Nos. 20-37, 20-38

IN THE
Supreme Court of the United States

NORRIS COCHRAN, ACTING 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 Writs of Certiorari to the United States Court of Appeals for the District of Columbia

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QUESTION PRESENTED

Whether the Secretary's approval of Medicaid demonstration projects in Arkansas and New Hampshire that condition health insurance coverage on satisfying work requirements was arbitrary and capricious, in violation of the Administrative Procedure Act.

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INTRODUCTION

Settled principles of administrative law decide this case. The Secretary of Health and Human Services approved work-requirement projects in Arkansas and New Hampshire under Section 1115 of the Social Security Act. That narrow provision allows the agency to waive certain statutory requirements of Medicaid for "experimental, pilot, or demonstration" projects "likely to assist in promoting the objectives" of the program. 42 U.S.C. § 1315(a). In turn, the "objectives" of Medicaid are set forth in the text: Congress enacted Medicaid for the express purpose of enabling States to "furnish … medical assistance" to families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services." *Id.* § 1396-1. The Secretary therefore was required to consider whether the proposed projects were likely to advance that purpose. He failed to do so. His approvals were thus arbitrary and capricious, in violation of the Administrative Procedure Act.

The Secretary's failure in this regard is no surprise at all. Rather than using this waiver authority as Congress intended—to approve valid experiments, limited in time and scope and in keeping with the statutory objectives of the program—the Secretary sought to "restructure" and "transform" Medicaid based on policy disagreements with Congress about who deserves coverage. The Section 1115 approvals followed unsuccessful efforts to undo the Affordable Care Act and its Medicaid expansion altogether, or to achieve a similar result by enacting work requirements into Medicaid that would target the expansion population.

With Congress unwilling to advance those policy goals, the Executive Branch took matters into its own hands. To accomplish what he called "the next great generation of transformation in Medicaid," the Secretary announced a new national policy in favor of work requirements and invited States to impose them through Section 1115 demonstration projects. He proceeded to rubber-stamp waiver applications for these projects in a dozen States. The projects, for the first time in the history of Medicaid, conditioned eligibility on compliance with work requirements, and did so as part of a package of restrictions, penalties, and reductions. The coverage loss threatened by these projects was massive. Kentucky, which received the first approved waiver, estimated that its project would cause the equivalent of 95,000 adults to lose coverage for an entire year. In Arkansas, more than 18,000 people lost coverage in just five months of partial implementation. New Hampshire suspended implementation because of the imminent threat of significant coverage loss.

When the Secretary began approving these waivers, including Arkansas's, he made no attempt to tie work requirements to Medicaid's core purpose of furnishing medical assistance. He instead forthrightly proclaimed that the work requirements would promote a different slate of objectives: beneficiary health and financial independence. Those may be statutory objectives of welfare programs, but they are not objectives of Medicaid. By focusing on those alternative objectives instead of coverage, the Secretary disregarded the core purposes of Medicaid, and thus exceeded his Section 1115 authority.

After an early loss in court, the Secretary changed course, making two new arguments. As the lower courts here well understood, however, both arguments would convert the carefully circumscribed waiver authority into a limitless power to "transform" Medicaid—precisely the Secretary's stated goal, but not one permitted by the Act.

First, the Secretary claimed that approving work requirements promoted coverage because the State might undo its Medicaid expansion if the Secretary did not grant the requested waiver, resulting in coverage loss. That rationale has no discernible limit (and the agency does not appear to seriously defend it here). Because Medicaid is voluntary, a State could always threaten to opt out, and then—because some coverage is better than none—any benefits it chose to provide would advance the statutory purpose. That *à la carte* approach to Medicaid bears no resemblance to the statute Congress enacted.

Second, invoking fiscal sustainability, the Secretary contended that work requirements would expand coverage in a different way: work requirements would improve beneficiary health and financial independence, which in turn would reduce costs, which in turn would generate savings that could be used to expand or maintain coverage by giving States additional resources to cover other populations or services. But that rationale simply makes another run at the impermissible objectives the Secretary invoked in his initial approvals, albeit by a more circuitous route. Those purposes cannot justify the Secretary's actions when invoked forthrightly, and they likewise cannot justify the

Secretary's actions when thinly disguised. Moreover, cutting benefits or beneficiaries can always appear to reduce costs and thereby enhance fiscal sustainability. But that is not the attention to costs this Court has approved—*i.e.*, considering costs to enhance Medicaid by (for example) improving delivery systems, simplifying payment mechanisms, and delivering coverage more efficiently. It is simply not for the Secretary to seek to improve sustainability by cutting benefits, tightening eligibility, and moving beneficiaries off Medicaid entirely. The statute requires the Secretary "as far as practicable" to "*furnish*" medical assistance, not eliminate it.

In reality, this case was never about "fiscal sustainability," and the waivers that the Secretary approved were not serious experiments intended to gather data and inform national policy. They were a transparent effort to undo the choices Congress made. The agency decided to "restructure the Medicaid program" because Congress's decision to expand Medicaid to "able-bodied individual[s]" "does not make sense." But that is not the agency's prerogative: whatever it thinks of Congress's decision, transforming and restructuring the social safety net are jobs for Congress through legislation, not for the Secretary through his authority to authorize limited experiments. At the very least, the Secretary cannot get there by ignoring both the evidence in the administrative record and the core purpose that Congress set forth in the text.

STATEMENT

A. Federal Medicaid Program

The Social Security Act establishes public benefit programs to support low-income people. *See* 42 U.S.C. §§ 301–1397mm. Each program has its own purpose, such as welfare (cash) assistance, nutrition assistance, and housing. Title XIX of the Act establishes the health insurance program known as Medicaid. *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.

If a State chooses to participate in Medicaid (which all States do), the federal government contributes the lion's share of the costs. In return, the State agrees to follow all federal requirements.

Congress has given States significant flexibility to administer the program within federal parameters, consistent with "the best interest of the recipients." *Id.* § 1396a(a)(19). States must provide medical assistance to individuals described in 42 U.S.C. § 1396a(a)(10)(A)(i), and have options to cover additional populations. *Id.* § 1396a(a)(10)(A)(ii), (a)(10)(C). States must cover *all* members of a covered population. *See id.* § 1396a(a)(10)(B). They cannot restrict eligibility through the imposition of additional requirements unless explicitly authorized. *Id.* § 1396a(a)(10)(A).

States must cover certain health services and have options to cover others. *Id.* §§ 1396a(a)(10)(A), 1396d(a). States have additional flexibility with respect to the amount, duration, and scope of covered benefits. *Id.* § 1396a(a)(10)(B).

The covered populations have changed over time. Initially, they included only families with dependent children and individuals who are aged, blind, or disabled. Eligibility for Medicaid depended in large part on eligibility for another public benefit program, such as Aid to Families with Dependent Children (AFDC). Beginning in the 1980s, Congress decoupled Medicaid eligibility from welfare programs. Eligibility became dependent on income, expressed as a percentage of the federal poverty level (FPL). *See, e.g.*, Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(IV)).

The Affordable Care Act (ACA) added another mandatory population. It required States to cover adults under age 65 with household income below 133% of FPL. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010). The ACA also increased the share of federal funding for this population, covering 100% of the expansion's costs initially and 90% of those costs today. 42 U.S.C. § 1396d(y)(1).[1] Although the Secretary cannot pull

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[1] For other populations, the federal government pays 50–77% of the costs. Studies show that Medicaid expansion has had a positive impact on state budgets. *See, e.g.*, Bryce Ward, *The Impact of*

existing Medicaid funding from States that refuse the expansion, *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 585 (2012), the expansion population is a mandatory coverage group in the Medicaid Act, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14).

B. Section 1115 Waiver Authority

Section 1115 of the Social Security Act authorizes the Secretary to "waive compliance" with particular requirements of programs established by the Act, including Medicaid. 42 U.S.C. § 1315(a). The waiver authority is limited by statute in several important respects. First, the Secretary may grant a waiver only for an "experimental, pilot, or demonstration" project. Second, that project must be "likely to assist in promoting the objectives" of Medicaid. Third, the Secretary may grant a waiver only to the extent and for the period necessary to enable the State to conduct the experiment. Fourth, the Secretary may waive compliance with the requirements of Section 1396a only. *Id.* § 1315(a)(1); *see id.* §§ 1396-1, 1396b–1396w-5 (setting forth additional requirements). Section 1115 demonstrations were "expected to be selectively approved by the Department and to be those which are designed to improve the techniques of administering assistance." S. Rep. No. 87-1589 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1962.

Congress created this authority in 1962, predating Medicaid. In the years following its enactment, most

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Medicaid Expansion on States' Budgets, Commonwealth Fund (May 5, 2020), http://bit.ly/3diT2DJ.

approved waivers were for AFDC, *i.e.*, cash welfare assistance. AFDC's stated purpose was improving the "care of dependent children" by seeking "to help such parents or relatives to attain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection." 42 U.S.C. § 601(a) (1996). Consistent with that purpose, and with work-requirement provisions already in the statute,[2] the Secretary approved demonstration projects allowing States to test more stringent work requirements. *See, e.g.*, *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973). By design, no one denied access to AFDC as a result of the work requirements would lose access to Medicaid. Leighton Ku & Brian Bruen, *The Continuing Decline of Medicaid Coverage*, Urban Institute (Dec. 1999), https://urbn.is/37mjg4f.

Work requirements were a central feature of the welfare reform debates of the 1990s. In 1996, Congress replaced AFDC with Temporary Assistance for Needy Families (TANF) and maintained a work requirement. Congress also enhanced the work requirement in the Supplemental Nutrition Assistance Program (SNAP).

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[2] *E.g.*, Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 105, 76 Stat. 172, 187 (authorizing federal funds for Community Work and Training programs and allowing States to deny benefits to certain individuals who refused to participate); Social Security Amendments of 1967, Pub. L. No. 90-248, § 204, 81 Stat. 821, 884 (1968) (requiring States to establish Work Incentive programs for a different set of AFDC recipients); Act of Dec. 28, 1971, Pub. L. No. 92-223, § 3, 85 Stat. 802, 803 (1972) (requiring unemployed AFDC parents to register for work or training with limited exceptions).

See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105. Despite amending Medicaid at the same time, Congress did not add a work requirement and instead decoupled the program from TANF. *See, e.g.*, 142 Cong. Rec. 17,604, 17,605 (1996). Congress did so out of concern that the more stringent eligibility requirements in TANF, including the work requirement, would result in individuals losing Medicaid coverage. *See* Leighton Ku & Teresa A. Coughlin, *How the New Welfare Reform Law Affects Medicaid*, Urban Institute (Feb. 1997), https://urbn.is/3qqpvLP.

Section 1115 waivers for Medicaid were historically small in scope and limited in duration, focusing on coverage expansion and delivery mechanisms rather than restricting eligibility for a population that Congress had decided to cover. *See, e.g.*, Alexander Somodevilla et al., *How Far Do Section 1115 Medicaid Experiments Designed to Restrict Eligibility and Enrollment Veer From the Norm? A 25-Year Perspective*, GW Health Pol'y & Mgmt. Matters (June 13, 2019), https://tinyurl.com/6joldpcz. In the 2000s, the Health Insurance Flexibility and Accountability (HIFA) initiative allowed States to expand coverage to otherwise ineligible populations with incomes below 200% of FPL. *Appendix: Side-by-Side Comparison of HIFA Guidance and Medicaid and CHIP Statutory Provisions*, Kaiser Family Foundation, https://bit.ly/3quVxX2. In the ACA, Congress extended access to affordable health insurance for the same populations that States had previously used demonstrations like HIFA to cover.

The ACA also amended Section 1115 itself. The amendments—directed specifically at Medicaid—required the Secretary to enact regulations for a transparent waiver application process, including mandatory notice and comment at the state and federal levels. 42 U.S.C. § 1315(d). The amendments also directed the Secretary to address "the expected State and Federal costs and coverage projections of the demonstration project" when reviewing applications. *Id.* § 1315(d)(2)(B)(ii).

C. Efforts To Transform Medicaid Through Novel Use Of Waiver Authority

When he took office, President Trump vowed to "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/2Zm95Gj. Seema Verma, Administrator of the Centers for Medicare & Medicaid Services (CMS), called the expansion "a clear departure from the core, historical mission of the program." JA85.[3] She declared that Congress's judgment to "move[] millions of working-age, non-disabled adults into" Medicaid "does not make sense." *Speech: Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference*, CMS.gov (Nov. 7, 2017), https://go.cms.gov/3qsQDd4.

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[3] "JA" refers to the Joint Appendix in *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2019).

After Congress in 2017 considered and rejected efforts to roll back the Medicaid expansion or provide States authority to impose work requirements on their own,[4] CMS took up the mantle. As part of an avowed effort to "restructure the Medicaid program," Administrator Verma announced that CMS would resist Medicaid expansion by approving State projects with work requirements. *The Future of: Health Care*, Wall St. J. (Nov. 10, 2017), https://on.wsj.com/2AMeGMW. This reversed the agency's prior position that work requirements were contrary to Medicaid's purposes. *See, e.g.*, JA88–92.

Fulfilling Administrator Verma's promise, CMS issued a State Medicaid Director Letter on January 11, 2018, "announcing a new policy" allowing States to impose work requirements. JA74–83. The new policy sought "to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability." JA74. CMS acknowledged its departure from "prior agency policy," but insisted that the new policy would "promote health and well-being." JA76. The letter also stated a desire to align Medicaid eligibility with TANF and SNAP, notwithstanding the distinct purposes of those

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[4] *See* American Health Care Act, H.R. 1628, 115th Cong. § 117 (2017); *see also* Medicaid Reform and Personal Responsibility Act of 2017, S. 1150, 115th Cong. (proposing mandatory work requirements for non-disabled adults).

programs. JA78. Absent from the letter was any cost-saving or fiscal-sustainability rationale.

Citing this "new policy," CMS then approved work-requirement "experiments" in a dozen States, starting with Kentucky. No State's application was denied. Kentucky's application estimated that the project—which also imposed premiums, lockouts, cost-sharing, and other coverage restrictions—would jettison the equivalent of 95,000 Medicaid recipients for an entire year; commenters suggested the coverage loss would be even higher. Before it was implemented, however, the United States District Court for the District of Columbia (Boasberg, J.) vacated the Secretary's approval. *See Stewart v. Azar*, 313 F. Supp. 3d 237, 245–47 (D.D.C. 2018). The court held that the Secretary had overlooked "a central objective of Medicaid" when he failed to "adequately consider[] whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens." *Id.* at 243. Likewise, the court held that the Secretary erred by focusing on other objectives such as promoting beneficiary health and financial independence at the expense of considering "Medicaid's central concern [of] covering health costs." *Id.* at 266 (citation omitted).

The agency doubled down on its efforts to restructure Medicaid. Administrator Verma declared that CMS remained "very committed" to work requirements and would "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. "We are undeterred," the Secretary agreed.

Colby Itkowitz, *The Health 202: Trump Administration 'Undeterred' by Court Ruling Against Medicaid Work Requirements*, Wash. Post (July 27, 2018), https://wapo.st/2I6Zz4k. The Secretary praised Administrator Verma for "overseeing the next great generation of transformation in Medicaid, through our efforts to encourage work and other forms of community engagement." Alex M. Azar II, Sec'y, U.S. Dep't of Health & Hum. Servs., *Remarks on State Healthcare Innovation at the American Legislative Exchange Council Annual Meeting* (Aug. 9, 2018), http://bit.ly/3rVBvWb. Sure enough, months later, the Secretary re-approved Kentucky HEALTH. In this second approval, the Secretary debuted a new "fiscal sustainability" rationale to justify the waiver. *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019).[5]

D. Approvals At Issue

1. Arkansas Works Amendment

Arkansas enacted the ACA Medicaid expansion in 2014. Through a Section 1115 project, Arkansas enrolled most individuals in private health plans, with Medicaid covering their premiums and cost-sharing. In 2014 and 2015, more than 278,000 Arkansans received medical assistance through the expansion, reducing the uninsured rate from 19% to 11%. Gov't App. 29a. The expansion also decreased uncompensated care costs by $150 million annually. JA1306. Researchers projected

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[5] Kentucky later changed course and abandoned Kentucky HEALTH. Letter from Eric Friedlander & Stephanie Bates, Ky. Health & Family Servs., to Andrea J. Casart, Dir., Dep't of Health & Hum. Servs. (Dec. 16, 2019), https://bit.ly/3pr7Ty0.

that Medicaid expansion would save Arkansas $444 million between 2018 and 2021. *See* Jesse Cross-Call, *Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics' Claims*, Ctr. on Budget & Pol'y Priorities (Oct. 9, 2018), http://bit.ly/3ps6BmH.

Against that backdrop, Arkansas requested to amend its project. The Arkansas Works Amendment (AWA) was intended to test "approaches to promoting personal responsibility, encouraging improved health and well-being and movement up the economic ladder" by requiring work and community engagement. Ark. App. 159a. The program sought authorization to mandate 80 hours of work activities each month for individuals aged 19 to 49; those who failed to document their compliance for any three months of the calendar year would lose coverage and could not re-enroll until the next year. Ark. App. 160a. AWA also limited retroactive coverage to one month. Ark. App. 5a.

Arkansas did not provide coverage loss projections, but numerous commenters predicted substantial gaps in and loss of coverage. Gov't App. 60a–63a. They emphasized that AWA would increase Arkansas's uninsured rate, even among those who were working. *See, e.g.*, JA1308, 1312–13, 1337. Commenters also noted that Arkansas would pay more money to insure fewer people, experiencing staggering administrative costs of "thousands of dollars per beneficiary," and "divert[ing] much-needed funds from beneficiary care to cover these new, unnecessary administrative costs." JA1277. They explained that "[t]he State will have to develop costly and burdensome administrative procedures to track

employment and exemptions, a budgetary impact that the proposal needs to quantify." JA1337.

The Secretary nevertheless approved AWA on March 5, 2018, effective through December 31, 2021. Gov't App. 129a. In the approval letter, which mirrored the original letter approving Kentucky HEALTH, CMS stated that it examined three questions: "whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes." Gov't App. 133a. The approval did not address whether AWA would reduce coverage and included no discussion of coverage or cost projections. While acknowledging that many comments expressed concerns about coverage loss, the approval said only: "We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment." Gov't App. 138a. The approval, issued before the initial Kentucky HEALTH decision, did not cite "fiscal sustainability" or otherwise suggest the demonstration would enable Arkansas to conserve resources in a way that would help maintain or expand coverage.

In June 2018, Arkansas implemented the work requirements, starting with individuals aged 30 to 49. By the end of the year, Arkansas had terminated coverage for over 18,000 people—about a quarter of the affected population. Gov't App. 16a; JA60. Arkansas had no plan (and was unable) to measure "what percentage of these individuals completed the work

requirements but did not report versus those who did not engage in the work itself." Gov't App. 31a. As commenters had predicted, the work requirements did not improve employment but did increase the uninsured rate, leading to missed medications and delays in care. *See* Benjamin D. Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts On Coverage, Employment, and Affordability of Care*, 39 Health Affairs 1522 (2020).

The District Court sustained a challenge to AWA, vacating the Secretary's approval. It held that, again, the Secretary "entirely failed to consider" whether the project would "help or hurt [Arkansas] in funding … medical services for the needy." Gov't App. 41a (alterations in original) (internal quotation marks omitted). The Secretary's failure to consider coverage—which he acknowledged below as the "core objective" of Medicaid—was fatal. Gov't App. 40a–41a. The court vacated the approval but confirmed that its decision "does not mean it will be impossible for the agency to justify its approval of a demonstration project like this one." Gov't App. 53a.

2. New Hampshire Granite Advantage

New Hampshire, like Arkansas, embraced the Medicaid expansion starting in 2014. Over 53,000 people gained coverage as a result, reducing the uninsured rate by 45%. Gov't App. 70a.

In 2018, New Hampshire submitted a proposal for a demonstration project called the Granite Advantage Health Care Program (Granite Advantage). NH App.

4377.[6] It sought permission to condition Medicaid coverage for most non-disabled adults aged 19 to 64 on completion of 100 hours per month of work or other community activities. Gov't App. 149a–150a. Those who did not comply were required to make up hours or prove an exemption; otherwise, they would lose coverage. Gov't App. 70a–71a. New Hampshire's application explained that the project would test whether "requiring participation in work and community engagement … will lead to improved health outcomes and greater independence through improved health and wellness." NH App. 4394. The Governor similarly articulated the goal as "lift[ing] thousands of Granite Staters towards independence and self-sufficiency." NH App. 4377.

New Hampshire estimated that Granite Advantage would have no material effect on Medicaid enrollment, but commenters disagreed. One commenter projected enrollment loss at 6% to 17% of the eligible population; others forecasted greater loss. Gov't App. 82a–83a, 103a–106a. Commenters also cited the substantial coverage loss during the first months of Arkansas's project, which had imposed less stringent requirements and applied them to a narrower age range. Gov't App. 83a. Commenters also explained how the project, through administrative expenses and costs resulting from gaps in coverage, could actually increase state expenditures. Gov't App. 104a. "These additional costs," they explained, "would detract significantly from

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[6] "NH App." refers to the appendix in *Philbrick v. Azar*, 397 F. Supp. 3d 11 (D.D.C. 2019).

any anticipated savings and would divert much-needed funds from beneficiary care to cover unnecessary administrative costs." NH App. 1480.

The Secretary approved Granite Advantage. Gov't App. 144a. He acknowledged "that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations." Gov't App. 145a. Yet according to the Secretary, that objective had "little intrinsic value" unless the medical assistance promoted health, wellness, and financial independence. *Ibid.* Thus, the Secretary concluded, advancing health and wellness must be a separate objective of Medicaid. *Ibid.* The Secretary found that Granite Advantage was likely to promote that alternative objective. Gov't App. 151a.

The Secretary also invoked fiscal sustainability. Gov't App. 146a–148a. However, the Secretary conducted no assessment of the sustainability of New Hampshire's Medicaid program. Similarly, he did not find that work requirements would enable the State to conserve resources, nor did he examine whether the State planned to reinvest savings to "provide coverage for more medical services to more Medicaid beneficiaries." Gov't App. 148a. The Secretary acknowledged "associated administrative costs" of the work requirement, yet failed to explain how a project that would impose additional costs could make Medicaid more fiscally sustainable. Gov't App. 163a.

The Secretary conceded that the work requirements might "impact overall coverage levels," Gov't App. 156a, and recognized comments expressing concerns and predictions about coverage loss, Gov't App. 164a. Yet

the approval dismissed those comments, stating that it was not the intent of the project to reduce coverage; that the actual impact on coverage could not be determined in advance; and that approval could ultimately promote coverage in the sense that the State might otherwise eliminate coverage for the expansion population altogether. Gov't App. 164a–168a. The Secretary provided no indication of the expected magnitude of coverage loss and no assessment of the various projections.

Within the first month of New Hampshire's attempted implementation of Granite Advantage, approximately 17,000 non-exempt beneficiaries (out of 25,000) had not documented their compliance. Gov't App. 71a–72a. Due to these difficulties, New Hampshire paused implementation of the work requirement. A July 2019 letter announcing the State's decision acknowledged that the roll-out efforts were unsuccessful and that enforcement would "more likely than not lead to persons losing coverage." Letter from Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Hum. Servs., to Christopher T. Sununu, Governor, N.H., *Re: Determination and Findings Relative to the Granite Advantage Community Engagement Requirement* (July 8, 2019), https://bit.ly/2Nd9hav.

Later that month, the District Court concluded that the Secretary's consideration of coverage loss was once again insufficient. Gov't App. 82a–86a. The court explained that although the Secretary acknowledged the possibility of coverage loss, his approval letter was devoid of analysis. Gov't App. 84a. That omission was "particularly startling" since the work requirements at

issue were even more exacting than the ones approved in AWA, which had rapidly caused widespread coverage loss. Gov't App. 65a. The Secretary needed to engage with coverage loss, especially when "the comments uniformly assert—and the record evidence from similar programs strongly suggests—that the loss will be substantial." Gov't App. 83a–84a. Yet the Secretary failed to do so.

The court also considered the Secretary's arguments that Granite Advantage would promote coverage. The Secretary claimed that any continued coverage qualified as increased coverage because, without the work requirement, New Hampshire would "simply de-expand Medicaid." Gov't App. 86a (quotation marks omitted). The court rejected the legitimacy of that rationale. "[T]he entire Medicaid program is optional for states," meaning the Secretary's argument had no limit: "if Defendants are correct that threats to terminate the expansion program can supply the baseline for the Secretary's § 1115 review," the same would be true "as applied to traditional Medicaid." Gov't App. 88a–89a. And that would mean any State could obtain any waiver of any requirement by threatening to de-expand or eliminate Medicaid, arguing that some coverage is better than none. Gov't App. 89a. "This reading of the Act would give HHS practically unbridled discretion to implement the Medicaid Act as 'an *à la carte* exercise, picking and choosing which of Congress's mandates it wishes to implement.'" *Ibid.* (citation omitted).

Finally, the court addressed the argument that Granite Advantage legitimately promoted other objectives. Gov't App. 90a–91a. With respect to

beneficiary health and financial independence, the court explained those were not independent objectives of Medicaid, and at any rate the Secretary failed to weigh them against the consequences for coverage. Gov't App. 90a–93a. As for fiscal sustainability, the court agreed it "was a valid consideration in a Section 1115 project." Gov't App. 94a. But the Secretary's explanation for why Granite Advantage promoted fiscal sustainability was unreasonable. New Hampshire represented that it neither intended nor expected to save costs, and the Secretary did not make any finding that it would. Gov't App. 94a–95a. Moreover, the record contained "substantial reasons to doubt whether the program will save any money given administrative costs and the possible rise in uncompensated care that would accrue to the State." Gov't App. 95a. This "glaring disconnect between the Secretary's position and New Hampshire's raise[d] substantial questions about how the agency came to believe the program would improve the State's fiscal circumstances, underscoring the need for reasoned analysis of this issue." *Ibid.* The court thus vacated the approval.

E. Decisions Below

The Secretary appealed the Arkansas and New Hampshire decisions. In *Gresham*, the D.C. Circuit upheld the District Court's decision on AWA in a unanimous opinion authored by Judge Sentelle. Gov't App. 1a–19a. The court began with the "indisputably correct" conclusion "that the principal objective of Medicaid is providing health care coverage." Gov't App. 9a–10a. The court relied on the statutory text that articulates the reasons for appropriating Medicaid

funds, which starts with "furnish[ing] medical assistance," 42 U.S.C. § 1396-1, defined as "payment of part or all of the cost of the following care and services or the care and services themselves," *id.* § 1396d(a). The court explained it was bound to give effect to Congress's "unambiguously expressed intent." Gov't App. 12a.

Having established Medicaid's primary purpose, the court applied settled Administrative Procedure Act (APA) principles to hold that the Secretary's approval of AWA was arbitrary and capricious. "In this situation," the court explained, "the loss of coverage for beneficiaries is an important aspect of the demonstration approval because coverage is a principal objective of Medicaid and because commenters raised concerns about the loss of coverage." Gov't App. 16a. The agency therefore needed to address loss of coverage, yet it failed to do so. Gov't App. 16a–17a.

The court rejected the Secretary's argument that he had reasonably concluded that AWA was likely to promote alternative objectives. While the court acknowledged "[t]here might be secondary benefits that the government was hoping to incentivize, such as healthier outcomes for beneficiaries or more engagement in their health care," it explained that "the 'means [Congress] has deemed appropriate' is providing health care coverage." Gov't App. 12a–13a (alteration in original) (quoting *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994)). Thus, the three alternative objectives listed in the approval letter could not sustain the approval: they "all point[ed] to better health outcomes as the objective of Medicaid, but that alternative objective lacks textual support." Gov't App.

12a. And while the Secretary claimed that AWA also advanced yet another objective of "transitioning beneficiaries away from governmental benefits through financial independence or commercial coverage," the court rejected that claim as a post-hoc rationalization, since the approval letter did not mention it. Gov't App. 13a–14a. Notably, because the Secretary had never invoked fiscal sustainability in this approval, the court did not address it.

Following this decision, the Secretary elected not to pursue full appellate briefing and argument with respect to Granite Advantage. Instead, the Secretary filed an unopposed motion for summary affirmance. Gov't App. 20a. Although the Secretary had defended his approval of Granite Advantage on additional grounds—fiscal sustainability—he asked the D.C. Circuit to summarily affirm based on the reasoning set forth in Judge Sentelle's opinion in *Gresham*. Thus, without being presented with or having the opportunity to address any fiscal-sustainability arguments, the D.C. Circuit granted the Secretary's motion. Gov't App. 20a–21a.

F. Subsequent Developments

No State was terminating coverage through work requirements prior to the onset of the COVID-19 global health pandemic. In response to that pandemic, Congress enacted the Families First Coronavirus Response Act. The Act bars States from imposing new restrictions on Medicaid eligibility as a condition of its enhanced federal funding match, which all States have accepted. *See* Pub. L. No. 116-127, div. F, § 6008(a), (b), 134 Stat. 178, 208–09 (2020). That bar will remain in effect for the duration of the public health emergency,

which is likely to continue through at least the end of 2021. *See* Letter from Norris Cochran, Acting Sec'y, Health & Hum. Servs., to Governors (Jan. 22, 2021), https://bit.ly/3ddBVmG.

Within ten days of taking office, President Biden signed an executive order to protect and improve Medicaid. Exec. Order No. 14,009, 86 Fed. Reg. 7793 (Jan. 28, 2021). The President directed the Secretary to review all "demonstrations and waivers … that may reduce coverage under or otherwise undermine Medicaid or the ACA." *Id.* § 3(ii). An accompanying statement confirmed that this directive "includ[ed] work requirements." *Fact Sheet: President Biden to Sign Executive Orders Strengthening Americans' Access to Quality, Affordable Health Care*, White House (Jan. 28, 2021), http://bit.ly/3rVDk5t.

Consistent with the Order, on February 12, 2021, CMS issued letters to all States previously granted waivers to implement work requirements. In these letters, CMS noted its statutory authority to maintain continued oversight of Section 1115 demonstrations and explained its conclusion that work requirements do not promote Medicaid's objectives. CMS stated that it was commencing the process of rescinding waivers for work requirements. Both New Hampshire and Arkansas received letters. *See* Letter from Elizabeth Richter, Acting Adm'r, CMS, to Dawn Stehle, Dir., Ark. Medicaid (Feb. 12, 2021), https://bit.ly/3pr9ow8; Letter from Elizabeth Richter, Acting Adm'r, CMS, to Lori Shibinette, Comm'r, N.H. Dep't of Health & Hum. Servs. (Feb. 12, 2021), https://bit.ly/3jRWR41. CMS also withdrew its 2018 letter that had announced the "new

policy" in favor of work requirements. Tami Luhby, *Biden Moves to Unwind Trump's Medicaid Work Requirements*, CNN.com (Feb. 12, 2021), http://cnn.it/37mDsD7.

SUMMARY OF ARGUMENT

I. The context of this case has changed dramatically. The Secretary has withdrawn the policy encouraging work requirements and has commenced proceedings to terminate granted waivers. These events have cast substantial doubt on whether *any* approved or pending waiver for work requirements will ever take effect, meaning a decision from this Court would likely be advisory.

II. If the Court nonetheless reviews the Secretary's approvals of AWA and Granite Advantage, that review is guided by basic principles of administrative law—namely, that the agency must consider important aspects of the problem and cannot use post-hoc rationalizations to justify its actions. The Secretary's arguments for heightened deference to his exercise of the Section 1115 waiver authority are meritless.

III. Text and precedent confirm that the core purpose of Medicaid is furnishing medical assistance. The Secretary does not dispute this. Yet the Secretary failed to explain how either demonstration project was likely to promote that objective, and he neglected to address overwhelming evidence in both administrative records that the projects would result in substantial coverage loss and could not rationally be expected to yield coverage gains.

IV. While disregarding Medicaid's core purpose, the Secretary claimed that the projects would advance a different slate of objectives related to beneficiary health and financial independence. Those are not Medicaid objectives, and the Secretary was not free to import purposes from welfare programs simply because they suited his policy preferences. Moreover, even if these were legitimate considerations, the Secretary failed to explain how work requirements would promote them, given the evidence and comments indicating otherwise.

V. The Secretary no longer defends reliance on these alternative objectives, but he attempts to recast them as "fiscal sustainability." For AWA, that argument is a post-hoc rationalization, as it appears nowhere in the Secretary's approval. For Granite Advantage, the Secretary waived this argument below. At any rate, the Secretary had no evidence in the administrative record to support a fiscal-sustainability rationale, which he also applied to this case in a way that ignores well-established limitations on cost considerations and negates Medicaid's core purpose.

ARGUMENT

I. The Context Of The Case Has Fundamentally Changed.

The context of these proceedings has changed in critical ways. After certiorari was granted, the Executive Branch withdrew its policy encouraging work requirements and announced its intent to rescind all previously approved waivers. CMS has commenced that process for both Arkansas and New Hampshire. *See supra* at 24–25. These developments mean not only that

the Court's decision in this case will likely be advisory, but also that the "exceptional importance to the federal government," Gov't Pet. 33–34, of allowing States to press ahead with their previously approved waivers has vanished.

Indeed, it is doubtful that these work requirements will ever go into effect in Arkansas, New Hampshire, or any other State. Every State has accepted increased federal funding during the global health pandemic that effectively bars it from imposing work requirements. That bar is likely to continue through at least the end of 2021. Practically speaking, this means that no State will implement work requirements for at least ten months, and is unlikely to implement them at all given the shift in Executive policy. Even absent termination of the waiver, the Secretary's approval of AWA expires on December 31, 2021. Gov't App. 129a; *see also* David Ramsey, *After Biden Nixes Work Requirements, Arkansas Explores New Path Forward for Medicaid Expansion*, Ark. Nonprofit News Network, (Feb. 17, 2021), http://bit.ly/37jkIV9 (reporting statements from Arkansas officials that the State will not seek a continuation of the work requirements). New Hampshire, for its part, halted the implementation of its work requirements even before the pandemic and has not given any indication that it intends to implement them during the public health emergency or its economic aftereffects.

These cases, in short, are not the ones this Court chose to review.

II. The Waiver Authority Is Subject To Traditional Constraints On Agency Action.

The Secretary begins his argument with a plea for extraordinary deference. As he would have it, traditional constraints on agency action do not apply; instead this Court should review under a narrow standard akin to the rational-basis test reserved for legislative enactments by elected officials. Gov't Br. 24–27. Thus, while the Secretary rightly abandons his position (rejected by every court to have considered it[7]) that the exercise of his waiver authority is unreviewable, he repackages the same arguments to support a standard that would render judicial review toothless. These arguments lack merit. This is a straightforward administrative law case governed by settled administrative law principles.

A. Basic APA Principles Govern Judicial Review Of The Secretary's Approvals.

The courts below determined that the Secretary's approvals violated the APA by applying settled precedent like *State Farm* and *Chenery*. That precedent is conspicuously absent from the Secretary's brief, and the APA itself receives only one passing reference. Gov't Br. 8. But the Secretary cannot simply wish away the basic APA principles that govern judicial review here.

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[7] *E.g.*, *Newton-Nations v. Betlach*, 660 F.3d 370, 378, 381–82 (9th Cir. 2011); *C.K. v. N.J. Dep't of Health & Hum. Servs.*, 92 F.3d 171, 187 (3d Cir. 1996); *Beno v. Shalala*, 30 F.3d 1057, 1063–64 (9th Cir. 1994).

"Federal administrative agencies are required to engage in reasoned decisionmaking," and this case is no exception. *Michigan v. EPA*, 576 U.S. 743, 750 (2015) (internal quotation marks omitted). To enforce that fundamental constraint, courts apply the familiar test articulated in *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co.*, asking whether "the agency has relied on factors which Congress has not intended it to consider, entirely failed to address an important aspect of the problem, [or] offered an explanation … that runs counter to the evidence before the agency." 463 U.S. 29, 43 (1983). Failure to consider an important aspect of the problem is the "first and most obvious reason for finding [agency action] arbitrary and capricious." *Id.* at 46. Moreover, this requirement is not satisfied by an agency's say-so. Even where the agency insists it "carefully considered all of the comments," the court must review the record and satisfy itself that the agency actually did. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126–27 (2016) (quotation marks omitted).

Administrative law likewise provides that the reviewing court "may uphold agency action only on the grounds that the agency invoked when it took the action." *Michigan*, 576 U.S. at 758 (citing *SEC v. Chenery Corp.*, 318 U.S. 80 (1943)). The court "will neither supply [its] own justifications for an order nor uphold an order based on [the agency's] post hoc rationalizations." *Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 839 (D.C. Cir. 2006) (Kavanaugh, J.). This doctrine promotes accountability by demanding that the agency "turn square corners in dealing with the

people." *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1909 (2020) (quotation marks omitted). Limiting agencies to their actual rationales instills confidence that the new rationales are not merely "convenient litigating position[s]." *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 155 (2012) (internal quotation marks omitted). At the same time, it ensures that litigants and courts are not forced to "chase a moving target." *Regents*, 140 S. Ct. at 1909.

B. "Rational Basis" Is Not The Proper Standard Of Review In This Case.

Seeking to avoid those basic constraints, the Secretary urges the Court to apply the "rational basis" standard reserved for reviewing the constitutionality of legislation. There is no basis for applying that "highly deferential" standard here. *Contra* Gov't Br. 26, 27.

First, the Secretary argues that the statutory text "exudes deference," leaving little room for judicial review. Gov't Br. 24–26. But the statute reflects congressionally imposed constraints on the waiver authority, not the unbridled discretion the Secretary perceives. *See supra* at 7. Among them, the Secretary must find that a project is "likely to assist in promoting the objectives" of Medicaid; even then, the Secretary may waive compliance only for specified statutory requirements and only as far as necessary to enable the State to conduct a genuine experiment. 42 U.S.C. § 1315(a)(1). Moreover, Congress reaffirmed and invigorated these constraints through the ACA's amendments to the waiver authority, *see supra* at 10, when Congress commanded the Secretary to promulgate regulations that would generate a robust

record to inform the exercise of the waiver authority for Medicaid—including two levels of public notice and comment, statements of programmatic goals, and projections for costs and coverage. 42 U.S.C. § 1315(d). Such substantive and procedural constraints are the hallmarks of decisions subject to—not free from—traditional judicial review.

Indeed, this Court has applied the familiar APA standards to provisions suggesting far more deference to the agency, such as one authorizing the Secretary of Commerce to design the census in "such form and content as he may determine," and to "obtain such other census information as necessary." *Dep't of Com. v. New York*, 139 S. Ct. 2551, 2568 (2019) (internal quotation marks omitted). Nor is *Webster v. Doe*, which the Secretary invokes, to the contrary. There, the Court held that the Central Intelligence Agency Director's decision to terminate an officer or employee was not reviewable at all. 486 U.S. 592, 601 (1988). *Webster* turned on considerations of national security entirely absent here. *See Dep't of Com.*, 139 S. Ct. at 2568.

The Secretary argues next that special deference is warranted for the agency's "predictive judgment." Gov't Br. 26. This argument misses the point. Countless statutes call on agencies to make predictive judgments, *e.g.*, *Weyerhaeuser Co. v. U.S. Fish & Wildlife Serv.*, 139 S. Ct. 361, 370 (2018); even so, those agencies must "remain[] within the bounds of reasoned decision-making" to reach those judgments, *Dep't of Com.*, 139 S. Ct. at 2569 (quotation marks omitted). After all, "[i]t is rudimentary administrative law that discretion as to the substance of the ultimate decision does not confer

discretion to ignore the required procedures of decisionmaking." *Bennett v. Spear*, 520 U.S. 154, 172 (1997). Thus, assuming the Secretary made a predictive judgment here, *but see* Gov't App. 17a, 43a, 82a–83a, he still had to consider the factors that Congress commanded in light of the record before him. Even in situations involving "substantial uncertainty," the APA applies. *State Farm*, 463 U.S. at 52.

The Secretary's arguments to the contrary are based on a misreading of *Aguayo v. Richardson*. *Aguayo* applied a "lower threshold for persuasion" to the Secretary's ultimate predictive determination only after confirming that the record reflected "a consideration of the relevant factors." 473 F.2d at 1103, 1106. *Aguayo* does not establish a "rational basis" standard for reviewing the Secretary's exercise of this waiver authority. *Contra* Gov't Br. 27. Nor could it do so. *State Farm* makes clear that rational-basis review applies to the actions of the people's elected representatives, not to the actions of an agency fulfilling its statutory command. 463 U.S. at 43 n.9. The Secretary's reliance on *Aguayo* also ignores the intervening amendments to Medicaid waiver authority, *see supra* at 10, 30–31, which are designed to generate the robust administrative record that the Second Circuit noted was absent in *Aguayo*, 473 F.2d at 1103.

Finally, the Secretary appeals to the experimental nature of Section 1115 projects, arguing that deferential review is warranted because these are localized and time-limited experiments with small costs and risks. *See* Gov't Br. 26–27. But that cannot overcome what the statute actually says: even for experiments, the

Secretary *still* must determine that proposed projects are "likely to assist in promoting the objectives" of Medicaid before approving them.

Moreover, these projects do not remotely resemble what Congress had in mind when it conferred this authority: projects "selectively approved by the Department" and "designed to improve the techniques of administering assistance." S. Rep. No. 87-1589, *as reprinted in* 1962 U.S.C.C.A.N. at 1962. Here, the Secretary announced a nationwide policy first—as part of his stated purpose of "transforming" Medicaid—and then rubber-stamped projects that last for years. Further, the Secretary approved these waivers without experimental designs or evaluation plans in place to test the purported hypotheses. JA45; NH App. 40. This concerted nationwide effort had the potential to strip healthcare coverage from millions of low-income Americans. Thus, the Secretary's efforts here to depict the waivers as modest experiments entitled to special deference are unavailing.

III. The Secretary Was Required But Failed To Address Impact On Coverage.

Applying traditional APA principles, the Secretary's waivers cannot stand. The Secretary's waiver authority is limited to experiments "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a). The courts below correctly concluded (and the Secretary does not dispute) that Medicaid's core objective is providing healthcare coverage. That is what the Act says, and that reading is confirmed by the Act as a whole. The Secretary nonetheless failed to sufficiently

address coverage in either approval letter, rendering his actions arbitrary and capricious.

A. The Text Of The Act Specifies That Medicaid's Core Purpose Is Providing Coverage.

Medicaid is a spending program. Within the Act's "appropriations" section, Congress established Medicaid's purpose. Section 1396-1 says that Congress appropriates Medicaid funds "[f]or the purpose of enabling each State, as far as practicable … to furnish (1) medical assistance on behalf of [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." 42 U.S.C. § 1396-1. "Medical assistance," in turn, is defined as "payment of part or all of the cost of the following care and services or the care and services themselves." *Id.* § 1396d(a). As the District Court observed, "[w]hat better place could the purpose of a spending program be found than in the provision that sets up the 'purpose' of its appropriations?" Gov't App. 48a. The core purpose of Medicaid is furnishing medical assistance.

This understanding of Medicaid's core purpose is well established. In *Arkansas Department of Health & Human Services v. Ahlborn*, this Court described Medicaid as a program providing "joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs." 547 U.S. 268, 275 (2006). Similarly, in *Schweiker v. Hogan*, this Court explained that Congress established Medicaid "for the purpose of providing federal financial assistance to States that

choose to reimburse certain costs of medical treatment for needy persons." 457 U.S. 569, 571 (1982). Multiple federal appellate courts agree. *See Pharm. Rsch. & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001), *aff'd*, 538 U.S. 644 (2003); *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991); *see also Price v. Medicaid Dir.*, 838 F.3d 739, 742 (6th Cir. 2016); *Univ. of Wash. Med. Ctr. v. Sebelius*, 634 F.3d 1029, 1031, 1034–35 (9th Cir. 2011).

Moreover, Medicaid's core purpose of furnishing medical assistance applies equally to all Medicaid recipients, including the expansion population established by the ACA. With the ACA, Congress "aim[ed] to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 567 U.S. at 538. The expansion made Medicaid "an element of a comprehensive national plan to provide universal health insurance coverage." *Id.* at 583. The ACA did not establish two parallel forms of Medicaid; it added a new population to the existing program, just as Congress has done previously when expanding coverage to new populations without amending Section 1396-1 to mention them.[8] Confirming

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[8] Congress amended Section 1396a(a)(10)(A)(i) to expand medical assistance to low-income pregnant women, emancipated children, and former foster youth. *See* Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750; Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2258; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4601, 104 Stat. 1388, 1388-166; Patient Protection and Affordable Care Act, § 2004, 124 Stat. at 283. Like the expansion population, Section 1396-1 mentions none of these

that coverage is the purpose of Medicaid for the expansion population no less than other covered populations, the ACA's amendments to the Act specifically directed the Secretary to consider coverage in connection with any exercise of his waiver authority. 42 U.S.C. § 1315(d)(2)(B)(ii); *see supra* at 10.

The Secretary does not dispute this core purpose or its application to the expansion population. Indeed, the Secretary's approvals acknowledged that "an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations." Gov't App. 145a (citing 42 U.S.C. § 1396-1). And, in briefing below, the Secretary agreed that furnishing medical care is "Medicaid's *core* objective." *See* Gov't App. 40a.

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groups. There is also nothing unusual about Congress's decision to specify a particular set of benefits for the expansion population. Congress has accounted for the unique needs of different Medicaid populations by altering the required benefits package for that population, not by creating different programs with different purposes. For example, since 1968, most Medicaid-eligible children and young adults under age 21 have been eligible for certain services not available to older adults. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396d (enacted by Pub. L. No. 90-248, § 302, 81 Stat. 821, 929 (1967), amended by Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2262 (1989)). Similarly, an amendment added in 1986 allows States to limit the medical assistance available to some low-income women to pregnancy-related services. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9501, 100 Stat. 82, 201 (1986).

B. The Secretary's Failure To Address Coverage Is Fatal To Both Approvals.

Because coverage is the core objective of Medicaid, the Secretary needed to address coverage loss and coverage promotion. Both administrative records contained substantial evidence that the proposed projects would strip coverage from significant numbers of low-income people. Yet in both cases, the Secretary failed to consider this evidence, rendering his approvals arbitrary and capricious.

Start with the record. In both cases, the Secretary faced substantial and unrefuted evidence that the proposed project would cause extensive coverage loss. For AWA, commenters predicted widespread issues with churn, gaps, and loss of coverage. *See* Gov't App. 43a, 60a–63a. Those forecasts proved accurate—in just five months, over 18,000 Arkansans lost coverage for failure to meet the work requirements. Gov't App. 16a. The Secretary nonetheless failed to address the comments or explain whether he agreed or disagreed. Indeed, the Secretary conceded this failure below, acknowledging that his review was limited to other factors. Gov't App. 24a.

Arkansas offers various excuses for the Secretary's failure, but each lacks merit. Arkansas argues that the Secretary fulfilled his responsibility by *acknowledging* the comments forecasting that work requirements would create barriers to coverage. Ark. Br. 50–51. But that is all the Secretary did; he promptly dismissed those comments with the vague non-sequitur that work requirements "create appropriate incentives." Gov't App. 138a. Acknowledging a factor only to dismiss it

without reason or discussion is no substitute for actually considering it. *Encino Motorcars*, 136 S. Ct. at 2126–27; Gov't App. 17a–18a. Similarly, the Secretary's mention of "beneficiary protections" supposedly designed to minimize coverage loss falls short. Gov't App. 135a. These "protections" were included in Arkansas's application for AWA, meaning that commenters made their estimates of massive coverage loss with these features in mind—indeed, some of them identified these "protections" as likely *sources* of coverage loss. *See* Gov't App. 41a–42a. Still, the Secretary neglected to explain whether and how such protections would affect the magnitude of coverage loss.

Finally, Arkansas contends that the courts below held the Secretary to an unreasonable and unattainable standard, demanding that he estimate the precise amount of coverage loss. Ark. Br. 50. Not so. Those courts properly faulted the Secretary for his undisputed failure to offer any sense of the magnitude of coverage loss he anticipated, Gov't App. 16a–19a, 42a–43a—particularly where Congress has required the agency to take "coverage projections of the demonstration project" into account, 42 U.S.C. § 1315(d)(2)(B)(ii). But in the end the courts below held only that the Secretary had failed to clear the low bar of addressing potential coverage loss at all.

In approving Granite Advantage, the Secretary fared no better. The Secretary did address coverage promotion, but his reasoning was flawed. He stated that the waiver promoted coverage because, absent a waiver, New Hampshire might end its Medicaid expansion altogether. Gov't App. 154a–155a. Even assuming

States can legally undo their Medicaid expansion,[9] the argument fails because it knows no bounds. The entire Medicaid program is optional for States, so the Secretary's approach would allow—indeed require—him to approve any waiver if a State threatened to cut a specific population or even eliminate its entire Medicaid program. Gov't App. 88a–89a. In other words, "any waiver would be coverage promoting compared to a world in which the state offers no coverage at all." Gov't App. 89a. But that hypothetical world is not the correct baseline; rather, Section 1115 confirms that the Secretary must consider whether a limited waiver will promote the program objectives compared to compliance with the statute's requirements. "[U]nderstanding the baseline as such is the only way this provision makes sense." Gov't App. 90a.[10]

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[9] The Court need not decide that question, but the District Court was correct to suggest that States cannot. Gov't App. 87a–89a. The expansion population is a "mandatory" Medicaid population, and States may not generally drop mandatory populations. *NFIB* is not to the contrary. Although *NFIB* prohibited the government from withholding funds from States that refused to expand Medicaid, it did not rewrite the Medicaid statute to render the expansion population optional. Following enactment of the ACA in 2010 and *NFIB* in 2012, States that opted into the expansion understood the bargain (including its generous federal funding) before choosing to expand. There is no unconstitutional coercion in treating the expansion population on par with "traditional" Medicaid populations once the State has exercised the option to expand in exchange for increased funding.

[10] This rationale is particularly inappropriate for a waiver because there is strong reason to doubt that States will follow through on their threats to de-expand. The enhanced federal funding match

The Secretary's discussion of coverage loss was likewise inadequate. While he acknowledged that "[t]he community engagement requirements may impact overall coverage levels if the individuals subject to the requirements choose not to comply with them," Gov't App. 156a, he did not engage with evidence that these losses would be substantial. For example, the Secretary ignored the loss estimates submitted by policy experts, Gov't App. 82a–84a, 103a–106a, as well as the available data from Arkansas, where thousands of enrollees were not demonstrating compliance with work requirements *less* stringent than New Hampshire's, *see* Gov't App. 65a, 83a. The Secretary, in short, repeated the error that doomed his approval of AWA.

All of that is sufficient to affirm the judgments below. Coverage is the core purpose of Medicaid, and the Secretary failed to grapple with the impact of the waivers on coverage. This Court need go no further.

IV. The Secretary's Alternative Objectives Are Unreasonable Interpretations Of The Act.

Notwithstanding this clarity of text and precedent, *see supra* at 34–35, the Secretary focused on a different slate of objectives—namely, promoting beneficiary health and financial independence. But Congress did not authorize those objectives in Medicaid, and analogies to other programs like AFDC/TANF and SNAP only confirm that Congress made a considered choice to

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makes de-expansion fiscally irrational and, as experience has shown, the political consequences of terminating coverage for an entire population currently covered make de-expansion unpalatable.

maintain Medicaid as a different program with different objectives.

The Secretary no longer defends health as an independent objective of Medicaid, and for good reason. While improving health outcomes is a desirable *result* of furnishing medical assistance, the Secretary lacks authority to isolate that desired outcome from the specific mechanisms Congress prescribed for achieving it. Agencies "are bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994). Here, the means Congress has prescribed to promote health and well-being is covering the costs of healthcare coverage. *See supra* at 22, 34–35.

Indeed, if Arkansas were correct that health is itself the primary objective of Medicaid, *see* Ark. Br. 19–26,[11] the Secretary could approve any policy that he concludes might improve health and wellness. He could, for

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[11] For its atextual and unprecedented argument, which the government does not join, Arkansas relies on a handful of provisions cherry-picked from a lengthy and complex statute. Ark. Br. 19–25. Those provisions do not demonstrate that the core purpose of Medicaid is health; at best, they indicate that Congress cared about the delivery and effectiveness of the coverage at the core of the spending program it was establishing. Notably, when Congress authorized Medicaid demonstrations to incentivize healthy behaviors, it prohibited States from making participation in such a program a condition of eligibility. The reason is clear: demonstrations aimed at improving health are not to come at the expense of coverage. Patient Protection and Affordable Care Act, § 4108, 124 Stat. at 564 (42 U.S.C. § 1396a note).

example, authorize States to require individuals to eat certain vegetables, adopt certain exercise regimens, or work in certain jobs to maintain coverage. That is not the law. As this Court has cautioned, an "agency's power to regulate in the public interest must always be grounded in a valid grant of authority from Congress," and "we must take care not to extend the scope of the statute beyond the point where Congress indicated it would stop." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 161 (2000) (internal quotation marks omitted).

The Secretary also abandons his argument that financial independence is a Medicaid objective. Arkansas, however, persists. Ark. Br. 38–41. Grasping at Section 1396-1's reference to "independence," *see* 42 U.S.C. § 1396-1 (defining one purpose of Medicaid as furnishing "rehabilitation and other services to help … families and individuals attain or retain capability for independence or self-care"), Arkansas insists that must refer to "financial independence." Ark. Br. 38–41. Yet the surrounding language confirms that the independence and self-care referenced here relate to medical and rehabilitative services—*i.e.*, functional independence, not financial independence. It is a "fundamental principle of statutory construction (and, indeed, of language itself) that the meaning of a word cannot be determined in isolation, but must be drawn from the context in which it is used." *See Yates v. United States*, 574 U.S. 528, 537 (2015) (quotation marks omitted). In the context of a clause that requires access to "rehabilitation services" as a means to attain a "capability for independence or self-care,"

"independence" refers to functional (not financial) independence; that is, the capacity to accomplish the various 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 other licensed practitioner of the healing arts … for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level").

Moreover, in seeking to justify Medicaid work requirements as facilitating financial independence, Arkansas fails to grapple with the contrast between Medicaid and programs such as AFDC/TANF and SNAP. *Contra* Ark. Br. 40–41; Gov't Br. 9–10, 31. AFDC's express statutory purpose tied financial assistance to helping beneficiaries "[attain] capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection." 42 U.S.C. § 601(a) (1996). And Congress expressly included work requirements in the statute—the Secretary simply permitted States to experiment with their form. *See supra* at 8.

When Congress replaced AFDC with TANF in the 1990s, it maintained the work requirement and simultaneously strengthened the work requirement in SNAP. *See* 42 U.S.C. § 607; 7 U.S.C. § 2015(o). Congress chose not to do the same for Medicaid, despite making other changes to the program at that time. *See supra* at 8–9. That is powerful evidence that Congress intended

for Medicaid's eligibility requirements to differ from TANF and SNAP. *See Gomez-Perez v. Potter*, 553 U.S. 474, 486 (2008). Congress's expansion of Medicaid in the ACA and its more recent rejection of work requirements in 2017—which led to the agency action here—reinforce this important distinction. *See supra* at 11.

Congress knows how to include work requirements in a benefits program, and it knows how to articulate purposes tied to financial independence. "The fact that it did not do likewise here is a textual point of comparison we are not entitled to ignore lightly." *United States v. Adame-Orozco*, 607 F.3d 647, 653–54 (10th Cir. 2010) (Gorsuch, J.) (citing *Custis v. United States*, 511 U.S. 485, 492 (1994)).[12]

The Secretary lacked authority to pursue goals that Congress rejected. "[T]he fact that [the agency] thinks a statute would work better if tweaked does not give [the agency] the right to amend the statute." *Ams. for Clean Energy v. EPA*, 864 F.3d 691, 712 (D.C. Cir. 2017)

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[12] Section 1396u-1(b), a narrow provision that permits States to coordinate Medicaid and TANF eligibility for people participating in both programs, does not transform Medicaid's core objective. *Contra* Gov't Br. 10; Ark. Br. 41. It simply reflects Congress's desire to balance the policy goals of Medicaid (furnishing medical assistance) with the policy goals of TANF (including promoting job preparation), and to ensure that the two programs do not conflict. This section does not give the Secretary license to import TANF's objectives into Medicaid and impose work requirements on populations that do not interact with TANF at all. After all, Congress "does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1626–27 (2018) (quotations marks omitted).

(Kavanaugh, J.). Put another way, the Secretary cannot use his authority under Section 1115 "to pursue policy ends other than those specified by" Medicaid. *NLRB v. Cmty. Health Servs.*, 812 F.3d 768, 783 (10th Cir. 2016) (Gorsuch, J., dissenting). By focusing on those goals—particularly at the expense of considering coverage, *see supra* at 33–40—the Secretary "relied on factors which Congress has not intended it to consider," rendering his approvals arbitrary and capricious. *State Farm*, 463 U.S. at 43.

Finally, even if beneficiary health and financial independence were permissible purposes (and they are not), the lower courts have not yet fully addressed Respondents' arguments that the Secretary failed to explain how these projects were likely to promote those purposes, given all the evidence and comments pointing in the opposite direction. *See, e.g.*, JA1265–66, 1304, 1314, 1320; NH App. 2712–13, 2587–89, 2596 (explaining that the demonstrations were likely to worsen health outcomes and have an overall negative impact on health); *see also* JA1285, 1312–14, 1334–36; NH App. 2578–79, 2703–06 (explaining that work requirements were unlikely to improve financial independence or self-sufficiency). Those arguments were embraced by the District Court in its decision on Granite Advantage, *see* Gov't App. 93a, but they were not addressed by the D.C. Circuit in that case, nor have they been adjudicated in the context of AWA. Thus, the proper outcome would be a remand to address that issue, consistent with this Court's role as "a court of review, not of first view." *Cutter v. Wilkinson*, 544 U.S. 709, 718 n.7 (2005).

V. "Fiscal Sustainability" Cannot Salvage Either Of The Secretary's Approvals.

While the Secretary abandons here many of the stated objectives for this "transformation" of Medicaid, he attempts to recast those objectives as part of a "fiscal sustainability" rationale tied to coverage. According to the Secretary, these waivers were designed to "stretch limited state resources by facilitating the transitions of adult beneficiaries to commercial coverage and improving their health," which in turn would "conserv[e] scarce resources enabl[ing] the States to expand or maintain coverage." Gov't Br. 22. That argument cannot save the approvals here.

A. For AWA, "Fiscal Sustainability" Is An Impermissible Post-Hoc Rationalization.

The Secretary's argument fails to justify AWA for a simple reason: "fiscal sustainability" appears nowhere in the Secretary's approval. Gov't App. 129a–143a. *Chenery* thus bars the Court from sustaining AWA on this basis.

The Secretary did not rely on fiscal sustainability in approving the Arkansas waiver. Given the sequence of events, that is no surprise. As the Secretary and Arkansas both concede, the initial waivers in Kentucky and Arkansas focused not on fiscal sustainability or coverage loss, but on a different slate of objectives. Gov't Br. 16–17; Ark. Br. 11; *see also* Gov't App. 133a. The District Court called those objectives into question when vacating the original approval of Kentucky HEALTH. *See supra* at 12. But that decision was issued months *after* the AWA approval. Only later did

the Secretary invoke fiscal sustainability as a basis for approving other States' waivers.

The Secretary suggests that he made a connection between various alternative objectives and the broader purpose of fiscal sustainability. Gov't Br. 30–33. Tellingly, though, the Secretary cites only to the Granite Advantage approval. Gov't Br. 31–33 (citing Gov't App. 153a, 155a–156a as to financial independence and commercial insurance, and Gov't App. 145a–146a, 151a–154a as to health and wellness). That is because nothing in the AWA approval letter supports the notion that he approved AWA with fiscal sustainability in mind.

Because AWA was not approved on fiscal sustainability grounds, it cannot be affirmed on those grounds now. It is a "fundamental rule of administrative law" that an agency's action must be judged "solely by the grounds invoked by the agency." *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947); *see also Michigan*, 576 U.S. at 758. This Court has repeatedly recognized the values behind this rule. *See supra* at 29–30. This case vividly illustrates their importance: the Secretary's present arguments for upholding his approval bear no resemblance to the reasons the Secretary actually gave.

Nor can this Court disregard *Chenery* here as "an idle and useless formality." Gov't Cert. Reply Br. 10. Just last Term, the Court rejected the same contention, explaining that *Chenery*'s rule vindicates "important values of administrative law." *Regents*, 140 S. Ct. at 1909 (vacating DHS's determination notwithstanding the government's argument that the Secretary would reach the same decision on remand). That holding applies with full force here. As *Morgan Stanley Capital Group Inc.*

v. Public Utility District No. 1 makes clear, *Chenery* applies to all discretionary agency decisions. 554 U.S. 527, 544 (2008). The "idle and useless formality" exception is limited to those rare circumstances where the agency is legally "required" to reach a "necessary result." *Id.* at 544–45. There is no argument here that the Secretary is *required* to grant a waiver on fiscal sustainability grounds. After all, an "agency's view of what is in the public interest may change, either with or without a change in circumstances." *State Farm*, 463 U.S. at 57 (quotation marks omitted). Of course, that is precisely what has happened. *See supra* at 24–25.

Finally, even if this Court determined that it could consider fiscal sustainability to justify AWA, that waiver would remain arbitrary and capricious, because the record does not support it. Arkansas did not submit any evidence that AWA would improve fiscal sustainability, and the evidence in the record indicated that the work requirements would have the opposite effect. *See supra* at 14. Moreover, the evidence did not support a conclusion that beneficiaries subject to the work requirements were, in fact, likely to gain in health or financial independence, meaning that Arkansas would be responsible for growing uncompensated care costs. That increased spending, coupled with staggering implementation costs, rendered irrational any conclusion that Arkansas was likely to capture savings from AWA or that Arkansas intended to use any hypothetical savings to promote or maintain coverage. Thus, even if the Court were to indulge this post-hoc rationalization, it cannot sustain the AWA approval.

B. The Secretary's Invocation Of "Fiscal Sustainability" Cannot Save Granite Advantage.

Although the Secretary did consider some version of "fiscal sustainability" to approve Granite Advantage, that cannot save his approval here.

First, the Secretary's fiscal sustainability argument was waived below. In the wake of the D.C. Circuit's decision regarding AWA, the Secretary moved for summary affirmance of the District Court's decision on Granite Advantage, and expressly "acknowledge[d] that the disposition of [*Philbrick*] is controlled by *Gresham*." Gov't App. 20a. It did so even though Judge Sentelle's opinion in *Gresham* did not consider (and could not have considered) fiscal sustainability. Having conceded for tactical purposes that the fiscal-sustainability rationale would make no difference, the government cannot evade the consequences of that concession by asking this Court to uphold Granite Advantage on that very rationale.

Second, the Secretary's invocation of fiscal sustainability was unreasonable. New Hampshire neither intended nor expected to reduce costs by implementing the project. Gov't App. 94a–95a. It told the District Court that reducing costs was not an objective of Granite Advantage, and it projected in its waiver application that spending would continue on the same growth trajectory. *Ibid.* Similarly, there was no evidence in the record that New Hampshire lacked the funding to maintain coverage for the expansion population (or other groups or services) absent approval of Granite Advantage. As the District Court concluded, this "glaring disconnect between the Secretary's

position and New Hampshire's raise[d] substantial questions about how the agency came to believe the program would improve the State's fiscal circumstances." Gov't App. 95a.

The broader record confirms that New Hampshire's proposal was not likely to advance fiscal sustainability. Commenters presented evidence that administrative costs would soar and uncompensated care could jump—leaving the State to foot the bill for healthcare costs that would otherwise fall overwhelmingly to the federal government. *See supra* at 17–18; *see also* 42 U.S.C. § 1396d(y)(1) (establishing the federal government's responsibility to cover 90–100% of costs for the expansion population). On the other side of the ledger, there was substantial evidence that the supposed cost-saving mechanisms would not work. For example, the evidence before the Secretary showed "that nearly all Medicaid recipients are already working, unable to work, or able to find only low-paying jobs that do not offer or lead to commercial coverage," meaning the work requirements were unlikely to lead to increased financial independence Gov't App. 95a; *see also* Gov't App. 96a (noting the Secretary failed to explain how work requirements that could be satisfied by education or volunteer activities would lead to financial independence). Similarly, the evidence did not support the Secretary's prediction that Granite Advantage would improve health. *See supra* at 45. Indeed, the Secretary approved the project without an experimental design in place that would enable the State to test this supposed coverage-promoting hypothesis. *See* NH App. 39–40.

Given this record evidence, the Secretary could not reasonably conclude that Granite Advantage was likely to promote fiscal sustainability. *Clark County v. FAA*, 522 F.3d 437, 442 (D.C. Cir. 2008) (Kavanaugh, J.) (finding decision arbitrary and capricious when "the only evidence in the record … actually supports the opposite conclusions"). More importantly, he did not even try.

Third, the Secretary's reliance on fiscal sustainability here was contrary to the statute. To be sure, the Secretary may consider costs when he reviews waiver applications, approving projects that, for example, improve delivery systems, simplify payment mechanisms, or deliver coverage more efficiently. But cost considerations cannot supersede the stated purpose of Medicaid to enable States "as far as practicable … to furnish … medical assistance." 42 U.S.C. § 1396-1.

That limiting principle is well established. Consider *New York State Department of Social Services v. Dublino*, which arose from implementation of AFDC work requirements. 413 U.S. 405, 408 (1973); *see supra* at 8, 43. Although the Court acknowledged that a State may consider fiscal sustainability, it stated that such considerations cannot lead to "interpret[ing] federal statutes to negate their own stated purposes." 413 U.S. at 419–20. The plurality in *Pharmaceutical Research & Manufacturers of America v. Walsh* reached the same conclusion. It stated that providing cheaper drugs to individuals not enrolled in Medicaid and cutting Medicaid costs "would not provide a sufficient basis for upholding the [supplemental drug rebate] program if it severely curtailed … recipients' access to" Medicaid services. 538 U.S. 644, 664–65 (2003) (plurality opinion).

These cases make clear that cutting costs cannot come at the expense of substantial coverage loss, and States cannot significantly burden their Medicaid recipients with eligibility restrictions and benefit cuts in the name of saving money. Indeed, it could hardly be otherwise: *any* program that slashed benefits or eligibility would always "promote coverage" in this sense because it would potentially free up dollars to spend in other ways.

Seeking to salvage his order in the face of this text and precedent, the Secretary tries a more circuitous route to the same destination: he argues that work requirements promote health and financial independence, which in turn produce cost savings, which in turn can be used to promote coverage. Gov't Br. 22. But that attenuated version of fiscal sustainability permits the Secretary to smuggle a host of impermissible objectives into his waiver authority. Indeed, it is telling that the Secretary through fiscal sustainability invokes purposes that he does not here defend on their own. Improving health and promoting financial independence do not suddenly become permissible considerations, because they might advance fiscal sustainability, which in turn might promote coverage for a different set of beneficiaries or services in the future. Congress did not authorize those objectives, and "[t]he proper avenue for addressing any dissatisfaction with congressional limits on agency authority lies in new legislation, not administrative ipse dixit." *Cmty. Health Servs.*, 812 F.3d at 786 (Gorsuch, J., dissenting). Fiscal sustainability is not a talisman that allows the Secretary to disregard Congress's choices.

Rather than adopting this strained and limitless view of fiscal sustainability, this Court should take the Secretary at his word. The Secretary's approval of Granite Advantage (like his approval of AWA) was never really about fiscal sustainability; it was about accomplishing a sweeping transformation of Medicaid based on a policy disagreement with Congress. But the discretion vested in the Secretary through the waiver authority is not license to undo Congress's choices by regulatory fiat, and it does not permit the Secretary to transform this cornerstone of health coverage based on his own policy preferences. The Secretary's fiscal sustainability argument therefore fails for the same reason the underlying rationales failed: they were based on judgments about the purpose of Medicaid that were not for the Secretary to make.

CONCLUSION

The judgments below should be affirmed.

Respectfully submitted,

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