

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND**

SONYA TAYLOR, *et al.*,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., *et al.*,

Defendants.

Case No. 1:26-cv-03705-GLR

**PLAINTIFFS’ MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT**

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INTRODUCTION

Medicaid coverage enables millions of low-income individuals with serious chronic conditions, including each Individual Plaintiff in this case, to gain uninterrupted access to medically necessary health care, to maintain their health status and quality of life, and to avoid catastrophic medical debt. Sonya Taylor, for example, relies on Medicaid to access treatment for diabetes, high cholesterol, high blood pressure, and chronic kidney disease. Similarly, Contonnia Turner relies on Medicaid to access treatment for HIV and narcolepsy.

In 2025, Congress amended the Medicaid Act, conditioning coverage for some individuals on their meeting work or other “community engagement” requirements. History has shown that the imposition of work requirements on Medicaid beneficiaries causes substantial coverage loss among people with serious health care needs. Thus, it is not surprising that Congress took care to limit the potential damage of the new nationwide requirements. In particular, Congress specified that those who, like the Individual Plaintiffs, are medically frail or otherwise have serious medical needs do not have to meet the work requirements to obtain or maintain access to their health care coverage. In doing so, Congress made clear that five categories of individuals, including those with a substance use disorder and those with a serious or complex medical condition, categorically qualify for the medically frail exclusion.

Defendants have flouted that clear directive, issuing an interim final rule (IFR) that improperly restricts who is medically frail in two material respects. First, even though Congress specified that anybody falling within the five categories listed in the statute is medically frail, and thus, excluded from the work requirements, the IFR would grant the exclusion to individuals within these categories only if they can also show that their condition significantly impairs their ability to comply with the work requirements. Second, Congress specified that anybody with a

substance use disorder should be treated as medically frail. But the IFR imposes an additional restriction on individuals with a substance use disorder; they can only qualify as medically frail if they are not in “stable recovery.” In adopting these restrictions, CMS made unsupported claims about the potential benefits of imposing work requirements on individuals with substantial health care needs, while entirely ignoring the obvious and well-documented harms of doing so. These provisions of the IFR violate the Medicaid Act and further, fail to reflect “reasoned decisionmaking.” *Michigan v. EPA*, 576 U.S. 743, 750 (2015) (internal quotation marks omitted).

What is more, the IFR erects procedural barriers that will make it unduly burdensome for medically frail individuals to access the exclusion to which they are entitled. Specifically, the IFR limits states’ use of claims data and of self-attestation to identify individuals who are medically frail. In adopting these restrictions, CMS failed to reasonably and adequately consider the record evidence and again failed to grapple with the negative effects of its actions on Medicaid applicants and beneficiaries.

By departing from the statutory language, and by adopting more onerous requirements than necessary without any reasoned explanation for doing so, the IFR compounds the damage that the new work requirements will cause. Independent experts project that a straight-forward reading of the statute that Congress enacted would lead to about six million people losing health coverage every year, but that the IFR’s restrictions will increase annual coverage losses by about two million more people annually.

The Individual Plaintiffs are harmed by the IFR because it puts them at risk of losing the health coverage that they desperately need. Further, because they cannot sit back and wait to see if they meet the IFR’s restrictive definition of medically frail, they are taking steps to try to comply with the work requirements, despite their health challenges, and will continue to do so. The

Organizational Plaintiffs will be harmed as well; their members are physicians and medical providers who will lose reimbursement as their patients lose health coverage and who will also face greater paperwork burdens for which they will not be paid. The City of Columbus is also a medical provider of last resort, and it too will be harmed as many of its residents lose health coverage, forcing the city to provide emergency and other services without any prospect of Medicaid reimbursement for those uninsured individuals.

Accordingly, Defendants' actions violated the Administrative Procedure Act and should be vacated.

BACKGROUND

I. The Medicaid Program

Title XIX of the Social Security Act establishes Medicaid. *See* 42 U.S.C. §§ 1396 to 1396w-8. The purpose of Medicaid is to “enabl[e] 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; *see, e.g., Gresham v. Azar*, 950 F.3d 93, 100 (D.C. Cir. 2020) (“[T]he primary objective of Medicaid is to provide access to medical care” for low-income people), *vacated as moot*, 142 S. Ct. 1665 (2022).

States do not have to participate in Medicaid, but all states do. Medicaid is jointly administered and funded by the states and the federal government. *See* 42 U.S.C. § 1396b(a). To receive federal funding, a state must operate its Medicaid program according to a state plan that has been approved by the Secretary. *Id.* § 1396a.

A. Medicaid Eligibility Requirements

The Medicaid Act requires states to cover certain population groups and gives states the option to cover additional groups. *Id.* § 1396a(a)(10)(A), (C). States must cover individuals who: (1) are part of a mandatory population group; (2) meet minimum financial eligibility criteria applicable to that population group; (3) are residents of the state in which they apply; and (4) are U.S. citizens or have a specific immigration status. *Id.* §§ 1396a(a)(10)(A), 1396a(b)(2)-(3), 1396b(v); 8 U.S.C. §§ 1611-1613, 1641. Mandatory Medicaid population groups include: children; parents and other caretaker relatives; pregnant women; and the elderly, blind, and disabled. 42 U.S.C. § 1396a(a)(10)(A)(i).

In 2010, as part of the Affordable Care Act, Congress amended the Medicaid Act to expand coverage to low-income adults, ages 19-65, who are not eligible for Medicare or another Medicaid eligibility group. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (ACA) (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)).¹ In *National Federation of Independent Business v. Sebelius*, the Supreme Court held that the U.S. Department of Health and Human Services could not terminate all Medicaid funding to states that failed to extend Medicaid to the expansion population. 567 U.S. 519, 585 (2012) (plurality opinion). To date, 40 states and the District of Columbia have implemented the Medicaid expansion.

Federal regulations that long predate the IFR detail how states must determine eligibility for Medicaid applicants and redetermine eligibility for beneficiaries. 42 C.F.R. §§ 435.900-

¹ The ACA prohibits the Secretary from promulgating “any regulation” that, among other things, “creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care” or “impedes timely access to health care services.” 42 U.S.C. § 18114.

435.960.² A state must redetermine eligibility without requiring information from the beneficiary if it is able to do so based on reliable information available to the state Medicaid agency, including information in its existing records or available through electronic data sources. *Id.* § 435.916(a)(2); *see id.* §§ 435.948, 435.949. This process is known as *ex parte* redetermination. If available information is insufficient to make an *ex parte* redetermination, the agency must send the beneficiary a renewal form (populated with available information) and request the missing information. *Id.* § 435.916(a)(3)(i). The agency must verify the information submitted by the beneficiary at application and renewal. *Id.* § 435.916(a)(3)(ii); *see id.* §§ 435.945-435.956.

Unless the Medicaid Act requires other procedures (*e.g.*, for verification of citizenship and immigration status), the state is entitled to accept self-attestation of information that is necessary to determine eligibility without requiring further information (including documentation) from the individual. *Id.* § 435.945(a). If information provided on an application or renewal form is not reasonably compatible with information obtained by the state through data sources, the state must seek additional information from the individual. *Id.* § 435.952(c)(2) (indicating the additional information may include a statement that reasonably explains the discrepancy or other information, which may, in certain circumstances, include documentation). In addition, the agency must permit, on a case-by-case basis, self-attestation for all eligibility criteria (other than citizenship or immigration status) when documentation does not exist or is not reasonably available, “such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster.” *Id.* § 435.952(c)(3).

² The IFR amended several of these regulations. *See* Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348, 33352-53 (June 3, 2026) (explaining the changes). These changes do not affect the substantive requirements referenced here.

B. The Scope of Medicaid Coverage

The Medicaid Act sets forth a wide range of mandatory services that participating states must cover and optional services that participating states can elect to cover. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a). States list covered benefits in their state plans.

In 2006, Congress amended the Medicaid Act to allow states to provide some population groups with a benefit package that is narrower than what is otherwise available through the state plan—coverage that has become known as an “Alternative Benefit Plan” (ABP). *See* Deficit Reduction Act of 2005, Pub. L. 109-171, § 6044, 120 Stat. 4, 88 (2006) (codified at 42 U.S.C. § 1396u-7). However, Congress placed limits on states’ use of ABPs. *See* 42 U.S.C. § 1396u-7(a)(2)(B). For example, states cannot require enrollment in an ABP if “[t]he individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).” *Id.* § 1396u-7(a)(2)(B)(vi). The regulations allow states some flexibility to define who is “medically frail or otherwise an individual with special medical needs” but require that definition to include six listed categories of individuals. 42 C.F.R. § 440.315(f). Along with certain children under age 19, the remaining five listed categories of people who must be treated as medically frail for purposes of being excused from required enrollment in an ABP are individuals with: “disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness);” “chronic substance use disorders”; “serious and complex medical conditions”; “a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living”; and “a disability determination based on Social Security criteria.” *Id.* According to CMS, these six categories were created for the purpose of ensuring that individuals with significant health care needs maintain access to comprehensive health coverage. *See, e.g.,* Medicaid and Children’s Health Insurance

Programs: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 42160, 42231, 42233 (July 15, 2013).

When it enacted the ACA, Congress directed states to provide coverage to the Medicaid expansion population through an ABP. 42 U.S.C. § 1396a(k)(1). Individuals in the expansion population who are medically frail must be given the option to enroll in an ABP that includes all of the benefits that are otherwise available to other Medicaid population groups under the state plan. *Id.*; see 42 C.F.R. § 440.315.

In addition, the Medicaid Act and implementing regulations address when states must pay health care providers. Medicaid beneficiaries must obtain services from providers who have agreed to participate in the Medicaid program and accept Medicaid payment as payment in full. 42 C.F.R. § 447.15; see also 42 U.S.C. § 1396a(a)(25)(C). Federal regulations allow Medicaid-participating providers up to 12 months to submit a claim for payment for a service they have provided to a Medicaid beneficiary. 42 C.F.R. § 447.45(d). Generally, states must pay a clean claim within 90 days after it is received. 42 U.S.C. §§ 1396a(a)(37), 1396u-2(f) (extending timely payment requirements to health care providers participating in managed care plans); 42 C.F.R. § 447.45(d).

II. The H.R. 1 Work Requirements

A. The Statutory Changes

H.R. 1 became law on July 4, 2025. See Pub. L. No. 119-21, 139 Stat. 72 (2025). The legislation made changes to the Medicaid Act. Several of these are specific to the expansion population. Starting January 1, 2027, states must redetermine eligibility every six months (rather than annually) for individuals enrolled in the expansion population. *Id.* § 71107 (codified at 42 U.S.C. § 1396a(e)(14)(L)).

Also starting January 1, 2027, states must require “applicable individuals” to demonstrate compliance with “community engagement requirements” (also called work requirements) as a condition of eligibility for Medicaid. *Id.* § 71119(a) (codified at 42 U.S.C. § 1396a(xx)). An applicable individual is defined to include someone who is eligible to enroll or is enrolled in the Medicaid expansion population. 42 U.S.C. § 1396a(xx)(9)(A)(i).

Importantly, H.R. 1 carves out “specified excluded individuals” from the definition of applicable individuals. *Id.* A specified excluded individual is an individual who is: a former foster child; an American Indian; the parent, guardian, caretaker relative, or family caregiver of a child under age 14 or a disabled individual; a veteran with a total disability; in compliance with the Temporary Assistance for Needy Families work requirement or a member of a household that receives Supplemental Nutrition Assistance Program (SNAP) benefits and is not exempt from the SNAP work requirement; participating in a drug addiction or alcoholic treatment and rehabilitation program; an inmate of a public institution (*i.e.*, prison or jail); or pregnant or entitled to postpartum Medicaid coverage. *Id.* § 1396a(xx)(9)(A)(ii)(I-IV), (VI-IX). Individuals who fall within these categories are categorically excluded from the work requirements, whether or not they are capable of working.

A specified excluded individual is also defined to include an individual “who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual” who is “blind or disabled (as defined in section 1382c of this title)”; “with a substance use disorder”; “with a disabling mental disorder”; “with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living”; or “with a serious or complex medical condition.” *Id.* § 1396a(xx)(9)(A)(ii)(V) (the “Medically Frail Exclusion”).

Those who are subject to the work requirements—applicable individuals—can demonstrate compliance in a given month by: working or engaging in community service for 80 hours, participating in a work program for 80 hours, enrolling in an education program at least half time, or engaging in a combination of the above activities for 80 hours; or having monthly or seasonal income that meets the federal minimum wage multiplied by 80 hours. *Id.* § 1396a(xx)(2).

Applicable individuals who are submitting a Medicaid application must demonstrate compliance for at least the month preceding the month of application. *Id.* § 1396a(xx)(1)(A); *see id.* (giving states the option to require compliance for up to three consecutive months preceding the month of application). Once enrolled, applicable individuals must demonstrate compliance for at least one month during the six-month period between each regularly scheduled eligibility redetermination. *Id.* § 1396a(xx)(1)(B) (allowing states to require compliance for more months), 1396a(e)(14)(L); *see id.* § 1396a(xx)(1)(B), (xx)(4) (giving states the option to require more frequent compliance checks). An applicable individual who was a specified excluded individual for part or all of a month must be deemed compliant for that month. *Id.* § 1396a(xx)(3)(A)(i)(I).

To verify that an applicable individual has met the work requirements or must be deemed compliant, or that an individual is a specified excluded individual, states must “establish processes and use reliable information available to the State . . . without requiring, where possible,” the individual to submit additional information. *Id.* § 1396a(xx)(5). The statute permits states to “elect to not require an individual to verify information” that resulted in the state deeming them compliant. *Id.* § 1396a(xx)(3)(A). Moreover, if a state cannot verify that an individual has met the work requirements, it must give the individual an opportunity to show that they met them, should be deemed to have met them, or is not an applicable individual. *Id.* § 1396a(xx)(6)(A)(i)-(ii). If the individual does not make a satisfactory showing, the state must deny their Medicaid

application or disenroll them from coverage, unless the individual qualifies for coverage under another category. *Id.* § 1396a(xx)(6)(A)(iii).

Congress directed the Secretary to promulgate an interim final rule (IFR) to implement the work requirements no later than June 1, 2026. Pub. L. No. 119-21, § 71119(d).

B. The Interim Final Rule and Challenged Regulations

The Secretary, through the Centers for Medicare & Medicaid Services (CMS), published the IFR on June 3, 2026. Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348 (June 3, 2026) (codified in relevant part at 42 C.F.R. §§ 435.550-435.563); Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 39028 (June 29, 2026) (correcting 42 C.F.R. §§ 435.557, 435.558). The IFR is effective as of July 31, 2026. 91 Fed. Reg. at 33348. There are four provisions in the IFR that, in particular, will cause people whom Congress excluded from the work requirements to be treated as applicable individuals who are subject to the work requirements.

1. The Medically Frail Definition

In the IFR, CMS defined an individual “who is medically frail or otherwise has special medical needs.” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V); *see* 91 Fed. Reg. at 33372. Per that definition, individuals who are described in one of the five statutory categories in the Medically Frail Exclusion do not categorically qualify as medically frail. Instead, these individuals are only excluded from the work requirements if they also prove their health condition “significantly impairs [their] ability to comply with the community engagement requirement.” 42 C.F.R. § 435.554(c)(5)(i) (the “Significant Impairment Requirement”). CMS included a list of conditions, such as diabetes, that it does not expect would meet its newly crafted Significant Impairment Requirement. *See* 91 Fed. Reg. at 33376.

2. The Separate Limit on the Substance Use Disorder Category

In the IFR, CMS imposed another limitation on the individual “with a substance use disorder” category. 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb). Although the statutory language includes no such limitation, these individuals only qualify as medically frail under the IFR if they prove that they are not “in stable recovery (which means, an individual who is in recovery for 5 or more years).” 42 C.F.R. § 435.554(c)(5)(i)(B).

3. The Verification Procedures for the Medically Frail Exclusion

As described above, to verify that someone is a specified excluded individual (and as a result, not subject to the work requirements), states must use reliable and available information “without requiring, where possible,” the individual to submit additional information. 42 U.S.C. § 1396a(xx)(5). In the IFR, CMS limited the information that states can use to establish that someone is medically frail. To verify medically frail status, a state must use “claim(s) relevant to the individual that have been adjudicated in the preceding 12 months, including those that have been paid, pended or denied, and encounter data, as relevant to the individual.” 42 C.F.R. § 435.557(f)(1); *see id.* § 435.557(a)(vii), (viii). CMS prohibited states from using claims or encounter data older than 12 months. 91 Fed. Reg. at 33405.

In addition, the IFR limited the use of self-attestation to verify medically frail status. Prior to January 1, 2028, states are permitted to accept self-attestation from applicants and beneficiaries when there is no reliable information available to the state or the reliable information is not reasonably compatible with information provided by the individual. 42 C.F.R. § 435.557(f)(1)(i). However, after January 1, 2028, a state is only permitted to accept self-attestation of medically frail status once during a period of enrollment. *Id.* § 435.557(f)(1)(ii). A “period of enrollment” is defined as “a continuous period of enrollment in coverage under the State plan or waiver

without the individual being disenrolled, regardless of the number of consecutive eligibility periods, of redeterminations or renewals, or of transitions between eligibility groups.” *Id.* § 435.557(a). After a state has accepted self-attestation once, it must verify medically frail status again in six months by using only reliable information that is available to the agency or documentation submitted by the individual (*i.e.*, not through self-attestation). *Id.* § 435.557(f)(1)(ii)(A)-(B). By comparison, CMS chose not to impose the same limits on self-attestation to verify that an applicant or beneficiary is compliant with or excluded from the work requirements on any other basis than being medically frail. *See id.* § 435.557(b)(2)(ii)-(iii). Rather, in these other circumstances, the IFR requires the state agency to accept self-attestation when there is no reasonably available documentation. *See id.* § 435.557(b)(2)(iii).

III. The Harmful Effects of the IFR on Plaintiffs

The IFR dramatically undermines the statute’s protection of medically frail people. Each of the provisions challenged here, individually and collectively, will cause individuals described in the Medically Frail Exclusion to lose health coverage to a far greater degree than anticipated by Congress. Independent experts project that the statute, as enacted, would cause 6.4 million people to lose coverage on an average annual basis between 2027 and 2034. Patricia M. Boozang et al., *CMS’ Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027-2034* at 6, Manatt (July 16, 2026) (Ex. A, hereto). With the IFR’s additional restrictions, those losses are estimated to increase to 8.2 million people each year—a roughly 30 percent increase. *Id.* These experts reviewed the empirical evidence from prior experiments with Medicaid work requirements, including test projects in Arkansas, Michigan, and New Hampshire, and determined that about 40 percent of Medicaid beneficiaries subject to the work requirements, as implemented in the IFR, would be unable to satisfy them. *Id.* at 5; *see also* AR 938-944

(recounting coverage losses under the test projects). As a result, about one in ten Medicaid enrollees nationwide will lose coverage. *Boozang et al.* at 6. Coverage losses would be widespread in every state in the country that has extended Medicaid to the expansion population. *Id.* at 8-11; *see also* AR 3875, 3947, 4851. Loss of Medicaid coverage means loss of access to the ongoing care and medication that individuals with chronic conditions need to maintain their health. *See, e.g.*, AR 3913.

1. The Individual Plaintiffs

Among the millions of individuals who are harmed by the IFR are the Individual Plaintiffs. Each Individual Plaintiff is eligible for or enrolled in Medicaid through the expansion population. Bush Decl. ¶ 6 (Ex. B, hereto); Taylor Decl. ¶¶ 8, 18, 20 (Ex. C, hereto); Turner Decl. ¶¶ 8, 24-27 (Ex. D, hereto); Bricken Decl. ¶ 15 (Ex. E, hereto); Byrd Decl. ¶ 8 (Ex. F, hereto). Each Individual Plaintiff has one or more health conditions that render them medically frail under the statute. *See* Bush Decl. ¶¶ 4, 7-10 (Type I diabetes, diabetic neuropathy, retinopathy); Taylor Decl. ¶¶ 5, 7, 15-16 (Type II diabetes, complicated by high cholesterol and blood pressure, and chronic kidney disease); Turner Decl. ¶¶ 4-6 (HIV, narcolepsy, depression); Bricken Decl. ¶¶ 5-6, 8, 11-14 (vision loss, Berger disease (an autoimmune condition), depression, substance use disorder); Byrd Decl. ¶ 9 (mental disorders, including treatment resistant major depressive disorder).

Each Individual Plaintiff needs ongoing care to manage their health conditions and maintain their health status to the greatest extent possible. Bush Decl. ¶¶ 7-10 (insulin, medical equipment and supplies, care from specialists, and medication); Taylor Decl. ¶¶ 12-16 (medication, medical supplies, and care from specialists); Turner Decl. ¶ 30 (mental health treatment, care from sleep specialists, and medication); Bricken Decl. ¶¶ 11-14 (mental health

treatment, care from specialists, and medication); Byrd Decl. ¶¶ 11-13 (behavioral health therapy, care from specialists, and medication).

Each Individual Plaintiff faces the serious risk or certainty that their health conditions will deteriorate if they lose Medicaid coverage. Bush Decl. ¶¶ 21-22 (“I do not have any other way to get health insurance. . . . My doctors have told me that if I go without insulin, I will go back into diabetic ketoacidosis, which nearly killed me in February.”); Taylor Decl. ¶ 38-40 (“Without Medicaid, I would have no way to pay for my medications and supplies. . . . My doctors have told me that if I stop taking my GLP-1, my blood sugar could once again rise to dangerous levels and put me at risk for diabetic ketoacidosis, which nearly killed me in January 2013.”); Turner Decl. ¶ 30; Bricken Decl. ¶ 30 (“If I lose Medicaid, the consequences would be severe. . . . I would not be able to see my eye specialists or get the eye drops that are critical to preserving the vision I still have.”); Byrd Decl. ¶¶ 21, 25 (“Without Medicaid, I would have no way to pay for my therapy, doctor appointments, and medications. Additionally, I would lose my housing in the transitional program. . . . If I go without treatment and medications, my suicidal ideation would not be controlled, and I would not feel safe.”).

As noted, each Individual Plaintiff not only has to prove that they are medically frail but also, because of the IFR, they face the additional burden of proving that their condition significantly impairs their ability to comply with the work requirement. *See* 91 Fed. Reg. at 33405 (explaining that states must verify both the presence of the diagnosis/condition and that the Significant Impairment Requirement is met). If the individual does not satisfy that additional burden, they will lose Medicaid coverage if they did not comply with the work requirements during the renewal period. *See id.* at 33389, 33402, 33416 (explaining the process for assessing exclusion from or compliance with the work requirements).

Knowing that their diagnosis or condition alone will not be sufficient to exclude them from the work requirements, the Individual Plaintiffs are taking various concrete steps to try to comply with the work requirements, including searching for additional work and volunteer opportunities. *See* Bush Decl. ¶¶ 15-19; Turner Decl. ¶ 20; Taylor Decl. ¶¶ 28-31; *see also* Turner Decl. ¶ 22 (noting that he is not certain any of his providers will provide the documentation he needs); Taylor Decl. ¶¶ 32-36 (same).

The Plaintiffs face mounting stress due to the substantial risk that they will lose Medicaid coverage. Without Medicaid coverage, Plaintiffs will not be able to access the critical health care services they need. Bush Decl. ¶ 23 (“Thinking about how this rule could affect my life and health causes me great stress and anxiety. Medicaid coverage enables me to do my current work. Without that coverage, I would no longer be able to sustain employment and instead would have to focus only on my health.”); Taylor Decl. ¶ 42 (“I can no longer control my diabetes, high blood pressure, and cholesterol by behavior modifications like diet and exercise alone. The disease is too advanced; my health will rapidly decline without my medications. It won’t just be hard to work; it will be hard to live.”); Turner Decl. ¶ 30 (“I would like to be able to work. My Medicaid coverage enables me to work as much as I am able, but without health coverage, my health would deteriorate to the point that I would not be able to work at all.”); Bricken Decl. ¶ 34 (“My entire career has been built upon my ability to read, watch, and write; the loss of my vision would be catastrophic to my ability to find employment. . . . I want to work . . . but without my visual and mental health, this will be impossible.”); Byrd Decl. ¶ 26 (stating that, shortly before and after September 2026, “the symptoms were getting worse. My moods were shifting quickly between extremes, and I was losing touch with what was real. . . . and I began having thoughts of suicide. I sought treatment at an urgent care that day where I was evaluated and my medication was

modified. Had I not had Medicaid, I would not have felt comfortable seeking care because I would have feared going into significant debt that I have no way to pay.”).

2. The Organizational Plaintiffs

Plaintiffs American College of Physicians, Inc. (ACP), American Academy of Pediatrics (AAP), Society for Adolescent Health and Medicine (SAHM), Doctors for America (DFA), New Hampshire Medical Society (NHMS), and New Hampshire Chapter of the American Academy of Pediatrics (NHAAP) are medical provider organizations whose missions involve supporting medical professionals and improving health outcomes for patients. Hicks Decl. ¶ 3 (ACP) (Ex. G, hereto); Del Monte Decl. ¶¶ 5-6 (AAP) (Ex. H, hereto); Norton Decl. ¶¶ 3-4 (SAHM) (Ex. I, hereto); Bewtra Decl. ¶ 3 (DFA) (Ex. J, hereto); Stratton Decl. ¶ 3 (Ex. K, hereto); Watson Decl. ¶¶ 3-6 (NHAAP) (Ex. L, hereto). They represent tens of thousands of medical providers, including pediatricians, psychiatrists, internal medicine doctors, and family doctors, across the country. Hicks Decl. ¶ 3; Del Monte Decl. ¶ 6; Norton Decl. ¶ 3; Bewtra Decl. ¶ 3; Stratton Decl. ¶ 3; Watson Decl. ¶ 3. The IFR will create significant hurdles for these physicians to provide medical care and will cause serious harm to both the physicians and the patients they treat.

First, the IFR’s erroneous interpretation of the Medically Frail Exclusion and onerous verification and reporting requirements will cause many eligible individuals to lose coverage, some because they fail to meet the requirements for an exclusion, and others simply because they are unable to successfully navigate the administrative process. Stratton Decl. ¶ 9; Lee Decl. ¶ 6 (Ex. M, hereto); Norton Decl. ¶ 6; Schafer Decl. ¶ 3 (Ex. N, hereto); Arsnow Decl. ¶ 4 (Ex. O, hereto); Rahmandar Decl. ¶ 4; (Ex. P, hereto); Heatherton Decl. ¶ 8 (Ex. Q, hereto); Taube Decl. ¶¶ 4-5 (Ex. R, hereto).

Second, when patients lose Medicaid coverage, medical providers will inevitably provide more uncompensated care. And, many patients who lose Medicaid will seek medical care less

frequently or stop seeking it out altogether. The result will be poorer health outcomes for patients and lower compensation for medical providers and their practices. Norton Decl. ¶¶ 6, 8, 10, 12; Watson Decl. ¶¶ 12-13; Schafer Decl. ¶¶ 4-6, 10; Arsnow Decl. ¶ 3; Rahmandar Decl. ¶ 12; Lee Decl. ¶¶ 7-8; Del Monte Decl. ¶¶ 14-15, 18; Taube Decl. ¶¶ 7-10; Stratton Decl. ¶¶ 11, 14.

Third, the IFR's restrictions will further burden medical practices that are already stretched thin. The process for assessing medically frail status, including the additional conditions on that exclusion imposed by CMS, will require physicians and their staffs to provide documentation, complete forms, respond to requests from state agencies, and verify whether individual patients qualify for the exclusion. Lee Decl. ¶¶ 9-11; Watson Decl. ¶¶ 10-11; Schafer Decl. ¶¶ 7-8; Arsnow Decl. ¶¶ 6-8; Rahmandar Decl. ¶¶ 6-8; Del Monte Decl. ¶ 12-13; Heatherton Decl. ¶¶ 9-10. The IFR provides no guidance to medical providers on how to determine whether a patient is medically frail, nor does it provide any framework for providers to determine whether a patient's condition significantly impairs their ability to work. Heatherton Decl. ¶¶ 9-10. Making and documenting these medically frail determinations will further divert physician and staff time away from direct patient care. Rahmandar Decl. ¶ 8; Lee Decl. ¶ 10; Taube Decl. ¶ 10; Stratton Decl. ¶ 12. For busy primary care practices working with limited personnel and resources, these added administrative burdens are substantial and may lead to clinician burnout, reduced efficiency, and decreased access to appointments for patients. Lee Decl. ¶ 10.

Finally, the IFR will impinge upon the patient-doctor relationship. The IFR requires physicians to document and report information to the state bearing on whether vulnerable patients can continue to receive critical health coverage. This requirement puts physicians in an adversarial position to their patients, causing patients to lose trust in their medical providers and leading to poorer health outcomes for patients. Watson Decl. ¶ 15; Norton Decl. ¶¶ 6, 9; Schafer Decl. ¶ 9;

Arsnow Decl. ¶ 10; Rahmandar Decl. ¶ 9; Lee Decl. ¶ 12; Del Monte Decl. ¶ 19; Heatherton Decl. ¶ 11; Taube Decl. ¶ 12; Stratton Decl. ¶ 13.

3. The City of Columbus

Plaintiff City of Columbus (Columbus) is the largest city in the State of Ohio and the fifteenth largest city in the United States. Johnson Decl. ¶ 8 (Ex. S, hereto). Columbus provides a wide range of services on behalf of its residents, including health services for families and children, public health, public assistance, and emergency medical care. *Id.* ¶ 10. These services include the Emergency Medical Services (EMS) system, which delivers urgent pre-hospital emergency medical care and transport; a community health center, which provides health care to uninsured or underinsured individuals who cannot obtain care elsewhere; and a collection of neighborhood health centers and specialty clinics, including clinics for alcohol and drug abuse prevention and immunizations, that serve the health care needs of vulnerable, uninsured, and underinsured Columbus residents. *Id.* ¶¶ 17-25.

Medicaid funds or reimburses many of these critical public services. *Id.* ¶¶ 13-14, 18. When individuals in Columbus who use these services lose Medicaid, however, Columbus will be forced to absorb the costs of these programs. *Id.* ¶¶ 13, 18-19. Moreover, as the rate of uninsured or underinsured individuals increases, the pool of residents who need to use Columbus' community health center, neighborhood health centers, and specialty clinics increases in turn. This will force Columbus to immediately alter its long-term municipal budgetary planning to mitigate the threat of service reductions or service funding shortfalls for these critical programs. *Id.* ¶¶ 24-25. The IFR will also burden Columbus' Public Health Department. The Department will need to make up for the shortfall in its budget because of losing Medicaid reimbursements while its finite municipal staff are forced to take on additional tasks of physically verifying income documents for individuals who lose Medicaid coverage and absorbing the direct clinical costs of

managing advanced, uncontrolled chronic conditions and additional emergency care. *Id.* ¶¶ 16, 19-20, 24-25. The IFR shifts the financial cost of caring for medically frail individuals onto Columbus’ supplemental network of care, and in cases of life-threatening medical crises, onto its emergency medical services. *Id.* ¶ 21. The result of the IFR will be an increase in the number of individuals who are unable to access medical care, thus creating a population in Columbus that is statistically less healthy, less productive, and less able to participate in city life. *Id.* ¶ 27.

STANDARD OF REVIEW

Under Federal Rule of Civil Procedure 56(a), “[t]he court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” “In a case involving review of a final agency action under the [APA], however, the standard set forth in Rule 56(a) does not apply because of the limited role of a court in reviewing the administrative record.” *Taylor v. U.S. Dep’t of Educ.*, No. GLR-26-402, 2026 WL 2209704 at *3 (D. Md. July 31, 2026) (cleaned up). “In the unique context of a case brought under the APA, the district court ‘sit[s] as an appellate tribunal,’” *id.* (quoting *Marshall Cnty. Health Care Auth. v. Shalala*, 988 F.2d 1221, 1222-23 (D.C. Cir. 1993)), and “[s]ummary judgment thus serves as a mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and is otherwise consistent with the APA standard of review.” *Ctr. for Sci. in the Pub. Int. v. Perdue*, 438 F. Supp. 3d 546, 557 (D. Md. 2020).

Under the APA, courts shall “hold unlawful and set aside agency action, findings and conclusions” that are “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 5 U.S.C. § 706(2)(A). An agency action is arbitrary and capricious “if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an

important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.” *Appalachian Voices v. U.S. Dep’t of Interior*, 25 F.4th 259, 269 (4th Cir. 2022) (quoting *Motor Vehicle Mfrs. Ass’n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). To comply with section 706(2)(A), the agency “must examine the relevant data and articulate a satisfactory explanation for its action.” *State Farm*, 463 U.S. at 43.

Judicial review is deferential, but this deference “does not reduce judicial review to a rubber stamp of agency action.” *Casa de Md. v. U.S. Dep’t of Homeland Sec.*, 924 F.3d 684, 703 (4th Cir. 2019) (quoting *Friends of Back Bay v. U.S. Army Corps. of Eng’rs*, 681 F.3d 581, 587 (4th Cir. 2012)). “In reviewing a rule, courts must engage in a searching and careful inquiry of the administrative record, so that [they] may consider whether the agency considered the relevant factors and whether a clear error of judgment was made.” *Mayor of Baltimore v. Azar*, 973 F.3d 258, 275 (4th Cir. 2020), *cert. dismissed*, 141 S. Ct. 2618 (2021) (cleaned up).

“The Administrative Procedure Act requires federal courts to set aside federal agency action that is ‘not in accordance with law,’” *FCC v. NextWave Pers. Commc’ns Inc.*, 537 U.S. 293, 300 (2003), and courts “will vacate agency action if it is not based on a consideration of the relevant factors or where there has been a clear error of judgment.” *Defenders of Wildlife v. U.S. Dep’t of Interior*, 931 F.3d 339, 345 (4th Cir. 2019) (cleaned up); *see also City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 772 (D. Md. 2021).

ARGUMENT

CMS ran afoul of the Medicaid Act and the APA when it announced the Significant Impairment Requirement, the additional restriction on the substance use disorder category, and the strict verification requirements for medically frail people.

Even when Congress delegates authority to an agency, the court has a duty to “independently interpret the statute and effectuate the will of Congress.” *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 395 (2024). In other words, the court must ensure the agency did not exceed its authority “by adopting a definition of a term that is inconsistent with the statute.” *Rutherford v. United States*, 146 S. Ct. 1320, 1334 (2026). That is precisely what the agency did here. To be sure, Congress gave the Secretary authority to promulgate an interim final rule and to define the phrase “an individual . . . who is medically frail or otherwise has special medical needs.” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). But that authority was not unbridled. Congress set a floor for the agency: its definition must include any individual who is described in one of the five categories set forth in the statute. CMS defied that directive twice over, removing from the Medically Frail Exclusion: (1) individuals who are described in one of the five categories but who do not meet the IFR’s newly minted Significant Impairment Requirement; and relatedly, (2) individuals who have a substance use disorder (and thus, are described in one of the five categories) but who are in “stable recovery.” 42 C.F.R. § 435.554(c)(5)(i). In doing so, the agency failed to “land within the statutory goalposts.” *Rutherford*, 146 S. Ct. at 1334.

What is more, CMS’s rationale for narrowing the Medically Frail Exclusion in these two respects was arbitrary and capricious. The agency repeatedly touted the potential benefits of imposing the work requirements on individuals described in the Medically Frail Exclusion, including individuals with an SUD who are in stable recovery, without ever acknowledging that its own prior findings (and other record evidence) show that there are no such benefits. Even more critically, CMS “entirely failed to consider” the obvious downsides of its policy decision: additional coverage loss among individuals with chronic conditions and the associated harms to their health and financial well-being. *State Farm*, 463 U.S. at 43.

Finally, CMS’s rationale for limiting the use of claims data and self-attestation to verify medically frail status was similarly flawed. The agency “offered an explanation for its decision that runs counter to the evidence,” *id.*, and failed to adequately consider reasonable alternatives, *see Casa de Md., Inc. v. Wolf*, 486 F. Supp. 3d 928, 961 (D. Md. 2020).

I. The Definition of “Medically Frail” Is Contrary to Law and Arbitrary and Capricious.

A. The Definition Is Contrary to Law.

When it established the mandatory Medicaid work requirements, Congress excluded

an individual . . . who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual – (aa) who is blind or disabled (as defined in section 1382c of this title); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition.

42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). The IFR is not in accordance with the Medically Frail Exclusion. CMS defined an individual “who is medically frail or otherwise has special medical needs” as an individual who is described in subsections (aa) through (ee) of the statutory Medically Frail Exclusion,³ but it did not stop there. CMS also required the individual to establish their health condition “significantly impairs [their] ability to comply” with the work requirements. 42 C.F.R. § 435.554(c)(5)(i); *see* 91 Fed. Reg. at 33373 (claiming its definition is “the best reading of the statutory phrase ‘medically frail or otherwise has special medical needs’”).

Here, the text and structure of the statute foreclose CMS’s definition. *See Food Mktng. Inst. v. Argus Leader Media*, 588 U.S. 427, 436 (2019) (explaining that statutory interpretation starts with “a careful examination of the ordinary meaning and structure of the law itself”). *First*,

³ As noted, CMS imposed an additional impermissible restriction on people who have a substance use disorder. *Compare* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb), *with* 42 C.F.R. § 435.554(c)(5)(i)(B). *See* Section II, below.

under the ordinary meaning of the words in the Medically Frail Exclusion, the definition of an individual “who is medically frail or otherwise has special medical needs” must at least include an individual listed in subsections (aa) through (ee). *See* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V); *see, e.g., Pharm. Coal. for Patient Access v. United States*, 126 F.4th 947, 960 (4th Cir. 2025) (“Both ‘any’ and ‘including’ are terms of enlargement, which clarify that given examples are merely illustrative.” (citing *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 162 (2012); *Dep’t of Hous. & Urb. Dev. v. Rucker*, 535 U.S. 125, 131 (2002))).

CMS’s Significant Impairment Requirement ignores the floor established in the statute, omitting individuals explicitly described in the Medically Frail Exclusion. *See* 91 Fed. Reg. at 33376 (acknowledging that some people “with a serious or complex medical condition” will not meet the “significantly impairs” criteria, and as a result, will not qualify for the exclusion). In narrowing the Medically Frail Exclusion in this way, CMS failed to “land within the statutory goalposts.” *Rutherford*, 146 S. Ct. at 1334 (holding the agency is empowered to “give meaning” to a statutory provision, not to adopt a definition inconsistent with it).

Second, the plain text of subsections (aa) through (ee) shows that Congress did not intend to impose an across-the-board, functional impairment requirement, much less a work-related impairment requirement. *Contra* 91 Fed. Reg. at 33373 (making the tautological argument that the Medically Frail Exclusion should not be read to “require automatic classification as medically frail or otherwise having special medical needs based solely on diagnosis or condition,” as such a reading would “risk sweeping in individuals whose conditions do not significantly impair their functional capacity”). To begin with, Congress adopted an explicit functional impairment requirement for some of the categories in the Medically Frail Exclusion but not others. For example, Congress specified that, for individuals with a mental disorder to qualify for the

exclusion, their disorder must be “disabling.” *Id.* § 1396a(xx)(9)(A)(ii)(V)(cc). Similarly, individuals with a physical, intellectual, or developmental disability must show that their disability “significantly impairs their ability to perform 1 or more activities of daily living.” *Id.* § 1396a(xx)(9)(A)(ii)(V)(dd). By contrast, neither subsection (bb), which refers to an individual “with a substance use disorder,” nor subsection (ee), which refers to an individual “with a serious or complex medical condition,” contain a functional impairment requirement. *Id.* § 1396a(xx)(9)(A)(ii)(V)(bb), (ee). Under the plain language of the statute, having an SUD or a serious or complex medical condition is sufficient to render an individual medically frail, whether or not the individual is impaired in their ability to work. CMS’s insertion of the Significant Impairment Requirement ignores Congress’s decisions to incorporate—or not—functional impairment requirements for only certain categories of medically frail people. *See Barnhart v. Sigmon Coal Co., Inc.*, 534 U.S. 438, 452 (2002) (“[I]t is a general principle of statutory construction that when Congress includes particular language in one section of a statute, but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.” (internal quotation marks omitted)).

What is more, in the subclauses where Congress did incorporate a functional impairment requirement, the standard it adopted was not the Significant Impairment Requirement that CMS created in the IFR. It is nonsensical to suggest that Congress silently intended to impose an *additional* impairment requirement *on top of* the differently worded impairment requirement in the text of the statute itself.

Subclause (aa) illustrates both of these congressional choices—selective application of a functional impairment requirement and, when used, an impairment requirement that differs from the Significant Impairment Requirement that CMS created. That provision refers to an individual

“who is blind or disabled (as defined in section 1382c of this title).” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa). Under section 1382c, an individual is blind if their visual acuity is 20/200 or less. *Id.* § 1382c(a)(2). The definition is strictly clinical in nature; it contains no assessment of functional capacity. A person who meets the visual acuity criteria is blind. Full stop. By contrast, the definition of “disabled” in section 1382c contains a technical, work-related impairment test that has existed since 1954. An individual is disabled only if they are “unable to engage in any substantial gainful activity by reason of any medically determinable” health condition that is expected to result in death or last for at least twelve months. *Id.* § 1382c(a)(3)(A). Application of CMS’s Significant Impairment Requirement would mean that when Congress incorporated these detailed definitions into the Medically Frail Exclusion, it did not mean what it said. Rather, Congress only intended the medically frail exclusion to apply to: (1) a person who is blind under section 1382c *if* they meet a work-related impairment requirement; and (2) a person who is disabled under that same section *if* they meet a *second and different* work-related impairment requirement (*i.e.*, the Significant Impairment Requirement). That is far from the “best reading” of the statute. 91 Fed. Reg. at 33373.

If Congress wanted to limit the Medically Frail Exclusion to people whose health condition significantly impairs their ability to comply with the work requirements, “it could easily have chosen language directed to that end.” *Trump v. Hawaii*, 585 U.S. 667, 695 (2018); *see, e.g.*, 7 U.S.C. § 2015(o)(3)(B) (exempting from SNAP work requirements an individual who is “medically certified as physically or mentally unfit for employment”). “The fact that [Congress] did not adopt this readily available and apparent alternative strongly supports rejecting” CMS’s interpretation of the Medically Frail Exclusion. *Knight v. Comm’r*, 552 U.S. 181, 188 (2008).

Third, other parts of the provision defining “specified excluded individuals” undercut CMS’s rationale for the IFR. The exclusion of other groups from the work requirements does not turn on whether an individual is able to comply with the requirements or not. *See* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(I-IV), (VI-IX). For example, an individual who is pregnant is categorically excluded from the work requirements, whether or not the pregnancy significantly impairs their ability to work, because Congress evidently made the judgment that additional values were at stake other than a desire to force every Medicaid beneficiary who can work to show that they are doing so. The IFR’s rationale that the Significant Impairment Requirement is needed to ensure that work requirements apply to all individuals “whose conditions do not significantly impair their functional capacity,” 91 Fed. Reg. at 33373, then, simply does not match the statute that Congress actually wrote. *See Advocate Christ Med. Ctr. v. Kennedy*, 605 U.S. 1, 19 (2025) (“no statute pursues a single policy at all costs, and [neither courts nor agencies are] free to rewrite this statute (or any other) as if it did”).

Finally, the history of the Medically Frail Exclusion supports rejecting CMS’s interpretation. Use of the phrase “medically frail or otherwise has special medical needs” is not new to H.R.1. In 2006, Congress amended the Medicaid Act to permit states to require some beneficiaries to enroll in an ABP. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044, 120 Stat. 4, 90 (codified at 42 U.S.C. § 1396u-7). However, Congress prohibited states from requiring an individual who “is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary)” to enroll. 42 U.S.C. § 1396u-7(a)(2)(B)(vi).

In crafting H.R. 1, Congress borrowed that language from the ABP provision and then went further. To begin with, Congress did not delegate boundless authority to the Secretary to

define who is medically frail. While including a parenthetical delegation of authority to the Secretary, Congress established clear guardrails. Those guardrails require the Secretary to include the five listed categories of individuals in any definition of an individual “who is medically frail or otherwise has special medical needs.” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa)-(ee). In other words, Congress created a floor below which the Secretary cannot go.

What is more, Congress imported the guardrails from the existing ABP regulation, making minor tweaks to broaden, not to narrow, those guardrails. *Compare* 42 C.F.R. § 440.315(f) *with* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa)-(ee); *see* 91 Fed. Reg. at 33372 (listing the differences between the categories in the ABP regulation and those in H.R. 1). When Congress uses a term “obviously transplanted from another legal source, it brings the old soil with it.” *George v. McDonough*, 596 U.S. 740, 746 (2022) (cleaned up). Thus, Congress is presumed to have imported CMS’s interpretation of the term “medically frail or otherwise an individual with special medical needs” and of the listed categories of individuals.

And, when it adopted the ABP regulation, CMS did not interpret the phrase “medically frail or otherwise an individual with special medical needs” to apply only to an individual who is unable to work. *Compare* 91 Fed. Reg. at 33373 (indicating the phrase “connotes diminished functional capacity” and specifically, inability to complete 80 hours of work-related activities per month). To the contrary, the agency explicitly recognized that people with a serious chronic condition “such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease” categorically qualify as medically frail. *Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans*, 78 Fed. Reg. 42160, 42233 (July 15, 2013). That makes sense. As CMS explained, the purpose of the medically frail exception, and thus of the ABP

regulation, is to “ensure that vulnerable individuals with special medical needs” receive “appropriate medical treatment for their individual medical condition.” *Id.* at 42231.

This chain of events reinforces what is clear from the text of H.R. 1: Congress intended for people who have special (*i.e.*, unique or particular) medical needs to continue to receive Medicaid coverage despite the work requirements. *See George*, 596 U.S. at 746 (holding where Congress used a term with “a long regulatory history in this very context,” it adopted the same meaning).

In sum, CMS’s definition of an individual “who is medically frail or otherwise has special medical needs” is contrary to the text, structure, and history of the statute and cannot stand.

B. The Definition Is Arbitrary and Capricious.

In addition, CMS’s decision to narrow the medically frail exclusion was arbitrary and capricious in several respects.

First, to justify imposing the work requirements on individuals described in the Medically Frail Exclusion who cannot meet the Significant Impairment Requirement, the agency stated that the work requirements have “the potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation and dependency, build confidence, achieve self-sufficiency and prosperity, and improve health.” 91 Fed. Reg. at 33372; *see id.* at 33374, 33376. More specifically, CMS claimed that the work requirements will lead to an increase in employment, which will lead to financial stability and better health outcomes. *Id.* at 33349.

But in 2021, CMS examined the relevant evidence and reached the opposite conclusion—work requirements do not cause an increase in employment. Between 2017 and 2021, CMS had approved 13 state projects that conditioned Medicaid coverage on compliance with work requirements. *Id.* at 33350. As of 2021, Arkansas was the only state to have fully implemented

work requirements, and multiple peer-reviewed studies examined their effects. *See* AR 940-43. CMS credited those studies, concluding that the Arkansas work requirements did not lead to an “increase in employment or other community engagement activities among low-income individuals subject to” the work requirements. AR 942. As for Medicaid work requirements generally, CMS concluded: “existing evidence from states that have implemented community engagement requirements, evidence from other public programs with work requirements, and the overall work patterns and job market opportunities for the low-income adults who would be subject to such requirements highlight the potential ineffectiveness of community engagement requirements at impacting employment outcomes for the target population.” AR 945; *see id.* (summarizing the research examining the outcomes of work requirements in TANF and SNAP). The agency noted that it was “not aware of any reason to expect that the community engagement requirement as a condition of eligibility . . . would have a different outcome in the future than what was observed during the initial implementation of such a requirement in Arkansas and other states.” AR 945-46.

And, indeed, in the IFR, CMS provided no “explanation whatsoever for abandoning its prior [factual] conclusion.” *City of Columbus*, 523 F. Supp. 3d at 754. In the background section of the IFR, the agency did make an oblique reference to the Arkansas “experience,” noting that it “provides insight into operational considerations, indicating that beneficiary awareness, clarity of requirements, and the accessibility of reporting mechanisms, as well as overall administrative complexity, can influence participation and compliance.” 91 Fed. Reg. at 33350. That statement does not explain why CMS changed its view of the facts and determined that Medicaid work requirements “have the potential” to increase employment. 91 Fed. Reg. at 33372; *City of Columbus*, 523 F. Supp. 3d at 755 (holding the agency must “provide a reasoned explanation for

discounting the importance of the facts that it had previously relied upon” (quoting *U.S. Sugar Corp. v. EPA*, 830 F.3d 579, 626 (D.C. Cir. 2016))).

Further, CMS did not point to any evidence at all to support its claim that the work requirements will increase employment or other “community engagement” activities among individuals described in the Medically Frail Exclusion.⁴ “An agency, although entitled to deference, cannot simply state it ‘believes’ something to be true—against the weight of all the evidence before it—without further support.” *Mayor of Baltimore*, 973 F.3d at 276. CMS’s unsupported claim about the potential benefits of imposing the Significant Impairment Requirement on individuals described in the Medically Frail Exclusion was arbitrary and capricious.

Second, CMS ignored the negative effects of imposing work requirements on this population. Undisputed record evidence shows that many individuals who will be subject to the work requirements because of the Significant Impairment Requirement will lose coverage for failure to demonstrate compliance, and their health will suffer as a result. As CMS acknowledged in 2021, the Arkansas work requirements led to “rapid coverage loss” and a marked increase in

⁴ The second link in CMS’s logic chain is similarly unsupported by the record evidence. Even if the work requirements could cause some small number of beneficiaries to obtain employment, it simply does not follow that those beneficiaries would achieve financial stability or better health outcomes. By definition, individuals with household income below 138% of FPL do not have financial stability. Further, as CMS conceded, while the literature generally shows a link between employment and better health, it does not show that the link is causal. *See* 91 Fed. Reg. at 33350 (acknowledging a bi-directional relationship between employment and health). And the link does not hold for the kinds of employment that people with low-income often have. *See* AR 767 (“low quality work (e.g., unstable, limited agency, low pay)”), AR 848-50 (nonstandard work hours); AR 864-65 (temporary employment), AR 870-82 (insecure employment); *see also Friends of Back Bay v. U.S. Army Corps of Eng’rs*, 681 F.3d 581, 588 (4th Cir. 2012) (holding “an unjustified leap of logic or unwarranted assumption . . . can erode any pillar underpinning an agency action”).

the uninsured rate among the target population. AR 940-41; *see* AR 943-44 (highlighting data from New Hampshire and Michigan showing that thousands of individuals were at risk of coverage loss when implementation was halted). Critically, the peer-reviewed studies that examined the Arkansas work requirements found that individuals with chronic conditions were more likely to lose coverage, AR 941, and those who lost coverage were more likely to report medical debt and financial barriers to care. *Id.* (noting that 50% had problems with medical bills, 56% delayed care because of cost, and 64% delayed taking medications due to cost). *See also* AR 4784-85 (Medicaid Medical Directors describing the consequences of coverage lapses). As CMS concluded in 2021, the research “findings indicate the serious and potentially long-term implications of the [work requirements] in terms of lost coverage and foregone health care among those who most need it, in sharp contrast to . . . [the] continued argument that the demonstration would lead to improved health among those subject to the requirements.” AR 941.

In addition, comments submitted to CMS in anticipation of the IFR raised specific concerns about coverage loss among individuals who are described in the Medically Frail Exclusion, but whose conditions are well-controlled. They warned that this population will face serious health consequences if they lose Medicaid coverage. *See, e.g.*, AR 4002-05 (explaining the health of individuals with an SUD, disabling mental disorder, or serious or complex condition will suffer without coverage), 3912-3914 (explaining that continuous coverage is critical for the health of people living with HIV and for public health), 3867-68 (same), 4317-18 (same), 4774-75.

In the IFR, however, the agency “entirely failed to consider” that its medically frail definition will cause additional coverage loss, which will have dire health and financial consequences for individuals with chronic conditions. *State Farm*, 463 U.S. at 43. Those are

“important aspect[s] of the problem” that CMS was required to consider. *Id.*; see *Casa de Md.*, 486 F. Supp. 3d at 961 (holding where the public raises a significant concern, the agency must ‘adequately analyze . . . the consequences’ of its actions” (quoting *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 931 (D.C. Cir. 2017))).⁵

Third, CMS’s explanation for why it deviated from the medically frail definition in the ABP regulation does not reflect “reasoned decisionmaking.” *Michigan v. EPA*, 576 U.S. 743, 750 (2015). As noted above, Congress used the same language—an individual who is “medically frail or otherwise” has “special medical needs”—in both the H.R. 1 work requirements provision and the ABP provision. *Compare* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V) *with id.* § 1396u-7(a)(2)(B)(vi). In the IFR, CMS stated it was not adopting the ABP medically frail definition because “the medically frail exclusion for the ABP only impacts . . . benefit package selection, while the medically frail exclusion under the community engagement requirement determines if an individual needs to demonstrate community engagement to maintain Medicaid eligibility.” 91 Fed. Reg. at 33372. That is no explanation at all. It was illogical for CMS to acknowledge that the stakes are higher for beneficiaries in the work requirements context, but to then proceed to adopt a narrower exclusion in that context. Put another way, there are medically frail individuals in the expansion population who are protected from a loss of benefits under the ABP regulation,

⁵ As part of its regulatory impact analysis, CMS concluded that 15% of the expansion population would lose coverage due to the work requirements. 91 Fed. Reg. at 33460. Even assuming for the sake of argument that this estimate was reasonable (which it was not, see AR 940, 944), it does not demonstrate that the agency adequately considered the consequences of its policy choice. See *Casa de Md.*, 486 F. Supp. 3d at 961. The relevant policy choice was to narrow the Medically Frail Exclusion by imposing the Significant Impairment Requirement. CMS was not free to “completely sidestep[]” the effects of that choice. *Id.* at 966. See also *Gresham*, 950 F.3d at 103 (“nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking”).

see 42 C.F.R. § 440.315(f), but who are not protected from a total loss of coverage under the IFR, *see id.* § 435.554(c)(5)(i). That is unreasonable.

As further justification for its definition, CMS noted that the five categories listed in the work requirements provision are not identical to the categories in the ABP regulation. 91 Fed. Reg. at 33372. For example, the work requirements exclusion “uses the term ‘or’ instead of ‘and’ for individuals with serious or complex medical conditions . . . [and] does not use the term ‘chronic’ for individuals with SUDs.” *Id.* But these differences make the work requirements categories *broadier* than the ABP categories, which should lead to a more inclusive medically frail definition. They simply do not explain CMS’s decision to narrow the exclusion. *See State Farm*, 463 U.S. at 43 (holding the agency must “articulate a satisfactory explanation for its action, including a rational connection between the facts found and the choice made” (cleaned up)).

II. The Separate Limit on the Substance Use Disorder Category Is Contrary to Law and Arbitrary and Capricious.

Congress excluded from the work requirements an individual “who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual . . . with a substance use disorder.” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb). In the IFR, CMS limited subclause (bb) to “an individual . . . with a substance use disorder, excluding an individual in stable recovery (which means, an individual who is in recovery for 5 or more years).” 42 C.F.R. § 435.554(c)(5)(i)(B). That violated the APA.

Even where Congress has delegated authority to an agency, the court must “police the outer statutory boundaries of those delegations” and “ensure that agencies exercise their discretion consistent with the APA.” *Loper Bright Enters.*, 603 U.S. at 404. Again, in H.R. 1, Congress directed CMS to exclude from the work requirements “an individual . . . with a substance use disorder.” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb). In the text of the regulation, as well as in the

preamble, CMS conceded that an individual in stable recovery is an individual “with a substance use disorder.” *See* 42 C.F.R. § 435.554(c)(5)(i)(B) (“an individual with a substance use disorder, *excluding* . . .”) (emphasis added); 91 Fed. Reg. at 33374 (“[W]e believe that it is inappropriate to include individuals *with an SUD* who are in stable recovery . . . in the medically frail exclusion.”) (emphasis added). As described in detail above, according to the text, structure, and history of the statute, an individual with an SUD is categorically medically frail. *See supra* at 22-28. CMS’s belief that an individual with an SUD who is in “stable recovery” should be subject to work requirements because they are “better able to participate in community engagement activities than an individual who is in active treatment or early or sustained recovery” is irrelevant. 91 Fed. Reg. at 33374. The agency was not free to “rewrite clear statutory terms to suit its own sense of how the statute should operate.” *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 150 (D. Md. 2025) (quoting *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014)). In doing so, CMS exceeded the “outer statutory boundaries” of its authority. *Loper Bright Enters.*, 603 U.S. at 374.

Although CMS was clear that it understood it was removing a subset of people with an SUD from the Medically Frail Exclusion, there is some language in the preamble that points at a different (and contradictory) rationale, namely, that the agency might not consider an individual in “stable recovery” to be an “individual . . . with a substance use disorder.” *See* 91 Fed. Reg. at 33374 (stating that there are three stages of recovery—early, sustained, and stable—and noting that it was “interpret[ing] the statutory reference to individuals with an SUD to include individuals . . . who are in early or sustained recovery”). If the agency were to attempt to justify its rule by pointing to this equivocal language, its effort would fail. Even assuming CMS had the authority to define this statutory term, the agency failed to “exercise [its] discretion consistent with the APA,” *Loper Bright Enters.*, 603 U.S. at 374, because the evidence it cited does not support its

conclusion. *See Cnty. of Los Angeles v. Shalala*, 192 F.3d 1005, 1021 (D.C. Cir. 1999) (finding agency action is arbitrary and capricious “where the record belies the agency’s conclusion”).

Specifically, CMS acknowledged that “the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) are most commonly used to define and classify SUDs.” 91 Fed. Reg. at 33374. But those sources do not support CMS’s definition. Neither even uses the term recovery. The DSM-5, which is the reference book that health care providers use to diagnose SUDs, describes an SUD as being “in remission” when an individual previously met the diagnostic criteria for the condition but has not met any of the criteria (other than craving or a strong desire to use the substance) for at least three months. An SUD is in “early remission” in months three through 12 and “sustained remission” after 12 months. According to the DSM-5, when an individual has an SUD that is in remission, the individual still has a diagnosable SUD. *See* Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) 553-54, 601-02, 609-10, 620-21 (5th ed. Text Rev. 2022) (directing clinicians to specify the severity of the SUD and whether the SUD is in remission by using different codes) (Ex. T, hereto); AR 4002-03 (describing how DSM-5 treats remission). CMS offered no explanation for departing from these authoritative diagnostic guidelines in defining an “individual . . . with a substance use disorder.”⁶

⁶ To illustrate the distinction between the DSM-5 and CMS’s position, consider an individual who is receiving medication to treat opioid use disorder, which can be needed long-term. AR 4002-04, 4460-61. Per the DSM-5, that individual has a diagnosable SUD in remission. DSM-5 at 608-10. That makes sense. Someone in need of medication to treat opioid use disorder would be characterized as having that disorder. However, under CMS’s definition, that individual would not have an SUD if they have “been in recovery for 5 or more years.” 42 C.F.R. § 435.554(c)(5)(i)(B).

CMS cited a single journal article, published in Occupational Health Science, to support its (possible) conclusion that an individual in “stable recovery” does not have a substance use disorder. *See* 91 Fed. Reg. at 33374 n.65 (citing AR 1838-74). But the article does not support CMS’s conclusion. Rather, the authors explain that “recovery” is a “conceptual lens for understanding SUDs” that has no uniform meaning. AR 1842. For example, under some definitions of recovery, abstinence is a necessary component, while under others it is not. AR 1841-42; *see* AR 1844 (highlighting disagreement about whether an individual taking medication to treat an opioid use disorder is in recovery).⁷ Tellingly, to answer the question “What is a Substance Use Disorder,” the authors of the article turned to the DSM-5. AR 1841. To the extent that CMS determined that an individual in stable recovery is not an “an individual . . . with a substance use disorder,” then, that determination was not based on the record evidence.

CMS’s justification for limiting subclause (bb) does not pass muster under the APA for several additional reasons. CMS stated its belief that “participating in community engagement activities, such as employment, has the potential to help” individuals in stable recovery “maintain their recovery by helping them escape isolation and dependency, build confidence, achieve self-sufficiency and prosperity, and improve health.” 91 Fed. Reg. at 33374. However, as described in detail in section I, *see supra* at 28-30, CMS had concluded in 2021 that work requirements do not cause an increase in employment or other “community engagement” activities (and, thus, had little potential to help people escape dependency, build confidence, or improve health). The IFR

⁷ The vagueness of the term further shows that CMS’s definition is not reasonable. *See, e.g., Nat’l Council of Nonprofits v. McMahon*, 836 F.Supp.3d 265, 313 (D. Mass. 2026) (noting “indeterminate standards” leave people “to guess at their obligations while reserving broad discretion to determine eligibility on an ad hoc basis,” and that “lack of ascertainable standards is itself a hallmark of arbitrary and capricious decision-making”).

failed to explain why CMS was “abandoning its prior [factual] conclusion.” *City of Columbus*, 523 F. Supp. 3d at 754.

Moreover, even if the work requirements could cause some small number of individuals in stable recovery to obtain employment, it simply does not follow that employment would help them “maintain their recovery.” 91 Fed. Reg. at 33374. The single journal article that CMS cited to support this conclusion does not suggest that employment is a universal good for individuals with an SUD. To the contrary, the authors found that employment can “positively or negatively” affect recovery. AR 1839; *see* AR 1848, 1854-61 (summarizing four primary “workplace recovery hazards” that can hamper recovery). CMS failed to “reasonably reflect upon the information contained in the record and grapple with contrary evidence.” *Fred Meyer Stores, Inc. v. NLRB*, 865 F.3d 630, 638 (D.C. Cir. 2017).

Finally, while overstating the theoretical benefits that could accrue to individuals in stable recovery who manage to comply with the work requirements, CMS again “entirely failed to consider” the downsides of its policy—additional coverage loss among individuals with an SUD and the health harms that follow. *State Farm*, 463 U.S. at 43. Comments explained that for many individuals in recovery, including individuals taking medication to treat opioid use disorder, Medicaid coverage and access to care is essential for their health and well-being. AR 4002-03. CMS did not acknowledge these facts, much less “actually give [them] meaningful consideration.” *Casa de Md.*, 486 F. Supp. 3d at 961. Its decision to impose work requirements on Medicaid applicants and beneficiaries in stable recovery was arbitrary and capricious.

III. The Restrictions on the Use of Self-Attestation Are Arbitrary and Capricious.

The IFR initially permits states to accept self-attestation of medically frail status when there is no reliable information available to the state or the reliable information is not reasonably

compatible with information provided by the applicant or beneficiary. 42 C.F.R. § 435.557(f)(1)(i). However, after January 1, 2028, the IFR allows states to accept self-attestation of medically frail status only once during a period of enrollment. *Id.* § 435.557(f)(1)(ii); *see id.* § 435.557(a). Further, after accepting self-attestation from an individual, states must verify medically frail status again—using only reliable information available to the agency or documentation submitted by the individual—at their next regularly scheduled redetermination in six months. *Id.* § 435.557(f)(1)(ii)(A)-(B); 42 U.S.C. § 1396a(e)(14)(L); *see supra* at 11-12 (further explaining verification procedures). In adopting these restrictions on self-attestation, CMS failed to “reasonably consider[] the relevant issues and reasonably explain[]” its decision. *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

First, CMS’s explanation for the restrictions runs counter to the evidence in the record. CMS stated that its self-attestation policy “will motivate individuals to access care,” and after they access care, the state will be able to use claims or encounter data to verify their medically frail status at their next regularly scheduled redetermination. 91 Fed. Reg. at 33406. But nothing in the record suggests that individuals described in the Medically Frail Exclusion need any additional motivation to seek necessary health care. Even more critically, ample record evidence undermines CMS’s assertion that claims and encounter data will save individuals from needing to use self-attestation a second time. Comments explained that Medicaid beneficiaries often cannot access necessary care quickly. Individuals sometimes wait months or even years to see a health care provider and get an accurate diagnosis. *See, e.g.*, AR 4008-09, 4036, 4395, 4460, 6544-45, 4775, 4785, 4797-98. And, after a beneficiary receives services, it can take twelve months or longer for the services to appear in claims or encounter data. *See* 42 C.F.R. §

447.45(d)(1). Given this evidence, CMS’s explanation amounts to little more than “because we said so.” *Mayor of Baltimore*, 973 F.3d at 276.

Second, CMS did not adequately consider a reasonable alternative policy, namely, adhering to the existing regulations governing verification of Medicaid eligibility criteria. Those regulations generally give states the option to accept self-attestation of information that is necessary to determine eligibility. 42 C.F.R. § 435.945(a). However, they require states to accept, on a case-by-case basis, self-attestation when documentation “does not exist . . . or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster.” *Id.* § 435.952(c)(3); *see* Medicaid and Children’s Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP, 81 Fed. Reg. 86382, 86420 (Nov. 30, 2016) (adopting the requirement because, for some individuals, providing documentation can “create an insurmountable procedural barrier to accessing coverage”). Comments urged CMS to adopt the same verification standards in the IFR. *See, e.g.*, AR 4009, 3956. CMS obviously declined to do so, but it did not say why. Certainly, CMS had no reason to think that medically frail beneficiaries are somehow immune to homelessness, domestic violence, or natural disaster. *See, e.g.*, AR 4223, 4739 (noting the link between homelessness and serious health conditions). CMS’s failure to consider “another reasonable path forward” rendered its action arbitrary and capricious. *Spirit Airlines, Inc. v. U.S. Dep’t of Transp.*, 977 F.3d 1247, 1255 (D.C. Cir. 2021); *see Casa de Md.*, 486 F. Supp. 3d at 961 (holding action arbitrary and capricious where agency did not adequately consider an “important alternative”).

Third, CMS “entirely failed” to consider the negative effects of its self-attestation policy on beneficiaries described in the Medically Frail Exclusion. *State Farm*, 463 U.S. at 43.

Substantial record evidence shows that adding administrative barriers, including paperwork requirements, reduces coverage among individuals who are otherwise eligible. *See, e.g.*, AR 944 (noting that evidence from approved work requirements projects “suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements”), 4007-10, 4187-89, 4192-93, 4395-96, 4228. And, as described above, comments warned that coverage loss is associated with poor health outcomes, in particular among the medically frail population. *See, e.g.*, AR 4002-05, 3913-14, 4317-18, 4784-85. In the IFR, the agency simply ignored those “important aspect[s] of the problem.” *State Farm*, 463 U.S. at 43.

IV. The Limit on the Use of Claims Data is Arbitrary and Capricious.

H.R. 1 requires states to verify that “an individual is a specified excluded individual” using “reliable information available to the State . . . without requiring, where possible,” the individual to submit additional information. 42 U.S.C. § 1396a(xx)(5). In the IFR, CMS specified that to verify medically frail status, a state must use “reliable information available to the State, including claim(s) relevant to the individual that have been adjudicated in the preceding 12 months, including those that have been paid, pended or denied, and encounter data, as relevant to the individual.” 42 C.F.R. § 435.557(f)(1); *see id.* § 435.557(a)(vii), (viii). CMS prohibited states from using claims or encounter data older than 12 months. 91 Fed. Reg. at 33405.

In adopting the limit on the lookback period, CMS failed to “reasonably consider[] the relevant issues and reasonably explain[] the decision.” *Prometheus Radio Project*, 592 U.S. at 423. Public health researchers from Harvard University submitted to CMS a research manuscript examining the relationship between the length of the claims lookback period and the percentage of beneficiaries who would be identified automatically by the state as medically frail. The

researchers found that under their baseline model, a 12-month lookback period led to 26.9% of beneficiaries being identified automatically, compared with 34.5% with a 24-month lookback period, and 39.3% with a 36-month lookback period.⁸ AR 4847-48, 4856. Further, the researchers found that beneficiaries identified as medically frail were older, had higher rates of hospitalization, emergency department utilization, and one-year mortality than other beneficiaries. AR 4849. The researchers concluded that extending the lookback period “could substantially reduce coverage losses among Medicaid beneficiaries most in need of ongoing medical care and who are at a high risk for adverse health consequences including emergency care, hospitalization, and death.” AR 4849; *see also* AR 4852 (finding the length of the lookback period “will have large effects on the number of enrollees exempted” in a population “at high risk for adverse health effects from coverage losses”). Other record evidence echoed the importance of using claims data to identify individuals who are medically frail given: (1) the high risk of erroneous coverage loss among individuals who are medically frail but are not automatically identified as such through *ex parte* review, AR 944, 4462, 4464-65, 3893; and (2) the severe health consequences that flow from coverage loss, AR 942, 4002-05, 3912-3914, 3867-68, 4317-18, 4388, 4784-86, 4191. *See also* AR 4313 (explaining the need to look at several years of health records to identify individuals who are medically frail).

In the face of that record evidence, CMS simply stated that states “may not consider information older than 12 months . . . because older information may not reflect an individual’s current condition.” 91 Fed. Reg. at 33405. CMS did not acknowledge the critical issues raised by

⁸ As the researchers explained, there could be multiple reasons for this finding, including: individuals experience gaps in access to services and/or Medicaid coverage; and individuals with multiple conditions might not have all of those conditions reflected in diagnosis codes “for any given visit addressing multiple problems simultaneously.” AR 4850.

the researchers and other comments, much less adequately grapple with them. *See Fred Meyer Stores, Inc.*, 865 F.3d at 638 (holding the agency must “grapple with contrary evidence”). Put another way, the agency failed to consider the clear downsides of gaining greater certainty about an “individual’s current condition” – additional coverage loss and the health and financial harms that follow. That was arbitrary and capricious. *See Appalachian Voices v. State Water Control Bd.*, 912 F.3d 746, 753 (4th Cir. 2019) (agency action is arbitrary and capricious if it “entirely ignores important aspects of the problem”).

In addition, CMS’s decision to impose the limit on the lookback period is arbitrary and capricious for a separate reason—it stems from the Significant Impairment Requirement. Many (if not most) of the individuals who fall within the statutory Medically Frail Exclusion have a chronic condition that is manageable with access to treatment but is not curable. *See, e.g.*, AR 4002-05, 3913, 4317-18, 4460-61. Thus, if they had the diagnosis/condition 24 or 36 months ago, they will continue to have the diagnosis/condition today. The only reason states would need more current information about their condition (as CMS claimed) is to determine whether they are meeting the Significant Impairment Requirement. *See* 91 Fed. Reg. at 33405 (explaining that states must verify both the presence of the diagnosis and condition and whether it significantly impairs an individual’s ability to comply with the work requirements). But as described above, the Significant Impairment Requirement is unlawful. Thus, the limit on the claims lookback period is based on an invalid premise and cannot stand.

CONCLUSION

For the reasons above, Plaintiffs respectfully ask the Court to grant their motion, enter summary judgment in their favor, and vacate the challenged portions of the IFR as requested in the Proposed Order.

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