval Letter at 2. Another is to provide those populations with “services to help them ‘attain or retain capability for independence or self-care.’” *Ibid.* A third objective is to “ensure the fiscal sustainability of the Medicaid program,” which “mak[es] it more practicable for states to furnish medical assistance to a broader range of persons in need.” *Ibid.* And a fourth goal is to “improve beneficiaries’ physical and mental health.” *Ibid.*

After outlining these purposes, the Secretary concluded that Nebraska’s demonstration project “is likely to promote Medicaid objectives” for “three independently sufficient reasons.” *Id.* at 3. First, it “will provide a subgroup of the adult group expansion population” with added services—namely, vision, dental, and OTC coverage. *Ibid.* Thus, “the demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration.” *Id.* at 7.

Second, the Secretary explained, the program will “test whether the opportunity to opt into additional services lowers program costs, including by improving beneficiary health, and thereby improves the fiscal sustainability of the Medicaid program.” *Id.* at 3. “The

demonstration is designed to incentivize individuals to participate in beneficiary engagement activities, such as completing a health risk assessment, attending an annual health visit, and keeping scheduled medical appointments.” *Id.* at 8. Those activities “are expected to assist in the prevention and early detection of any potential health issues and may thus lead to improved health and wellness.” *Ibid.* Such improvements in health, the Secretary concluded, “may reduce health care costs.” *Ibid.* In addition, requiring beneficiaries to (1) “timely report[] changes in circumstances that may affect eligibility” and (2) “maintain[] access to affordable employer-sponsored coverage” “may help to ensure the efficient use of Nebraska’s medical assistance budget.” *Ibid.* And including the community-engagement requirements will test whether those obligations cause some beneficiaries to “improve their health outcomes” and “increase their earnings to the point where they no longer need to rely on Medicaid.” *Id.* at 8–9.

Third, the Secretary concluded that “the demonstration will test whether the incentive structure and availability of [Prime] coverage will result in improved health outcomes and wellbeing.” *Id.* at 3. The Secretary concluded that improved wellbeing is likely because, among other reasons, the demonstration will promote “use of preventive care” and thus “positively affect[] overall health outcomes.” *Id.* at 10.

HHS approved this project, which, again, will not remove Medicaid eligibility from anyone, for a limited time. It will start on April 1, 2021, and last until March 31, 2026. *Id.* at 1. “In order to ensure that the

experiment yields informative evidence,” the Secretary instructed Nebraska “to develop appropriate evaluation hypotheses and research questions that are designed to capture useful data to support the demonstration’s evaluation design.” *Id.* at 9. This will aid HHS and Nebraska in determining whether to continue the program beyond 2026. And it will also help HHS and other States to evaluate whether the Nebraska model should be replicated elsewhere.

II. The court of appeals improperly cabined the Secretary’s broad discretion to approve Medicaid demonstration projects.

The Secretary has broad discretion to approve demonstration projects. The statutory text confirms this. It does so by empowering the Secretary to approve “*any* experimental, pilot, or demonstration project” and to “waive compliance with *any* of [Medicaid’s] requirements.” 42 U.S.C. §1315(a)–(a)(1) (emphasis added). The statute entrusts this approval authority to “the judgment of the Secretary” and authorizes him to use it whenever he determines that the project “is likely to assist in promoting” Medicaid’s objectives. 42 U.S.C. §1315(a). Notably, he need not conclude that the project will directly promote those objectives, but only that it is likely *to assist* in promoting them. This broad language, which allows projects that indirectly advance one of Medicaid’s objectives, affords the Secretary wide discretion.

This statutory text explains why the Secretary may consider factors that contribute to Medicaid’s fiscal sustainability—factors such as “healthy outcomes, financial independence or transition to commercial coverage,” all of which were eschewed by the

court of appeals. Pet. App. 16a (No. 20-37). Even assuming that Medicaid’s “primary purpose . . . is providing health care coverage,” *ibid.*, it is undeniable that the States cannot provide coverage if they run out of money. So fiscal sustainability and the factors that contribute to it are critical considerations when assessing whether a demonstration project is likely to assist in promoting health-care coverage.

It is no surprise, then, that three past Justices of this Court have already recognized that “curtailing the State’s Medicaid costs” is a “rather obvious Medicaid purpose.” *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 663–65 (2003) (Stevens, J., joined by Souter, J., and Ginsburg, J.). Justice Thomas’s concurring opinion in *Walsh* likewise observed that the Medicaid Act pursues the objective of “cost control.” *Id.* at 676 (Thomas, J., concurring).

The court of appeals thus erred in holding that fiscal-sustainability factors like “healthy outcomes” and “financial independence” “are not consistent with Medicaid.” Pet. App. 16a (No. 20-37). Since a financially unsustainable program cannot function, evaluating those factors is part and parcel of assessing whether a demonstration project promotes Medicaid’s objective of providing coverage. Nothing about those factors is inconsistent with the core purposes of Medicaid.

Once this central error in the lower court’s analysis is corrected, it is readily apparent that the Secretary acted lawfully in approving Arkansas’s and New Hampshire’s community-engagement requirements. The Secretary concluded that those requirements would promote fiscal sustainability by enabling

some beneficiaries to “transition from Medicaid to financial independence and commercial insurance.” *Id.* at 151a. That, in turn, would free up funds to provide health-care coverage for others. *Id.* at 153a, 155a–156a. The Secretary also referred to “research” showing that the requisite community-engagement activities are “correlated with improved health and wellness.” *Id.* at 133a–134a. Such improved wellness, the Secretary explained, will further reduce the State’s costs of providing health-care coverage. *Id.* at 145a–146a. Since it is legitimate for the Secretary to consider fiscal-sustainability factors such as financial independence and improved health, HHS acted appropriately in approving Arkansas’s and New Hampshire’s waiver requests.

For similar reasons, the Secretary did not err in approving Nebraska’s project. Nebraska’s Prime coverage incentivizes people to engage in health-promoting wellness initiatives, which require an initial health-risk screening and an annual health visit. By promoting beneficiaries’ health, Nebraska’s demonstration project is likely to reduce the costs of health-care coverage. Moreover, requiring beneficiaries to report changes affecting their eligibility and to maintain access to affordable employer-sponsored coverage helps to ensure the efficient use of state Medicaid funds. And community-engagement activities may prompt some beneficiaries to improve their health and increase their income so that they no longer need Medicaid. This is likely to save Nebraska money and increase the funds available for health-care coverage, all without stripping Medicaid eligibility from anyone.

Because these are valid considerations when assessing a State's waiver application, the Secretary did not err in approving Nebraska's proposal.

III. The court of appeals' decision imperils ongoing Medicaid experimentation.

The court of appeals' decision upends federally approved state efforts to experiment with community-engagement requirements in Medicaid expansion. By narrowly construing the Secretary's approval authority, the court invalidated Arkansas's and New Hampshire's projects. And in so doing, it shut down experiments that are important to the continued improvement of Medicaid.

This Court should choose a different course. Affirming the Secretary's authority to consider fiscal-sustainability factors like beneficiary health and financial independence would ensure that state experiments with community-engagement requirements will not be cut short. Under such a ruling, Arkansas's, New Hampshire's, and Nebraska's demonstration projects all would continue. Allowing these diverse experiments to proceed would enable HHS and the States to evaluate the effectiveness of these options, with the ultimate goal of improving Medicaid in all 50 States.

But if this Court were to affirm the court of appeals, that would drastically restrict state-by-state testing. Arkansas's and New Hampshire's projects would be permanently halted. And the fate of Nebraska demonstration would be unclear. Nebraska's unique model should still survive because it, unlike Arkansas's or New Hampshire's approach, will not cause any beneficiary to "lose Medicaid eligibility or

coverage.” Neb. Approval Letter at 13. *Cf.* Pet. App. 16a (No. 20-37) (claiming that the Secretary’s approval of Arkansas’s project “fail[ed] to account for loss of coverage”). In fact, if the Court rules for respondents, it might consider illustrating the limits of its holding by pointing to Nebraska’s program as a materially different model.

But even if Nebraska’s project continues, a ruling for respondents would sacrifice the benefits of widespread and diverse testing. The termination of Arkansas’s and New Hampshire’s projects means that HHS and the States will never know whether the Arkansas/New Hampshire version or the Nebraska model achieves better outcomes. And if, though unlikely, this Court’s decision has the effect of invalidating Nebraska’s project too, federal and state Medicaid administrators would have even less available data. Either way, the state Medicaid experiments that Congress authorized the Secretary to approve—and the benefits that flow from that testing—will be thwarted.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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