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' REPLY IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT AND PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS' CROSS-MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

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INTRODUCTION

This case challenges provisions of an Interim Final Rule (IFR) that will harm millions of low-income, medically frail people and the health care practitioners and localities that serve them. This includes Mr. Bricken, who needs Medicaid coverage for ongoing specialty care and medications to treat vision loss and mental health conditions, and who, since the IFR was announced, has aggressively but unsuccessfully looked for work even as his stress and anxiety levels increase. It also includes Ms. Taylor, who needs Medicaid coverage for insulin, medications, and specialty care to treat diabetes and other chronic conditions, and who, since learning of the IFR, has enlarged her efforts to find work while attempting to move up health care visits.

As established in our opening brief and reinforced below, the challenged provisions are contrary to law and are arbitrary and capricious in violation of the APA.

ARGUMENT

I. Plaintiffs Have Standing to Pursue Their APA Claims.

To show standing, a plaintiff must have "suffered an injury in fact" that is "fairly traceable to the challenged conduct of the defendant," and "that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016). This Court has jurisdiction to proceed to the merits so long as at least one plaintiff has standing. *See Carolina Youth Action Project v. Wilson*, 60 F.4th 770, 778 (4th Cir. 2023).

A. The Individual Plaintiffs Have Standing.

Each Individual Plaintiff has enrolled in coverage through the Medicaid expansion and has one or more medical conditions that would qualify them as medically frail (and therefore exclude them from work requirements) under a plain-language reading of the statute. Because of the IFR, however, each Individual Plaintiff will only be excluded if they make an additional showing: they

meet the Significant Impairment Requirement. At a minimum, the Significant Impairment Requirement imposes an additional paperwork burden on the Individual Plaintiffs. *See* Turner Decl. ¶ 21, ECF No. 29-6; Taylor Decl. ¶¶ 32-36, ECF No. 29-5. "Such a need to take affirmative steps to avoid risk of harm constitutes a cognizable injury supporting standing." *Dep't of Homeland Sec. v. League of Women Voters*, --- S. Ct. ---, No. 26A308, 2026 WL 2879700, at *2 (Sept. 25, 2026) (cleaned up); *see also Meese v. Keene*, 481 U.S. 465, 475 (1987).

The Individual Plaintiffs also have standing because they have demonstrated a "substantial risk" that they will lose the Medicaid coverage they need to manage their serious medical conditions due to the IFR. *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014) (quoting *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409, 414 n.5 (2013)); Pls.' Mem. in Supp. of Mot. for S.J. 14-15, ECF No. 29-1 ("Pls.' Br."). This shows an injury-in-fact; agency actions that "threaten an individual's ability to obtain Medicaid coverage … satisfy the injury element of constitutional standing." *NB ex rel. Peacock v. Dist. of Columbia*, 682 F.3d 77, 83 (D.C. Cir. 2012); *see Philbrick v. Azar*, 397 F. Supp. 3d 11, 22 (D.D.C. 2019) (according standing to Medicaid beneficiary who had shown a "substantial risk" of losing coverage due to CMS's approval of project imposing work requirements), *aff'd*, No. 19-5293, 2020 WL 2621222 (D.C. Cir. May 20, 2020), *vacated and remanded on other grounds*, 142 S. Ct. 1665 (2022).

Defendants argue that the Individual Plaintiffs do not have standing because "they have not lost their coverage yet." Defs.' Combined Mem. in Supp. of Their Mot. to Dismiss 10, ECF No. 74-1 ("Defs.' Br."). But "it could hardly be thought that administrative action likely to cause harm cannot be challenged until it is too late." *Adams v. Watson*, 10 F.3d 915, 921 (1st Cir. 1993) (quoting *Rental Hous. Ass'n of Greater Lynn v. Hills*, 548 F.2d 388, 389 (1st Cir. 1977)). Plaintiffs need not wait to challenge the IFR when they have shown the substantial risk that they will lose coverage

and the devastating effect that loss would have on their well-being.

Moreover, the Individual Plaintiffs are injured in the here and now. Because they will have difficulty showing that they meet the Significant Impairment Requirement, and because they do not currently meet the work requirements, they have no choice but to take concrete steps now to try to comply with those requirements. Otherwise, they will lose health coverage. *See* Pls.' Br. 15. This is not self-inflicted harm, as Defendants suggest. Defs.' Br. 11. The Individual Plaintiffs are subject to the challenged policy and face a substantial risk of coverage loss as a result. *See Hutton v. Nat'l Bd. of Exam'rs in Optometry*, 892 F.3d 613, 622 (4th Cir. 2018) (finding standing where plaintiffs incurred costs "to mitigate or avoid harm when a substantial risk of harm actually exists" (citing *Clapper*, 568 U.S. at 414 n.5)).

Defendants also contend that the extent of the Individual Plaintiffs' injuries "depends upon the actions of third parties," namely, state Medicaid agencies that will implement the requirements that CMS has imposed in the IFR. Defs.' Br. 10. But given that Medicaid is a cooperative venture between the federal and state governments, that is true of every federal Medicaid regulation. These beneficiaries still have standing to challenge such a regulation if it "is at least in part responsible for frustrating" their efforts to retain coverage. *Libertarian Party of Va. v. Judd*, 718 F.3d 308, 316 (4th Cir. 2013); *see also Tex. Child.'s Hosp. v. Azar*, 315 F. Supp. 3d 322, 336 (D.D.C. 2018). Here, the IFR instructs states not to apply the Medically Frail Exclusion to beneficiaries who do not meet the Significant Impairment Requirement; absent the IFR, the states could not legally impose the work requirements on this group. Plaintiffs' injuries are traceable to CMS's rule. *See Orangeburg, S.C. v. FERC*, 862 F.3d 1071, 1080 (D.C. Cir. 2017).

B. The Organizational Plaintiffs Have Standing.

The Organizational Plaintiffs, six professional organizations that represent hundreds of thousands of medical providers across the country, have also demonstrated standing because the IFR will have "predictable effect[s]" on their members, including increased costs in the form of uncompensated care along with new, unpaid administrative burdens, as well as interference in the doctor-patient relationship. *Dep't of Com. v. New York*, 588 U.S. 752, 768 (2019); Pls.' Br. 16-17. As with the Individual Plaintiffs, Defendants contend that the doctors' injuries depend on the actions of the states. Defs.' Br. 12. But it is the IFR that instructs states to revoke coverage from beneficiaries in cases where coverage could not be revoked absent the IFR. This suffices to show the doctors' injuries are traceable to CMS's rule. *See Tex. Child.'s Hosp.*, 315 F. Supp. 3d at 336.

Defendants also argue that the doctors' injuries would be caused by their patients, rather than the IFR, because those patients will decide whether to comply with the work requirements, find some other way to pay for needed care, or forgo care altogether. Defs.' Br. 12. But as this Court has explained, "[a] causal chain does not fail simply because it has several 'links,' provided those links are not hypothetical or tenuous." *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 146 (D. Md. 2025), *appeal docketed*, No. 26-1938 (4th Cir. July 28, 2026). "What matters is not the 'length of the chain of causation,' but rather the 'plausibility of the links that comprise the chain.'" *Nat'l Audubon Soc'y, Inc. v. Davis*, 307 F.3d 835, 849 (9th Cir. 2002) (quoting *Autolog Corp. v. Regan*, 731 F.2d 25, 31 (D.C. Cir. 1984)). And where third parties are a link in the chain, a plaintiff need only prove that the agency action is "at least in part responsible" for the third parties' actions. *Libertarian Party of Va.*, 718 F.3d at 316.

The IFR will cause injuries to the doctor members of the Organizational Plaintiffs as a result of the "predictable" behavior of third parties in response to the rule. *Diamond Alt. Energy,*

LLC v. EPA, 606 U.S. 100, 116 (2025). The rule will cause about one in ten Medicaid enrollees throughout the country—a number in the millions—to lose health coverage. Pls.' Br., Ex. A, at 6, ECF No. 29-3. When patients lose health coverage, it is predictable that medical providers will take on more uncompensated care. *See* Pls.' Br. 16-17. This demonstrates the Organizational Plaintiffs' standing. *See Phila. Yearly Meeting of Religious Soc'y of Friends v. U.S. Dep't of Homeland Sec.*, 187 F.4th 187, 200 (4th Cir. 2026).

Plaintiffs have shown how the IFR will cause their practices to lose revenue due to taking on more uncompensated care. *See* Pls.' Br. at 16-17 (citing provider declarations). This kind of economic harm is the "classic and paradigmatic form of injury in fact." *Air Evac. EMS, Inc. v. Cheatham*, 910 F.3d 751, 760 (4th Cir. 2018). Defendants contend that the doctors will inflict this harm upon themselves because they could choose not to treat patients who cannot pay. Defs.' Br. 12. Even if the doctors felt free to turn their indigent patients away, the IFR's "constriction of the buyer's market" for their services would still constitute an injury-in-fact. *GenBioPro, Inc. v. Raynes*, 144 F.4th 258, 269 (4th Cir. 2025) (cleaned up). In any event, the Organizational Plaintiffs' members include providers of last resort—who do not have the "choice," as the government misleadingly calls it—to turn away uninsured patients. Lee Decl., ¶¶ 3-4, ECF No. 29-15; Heatherton Decl. ¶ 12, ECF No. 29-19. Just as other providers of last resort were able to challenge rules that predictably increased their costs of uncompensated care, the Organizational Plaintiffs and their members may challenge this rule to protect themselves from these harms. *See Massachusetts v. HHS*, 923 F.3d 209, 225 (1st Cir. 2019); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018).

C. The City of Columbus Has Standing.

The City of Columbus is injured because the IFR will cause many of its residents to lose Medicaid coverage, leaving the City without compensation for health and emergency services it provides. Pls.' Br. 18-19. Defendants seek to cast doubt upon this conclusion, implausibly, by disputing whether anybody would lose coverage at all as a result of the rule. Defs.' Br. 14. Defendants' argument on standing cannot be squared with its argument on the merits that it (purportedly) engaged in reasoned decision making because it acknowledged that its rule would cause Medicaid beneficiaries to lose coverage. *See id.* 33. In any event, none of Defendants' arguments casts doubt on Columbus's standing.

Defendants spill a great deal of ink attacking a Manatt Report (Pls.' Br., Ex. A, ECF No. 29-3), treating it as Columbus's only evidence of the coverage losses that the IFR will cause. They also ask the Court to ignore this report as hearsay. To begin, the City's harms are substantiated through multiple sources in addition to the Manatt Report, including the declaration of its Assistant Public Health Commissioner, which discusses service funding shortfalls for critical public health programs, service reductions, increased administrative burdens, and an increased number of residents unable to access medical care. Johnson Decl. ¶¶ 12-25, ECF No. 29-21.

Nor is the Manatt Report inadmissible hearsay. "The court and the parties have great flexibility with regard to the evidence that may be used on a [summary judgment] proceeding," and courts may consider material that would be admissible, or whose content can be put in admissible form, at trial. *Humphreys & Partners Architects, L.P. v. Lessard Design, Inc.*, 790 F.3d 532, 538-39 (4th Cir. 2015), *as amended* (June 24, 2015) (alteration in original). If there were any doubt on this score, the senior managing director of Manatt Health, who oversaw the publication of the report, has attested to its accuracy. Guyer Decl. (Ex. U, hereto). This "allows the court to

consider the [report] on a motion for summary judgment." *Humphreys & Partners Architects, L.P.*, 790 F.3d at 539. After all, one accepted method for a plaintiff to show injuries that are traceable to a federal regulation is through "statistical analysis," *New York v. Dep't of Com.*, 351 F. Supp. 3d 502, 576 (S.D.N.Y. 2019), *aff'd in relevant part*, 588 U.S. 752, 768 (2019), such as the analysis presented in the Manatt Report.[1]

Moreover, Defendants' critiques undermine neither the Manatt Report's conclusion that about 1.8 million people would lose Medicaid coverage annually as a result of the IFR, Guyer Decl. ¶ 21, nor the approach that Manatt used to arrive at this conclusion, *id*. ¶¶ 7-20. That report was based in part on the coverage losses that were projected under a New Hampshire demonstration project that imposed work requirements on Medicaid beneficiaries. Although Defendants highlight minor distinctions between that project and the IFR, none of those distinctions affects the conclusion that the IFR will lead to widespread coverage losses. *Id*. ¶¶ 10-11, 14, 16, 20; *see also* Stratton Decl. ¶ 8, ECF No. 29-13; Watson Decl. ¶ 18, ECF No. 29-14.

The City has "adequately outlined the predictable results" of the IFR: the rate of uninsured people will go up, straining City resources. *City of Columbus*, 796 F. Supp. 3d at 147 (cleaned up). The IFR will "force[] Columbus to immediately alter its long-term municipal budgetary planning to mitigate the threat of service reductions and/or severe funding shortfalls" at neighborhood health centers and clinics and will cause the City to lose revenue from uncompensated emergency services. Johnson Decl. ¶ 24. The government suggests that the City would not begin to suffer harm from uncompensated care costs until 2028, but this is both inaccurate, *see* Guyer Decl. ¶¶ 18-

[1] Similarly, this Court may in its discretion consider the Guyer Declaration and the Manatt Report under Fed. R. Evid. 702, particularly given that the government has not put forth any contrary evidence to support its remarkable claim that the IFR would not cause any beneficiaries to lose Medicaid coverage. *See United States v. Wood*, 741 F.3d 417, 425 (4th Cir. 2013).

20, and irrelevant; "standing depends on the probability of harm, not its temporal proximity." *Stone v. Trump*, 400 F. Supp. 3d 317, 348 (D. Md. 2019) (internal quotation omitted). The City has standing to challenge a rule that would "increase costs incurred by the City … in the form of shouldering the expense of uncompensated care." *City of Columbus*, 796 F. Supp. 3d at 147-48.

II. The "Medically Frail" Definition Is Contrary to Law and Arbitrary and Capricious under the APA.

A. The Definition Is Contrary to Law.

Congress spoke with unmistakable clarity when it enacted H.R. 1. Any individual "who is medically frail or otherwise has special medical needs" is excluded from the statute's new work requirements. 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). And any individual who falls within one of five categories, such as an individual "with a substance use disorder," is "medically frail or otherwise has special medical needs" and is therefore excluded. *Id*. § 1396a(xx)(9)(A)(ii)(V)(aa)-(ee). CMS refused to honor Congress's instructions. Under the IFR, these individuals cannot qualify for the exclusion unless they also show that their ability to comply with the work requirements is significantly impaired. The rule is plainly contrary to Congress's instructions and should therefore be vacated.

Defendants resist this conclusion on several grounds, none of which is persuasive. *First*, they point repeatedly to the fact that Congress granted CMS the authority to define the phrase "medically frail or otherwise has special medical needs." *See* Defs.' Br. 20; *see also id*. 22, 24, 25, 26. True enough, but Congress also imposed limits that the agency was required to observe. Any definition that the agency chooses must include the individuals who come within the five categories that Congress specified. Even where a statute permits an agency to define a term or a phrase, courts must "independently identify" and "police the outer statutory boundaries" of that delegated authority. *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 404 (2024). Courts, after all,

"have a duty to independently interpret the statute and effectuate the will of Congress," and so may not permit an agency to "adop[t] a definition of a term that is inconsistent with the statute." *Rutherford v. United States*, 608 U.S. 454, 473 (2026).[2] So, even though CMS has a certain degree of discretion to define who is "medically frail or otherwise has special medical needs," it exceeded the "boundaries of the delegated authority," *Loper Bright Enters.*, 603 U.S. at 404, by ignoring the categories of individuals whom Congress specified must fall under that exclusion.

Second, Defendants point to dictionaries that equate the term "frail" with phrases like "physically weak" and infer from those dictionaries that Congress must have meant to limit the exclusion to those who are impaired in their ability to work. Defs.' Br. 20. Their conclusion does not follow; many weak people are able to work, and it is perfectly possible for a physically strong person to face barriers in their ability to hold a job. In any event, Congress did not limit the exclusion to those who are "frail"—it excluded individuals who are "*medically* frail *or* otherwise [have] special *medical* needs." 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V) (emphases added). Congress decided that these individuals have health care needs that are pressing enough that they should maintain coverage regardless of their ability to comply with the work requirements.

Third, when Defendants do get around to acknowledging that Congress specified that certain categories of people must be included in any definition of "medically frail or otherwise has

[2] Defendants also mention a provision that empowers CMS to "specif[y]" the "standards" by which states "determin[e]" whether an individual is excluded from work requirements. Defs.' Br. 19 (citing 42 U.S.C. § 1396a(xx)(9)(A)(ii)). The point of this citation is unclear; CMS did not claim in the IFR that it exercised this authority when it adopted the Significant Impairment Requirement. *See Mayor of Baltimore v. Azar*, 973 F.3d 258, 279 (4th Cir. 2020) (en banc) (agency rule may be upheld "only on the basis upon which the record discloses that its action was based"), *cert. dismissed*, 141 S. Ct. 2618 (2021). In any event, clause (9)(A)(ii) permits CMS to establish a process for making medical frailty determinations, but it does not empower the agency to ignore the statutory minimum for who qualifies as medically frail. *See Chamber of Com. of U.S. v. NLRB*, 721 F.3d 152, 161 (4th Cir. 2013); *City of Columbus v. Kennedy*, 839 F. Supp. 3d 353, 367 (D. Md. 2026), *appeal docketed*, No. 26-1938 (4th Cir. July 21, 2026).

special medical needs," they assert that the statute requires CMS only to include "at least some such persons" within each category, because "a category does not mean that it must include every possible element within that category." Defs.' Br. 20. But that is precisely what the statute instructs; each "individual" who fits within one or more of these categories is excluded. The term "including," after all, "sets a floor, not a ceiling." *Project Vote/Voting for Am., Inc. v. Long*, 682 F.3d 331, 337 (4th Cir. 2012). So, if a conductor instructs her concertmaster to invite the orchestra to an end-of-season party, including the string, brass, and percussion sections, the concertmaster would not honor her wishes if he invited only the violinists, trumpeters, and cymbalists.

Defendants resist this conclusion, noting that in some instances the terms following an "including" clause are best read to be limited to fit within the general category of which they are a part. Defs.' Br. 22 (citing *Hincapie-Zapata v. U.S. Att'y Gen.*, 977 F.3d 1197, 1200–02 (11th Cir. 2020)). As an example, *Hincapie-Zapata* discussed the phrase "any American automobile, including any truck or minivan," which is best read to exclude foreign trucks or minivans. "But this situation only arises when a particular word or phrase from the first clause is implicitly carried forward into the second clause." *Epsilon Elecs., Inc. v. U.S. Dep't of Treasury*, 857 F.3d 913, 922 (D.C. Cir. 2017). "For instance, a statute covering 'any American automobile, including any truck or minivan' would be most naturally read to mean 'any American automobile, including any [American] truck or minivan.'" *Id*. (alteration in original). This example is not useful here, then: there is no limiting term before "including" in subclause (9)(A)(ii)(V) that carries forward to the examples in the text after "including." So, the Court is left with the words of the statute itself, which do not contain the limitations that CMS now seeks to graft on to them. *See Massachusetts v. Oz*, --- F. Supp. 3d ---, 2026 WL 3257397, at *4 (D. Mass. Oct. 29, 2026).

Fourth, Defendants argue that Congress must not have meant what it said because a

straight-forward reading "would result in CMS having less discretion over subclause (V) than over" the other subclauses that set forth exclusions but that do not give CMS the authority to define terms. Defs.' Br. 21. Not so. Congress granted CMS wide authority to add to the list of categories that qualify as medically frail, so long as the agency, at a minimum, included the five categories of individuals that were specified in the statute itself. CMS chose not to exercise that discretion in the IFR, but it retains the power to do so in the future. But this did not authorize the agency to fall beneath the statutory floor.[3]

Fifth, Defendants attempt to minimize the relevance of the differing impairment standards within the categories specified in the Medically Frail Exclusion. As we explained in our opening brief, some of those categories independently require a finding that an individual is functionally impaired. *See* Pls.' Br. 23-25. For example, a person must have a "disabling" mental disorder to be excluded. 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(cc). Or certain disabled individuals must meet a different impairment standard, showing that their disability "significantly impairs their ability to perform 1 or more activities of daily living." *Id*. § 1396a(xx)(9)(A)(ii)(V)(dd). But individuals in other categories need not show any impairment at all. *See id.* § 1396a(xx)(9)(A)(ii)(V)(bb), (ee). CMS's imposition of a categorical, overarching Significant Impairment Requirement for all of the categories in subclause (V) "would eliminate the variation" the statute itself sets forth, and so cannot be squared with the statutory text. *Enbridge Energy, LP v. Nessel*, 146 S. Ct. 1074, 1083 (2026); *see also Bittner v. United States*, 598 U.S. 85, 94 (2023). Defendants resist this conclusion,

[3] For related reasons, Defendants' argument that Congress could have written the statute differently is unavailing. *See* Defs.' Br. 21-22 (proposing alternative language that would also exclude individuals within the five categories from work requirements). That Congress might have achieved the same result through different language is immaterial; this Court "cannot ignore the plain meaning of the statute because Congress could have, arguably, made the statute's meaning even plainer." *Hammer v. U.S. Dep't of Health & Hum. Servs.*, 905 F.3d 517, 528 (7th Cir. 2018).

pointing again to the authority that Congress gave it to define the phrase "medically frail or otherwise has special medical needs." Defs.' Br. 23-24. The agency needed to "land within the statutory goalposts" in exercising that definitional authority. *Rutherford*, 608 U.S. at 472-73. Here, it chose a definition that sailed wide right.

Finally, Defendants ask the Court to ignore CMS's own definition of medical frailty in a different context. As we explained, Pls.' Br. 26-28, Congress exempted any Medicaid beneficiary who "is medically frail or otherwise an individual with special medical needs" from mandatory enrollment in an alternative benefit plan, and it instructed CMS to define that phrase. 42 U.S.C. § 1396u-7(a)(2)(B)(vi). CMS responded with a list of categories of exempt individuals but did not require that all of these individuals be impaired in their ability to work. In H.R. 1, Congress borrowed from that regulatory list when it crafted the Medically Frail Exclusion. Because Congress brought the "old soil" with it when it imported the definition of medical frailty from a different source, the new statute should not be read to include the Significant Impairment Requirement. *See George v. McDonough*, 596 U.S. 740, 746 (2022). Defendants note that H.R. 1 modified the old regulatory definition of medical frailty in certain respects. Defs.' Br. 25. True enough, but those minor modifications served to broaden, not to narrow, the categories of medically frail individuals. *See* Pls.' Br. 27. So, Defendants seek to stand the statute on its head by adopting a less forgiving standard in a circumstance where an individual would lose Medicaid coverage altogether if they are not found to be medically frail.

B. The Definition is Arbitrary and Capricious.

Throughout their brief, Defendants try to avoid accountability for arbitrary and capricious rulemaking by noting that Congress directed CMS to issue an IFR. But authorization to dispense with the notice-and-comment process did not relieve the agency "of the requirement to provide a reasoned explanation" for its action. *Defy Ventures, Inc. v. U.S. Small Bus. Admin.*, 469 F. Supp.

3d 459, 474-75 (D. Md. 2020); *see also Biden v. Missouri*, 595 U.S. 87, 96-97 (2022) (per curiam) (examining whether IFR was arbitrary and capricious).

As for the reasonableness of the Significant Impairment Requirement, Defendants rehash their arguments about the meaning of the statute. For the reasons stated above, those arguments fail. They also claim that the "feedback" CMS received is "consistent with" the Significant Impairment Requirement. Defs.' Br. 28. That is a gross mischaracterization of the comments. Some of the materials they cite do mention functional impairment, but none urge CMS to *restrict* the exclusion to only those individuals whose conditions significantly impair their ability to comply with the work requirements. *See* AR 3885 (indicating the exclusion "does not require someone to show inability to work"), 4038 (urging CMS to define the exclusion broadly and to prohibit states from using ability to work to determine medically frail status), 4802 (arguing that to evaluate whether individuals with a brain injury are medically frail, states should evaluate "functional impact rather than solely … the timing or documentation of an injury"). One of the cited documents is not even about the work requirements, but rather about transportation benefits; it simply recommends that, to help identify individuals who are medically frail, states should ask about "functional limitations in addition to specific illnesses." AR 3804. Defendants also cite to a logic model submitted by a technology company, *see* Defs.' Br. 29, but that model does not link medical frailty to ability to comply with the work requirements. AR 4417. Finally, Defendants cite draft state policies and South Dakota's unapproved 2018 waiver request. These discarded policy plans do not somehow demonstrate that the Significant Impairment Requirement is reasonable. *See* Defs.' Br. 29 (citing AR 4001, 3985).

Defendants' remaining attempts to defend the rationality of CMS's decision-making are unconvincing. *First*, the agency failed to explain why it abandoned its prior factual conclusion that

Medicaid work requirements do not cause an increase in employment. *See* Pls.' Br. 28-30. Defendants say CMS did explain its departure, pointing to a statement in the regulatory impact analysis (RIA). Defs.' Br. 30 (quoting Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348, 33456 (June 3, 2026)). But that statement has nothing to do with the effects of Medicaid work requirements on employment. At most, it indicates why CMS did not use data from states' prior experiences implementing work requirements to estimate coverage loss.[4] Indeed, the RIA was clear that its estimate does not "capture potential behavioral responses, such as increased workforce participation or educational enrollment in response to the requirements." 91 Fed. Reg. at 33456. The RIA statement that Defendants cite simply does not reveal why CMS now believes that Medicaid work requirements will increase employment.

In the same vein, Defendants argue that an article cited in the RIA offered sufficient support for CMS's conclusion that the work requirements will increase employment among individuals described in the Medically Frail Exclusion who do not meet the Significant Impairment Requirement. Defs.' Br. 30. That article assessed how termination of Medicaid for approximately 170,000 people in Tennessee affected the labor supply. AR 3653-3720. It had nothing to do with whether Medicaid work requirements will increase employment, and CMS did not suggest otherwise in the RIA. CMS referred readers to the article for "possible effects of Medicaid participation on work" after noting that the RIA does not account for those effects. 91 Fed. Reg. at 33462 (stating that the RIA "ignores those who work due to exiting the Medicaid program").[5]

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[4] Defendants gloss over the point that CMS's prior factual conclusion was *also* based on "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." AR 945; *see* Defs.' Br. 29. The IFR does not mention this important evidence.

[5] Defendants' claim to the contrary is remarkable. It would mean the agency concluded that the work requirements will increase employment by imposing an across-the-board eligibility cut (*i.e.*, by terminating coverage), not by incentivizing individuals to work.

Second, CMS ignored the negative effects of the Significant Impairment Requirement. *See* Pls.' Br. 30-32. Defendants counter that CMS "robustly discussed enrollment effects" in the RIA. Defs.' Br. 31. But the RIA's estimate of the enrollment effects of the work requirements *overall* does not show that the agency adequately considered the consequences of the Significant Impairment Requirement. *See* Pls.' Br. 32 n.5. Plaintiffs do not, as CMS suggests, argue that the agency was required to "break down which portion of the total projected disenrollment was attributable to each part of the IFR." Defs.' Br. 31. We do contend that CMS needed to acknowledge and grapple with the effects of its decision to impose the Significant Impairment Requirement. *See Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 923 (D.C. Cir. 2017) (holding agency must "examine all relevant factors and record evidence" and "articulate a reasoned explanation for its decision"). As record evidence made clear, those effects include additional coverage loss and worse health outcomes. *See, e.g.*, AR 941, 3867-68, 3912-14, 4002-05, 4317-18, 4774-75, 4784-85 (all describing the serious health consequences medically frail individuals will face if they lose coverage). CMS did not acknowledge, much less grapple with, these "important aspect[s] of the problem." *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).[6]

Third, as we described, CMS failed to offer a satisfactory explanation for why it did not hew to the medical frailty definition in the ABP regulation. Pls.' Br. 32-33. Instead of engaging with that argument, Defendants repeat their position that it was reasonable to limit the Medically Frail Exclusion to individuals who meet the Significant Impairment Requirement. Defs.' Br. 31-32. Defendants do not (and cannot) explain how the differences between the ABP regulation and

[6] Defendants cite *Massachusetts v. Oz*. *See* Defs.' Br. 31. That opinion does not consider whether the Significant Impairment Requirement was arbitrary and capricious. *Massachusetts*, 2026 WL 3257397, at *4 n.7.

the Medically Frail Exclusion could reasonably lead CMS to adopt a narrower definition of medical frailty in the work requirements context. *See* Pls.' Br. 32-33.

In sum, in adopting the Significant Impairment Requirement, CMS failed to "reasonably consider[] the relevant issues and reasonably explain[] the decision" it made. *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

III. The IFR's Separate Limitation on the Substance Use Disorder Category Is Contrary to Law and Arbitrary and Capricious.

A. The Limitation Is Contrary to Law.

Congress declared that any individual "who is medically frail or otherwise has special medical needs" is excluded from work requirements, and it specified that this exclusion must extend to any individual "with a substance use disorder." 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb). In the IFR, however, CMS limited this exclusion 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). CMS's attempt to add an extra-statutory condition to this exclusion cannot be squared with Congress's language and should be vacated.

Defendants concede that an individual in stable recovery is an individual "with a substance use disorder" who falls within the plain language of the exclusion that Congress enacted. Defs.' Br. 27 n.4. They instead assert that CMS may ignore Congress's language because, in its view, it would be "inappropriate" to exclude such an individual. Defs.' Br. 26-27 (quoting 91 Fed. Reg. at 33374). But "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Reg. Grp. v. EPA*, 573 U.S. 302, 328 (2014).

Once again, CMS falls back on its authority to define the phrase "medically frail or otherwise has special medical needs." Defs.' Br. 26. But, as explained above, Congress imposed limits on that authority; CMS holds discretion to define that phrase, but only so long as it follows

the statute's instruction that every individual who is described in one or more of the five categories specified in the statutory text, including every individual "with a substance use disorder," is treated as excluded from the work requirements. *See supra*, at 8-11. Instead, CMS chose a definition that fell outside "the statutory goalposts," *Rutherford*, 608 U.S. at 472-73, and thus, acted contrary to law.

B. The Limitation Is Arbitrary and Capricious.

Limiting the exclusion was also arbitrary and capricious for the reasons we explained in our opening brief. *See* Pls.' Br. 36-37. Defendants' responses do not establish otherwise.

First, CMS justified its action on the basis that imposing the work requirements on individuals in stable recovery will increase employment and thereby "help these individuals maintain their recovery." 91 Fed. Reg. at 33374. But, as with the Significant Impairment Requirement, CMS never explained why it abandoned its prior factual conclusion that Medicaid work requirements do not increase employment. *See* Pls.' Br. 36. As described in section II.B. above, Defendants cannot now fill that gaping hole in the IFR.

Second, the record does not support CMS's conclusion that the work requirements will help individuals "maintain their recovery." Pls.' Br. 37. In arguing otherwise, Defendants doubled down on CMS's selective reading of the single article relied on in the IFR. *See* Defs.' Br. 34; *Genuine Parts Co. v. EPA*, 890 F.3d 304, 313 (D.C. Cir. 2018) (finding it arbitrary for agency to rely on only "portions of studies in the record that support its position, while ignoring" portions that do not). The stated goal of the article is to "present an initial overview of SUD recovery and how the workplace may broadly affect, either positively or negatively, employee recovery." AR 1839. To that end, the authors "present a conceptual model showing how the workplace might impact the SUD recovery process," AR 1839, and "outline a series of general research propositions to guide

future research on how work conditions may support or undermine the process of employee SUD recovery," AR 1841. *See* AR 1855-65 (describing the mechanisms by which the workplace may support or undermine recovery). The article in no way validates CMS's "broader point," Defs.' Br. 34, that forcing individuals in stable recovery to work to keep their Medicaid coverage will aid in their recovery (regardless of the work conditions they find themselves in).

Indeed, if CMS had been "focused on the big picture" as Defendants contend, Defs.' Br. 34, it would have considered obvious drawbacks of its policy, namely, additional coverage loss among individuals with an SUD and the important health and financial consequences identified in comments. *See* Pls.' Br. 37 (citing AR 4002-03). CMS tries to evade that conclusion, arguing: (1) the RIA's estimate of total coverage loss shows it considered these drawbacks; and (2) CMS was not required to consider these drawbacks at all because it issued an IFR. *See* Defs.' Br. 35. The first assertion fails for the same reasons described above. *See supra*, at 15. As for the second assertion, CMS was not free to ignore record evidence it did not solicit. *See supra*, at 12-13. Yet again, the agency did not "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).

IV. The IFR's Limit on the Use of Claims Data Is Arbitrary and Capricious.

Substantial record evidence demonstrated that prohibiting states from using claims data older than 12 months to verify medical frailty would increase coverage loss among individuals with the greatest need for ongoing care, causing serious financial and health harms. In the IFR, CMS did not acknowledge or engage with those critical issues. *See* Pls.' Br. 40-42.

Defendants argue that it was reasonable to limit the use of claims data to balance competing concerns—completing *ex parte* review where possible and "the desire to avoid making designations based on stale data." Defs.' Br. 36. But they point to nothing in the IFR showing that

CMS engaged in that balancing exercise. Further, none of the record evidence that Defendants highlight indicates the agency balanced competing priorities. The logic model submitted by a technology company, *see* Defs.' Br. 35 (citing AR 4417), does not discuss the positives and negatives of a 12-month lookback period. Moreover, the public health researchers' manuscript Defendants cite raised critical issues that CMS ignored. *See* AR 4847-48, 4856 (finding 5,660,065 individuals were automatically excluded with a 12-month lookback, compared to 7,260,275 with 24 months and 8,283,171 with 36 months), AR 4849 (concluding 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"). That the researchers tested lookback periods ranging from three to 36 months, *see* Defs.' Br. 35-36, does not somehow suggest that three months could be reasonable, particularly when their findings reveal the opposite. *See* AR 4847-48, 4856.

In an effort to evade these findings, Defendants argue that the 12-month limit "does not necessarily mean an individual will not be designated as 'medically frail.'" Defs.' Br. 36. That misses the point. The record evidence made clear that the limit will dramatically increase the number of medically frail individuals who are not automatically excluded, and thus, the number of individuals who lose coverage for failure to comply with the work requirements.[7] *See, e.g.*, AR 944, 3893, 4462, 4464-65, 4843-60 (all describing the high risk of erroneous coverage loss among individuals not automatically identified as medically frail). CMS did not grapple with that evidence

[7] Defendants contend that states can use SSDI data to automatically identify someone as medically frail. *See* Defs.' Br. 36. That rationale suffers from several defects. First, it is an impermissible post hoc rationalization. *See Appalachian Voices v. Dep't of Interior*, 25 F.4th 259, 274 (4th Cir. 2022). Second, while SSDI data could identify an individual who is "blind or disabled," it would not identify someone described in one of the other four categories in the Medically Frail Exclusion. In other words, SSDI data will only capture a small percentage of medically frail individuals. *See, e.g.,* AR 4019-20, 4184-85, 4218, 4389, 4778-79, 4797.

at all. (Again, as described in section II.B. above, the RIA's estimate of total coverage loss does not show otherwise. *Contra* Defs.' Br. 36.) Nor did it grapple with the health and financial harms that will flow from the additional coverage loss, which are "important aspects of the problem" that CMS was required to consider. *See Appalachian Voices v. State Water Control Bd.*, 912 F.3d 746, 753 (4th Cir. 2019); Pls.' Br. 41 (citing record evidence).

Finally, Defendants' attempt to untangle the 12-month limit from the Significant Impairment Requirement falls flat given that Defendants *themselves* use the Significant Impairment Requirement to justify the 12-month limit. *See* Defs.' Br. 36 (arguing that "expanding the time window … increases the odds that the diagnostic code no longer reflects a condition" that meets the Significant Impairment Requirement).[8]

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

Defendants argue that the IFR's restrictions on self-attestation are reasonable because of "feedback" urging CMS to prohibit the use of self-attestation altogether. Defs.' Br. 38. But the feedback that Defendants cite does not go to, much less support, CMS's explanation for the restrictions: allowing medically frail individuals to use self-attestation only once will "motivate [them] to access care," which will in turn generate claims data and make it unnecessary for individuals to use self-attestation again. 91 Fed. Reg. at 33406; *see* AR 4753-58 (arguing CMS has the legal obligation to prohibit self-attestation, a position that CMS did not adopt); AR 4053, 4077-

[8] *Massachusetts v. Oz*, cited by Defendants at pages 36 and 38, only briefly discussed similar claims regarding restrictions on the use of claims data and self-attestation. That court upheld the restrictions on the basis that they were "non-frivolous," 2026 WL 3257397, at *5. That is not the standard under the APA. *See, e.g.*, *Schurz Comm'ns, Inc. v. FCC*, 982 F.2d 1043, 1049 (7th Cir. 1992) ("It is not enough that a rule might be rational"; the agency "must show that it is rational—must demonstrate that a reasonable person upon consideration of all the points urged pro and con the rule would conclude that it was a reasonable response to a problem that the agency was charged with solving."). And, while the court concluded that CMS explained "why it did not find … concerns of disenrollment compelling," the portions of the IFR it quoted to support its conclusion do not discuss or even refer to disenrollment. *See Massachusetts*, 2026 WL 3257397, at *5.

78 (simply noting that Guam does not accept self-attestation of medical frailty for ABP purposes). Defendants further assert that the agency balanced concerns raised in comments, Defs.' Br. 38, but CMS did not explain in the IFR that it was weighing competing concerns. *See Appalachian Voices*, 25 F.4th at 274 (refusing to credit post hoc rationalization for agency action). What is more, while CMS points to a single comment expressing opposition to self-attestation generally, *see* Defs.' Br. 38 (quoting AR 4753-58), that could not reasonably outweigh the many comments raising evidence-based concerns about the negative effects of limiting self-attestation.[9]

Faced with this mismatch between the record evidence and the IFR's explanation, Defendants resort to misconstruing Plaintiffs' claims. *First*, Defendants argue that these claims "all rest on the presumption that CMS was required" to allow states to accept self-attestation of medically frail status. Defs.' Br. 39. That is not accurate. Plaintiffs' claims rest on the fundamental administrative law principle that the agency is obligated to "reasonably consider[] the relevant issues and reasonably explain[]" its decision. *Prometheus Radio Project*, 592 U.S. at 423. We did not question whether CMS has the authority to "set the standards by which" states determine medically frail status, Defs.' Br. 39, but rather whether CMS engaged in reasoned decision making when it exercised that authority. *See* Pls.' Br. 38-40.

Second, Defendants mischaracterize our argument that CMS's rationale runs counter to the record evidence. We argued CMS created a solution in search of a problem, as nothing in the record even hints that medically frail beneficiaries need additional motivation to seek care.[10] *See* Pls.' Br.

[9] To be sure, some of those comments raised particular concerns about applicants, as well as beneficiaries with a new condition, *see* Defs.' Br. 38-39, but the concerns were not limited to those groups. *See, e.g.*, AR 4007, 4395, 4460, 4775-79.

[10] While Defendants purport to quote our brief, *see* Defs.' Br. 39 (final paragraph), the quoted language does not appear there. Defendants seem to have confused our brief with the states' brief in *Massachusetts v. Oz*. *See* Pl. States' Mem. in Supp. of Mot. for Partial Summ. J. at 27,

38. Defendants have no answer to that. In arguing that Plaintiffs "accidentally prove the opposite," they twist our brief and ignore the cited evidence. Defs.' Br. 40. Plaintiffs said: "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." Pls.' Br. 38 (emphasis added). As those pages of the record show, Medicaid beneficiaries struggle to get access to care they need for a variety of reasons, including too few providers.

Further, Defendants cannot dismiss the relevance of the lag in claims data. The IFR *did* point to states' use of claims data "as part of its rationale for the self-attestation standards it adopted."[11] Defs.' Br. 40; *see* 91 Fed. Reg. at 33406-07 (claiming its policy is reasonable because "once a beneficiary has enrolled in coverage and started receiving covered services to address their health condition, we expect States will be able to reverify their" medically frail status "on an ex parte basis"). CMS's statement that states cannot use the absence of claims data to find that an individual is not medically frail simply does not speak to why the agency restricted the use of self-attestation. *See* Defs.' Br. 40. In other words, that statement does not support CMS's unsupported assertion that beneficiaries will have no need to use self-attestation more than once during a period of continuous enrollment.

Third, Defendants reframe Plaintiffs' argument that CMS failed to consider a reasonable alternative policy—its existing regulations governing verification of Medicaid eligibility criteria—as an argument that CMS failed to respond to "unsolicited comments in the record." Defs.' Br. 40.

Massachusetts v. Oz, No. 1:26-cv-12962-RGS, (D. Mass. Sept. 1, 2026), ECF No. 104. As a result, Defendants responded to an argument that differed from the one that we advance in this case.

[11] Defendants' contrary claim is perplexing given their argument two pages later that CMS adopted the restrictions for the purpose of generating the claims data states need to automatically identify individuals as medically frail. *See* Defs.' Br. 41-42.

CMS was not free to disregard information in unsolicited comments. *See supra*, at 12-13. Regardless, existing CMS regulations are a "reasonably obvious alternative" that CMS was required to consider "and explain its reasons for rejecting." *Walter O. Boswell Mem. Hosp. v. Heckler,* 749 F.2d 788 (D.C. Cir. 1984) (cleaned up). Nowhere in the IFR did CMS do that. Defendants' post hoc rationalization for why CMS dismissed the existing regulations is impermissible, as well as nonsensical. *See* Defs.' Br. 41 (arguing the existing regulations would not advance CMS's goal of motivating individuals to access care). For example, the existing regulations require states to accept self-attestation from individuals who do not have access to documentation due to homelessness, domestic violence, or a natural disaster. *See* Pls.' Br. 39; 42 C.F.R. § 435.952(c)(3). It is far from clear how removing that requirement will increase utilization of care among medically frail individuals who find themselves in those circumstances. Indeed, if CMS's true goal was to increase utilization of care among individuals with special medical needs, it is hard to see how the agency would advance that goal by terminating coverage for the subset of those individuals who, due to circumstances outside of their control, cannot obtain documentation of their needs.

Finally, Defendants' efforts to dismiss Plaintiffs' claim that CMS "entirely failed" to consider the harmful consequences of its self-attestation policy—additional coverage loss and worse health outcomes among the medically frail population, *see* Pls.' Br. 39-40—fall short for the same reasons described above. *See supra*, at 15.

VI. The Court Should Vacate the Challenged Provisions of the IFR.

Under the APA, "[t]he reviewing court shall … set aside agency action, findings, and conclusions found to be … arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). "To set aside means to vacate. … [V]acatur is by

definition universal." *Am. Fed'n of Teachers v. Dep't of Educ*., 796 F. Supp. 3d 66, 120 (D. Md. 2025) (citing *Corner Post, Inc. v. Bd. of Governors of Fed. Res. Sys*., 603 U.S. 799, 830 (2024) (Kavanaugh, J., concurring)).

Defendants acknowledge vacatur as available relief but nevertheless ask the Court to limit relief to remand without vacatur. Defs.' Br. 42-43. This request should be denied. CMS acted contrary to law when it issued an IFR that added the Significant Impairment Requirement and narrowed the substance use disorder category. "Where agency action is found contrary to law, it is clear that vacatur is required." *City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 772 (D. Md. 2021)); *see also Perez v. Cuccinelli*, 949 F.3d 865, 873 (4th Cir. 2020) (en banc) (requiring vacatur given the agency's misconception of the scope of its legal authority). Further, the APA provides that a reviewing court is bound to "hold unlawful and set aside agency action" that is arbitrary and capricious. 5 U.S.C. § 706(2)(A). "[A] court must 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." *Am. Fed'n of Teachers*, 796 F. Supp. 3d at 89-90 (internal quotation omitted). Vacatur is warranted here.

Remand without vacatur is "an unusual and disfavored remedy." *Green & Healthy Homes Initiative, Inc., v. EPA*, 788 F. Supp. 3d 676, 704 (D. Md. 2025). Under the D.C. Circuit's test, the court considers two factors: "the seriousness of the deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed." *Allied-Signal, Inc. v. U.S. Nuclear Regul. Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993). The Fourth Circuit has not adopted this test, and in any event, it does not support remand without vacatur. As to the first factor, courts "have not hesitated to vacate a rule when the agency has not responded to empirical data or to an argument inconsistent with its conclusion." *Comcast Corp. v. FCC*, 579 F.3d 1, 8 (D.C. Cir. 2009). That is precisely what happened here.

The second factor also weighs in favor of vacatur. Some level of disruption, including costs to the government and confusion among stakeholders, *see* Defs.' Br. at 43-44, occurs any time a government entity is ordered to stop using improper policies. And here, it is the government that created confusion in the first place. CMS's surprise adoption of the IFR's restrictions contradicted the information CMS gave states during months of regular communications and preliminary guidance materials, upon which states made implementation plans. *See* Compl., *Massachusetts v. Oz*, No. 26-12962 (D. Mass. June 29, 2026), ECF No. 1. And in another surprise move, CMS has now announced that it will offer states a "hold harmless" period through June 30, 2027, during which states may choose to suspend denials of eligibility and disenrollments so long as they continue to require beneficiaries to prove their compliance with the new requirements. *See* Letter from Daniel Brillman, CMS Deputy Adm'r. & Dir., to State Medicaid Dirs. (Nov. 13, 2026), https://perma.cc/UZZ5-CYKK. This announcement shows that the agency is perfectly capable of managing any challenges that might arise when a court addresses its illegal behavior.

On the other side of the coin, if the challenged IFR provisions were to remain in effect, this would indisputably disrupt access to essential Medicaid coverage and medically necessary care for millions of medically frail people. *See Stewart v. Azar*, 313 F. Supp. 3d 237, 273 (D.D.C. 2018) (vacating CMS's approval of work requirements project because allowing it to take affect during remand could be "exceptionally disruptive" for beneficiaries, many of whom "suffer from various chronic conditions" and "fear even a temporary implementation … could cause serious harm").

CONCLUSION

Plaintiffs respectfully ask the Court to grant their summary judgment motion, deny Defendants' cross-motion, and vacate the challenged portions of the IFR.

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Respectfully submitted,

/s/ Joel McElvain
Joel McElvain (Bar No. 31673)
Anashua Dutta*
Democracy Forward Foundation
P.O. Box 34553
Washington, D.C. 20043
(202) 935-2082
jmcelvain@democracyforward.org
adutta@democracyforward.org

/s/ Catherine McKee
Catherine McKee*
Jane Perkins*
Katy DeBriere*
National Health Law Program
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
(919) 968-6308
mckee@healthlaw.org
perkins@healthlaw.org
debriere@healthlaw.org

Meghan P. Carter*
Legal Council for Health Justice
17 N. State St., Ste. 900
Chicago, IL 60602
(312) 605-1979
mcarter@legalcouncil.org

Adam Mueller*
Indiana Justice Project
1100 W. 42nd St., Ste. 200
Indianapolis, IN 46208
(317) 912-1135
amueller@injp.org

James M. Smith*
Legal Aid of Western Missouri
4001 Dr. Martin Luther King Jr. Blvd.
Ste. 300
Kansas City, MO 64130
(816) 474-6750
jsmith@lawmo.org

Counsel for Plaintiffs

**Admitted pro hac vice*