No.

In the Supreme Court of the United States

ALEX M. AZAR II, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

CHARLES GRESHAM, ET AL.

ALEX M. AZAR II, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

SAMUEL PHILBRICK, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Social Security Act, 42 U.S.C. 301 *et seq.*, authorizes the Secretary of Health and Human Services to approve "any experimental, pilot, or demonstration project" proposed by a State that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid program. 42 U.S.C. 1315(a). Exercising that authority, the Secretary approved demonstration projects in Arkansas and New Hampshire designed to test whether certain requirements promote those objectives by requiring certain working-age, nondisabled adults to engage in work or skill-building activities (such as job-skills training or general education) as a condition of continued eligibility for Medicaid benefits. The Secretary determined that such requirements may help beneficiaries transition to employer-sponsored or federally subsidized commercial coverage and may lead to improved beneficiary health, which in turn may help States conserve resources that can be redirected to providing other coverage. The court of appeals held the Secretary's approvals unlawful. It concluded that "the principal objective of Medicaid is providing health care coverage," and that the Secretary had failed adequately to consider whether the projects would further that objective. App., *infra*, 9a-10a; see *id.* at 12a-21a. The question presented is as follows:

Whether the court of appeals erred in concluding that the Secretary may not authorize demonstration projects to test requirements that are designed to promote the provision of health-care coverage by means of facilitating the transition of Medicaid beneficiaries to commercial coverage and improving their health.

PARTIES TO THE PROCEEDING

Petitioners in this Court are Alex M. Azar, in his official capacity as Secretary of Health and Human Services; Seema Verma, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; the United States Department of Health and Human Services; and the Centers for Medicare & Medicaid Services—all of which were defendants in the district court, appellants in the court of appeals in Nos. 19-5094 and 19-5293, and appellees in the court of appeals in Nos. 19-5096 and 19-5295.

Respondents in this Court are Charles Gresham, Cesar Ardon, Marisol Ardon, Adrian McGonigal, Veronica Watson, Treda Robinson, Anna Book, Russell Cook, and Jamie Deyo, who were the plaintiffs in the district court and appellees in the court of appeals in Nos. 19-5094 and 19-5096; the State of Arkansas, which intervened as a defendant in the district court and was an appellant in the court of appeals in No. 19-5096; Samuel Philbrick, Ian Ludders, Karin Vlk, and Joshua Vlk, who were plaintiffs in the district court and appellees in the court of appeals in Nos. 19-5293 and 19-5295; and the New Hampshire Department of Health and Human Services, which intervened as a defendant in the district court and was an appellant in the court of appeals in No. 19-5295.

RELATED PROCEEDINGS

United States District Court (D.D.C.):

Gresham v. *Azar*, No. 18-cv-1900 (Apr. 4, 2019)

Philbrick v. *Azar*, No. 19-cv-773 (Aug. 27, 2019)

United States Court of Appeals (D.C. Cir.):

Gresham v. *Azar*, Nos. 19-5094 and 19-5096 (Feb. 14, 2020)

Philbrick v. *Azar*, Nos. 19-5293 and 19-5295 (May 20, 2020)

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The Acting Solicitor General, on behalf of the Secretary of Health and Human Services, et al., respectfully petitions for a writ of certiorari to review the judgments of the United States Court of Appeals for the District of Columbia Circuit in these cases. Pursuant to this Court's Rule 12.4, the United States is filing a "single petition for a writ of certiorari" because the "judgments * * * sought to be reviewed" are from "the same court and involve identical or closely related questions." Sup. Ct. R. 12.4.

OPINIONS BELOW

The opinion of the court of appeals in *Gresham* v. *Azar*, Nos. 19-5094 and 19-5096 (App., *infra*, 1a-19a) is reported at 950 F.3d 93. The opinion of the district court (App., *infra*, 22a-63a) is reported at 363 F. Supp. 3d 165.

The order of the court of appeals in *Philbrick* v. *Azar*, Nos. 19-5293 and 19-5295 (App., *infra*, 20a-21a) is not published in the Federal Reporter but is available at 2020 WL 2621222. The opinion of the district court (App., *infra*, 64a-106a) is reported at 397 F. Supp. 3d 11.

JURISDICTION

The judgment of the court of appeals in *Gresham* was entered on February 14, 2020.

The judgment of the court of appeals in *Philbrick* was entered on May 20, 2020.

On March 19, 2020, the Court extended the time within which to file any petition for a writ of certiorari due on or after that date to 150 days from the date of the lower-court judgment, order denying discretionary review, or order denying a timely petition for rehearing. The effect of that order was to extend the deadline for filing a petition for a writ of certiorari in *Gresham* to July 13, 2020, and to extend the deadline in *Philbrick* to October 17, 2020.

In both *Gresham* and *Philbrick*, the jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

Pertinent statutory provisions are reprinted in the appendix to this petition. App., *infra*, 107a-128a.

STATEMENT

A. Statutory Background

1. The Medicaid program, enacted in 1965 as Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "is a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons," *Bowen* v. *Massachusetts*, 487 U.S. 879, 883 (1988) (citation and internal quotation marks omitted). To participate in Medicaid and receive federal funding, a State must submit a plan for medical assistance that meets various statutory requirements, which must be approved by the Secretary. 42 U.S.C. 1396a(a) and (b). The State's plan, once approved, defines the categories of persons who are eligible for benefits under the plan and the types of medical services that are covered. 42 U.S.C. 1396a(a)(10) and (17). "By 1982 every State had chosen to participate in Medicaid." *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 542 (2012) (*NFIB*).

Since Medicaid's enactment in 1965, federal law has required that participating States' plans cover certain specified benefits for particular populations, while giving States the option to cover certain additional populations, additional benefits, or both. See *NFIB*, 567 U.S. at 541-542. Under the traditional Medicaid program, a State's plan was required to provide coverage for discrete categories of low-income individuals: persons who are disabled or blind, the elderly, children, parents of dependent children, and pregnant women. See *ibid.*; 42 U.S.C. 1396a(a)(10). Beyond those categories of required coverage, States may elect (with the approval of the Department of Health and Human Services (HHS)) to cover additional individuals, services, or both. Indeed, the majority of Medicaid spending is for optional

populations and optional benefits.[1] And even with respect to mandatory coverage, States have substantial discretion to set limits on the amount, scope, and duration of coverage, as long as the care and services are provided in the best interests of the beneficiaries. See, *e.g.*, *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985) (upholding State's decision to reduce the number of annual inpatient hospital days for which the State would pay on behalf of Medicaid recipients).

2. Before 2010, "[t]here [wa]s no mandatory coverage for most childless adults, and the States typically d[id] not offer any such coverage." *NFIB*, 567 U.S. at 575 (opinion of Roberts, C.J.). In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, which provided (as relevant here) that, as of 2014, States would be required to expand their Medicaid programs to cover all individuals under the age of 65 who had incomes up to 133% of the federal poverty level. See *NFIB*, 567 U.S. at 542; ACA Tit. II, Subtit. A, sec. 2001(a)(1)(C), § 1902(a)(10)(A)(i)(VIII), 124 Stat. 271 (42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (Supp. V 2011)). The ACA provided for additional federal funding for most (and initially all) of the increased cost of furnishing that expanded overage; a State that did not expand its Medicaid plan to cover that additional population could lose all of its Medicaid funds. See *NFIB*, 567 U.S. at 542 (citing 42 U.S.C. 1396c (2006); 42 U.S.C. 1396d(y)(1) (Supp. V 2011)).

In *NFIB*, however, a majority of this Court concluded that Congress could not condition a State's traditional

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[1] See, *e.g.*, Medicaid & CHIP Payment & Access Comm'n, *Report to Congress on Medicaid and CHIP* 2, 4, 16 (June 2017), https://go.usa.gov/xfCmY (optional coverage accounted for more than 52% of all Medicaid spending in FY2013).

Medicaid funding on its compliance with that new adult-eligibility expansion requirement. See 567 U.S. at 575-585 (opinion of Roberts, C.J.); *id.* at 671-689 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting (joint dissent)). A different majority of the Court concluded that the ACA provision conditioning a State's traditional Medicaid funding on its adopting the expansion was severable from the rest of the ACA. See *id.* at 585-588 (opinion of Roberts, C.J.); *id.* at 645-646 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). Following *NFIB*, as many States were evaluating whether to participate in the ACA's expansion of adult eligibility, HHS acknowledged that coverage of the expansion population was optional and that States have "flexibility to start or stop the expansion." Centers for Medicare & Medicaid Services (CMS), HHS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* 11 (Dec. 10, 2012) (CMS FAQ), https://go.usa.gov/xmN4j.

3. Although state Medicaid plans generally must comply with the requirements set forth in 42 U.S.C. 1396a, the Secretary may waive the statute's requirements temporarily to allow a State to test variations from the generally applicable requirements. 42 U.S.C. 1315(a)(1). Section 1315 provides in relevant part that, "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" Title XIX of the Social Security Act—*i.e.*, the Medicaid statute—"in a State or States * * * the Secretary may waive compliance with any of the requirements of * * * section 1396a of [Title 42] * * * to the extent and for the period he finds necessary to enable such State or States to carry out such

project." *Ibid.*; see 42 U.S.C. 1315(a)(2)(A) (the Secretary may treat state expenditures for an approved demonstration project as expenditures that are eligible for federal funding even though they would not otherwise qualify).

The waiver authority conferred by Section 1315 predated Medicaid. It was enacted in 1962 to facilitate demonstration projects under other programs governed by the Social Security Act—such as grants to States to provide old-age benefits and the former Aid to Families with Dependent Children (AFDC) program (since replaced by Temporary Assistance for Needy Families (TANF), see 42 U.S.C. 601 *et seq.*). See Act of July 25, 1962, Pub. L. No. 87-543, Tit. I, § 122, 76 Stat. 192 (42 U.S.C. 1315 (1964)). Congress sought to ensure that federal requirements would not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 1589, 87th Cong., 2d Sess. 19 (1962) (Senate Report). When Congress established the Medicaid program in 1965, it amended Section 1315 to authorize waivers of the Medicaid statute's requirements as well. See Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 121(c)(3), § 1115, 79 Stat. 352 (42 U.S.C. 1315 (Supp. I 1965)).

Demonstration projects and accompanying waivers approved under Section 1315 by HHS and its precursor in other federal benefit programs have previously been used to test work requirements that Congress later adopted. By 1996, the Secretary had approved demonstration projects for dozens of States that imposed work requirements as a condition of receiving AFDC benefits. See Rebecca M. Blank, *Evaluating Welfare Reform in the United States*, 40 J. Econ. Literature 1105,

1106 (Dec. 2002) (noting that 27 States had such demonstrations). In an opinion by Chief Judge Friendly, the Second Circuit upheld the approval of such a demonstration project. See *Aguayo* v. *Richardson*, 473 F.2d 1090, 1103-1108 (1973), cert. denied, 414 U.S. 1146 (1974).

Informed by the experience of those demonstration projects, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, which established work and work-related requirements for certain recipients of benefits under both the TANF program that replaced AFDC, 42 U.S.C. 607, and the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, 7 U.S.C. 2015(*o*). Congress also incorporated such requirements to a limited extent in the Medicaid statute itself, providing that a State may terminate the Medicaid benefits of certain adults whose TANF benefits are terminated for failure to comply with TANF's work-related requirements. 42 U.S.C. 1396u-1(b)(3)(A). The experience of the demonstration projects in which States were permitted to experiment with work-related requirements for AFDC was "a major reason why policymakers supported work-oriented welfare reform in the 1990s." Blank 1122.[2]

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[2] Although the TANF, SNAP, and Medicaid statutes use the shorthand label of "work" requirements, 7 U.S.C. 2015(*o*); 42 U.S.C. 607, 1396u-1(b)(3), those requirements may be fulfilled either by working or by engaging in skill-building activities that enhance a person's employability, such as vocational education, community service, and job-skills training. See 7 U.S.C. 2015(*o*); 42 U.S.C. 607(d), 1396u-1(b)(3)(A); 7 C.F.R. 273.24; 45 C.F.R. 261.30.

B. The Present Controversies

The ACA's optional expansion of adult eligibility for Medicaid brought large numbers of working-age, non-disabled adults into States' Medicaid programs. As States began to participate in that expansion, some requested that HHS approve demonstration projects to test work and skill-building requirements. HHS initially denied such requests.[3] HHS later revisited the issue, however, and in 2018 it began approving certain Medicaid demonstrations that incorporated work and skill-building (also called "community engagement," App., *infra*, 4a-5a (citation omitted)) requirements similar to those Congress had adopted in the context of TANF and SNAP.

These cases concern demonstration projects the Secretary approved for two States: Arkansas and New Hampshire. Similar demonstration projects have been approved for seven other States (Arizona, Indiana, Michigan, Ohio, South Carolina, Utah, and Wisconsin), and ten others are pending before HHS (Alabama, Georgia, Idaho, Mississippi, Montana, North Carolina, Nebraska, Oklahoma, South Dakota, and Tennessee).[4]

1. a. *Gresham* concerns the Secretary's approval in 2018 of an amendment requested by Arkansas to an existing demonstration project (Arkansas Works) that HHS had previously approved. App., *infra*, 4a-7a, 129a. The existing project had included a voluntary work-referral program to assist enrollees in seeking employment. *Id.* at 134a-135a. Arkansas had found, however, that its existing

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[3] See, *e.g.*, Letter from Andrew M. Slavitt, Acting Administrator, CMS, to Thomas Betlach, Director, Arizona Health Care Cost Containment Sys. (Sept. 30, 2016) (Arizona 2016 Letter), https://go.usa.gov/xmNDx.

[4] HHS also approved similar demonstrations projects for Kentucky and Maine, but those States have terminated their projects.

voluntary-referral approach was ineffective; although 23% of enrollees who took advantage of the referral became employed, "only 4.7 percent of beneficiaries followed through with the referral" and took advantage of the programs the State offered. *Id.* at 135a.

In June 2017, in light of that experience, Arkansas applied to HHS for approval to amend the existing Arkansas Works program to experiment with work and skill-building requirements. App., *infra*, 3a, 129a-135a. As relevant here, the proposed amendment requires certain adult Medicaid beneficiaries to spend at least 80 hours per month performing activities that include working, looking for work, job-skills training, education, and community service. *Id.* at 13a. The requirement applies only to the ACA's adult-expansion population, and it contains exemptions for beneficiaries who are medically frail or pregnant, are caring for a dependent child under age six, are participating in a substance-treatment program, or are full-time students. *Gresham* Administrative Record (A.R.) 21, 28. Arkansas explained that the proposed changes were expected to "increase the sustainability of the Arkansas Works program," to "test innovative approaches to promoting personal responsibility and work," to "encourag[e] movement up the economic ladder, and [to] facilitat[e] transitions from Arkansas Works to employer-sponsored insurance" or individual coverage offered on an ACA Exchange. *Id.* at 2057; see *id.* at 2058-2120.[5]

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[5] In addition to the work and skill-building requirements, Arkansas's demonstration project includes a provision that limits retroactive Medicaid coverage to a period of 30 days. App., *infra*, 136a. That limitation is "intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick." *Ibid.*; see *id.* at 142a.

In March 2018, the Secretary approved Arkansas's proposed amendments (with modifications not at issue here) for a three-year period beginning June 1, 2018. App., *infra*, 4a-6a, 129a-143a; see *id.* at 6a (work requirements to take effect in January 2019 for those aged 20-29). HHS's approval letter observed that the work and skill-building requirements would (among other things) "facilitate transitions between and among" Arkansas's Medicaid program, commercial (including employer-sponsored) insurance, and coverage through the Exchange established under the ACA. *Id.* at 130a; see *Gresham* A.R. 14-15.

b. In August 2018, the plaintiffs in *Gresham* (who are respondents here)—nine Arkansas Medicaid beneficiaries—brought suit challenging the Secretary's approval of the 2018 amendments to Arkansas's demonstration project, including its work and skill-building requirements. App., *infra*, 6a, 22a-24a, 33a; *Gresham* Am. Compl. ¶¶ 13-21. Arkansas intervened to defend its project. *Gresham* D. Ct. Docket entry (Sept. 6, 2018). In March 2019, after the 2018 amendments had been in effect for nearly ten months, the district court granted summary judgment for the plaintiffs, vacated the Secretary's approval of the amendments, and remanded to the agency for further proceedings. App., *infra*, 22a-59a.

The district court in *Gresham* relied on two decisions it had issued in related litigation challenging the Secretary's approval of a demonstration project in Kentucky. See App., *infra*, 24a-25a, 37a-52a (discussing *Stewart* v. *Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018) (*Stewart I*), and *Stewart* v. *Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019) (*Stewart II*), appeal dismissed, Nos. 19-5095 and 19-5097 (D.C. Cir. Jan. 8, 2020)). In *Stewart I*, the court vacated HHS's

approval of Kentucky's demonstration project that included similar work and skill-building requirements. 313 F. Supp. 3d at 250-274. The court concluded that the agency had not adequately considered "the effect of [the] demonstration project on the State's ability to help provide medical coverage," which the court identified as the principal objective of the Medicaid statute. *Id.* at 272; see *id.* at 259-274.

On remand, HHS reopened the comment period regarding Kentucky's proposed demonstration project, and in November 2018, after reviewing additional comments, it reapproved the project. See Letter from Paul Mango, Chief Principal Deputy Administrator and Chief of Staff, CMS, to Carol H. Steckel, Commissioner, Kentucky Dep't for Medicaid Servs. (Nov. 20, 2018), https://go.usa.gov/xwHTq. In March 2019, the district court in *Stewart II* again granted summary judgment to the plaintiffs and vacated HHS's reapproval. See *Stewart II*, 366 F. Supp. 3d at 135-156. The court acknowledged the Secretary's determination that work and skill-building requirements are likely to advance the statutory objective of providing coverage. See *id.* at 134, 148. As the agency had explained, by facilitating the transition of adults from Medicaid to commercial coverage, such requirements enhance the fiscal sustainability of a State's Medicaid program and free up scarce resources that may be used to provide coverage to other needy persons—including optional coverage for the ACA's adult-expansion population itself. See *ibid.* The court also agreed that HHS may "take into account fiscal sustainability in determining under [Section 1315] whether a demonstration project promotes the objectives of the Act." *Id.* at 149. But the court concluded that the Secretary may not approve a demonstration

project based on that rationale without making a finding supported by substantial evidence that the project will in fact result in savings for the State. *Ibid.*

In its decision in *Gresham*, issued the same day as *Stewart II*, the district court similarly concluded that HHS had failed adequately to address "whether and how [Arkansas's] project would implicate the 'core' objective of Medicaid: the provision of medical coverage to the needy." App., *infra*, 51a. The *Gresham* court acknowledged the government's contention that the work and skill-building requirements, like those in Kentucky, will "help adults 'transition from Medicaid to financial independence,' thereby enhancing 'the fiscal sustainability of Arkansas's Medicaid program'—an objective of the Act." *Id.* at 49a (citation omitted). But the court rejected that contention. *Id.* at 49a-51a. The court first reasoned that HHS's letter approving Arkansas's demonstration project had not specifically articulated the fiscal-sustainability rationale on which the agency had elaborated in its letter reapproving Kentucky's demonstration project. *Id.* at 59a. But the court nevertheless went on to address that contention on its merits and rejected it for the reasons stated in its simultaneous decision in *Stewart II*. *Id.* at 50a.

2. a. *Philbrick* concerns the Secretary's approval in 2018 of an amendment requested by New Hampshire to an existing demonstration project (now called Granite Advantage) that HHS had previously approved and through which New Hampshire had provided coverage for the ACA's optional expansion population. App., *infra*, 70a. New Hampshire proposed to add a requirement that certain adult Medicaid beneficiaries spend 100 hours per month in work or skill-building activities like those required under the Arkansas project. See *id.* at

150a. As in Arkansas's project, that requirement applies only to the ACA's adult-expansion population, and it is subject to exemptions similar to those in the Arkansas project. See *ibid.* In November 2018, the Secretary approved the New Hampshire project for a five-year period beginning January 1, 2019. See *id.* at 144a-171a.[6]

b. In March 2019, the plaintiffs in *Philbrick* (who are respondents here)—four New Hampshire Medicaid beneficiaries—brought suit challenging the Secretary's approval of New Hampshire's demonstration project. App., *infra*, 75a; *Philbrick* Compl. ¶¶ 16-19. The New Hampshire Department of Health and Human Services intervened to defend its project. *Philbrick* D. Ct. Docket entry (Apr. 25, 2019). Following its decisions in *Stewart II* and *Gresham*, the district court granted summary judgment for the *Philbrick* plaintiffs and vacated the Secretary's approval of New Hampshire's demonstration project. See App., *infra*, 64a-106a.

As in its prior decisions, the district court in *Philbrick* concluded that the Secretary had "failed to adequately consider" the "core objective of the Medicaid Act" of "furnish[ing] health-care coverage to the needy." App., *infra*, 80a; see *id.* at 79a-98a. And as in *Gresham*, the court again relied on its decision in *Stewart II* in rejecting the government's contention that work and skill-building requirements advance that objective by enhancing the fiscal sustainability of a State's Medicaid program and by facilitating the transition of Medicaid recipients to other coverage. See *id.* at 90a-97a. The *Philbrick* court "offer[ed] an abbreviated restatement of" that reasoning. *Id.* at 80a.

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[6] New Hampshire's project also includes a limitation on retroactive coverage. App., *infra*, 144a.

3. The federal government and the States appealed.[7]

a. The court of appeals in *Gresham* affirmed. App., *infra*, 1a-19a. It agreed with the district court that "the principal objective of Medicaid is providing health care coverage." *Id.* at 9a-10a; see *id.* at 9a-12a. The court of appeals concluded that, in approving Arkansas's demonstration project under Section 1315, the Secretary had focused instead on "three alternative objectives": "'improving health outcomes,'" "'address[ing] behavioral and social factors that influence health outcomes,'" and "'incentiviz[ing] beneficiaries to engage in their own health care and achieve better health outcomes.'" *Id.* at 12a (citation omitted). The court concluded that those goals are not objectives of the Medicaid program in and of themselves within the meaning of Section 1315. *Id.* at 13a.

The court of appeals then addressed the government's contention that the work and skill-building requirements would promote the objective of providing health coverage by facilitating transitions of Medicaid beneficiaries to commercial coverage and, in turn, enhancing the fiscal sustainability of Arkansas's Medicaid program and enabling the State to spend scarce resources on other needy individuals. App., *infra*, 13a-16a. The court read HHS's approval letter not to have relied on that rationale in approving Arkansas's demonstration project, stating that the letter did not discuss commercial coverage and describing the rationale as a "post hoc rationalization[]." *Id.* at 14a; see *id.* at 13a-14a. But instead of remanding for the agency

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[7] The federal government and Kentucky also appealed the district court's judgment in *Stewart II*, and that appeal was briefed and argued together with *Gresham*. But the *Stewart II* appeal became moot when Kentucky terminated the demonstration project at issue in that case. App., *infra*, 7a.

to provide additional explanation concerning that rationale, the court proceeded to address and reject that rationale on its merits. *Id.* at 14a-16a.

The court of appeals held that the Secretary could not properly "have rested his decision on the objective of transitioning beneficiaries away from government benefits through either financial independence or commercial coverage." App., *infra*, 14a. The court did not question the central premises of the government's argument on this point: that States' Medicaid dollars are finite; that requirements that help beneficiaries transition to commercial coverage free up scarce resources, which can then be used to provide health-care coverage to other needy persons; and that the demonstration's requirements may facilitate such transitions. See *id.* at 14a-16a. Instead, the court held that HHS could not rely on "financial independence or transition to commercial coverage" because those goals are not themselves statutory objectives of the Medicaid program. *Id.* at 16a; see *id.* at 14a-16a. The court stated that "[t]he text of the statute includes one primary purpose, which is providing health care coverage." *Id.* at 16a. And it noted that, unlike in the TANF and SNAP programs—where Congress has enacted work and work-related requirements—in the Medicaid statute "Congress has not conditioned the receipt of Medicaid benefits on fulfilling work requirements or taking steps to end receipt of governmental benefits." *Id.* at 14a.

Having thus "defined" "the objective of Medicaid," the court of appeals held that the Secretary's approval of Arkansas's demonstration project was arbitrary and capricious for failing to consider the potential effect of such requirements on coverage. App., *infra*, 16a; see *id.* at 16a-19a. The court cited public comments during

the approval process that had described "the potential for substantial coverage loss" and data postdating the Secretary's approval of Arkansas's project indicating that approximately one-fourth of beneficiaries subject to the work requirement lost coverage following its implementation. *Id.* at 16a-17a. The court did not separately analyze the demonstration's limit on retroactive coverage, see p. 9 n.5, *supra*, but it affirmed the judgment vacating that aspect as well.

b. The appeals in *Philbrick* were held in abeyance pending the court of appeals' decision in *Gresham*. Following the court's decision in *Gresham*, the government moved unopposed for summary affirmance in *Philbrick*, without prejudice to seeking further appellate review. App., *infra*, 20a-21a. The government observed that *Gresham* had "rejected the agency's view" that "'healthy outcomes, financial independence [and] transition to commercial coverage'" are "valid objectives for a demonstration project because they are potential means of achieving the concededly valid purpose of providing more health care coverage to the needy in a world of limited resources." *Philbrick* Gov't C.A. Mot. for Summ. Affirmance 4 (Mar. 12, 2020) (citation omitted). A panel of the court of appeals, which included the author of the *Gresham* decision, granted the motion, citing the government's acknowledgment that "the disposition of this case is controlled by" *Gresham*. App., *infra*, 20a-21a.

REASONS FOR GRANTING THE PETITION

In establishing the Medicaid program, Congress prescribed a wide range of requirements that a State's Medicaid program must satisfy. 42 U.S.C. 1396a. But Congress also authorized the Secretary to approve experiments by States that in the Secretary's judgment

are "likely to assist in promoting the objectives" of Medicaid and to "waive compliance with any of the requirements" in Section 1396a that he "finds necessary to enable" such an experiment. 42 U.S.C. 1315(a)(1). Notwithstanding that broad statutory authority, the court of appeals has concluded that the Secretary may not exercise his power to permit a State to test requirements designed to free up scarce Medicaid resources, which allows the State to provide coverage to other needy persons.

The court of appeals' decisions are incorrect and warrant this Court's review. The court's holding that HHS may not approve requirements that may serve as means to the ultimate end of providing coverage reflects a fundamental misreading of the statutory text and context. And its conclusion that work and skill-building requirements specifically are impermissible objects of experimentation in this context cannot be squared with history. Following past experiments with such requirements in another federal benefit program—approved under the same statutory authority, Section 1315—Congress codified such requirements in other statutes.

The court of appeals' holding that Section 1315 does not permit such demonstration projects also casts a shadow on multiple other States' approved or pending demonstration projects. And its reasoning threatens to impede innovations that may make States' Medicaid programs more effective and sustainable. Nor is there any reason to await conflicting decisions from other courts: under the applicable venue statute, future plaintiffs will have the ability and incentive to bring suit in the same district. The petition for a writ of certiorari should be granted.

I. THE COURT OF APPEALS' DECISIONS INVALIDATING THE DEMONSTRATION PROJECTS ARE INCORRECT

The court of appeals concluded that the Secretary may not approve a Medicaid demonstration project under 42 U.S.C. 1315 to test whether work-related and other requirements can serve as a means of achieving the objective of providing health coverage. App., *infra*, 12a-16a. That conclusion is incorrect and rests on a basic misunderstanding of Section 1315's text, context, and purpose.

A. The Secretary Has Broad Statutory Authority To Approve Projects To Test Features That In His Judgment Are Likely To Assist In Promoting The Objectives Of Medicaid

As a condition of participating in the Medicaid program and receiving federal financial assistance, the Medicaid statute requires a State to submit a plan for its program that comports with a wide array of detailed statutory requirements. See 42 U.S.C. 1396a. As it had done in the context of other federal benefit programs, however, Congress recognized that allowing experimentation with variations from those requirements could yield lessons and experience that might improve the Medicaid program itself. Section 1315 authorizes the Secretary to approve experiments, called "demonstration project[s]," designed to test variations that might better serve the Medicaid statute's overarching aims. 42 U.S.C. 1315(a). It provides in relevant part:

> In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of * * * [Title XIX of the Social Security Act, *i.e.*, the Medicaid statute] * * * in a State or States—

> (1) the Secretary may waive compliance with any of the requirements of section * * * 1396a of this title * * * to the extent and for the period he finds necessary to enable such State or States to carry out such project.

42 U.S.C. 1315(a)(1).

That conferral of authority is conspicuous for its breadth and for the discretion it entrusts to the agency. Section 1315(a) permits "any * * * demonstration project" that the Secretary deems "likely to assist in promoting the objectives of" Medicaid. 42 U.S.C. 1315(a). And it authorizes waiving compliance with "any * * * requirements" imposed by Section 1396a "to the extent and for the period [the Secretary] finds necessary." 42 U.S.C. 1315(a)(1). The text makes clear Congress's intent to give the Secretary broad discretion to authorize experiments in this context. The provision's history confirms that intention. See Senate Report 19 (Section 1315(a) was enacted to ensure that federal requirements would not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients").

The wide latitude that Section 1315's text accords the Secretary leaves a correspondingly limited role for courts. The provision's text permitting the Secretary to approve any project that, "in the judgment of the Secretary," is "likely to assist in promoting the objectives" of Medicaid, 42 U.S.C. 1315(a), and to determine the scope and duration of waivers of the statutory requirements as he "finds necessary," 42 U.S.C. 1315(a)(1), "exudes deference" to the Secretary's determination. *Webster* v. *Doe*, 486 U.S. 592, 600 (1988). And Section 1315's language referring to a project the Secretary deems "likely to assist in promoting" Medicaid's objectives (42 U.S.C. 1315(a)) calls

for an "agency's predictive judgment," which this Court has long recognized "merits deference." *FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 521 (2009); see *FCC* v. *National Citizens Comm. for Broad.*, 436 U.S. 775, 813-814 (1978). The statutory text and context thus establish that any judicial review of the Secretary's determination must be highly deferential.

The appropriate degree of deference is greater still because demonstration projects are time-limited experiments that can "influence policy making at the State and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other States." *Medicaid Program; Review and Approval Process for Section 1115 Demonstrations*, 77 Fed. Reg. 11,678, 11,680 (Feb. 27, 2012). The purpose of such experiments is not to impose permanent policies that the agency has concluded will achieve a particular outcome, but instead to test a hypothesis. And an experiment can further the statute's goals whether or not it yields the results the agency anticipates—either by validating a hypothesis that might lead to new innovations, or by refuting a hypothesis, helping Congress and HHS avoid mistaken policies. Demonstrations "can document policies that succeed or fail," and "the degree to which they do so informs decisions about the demonstration at issue, as well as the policy efforts of other States and at the Federal level." *Id.* at 11,679; accord *C.K.* v. *New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171, 187 (3d Cir. 1996) (Section 1315 "experiments are supposed to demonstrate the failings or success of such programs"). The costs and risks of such experimentation are much smaller at the state level than on a nation-

wide basis, and the experiments take place under a statute that affords States flexibility in designing their own Medicaid programs to begin with.

Any judicial review of decisions approving demonstration projects is accordingly circumscribed. As Chief Judge Friendly observed in *Aguayo* v. *Richardson*, 473 F.2d 1090 (2d Cir. 1973), cert. denied, 414 U.S. 1146 (1974), "it is legitimate for an administrator to set a lower threshold for persuasion when he is asked to approve a program that is avowedly experimental and has a fixed termination date than a proposal * * * which is irreversible." *Id.* at 1103 (footnote omitted); see *id.* at 1103-1108 (upholding approval under Section 1315 of a demonstration project that established work requirements for AFDC recipients). Judicial review consists only of asking "whether the Secretary had a rational basis for determining" that the demonstrations at issue were "'likely to assist in promoting'" the objective of providing health care coverage. *Id.* at 1105.

B. The Secretary Properly Approved Demonstration Projects To Test Work And Other Requirements That Might Enable States To Stretch Scarce Medicaid Resources Further

1. The Secretary acted well within his broad authority under Section 1315 in approving Arkansas's demonstration project at issue in *Gresham* and New Hampshire's project at issue in *Philbrick*. The court of appeals stated that "the principal objective of Medicaid is providing health care coverage." App., *infra*, 9a-10a (citing 42 U.S.C. 1396-1). Assuming arguendo that providing such coverage is the exclusive objective of the Medicaid program, the Secretary has appropriately determined that testing measures designed to help States stretch their Medicaid dollars—in turn enabling States to expand or maintain coverage for needy individuals—

is "likely to assist in promoting" (42 U.S.C. 1315(a)) that objective.

A State's provision of health-care coverage through its Medicaid program depends on finite state resources. That is why Congress authorized federal financial assistance for States. That understanding is also reflected in the very provision on which the court of appeals relied. Section 1396-1 authorizes federal funding "[f]or the purpose of enabling each State, *as far as practicable under the conditions in such State*, to furnish" both "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services," and certain "rehabilitation and other services" for "such families and individuals." 42 U.S.C. 1396-1 (emphasis added).

As this Court has recognized, requirements that enable States to stretch limited resources promote the objectives of public-welfare programs. In upholding a State's work requirements in the context of the AFDC program, this Court emphasized that States may "attempt to promote self-reliance and civic responsibility" in order "to assure that limited state welfare funds be spent on behalf of those genuinely incapacitated and most in need, and to cope with the fiscal hardships enveloping many state and local governments." *New York State Dep't of Soc. Servs.* v. *Dublino*, 413 U.S. 405, 413 (1973). A plurality of the Court echoed that understanding in the context of Medicaid in *Pharmaceutical Research & Manufacturers of America* v. *Walsh*, 538 U.S. 644, 666-667 (2003), which upheld drug-rebate and prior-authorization requirements that were designed to keep borderline populations out of Medicaid and thus conserve scarce state resources.

Opportunities for stretching limited state resources are particularly significant in the context of Medicaid, given the discretion the statute affords to States to tailor their Medicaid programs. Although coverage for certain categories of individuals and for certain benefits is mandatory, States are otherwise generally free to provide additional coverage. Indeed, the majority of Medicaid spending goes toward optional benefits and populations that States have elected but are not required to cover—including, of particular relevance here, the adult-expansion population that became optional as a result of this Court's decision in *NFIB*. See pp. 3-4, *supra*. And even with respect to coverage that is mandatory, the Medicaid statute gives States significant latitude to determine the amount, scope, and duration of coverage, see *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985), and the rates they pay providers, see *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 328 (2015); see also App., *infra*, 147a n.1 (noting States' "considerable flexibility in the design of their Medicaid programs," including to provide optional coverage).

Every Medicaid dollar a State saves is a dollar that it can spend providing coverage for additional individuals or providing additional benefits. Savings also may enable a State that faces financial strain and is considering paring back its optional coverage to continue providing some or all of that coverage. Demonstration projects that test whether particular adjustments to the Medicaid statute's default requirements can yield such savings in a manner compatible with the broader statutory framework thus can "assist in promoting" the "objective[]" (42 U.S.C. 1315(a)) of providing coverage. As HHS explained, demonstration projects "provide an op-

portunity for [S]tates to test policies that ensure the fiscal sustainability of the Medicaid program, better 'enabling each [S]tate, as far as practicable under the conditions in such [S]tate' to furnish medical assistance, while making it more practicable for [S]tates to furnish medical assistance to a broader range of persons in need." App., *infra*, 146a; see *id.* at 165a.

2. The Secretary acted well within his discretion under Section 1315 in determining that the Arkansas and New Hampshire demonstration projects are likely to assist in promoting Medicaid's objectives. The challenged work and skill-building requirements test whether such requirements can help States stretch their limited Medicaid resources further. App., *infra*, 145a-148a, 153a-156a; see *id.* at 129a-136a.

a. Both demonstration projects require certain working-age, nondisabled adults to engage in a specified number of hours of work or skill-building activities (such as job-skills training or education). See App., *infra*, 130a-132a, 148a-150a. Arkansas's project, for example, requires individuals within the ACA's expansion population (subject to various exemptions) to spend at least 80 hours per month working or performing other activities such as seeking work, job-skills training or other education, or community service. See *id.* at 130a; see also *id.* at 149a-150a (New Hampshire project requiring 100 hours per month, subject to similar limitations and exemptions).

Those requirements are modeled on work requirements that have been statutory conditions of eligibility since 1996 for cash assistance under the TANF program and food assistance under SNAP—conditions that Congress enacted following demonstration projects experi-

menting with such requirements under the AFDC program that TANF replaced. See pp. 6-7, *supra*. Under TANF, a State may require 30 hours per week of qualifying activities for a one-parent family (on average, 120 hours per month) and 35 hours per week (140 hours per month) for a two-parent family. 42 U.S.C. 607(c); 45 C.F.R. 261.30-261.32; see 42 U.S.C. 1396u-1(b)(3)(A). The Medicaid statute itself incorporates TANF's requirement to an extent, permitting a State to terminate the Medicaid benefits of certain adults whose TANF benefits are terminated for failure to comply with TANF's work-related requirements. 42 U.S.C. 1396u-1(b)(3)(A). And under SNAP, able-bodied adults without dependents must engage in at least 20 hours per week (on average, 80 hours per month) of work or certain other activities to receive SNAP benefits for more than three months in a 36-month period. 7 U.S.C. 2015(*o*); 7 C.F.R. 273.24.

b. As HHS explained, demonstration projects under Medicaid enable the States to test whether and to what extent such work and skill-building requirements can help enable a State "to stretch its limited Medicaid resources." App., *infra*, 155a. Enabling a State to conserve its resources, HHS observed, "w[ould] assist in ensuring the long-term fiscal sustainability of the program and preserving the health care safety net for those * * * residents who need it most." *Id.* at 155a-156a. And it could "allow[] [a] [S]tate to provide services to Medicaid beneficiaries that it could not otherwise provide." *Id.* at 156a. For example, New Hampshire had informed HHS that, without the ability to undertake the demonstration project, it would be required to terminate coverage of the expansion population. *Id.* at 155a. HHS found that "[i]t furthers the Medicaid program's

objectives to allow [S]tates to experiment with innovative means of deploying their limited state resources in ways that may allow them to provide services beyond the legal minimum." *Id.* at 156a; see *id.* at 165a.

HHS has identified two potential ways by which work and skill-building requirements could help enable States to stretch limited Medicaid resources, which the demonstration projects would test.

i. First, including those requirements would "help the [S]tate[s] and CMS evaluate whether" they enable non-exempt adults in the expansion population to "transition from Medicaid to financial independence and commercial insurance." App., *infra*, 151a. The requirements are designed to give covered individuals a strong incentive to acquire the skills and experience needed for sustained employment. See *id.* at 132a-136a, 145a-147a, 151a-153a, 159a. Sustained employment may in turn cause a Medicaid beneficiary's income to increase above the threshold for Medicaid eligibility—approximately $17,600 for a single-person household—freeing up the funds the State would otherwise spend providing coverage to that individual to provide coverage for others. See *id.* at 153a, 155a-156a; see also 42 U.S.C. 1396(e)(14)(I), 1396a(a)(10)(A)(i)(VIII); CMS, HHS, *Federal Poverty Level (FPL)*, https://go.usa.gov/xwt9D.

As HHS further explained, an individual who loses eligibility for Medicaid because he or she obtains sustained employment and increased income may obtain commercial health-care coverage. App., *infra*, 153a. The individual "may receive an offer of employer-sponsored insurance." *Ibid.* Alternatively, the individual may obtain federally subsidized coverage through an Exchange. *Ibid.* To make such coverage more affordable, Con-

gress has authorized billions of dollars in annual premium tax credits to help individuals pay for insurance sold on the Exchanges. See 26 U.S.C. 36B. The vast majority (approximately 87%) of people who buy coverage on an Exchange do so with tax credits. See *King* v. *Burwell*, 135 S. Ct. 2480, 2493 (2015). For example, for individuals whose household income is below 200% of the federal poverty level, the tax credit covers approximately 80% of the premium.[8]

HHS determined that, if the work and skill-building requirements operate as intended—by "help[ing] individuals achieve financial independence and transition into commercial coverage"—then "the demonstration[s] may reduce dependency on public assistance while still promoting Medicaid's purpose of helping [S]tates furnish medical assistance by allowing [the States] to stretch [their] limited Medicaid resources." App., *infra*, 155a. "[A]llow[ing] [S]tates to experiment" with the requirements to examine whether in fact they function in that fashion thus "furthers the Medicaid program's objectives." *Ibid.*

ii. Second, HHS determined that work and skill-building requirements may lead to increased health and wellness of beneficiaries, which in turn reduces the cost of providing them health-care coverage. See App., *infra*, 145a-156a, 151a-154a. As HHS explained, "measures designed to improve health and wellness may reduce the volume of services furnished to beneficiaries, as healthier, more engaged beneficiaries tend to receive fewer medical services and are generally less costly to cover." *Id.* at 146a. "Promoting improved health and wellness" thus

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[8] See Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 19-20 (Nov. 30, 2009), https://go.usa.gov/xpfCH.

"ultimately helps to keep health care costs at more sustainable levels," further enabling a State to "stretch its limited Medicaid resources." *Id.* at 155a. And an overarching purpose of "furnish[ing] medical assistance and other services to vulnerable populations" is "advancing the health and wellness of the individual receiving them." *Id.* at 145a.

As HHS has additionally explained, "research has shown" that the types of activities required by the work and skill-building requirements are "correlated with improved health and wellness." App., *infra*, 133a-134a. And "CMS has long supported policies that recognize meaningful work as essential to," among other things, the "well-being" and "improved health of people with disabilities." *Id.* at 134a. HHS accordingly determined that States "should be able to design and test incentives," including work and skill-building requirements, for Medicaid beneficiaries to undertake those activities, potentially resulting in improved health for beneficiaries and lower per capita costs for States. *Ibid.*[9]

Permitting States to experiment with that approach comported with Congress's own judgments and HHS's past practice. In the ACA, Congress authorized grants for States that give Medicaid beneficiaries incentives for various "healthy behaviors," including "[c]easing use

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[9] Recent research during the COVID-19 pandemic indicates that factors such as a lack of economic participation, social isolation, and other economic stressors have negative impacts on mental and physical health. See, *e.g.*, Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, Kaiser Family Found. (Apr. 21, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/. Structured properly, community-engagement incentives and requirements that increase such participation may have a positive effect on beneficiary health and economic mobility.

of tobacco products," "[c]ontrolling or reducing their weight," "[l]owering their cholesterol," or "[a]voiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition." ACA Tit. IV, Subtit. B, § 4108(a), 124 Stat. 561-562. In 2012, HHS had encouraged States to develop demonstration projects "aimed at promoting healthy behaviors" and "accountability tied to improvement in health outcomes." CMS FAQ 15. And in 2016, HHS approved an Arizona project requiring Medicaid recipients to pay premiums, which recipients could avoid by adopting healthy behaviors.[10]

The Secretary thus had an ample basis to determine that permitting the States to test the work and skill-building requirements is "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. 1315(a). Under the statute's plain terms, nothing more was required.

C. The Court Of Appeals Fundamentally Misconstrued The Secretary's Authority Under 42 U.S.C. 1315

The court of appeals nevertheless concluded that the Secretary exceeded his authority under 42 U.S.C. 1315 by allowing the States to test whether work and skill-building requirements (among others) advance the Medicaid statute's objectives. App., *infra*, 9a-16a, 20a-21a. That conclusion rests on a basic misunderstanding of Section 1315.

1. The court of appeals in *Gresham* began from the premise that "the primary objective of Medicaid is to provide access to medical care." App., *infra*, 12a. Even assuming arguendo that providing access to medical care is the program's exclusive objective, the court mistakenly

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[10] Arizona 2016 Letter 1-3. As noted above, in its 2016 letter, HHS declined to approve a work requirement. *Ibid.*; see p. 8 n.3, *supra*.

concluded that in exercising his authority under Section 1315 the Secretary must focus exclusively on "providing health care coverage" simpliciter and not on measures that may be means to that end. *Id.* at 9a-10a; see *id.* at 12a-16a. The court held that the Secretary could not lawfully "rest[] his decision" to allow the testing of work and skill-building requirements "on the objective of transitioning beneficiaries away from government benefits through either financial independence or commercial coverage." *Id.* at 14a. Doing so, the court reasoned, would contravene Medicaid's "one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence, or transition to commercial coverage." *Id.* at 16a.

That remarkably cramped reading of the Secretary's authority cannot be reconciled with Section 1315. Nothing in that provision precludes the Secretary from approving demonstration projects to test measures that may help indirectly advance the Medicaid objective of providing coverage. To the contrary, the text authorizes "any * * * demonstration project which, in the judgment of the Secretary, is *likely to assist in promoting* the objectives of" Medicaid. 42 U.S.C. 1315(a) (emphasis added). That language naturally encompasses measures that are means to achieve the Medicaid objective of furnishing medical assistance.

Context reinforces that reading. Section 1315 authorizes experiments to test whether particular adjustments to the default Medicaid requirements advance the statute's aims. In that setting, it makes perfect sense that Congress allowed projects to evaluate measures one step removed from the provision of coverage itself. It is implausible, moreover, that Congress failed to appreciate

the potential interplay of various aspects of a State's Medicaid program on its ability to provide coverage, or that Congress intended the Secretary to ignore those interactive effects. Cf. *Aguayo*, 473 F.2d at 1103-1104 (upholding AFDC demonstration project incorporating work requirement and explaining that "Congress must have realized" that paying benefits to families that were able to earn income would "diminish the funds available for cases where they were not").

The court of appeals' reliance on the fact that the Medicaid statute, unlike the TANF and SNAP statutes, generally does not itself expressly condition eligibility on working as a means of "ending the dependence of needy parents on government benefits," App., *infra*, 14a (brackets and citation omitted), was misplaced for similar reasons. Those are permanent provisions applicable nationwide. This case involves temporary, State-specific experiments. Moreover, the Secretary here noted the potential of work requirements to reduce dependency on public assistance not merely as an end in itself but also as a means of helping stretch limited Medicaid funds further. See pp. 26-27, *supra*. The court's reliance on those other programs' work requirements is even more puzzling, given that they are the outgrowth of earlier AFDC demonstration projects approved under Section 1315 on which the projects at issue here are modeled.

2. The court of appeals in *Gresham* went on to hold that the Secretary's approval of Arkansas's demonstration project was arbitrary and capricious, but that holding rested on the court's misunderstanding of Section 1315. App., *infra*, 16a-19a. The court concluded that "the Secretary disregarded th[e] statutory purpose" of providing coverage. *Id.* at 19a. But that conclusion fails

to account for the Secretary's judgment that work and skill-building requirements (among others) can be means of helping States to provide coverage.

The court of appeals' summary affirmance of the district court's order vacating the Secretary's approval in *Philbrick*—by a panel that included the author of *Gresham*—confirms that its rejection of the Secretary's approvals rests on its misreading of the statute. HHS's letter approving New Hampshire's demonstration project in *Philbrick* made unmistakably clear the Secretary's judgment that the project, including its work and skill-building requirements, would advance the Medicaid objective of furnishing coverage by means of "[h]elping the [S]tate stretch its limited Medicaid resources." App., *infra*, 155a. The district court in *Philbrick* acknowledged the Secretary's determination but rejected it because in the court's view the record did not contain a definitive finding by HHS supported by substantial evidence showing that the project would in fact achieve that result. See *id.* at 88a-95a. That analysis overlooked the critical feature of demonstration projects as *experiments*, designed to test whether such hypotheses are true.

As the government acknowledged on appeal in *Philbrick*, however, the court of appeals' intervening decision in *Gresham* "control[led]" because that decision had categorically "rejected the agency's view" that "'healthy outcomes, financial independence or transition to commercial coverage'" are "valid objectives for a demonstration project because," among other reasons, "they are potential means of achieving the concededly valid purpose of providing more health care coverage to the needy in a world of limited resources." *Philbrick* Gov't C.A. Mot. for Summ. Affirmance 4. The court of appeals evidently agreed: it granted the government's

request for summary affirmance on the ground that *Gresham* "controlled." App., *infra*, 20a.[11]

II. THE COURT OF APPEALS' RULINGS PRESENT A QUESTION OF SUBSTANTIAL PRACTICAL IMPORTANCE THAT WARRANTS THIS COURT'S REVIEW

The court of appeals' decisions erroneously invalidating the Secretary's approvals of two States' demonstration projects present an issue of exceptional importance to the federal government and States that have obtained, are seeking, or may seek approval for such projects. Most immediately, the decisions below preclude Arkansas and New Hampshire from undertaking experiments to test adjustments to their statewide Medicaid programs that the States and the Secretary determined may have significant value. While those demonstration projects remain in limbo, the States are deprived of the advantages that their projects may produce, and the Secretary and other States are deprived of the lessons and experience that those experiments may yield. If this Court grants review and reverses the judgments below, the States will be able to implement those projects once public-health conditions related to COVID-19 allow.

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[11] For the same reason, although the court of appeals in *Gresham* alternatively (and erroneously) held that the Secretary had not adequately articulated the agency's position that stretching resources is a means of achieving the objective of providing coverage, App., *infra*, 12a-13a, that additional holding does not diminish the court's error in interpreting the statute. The *Gresham* court went on to address the Secretary's position on the merits. *Id.* at 13a-16a. And on that basis, in *Philbrick*, it summarily affirmed the district court's judgment vacating the Secretary's approval of New Hampshire's demonstration project, which had set forth the Secretary's position in considerable detail. *Id.* at 20a-21a.

In addition, the decisions below will jeopardize, and might prove fatal to, as many as 17 other States' demonstration projects that incorporate similar requirements and that have been approved or for which approval is pending. See p. 8, *supra*. If the court of appeals' decision in *Gresham* is allowed to stand, it very likely will be binding in litigation over any of those other projects. Under the applicable venue statute, any plaintiff challenging the Secretary's approval of other projects may likewise bring suit in the District Court for the District of Columbia. See 28 U.S.C. 1391(e)(1). And because *Gresham* is now controlling circuit precedent, plaintiffs have every reason to do so. Suits filed in that district challenging approved demonstration projects in Indiana and Michigan are already underway.[12] No sound reason exists to await decisions from other courts of appeals in suits that are unlikely to be brought elsewhere. This Court should review the D.C. Circuit's holding before it becomes entrenched as a de facto nationwide rule.

Moreover, the court of appeals' reasoning casts a cloud over other demonstration-project components beyond the work and skill-building requirements centrally at issue in these cases. A separate provision of the Arkansas demonstration project limits retroactive coverage for members of the ACA's adult-expansion population to a period of 30 days. See App., *infra*, 131a. That provision is similar to limits on retroactive coverage that HHS previously approved as part of other demonstration projects. See, *e.g.*, C.A. App. 132, 134, 137, 143; see also App., *infra*, 149a, 155a-156a (New Hampshire). As the Secretary explained, it is designed to encourage

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[12] See *Rose* v. *Azar*, No. 19-cv-2848 (D.D.C. filed Sept. 23, 2019) (Indiana project); *Young* v. *Azar*, No. 19-cv-3526 (D.D.C. filed Nov. 22, 2019) (Michigan project).

beneficiaries to obtain and maintain health coverage, even when healthy, which in turn may increase use of preventive services that improve health outcomes. App., *infra*, 136a, 141a-142a, 153a-154a, 169a. Without specifically addressing that limitation, the court of appeals vacated the approval of it as well.

By severely curtailing the Secretary's authority to approve demonstration projects, the decisions below may have the unintended consequence of discouraging States from providing optional Medicaid coverage. It is not unusual for a State to pair optional coverage with a demonstration project that tests new requirements. See, *e.g.*, *Spry* v. *Thompson*, 487 F.3d 1272, 1276 (9th Cir. 2007). The uncertainty engendered by the decision below and the risk of protracted litigation that prevents implementation of a demonstration project may dissuade other States from electing to provide or maintain optional coverage, undermining what the court of appeals described as Medicaid's core aim.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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JULY 2020

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19-5094
Consolidated with 19-5096

CHARLES GRESHAM, ET AL., APPELLEES

v.

ALEX MICHAEL AZAR, II, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES IN HIS OFFICIAL CAPACITY, ET AL., APPELLANTS

STATE OF ARKANSAS, APPELLEE

Argued: Oct. 11, 2019
Decided: Feb. 14, 2020

Appeals from the United States District Court
for the District of Columbia
(No. 1:18-cv-01900)

Before: PILLARD, *Circuit Judge*, and EDWARDS and SENTELLE, *Senior Circuit Judges*.

Opinion for the Court filed by *Senior Circuit Judge* SENTELLE.

SENTELLE, *Senior Circuit Judge*: Residents of Kentucky and Arkansas brought this action against the Secretary of Health and Human Services. They contend that the Secretary acted in an arbitrary and capri-

cious manner when he approved Medicaid demonstration requests for Kentucky and Arkansas. The District Court for the District of Columbia held that the Secretary did act in an arbitrary and capricious manner because he failed to analyze whether the demonstrations would promote the primary objective of Medicaid—to furnish medical assistance. After oral argument, Kentucky terminated the challenged demonstration project and moved for voluntary dismissal. We granted the unopposed motion. The only question remaining before us is whether the Secretary's authorization of Arkansas's demonstration is lawful. Because the Secretary's approval of the plan was arbitrary and capricious, we affirm the judgment of the district court.

I. Background

Originally, Medicaid provided health care coverage for four categories of people: the disabled, the blind, the elderly, and needy families with dependent children. 42 U.S.C. § 1396-1. Congress amended the statute in 2010 to expand medical coverage to low-income adults who did not previously qualify. *Id.* at § 1396a(a)(10)(A)(i)(VIII); *NFIB v. Sebelius*, 567 U.S. 519, 583 (2012). States have a choice whether to expand Medicaid to cover this new population of individuals. *NFIB*, 567 U.S. at 587. Arkansas expanded Medicaid coverage to the new population effective January 1, 2014, through their participation in private health plans, known as qualified health plans, with the state paying premiums on behalf of enrollees. Appellees' Br. 14; *Gresham v. Azar*, 363 F. Supp. 3d 165, 171 (D.D.C. 2019).

Medicaid establishes certain minimum coverage requirements that states must include in their plans.

42 U.S.C. § 1396a. States can deviate from those requirements if the Secretary waives them so that the state can engage in "experimental, pilot, or demonstration project[s]." 42 U.S.C. § 1315(a). The section authorizes the Secretary to approve "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid. *Id.*

Arkansas applied to amend its existing waiver under § 1315 on June 30, 2017. Arkansas Administrative Record 2057 ("Ark. AR"). Arkansas gained approval for its initial Medicaid demonstration waiver in September 2013. In 2016, the state introduced its first version of the Arkansas Works program, encouraging enrollees to seek employment by offering voluntary referrals to the Arkansas Department of Workforce Services. Dissatisfied with the level of participation in that program, Arkansas's new version of Arkansas Works introduced several new requirements and limitations. The one that received the most attention required beneficiaries aged 19 to 49 to "work or engage in specified educational, job training, or job search activities for at least 80 hours per month" and to document such activities. *Id.* at 2063. Certain categories of beneficiaries were exempted from completing the hours, including beneficiaries who show they are medically frail or pregnant, caring for a dependent child under age six, participating in a substance treatment program, or are full-time students. *Id.* at 2080-81. Nonexempt "beneficiaries who fail to meet the work requirements for any three months during a plan year will be disenrolled . . . and will not be permitted to re-enroll until the following plan year." *Id.* at 2063.

Arkansas Works included some other new requirements in addition to the much-discussed work requirements. Typically, when someone enrolls in Medicaid, the "medical assistance under the plan . . . will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application." 42 U.S.C. § 1396a(a)(34). Arkansas Works proposed to eliminate retroactive coverage entirely. Ark. AR 2057, 2061. It also proposed to lower the income eligibility threshold from 133% to 100% of the federal poverty line, meaning that beneficiaries with incomes from 101% to 133% of the federal poverty line would lose health coverage. *Id.* at 2057, 2060-61, 2063. Finally, Arkansas Works eliminated a program in which it used Medicaid funds to assist beneficiaries in paying the premiums for employer-provided health care coverage. *Id.* at 2057, 2063, 2073. Arkansas instead used Medicaid premium assistance funds only to help beneficiaries purchase a qualified health plan available on the state Health Insurance Marketplace, requiring all previous recipients of employer-sponsored coverage premiums to transition to coverage offered through the state's Marketplace. *Id.* at 2057, 2063, 2073.

On March 5, 2018, the Secretary approved most of the new Arkansas Works program via a waiver effective until December 31, 2021, but with a few changes. He approved the work requirements but under the label of "community engagement." *Id.* at 2. The Secretary authorized Arkansas to limit retroactive coverage to thirty days before enrollment rather than a complete elimination of retroactive coverage. *Id.* at 3, 12. He also approved Arkansas's decision to terminate the

employer-sponsored coverage premium assistance program. *Id.* at 3. The Secretary did not, however, permit Arkansas to limit eligibility to persons making less than or equal to 100% of the federal poverty line. *Id.* at 3 n.1, 11. Instead, the Secretary kept the income eligibility threshold at 133% of the federal poverty line. *Id.* at 3 n.1, 11.

In the approval letter, the Secretary analyzed whether Arkansas Works would "assist in promoting the objectives of Medicaid." *Id.* at 3. The Secretary identified three objectives that he asserted Arkansas Works would promote: "improving health outcomes; . . . address-[ing] behavioral and social factors that influence health outcomes; and . . . incentiviz[ing] beneficiaries to engage in their own health care and achieve better health outcomes." *Id.* at 4. In particular, the Secretary stated that Arkansas Works's community engagement requirements would "encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness." *Id.* Further, the Secretary thought the shorter timeframe for retroactive eligibility would "encourage beneficiaries to obtain and maintain health coverage, even when they are healthy," which, in turn, promotes "the ultimate objective of improving beneficiary health." *Id.* at 5. The letter also summarized concerns raised by commenters that the community engagement requirement would "caus[e] disruptions in care" or "create barriers to coverage" for beneficiaries who are not exempt. *Id.* at 6-7. In response, the Secretary noted that Arkansas had several exemptions and would "implement an outreach strategy to inform beneficiaries about how to report compliance." *Id.*

The new work requirements took effect for those aged 30 to 49 on June 1, 2018, and for those aged 20 to 29 on January 1, 2019. *Gresham*, 363 F. Supp. 3d at 172. Charles Gresham along with nine other Arkansans filed an action for declaratory and injunctive relief against the Secretary on August 14, 2018. The district court on March 27, 2019, entered judgment vacating the Secretary's approval, effectively halting the program. *Gresham*, 363 F. Supp. 3d at 176-85. In its opinion supporting the judgment, the district court relied on *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018) (*Stewart I*), which is the district court's first opinion considering Kentucky's similar demonstration, *Gresham*, 363 F. Supp. 3d at 176. In *Stewart I*, the district court turned to the provision authorizing the appropriations of funds for Medicaid, 42 U.S.C. § 1396-1, and held that, based on the text of that appropriations provision, the objective of Medicaid was to "furnish . . . medical assistance" to people who cannot afford it. *Stewart I*, 313 F. Supp. 3d at 260-61.

With its previously articulated objective of Medicaid in mind, the district court then turned to the Secretary's approval of Arkansas Works. First, the district court noted that the Secretary identified three objectives that Arkansas Works would promote: "(1) 'whether the demonstration as amended was likely to assist in improving health outcomes'; (2) 'whether it would address behavioral and social factors that influence health outcomes'; and (3) 'whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes.'" *Gresham*, 363 F. Supp. 3d at 176 (quoting Ark. AR 4). But "[t]he Secretary's approval letter did not consider whether [Arkansas Works] would reduce Medicaid coverage. Despite acknowledging at

several points that commenters had predicted coverage loss, the agency did not engage with that possibility." *Id.* at 177. The district court also explained that the Secretary failed to consider whether Arkansas Works would promote coverage. *Id.* at 179. Instead, the Secretary considered his alternative objectives, primarily healthy outcomes, but the district court observed that "'focus on health is no substitute for considering Medicaid's central concern: covering health costs' through the provision of free or low-cost health coverage." *Id.* (quoting *Stewart I*, 313 F. Supp. 3d at 266). "In sum," the district court held:

> the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address—despite receiving substantial comments on the matter—whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy.

Id. at 181. The district court entered final judgment on April 4, 2019, and the Secretary filed a notice of appeal on April 10, 2019.

This case was originally a consolidated appeal from the district court's judgment in both the Arkansas and Kentucky cases. The district court twice vacated the Secretary's approval of Kentucky's demonstration for the same failure to address whether Kentucky's program would promote the key objective of Medicaid. *Stewart v. Azar*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019) (*Stewart II*); *Stewart I*, 313 F. Supp. 3d at 274. On December 16, 2019, Kentucky moved to dismiss its appeal as moot because it "terminated the section [1315] demonstration project." Intervenor-Def.-Appellant's Mot. to Voluntarily Dismiss Appeal 1-2 (Dec. 16, 2019), ECF No.

1820334. Neither the government nor the appellees opposed the motion. Gov't's Resp. (Dec. 18, 2019), ECF No. 1820655; Appellees' Resp. (Dec. 20, 2019), ECF No. 1821219.

Although the Secretary has considerable discretion to grant a waiver, we reject the government's contention that such discretion renders his waiver decisions unreviewable. The Administrative Procedure Act's (APA) exception from judicial review for an action committed to agency discretion is "very narrow," *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 410 (1971); *see also Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2568 (2019), barring judicial review only in those "rare instances" where "there is no law to apply," *Overton Park*, 401 U.S. at 410 (internal quotation marks and citation omitted). The Medicaid statute provides the legal standard we apply here: The Secretary may only approve "experimental, pilot, or demonstration project[s]," and only insofar as they are "likely to assist in promoting the objectives" of Medicaid, 42 U.S.C. § 1315(a). Section 1315 approvals are not among the rare "categories of administrative decisions that courts traditionally have regarded as committed to agency discretion." *Dep't of Commerce*, 139 S. Ct. at 2568.

Additionally, the government asked that we address "the reasoning of the district court's opinion in *Stewart* and the underlying November 2018 HHS approval of the Kentucky demonstration," and second that we vacate the district court's judgment against the federal defendants in the Kentucky case *Stewart II*, 66 F. Supp. 3d 125. Gov't's Resp. 1-2. The appellees opposed both of those additional requests. Appellees' Resp. 1-4. We granted the motion to voluntarily dismiss but declined to vacate

the district court's judgment against the federal defendants in *Stewart II*. As to the government's first request, we do not rely on the Secretary's reasoning in the November 2018 approval of Kentucky's demonstration when considering the Secretary's approval of Arkansas's demonstration.

"We review *de novo* the District Court's grant of summary judgment, which means that we review the agency's decision on our own." *Castlewood Prods., L.L.C. v. Norton*, 365 F.3d 1076, 1082 (D.C. Cir. 2004). Therefore, we will review the Secretary's approval of Arkansas Works in accordance with the Administrative Procedure Act and will set it aside if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *see also C.K. v. New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171, 181-82 (3d Cir. 1996) (applying the arbitrary and capricious standard of review to a waiver under § 1315); *Beno v. Shalala*, 30 F.3d 1057, 1066-67 (9th Cir. 1994) (same); *Aguayo v. Richardson*, 473 F.2d 1090, 1103-08 (2d Cir. 1973) (same). An agency action that "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" is arbitrary and capricious. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

II. DISCUSSION

A. Objective of Medicaid

The district court is indisputably correct that the principal objective of Medicaid is providing health care

coverage. The Secretary's discretion in approving or denying demonstrations is guided by the statutory directive that the demonstration must be "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315. While the Medicaid statute does not have a standalone purpose section like some social welfare statutes, *see, e.g.*, 42 U.S.C. § 601(a) (articulating the purposes of the Temporary Assistance for Needy Families program); 42 U.S.C. § 629 (announcing the "objectives" of the Promoting Safe and Stable Families program), it does have a provision that articulates the reasons underlying the appropriations of funds, 42 U.S.C. § 1396-1. The provision describes the purpose of Medicaid as

> to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled 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. In addition to the appropriations provision, the statute defines "medical assistance" as "payment of part or all of the cost of the following care and services or the care and services themselves." 42 U.S.C. § 1396d(a). Further, as the district court explained, the Affordable Care Act's expansion of health care coverage to a larger group of Americans is consistent with Medicaid's general purpose of furnishing health care coverage. *See Stewart I*, 313 F. Supp. 3d at 260 (citing Pub. L. No. 111-148, 124 Stat. 119, 130, 271 (2010)). The text consistently focuses on providing access to health care coverage.

Both the First and Sixth Circuits relied on Medicaid's appropriations provision quoted above in concluding that "[t]he primary purpose of Medicaid is to enable states to provide medical services to those whose 'income and resources are insufficient to meet the costs of necessary medical services.'" *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) (quoting 42 U.S.C. § 1396 (2000)), *aff'd*, 538 U.S. 644 (2003); *Price v. Medicaid Dir.*, 838 F.3d 739, 742 (6th Cir. 2016). Similarly, the Ninth Circuit relied on both the appropriations provision and the definition of "medical assistance" when describing Medicaid as "a federal grant program that encourages states to provide certain medical services" and identifying a key element of "medical assistance" as the spending of federally provided funds for medical coverage. *Univ. of Wash. Med. Ctr. v. Sebelius*, 634 F.3d 1029, 1031, 1034-35 (9th Cir. 2011).

Beyond relying on the text of the statute, other courts have consistently described Medicaid's objective as primarily providing health care coverage. For example, the Third Circuit succinctly stated, "We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it." *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991). Likewise, the Supreme Court characterized Medicaid as a "program . . . [that] provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs." *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006); *see also Virginia ex rel. Hunter Labs., L.L.C. v. Virginia*, 828 F.3d 281, 283 (4th Cir. 2016) (quoting *Ahlborn* in the section of the decision explaining the important aspects of Medicaid).

The statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care. There might be secondary benefits that the government was hoping to incentivize, such as healthier outcomes for beneficiaries or more engagement in their health care, but the "means [Congress] has deemed appropriate" is providing health care coverage. *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994). In sum, "the intent of Congress is clear" that Medicaid's objective is to provide health care coverage, and, as a result, the Secretary "must give effect to [that] unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984).

Instead of analyzing whether the demonstration would promote the objective of providing coverage, the Secretary identified three alternative objectives: "whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes." Ark. AR 4. These three alternative objectives all point to better health outcomes as the objective of Medicaid, but that alternative objective lacks textual support. Indeed, the statute makes no mention of that objective.

While furnishing health care coverage and better health outcomes may be connected goals, the text specifically addresses only coverage. 42 U.S.C. § 1396-1. The Supreme Court and this court have consistently reminded agencies that they are "bound, not only by the ultimate purposes Congress has selected, but by the

means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms.*, 512 U.S. at 231 n.4; *see also Waterkeeper All. v. EPA*, 853 F.3d 527, 535 (D.C. Cir. 2017); *Colo. River Indian Tribes v. Nat'l Indian Gaming Comm'n*, 466 F.3d 134, 139-40 (D.C. Cir. 2006). The means that Congress selected to achieve the objectives of Medicaid was to provide health care coverage to populations that otherwise could not afford it.

To an extent, Arkansas and the government characterize the Secretary's approval letter as also identifying transitioning beneficiaries away from governmental benefits through financial independence or commercial coverage as an objective promoted by Arkansas Works. Ark. Br. 14, 37-42; Gov't Br. 24-25, 32. This argument misrepresents the Secretary's letter. The approval letter has a specific section for the Secretary's determination that the project will assist in promoting the objectives of Medicaid. Ark. AR 3-5. The objectives articulated in that section are the health-outcome goals quoted above. That section does not mention transitioning beneficiaries away from benefits. The district court's discussion of the Secretary's objectives confirms our interpretation of this letter. It identifies the Secretary's alternative objective as "improv[ing] health outcomes." *Gresham*, 363 F. Supp. 3d at 179. There is no reference to commercial coverage in the Secretary's approval letter, and the only reference to beneficiary financial independence is in the section summarizing public comments. In response to concerns about the community engagement requirements creating barriers to coverage, the Secretary stated, "Given that employment is positively correlated with health outcomes, it furthers the purposes of the Medicaid statute to test

and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence." Ark. AR 6. But "[n]owhere in the Secretary's approval letter does he justify his decision based . . . on a belief that the project will help Medicaid-eligible persons to gain sufficient financial resources to be able to purchase private insurance." *Gresham*, 363 F. Supp. 3d at 180-81. We will not accept post hoc rationalizations for the Secretary's decision. *See State Farm*, 463 U.S. at 50.

Nor could the Secretary have rested his decision on the objective of transitioning beneficiaries away from government benefits through either financial independence or commercial coverage. When Congress wants to pursue additional objectives within a social welfare program, it says so in the text. For example, the purpose section of TANF explicitly includes "end[ing] the dependence of needy parents on government benefits by promoting job preparation, work, and marriage" among the objectives of the statute. 42 U.S.C. § 601(a)(2). Also, both TANF and the Supplemental Nutrition Assistance Program (SNAP) condition eligibility for benefits upon completing a certain number of hours of work per week to support the objective of "end[ing] dependence of needy parents on government benefits." 42 U.S.C. §§ 601(a)(2), 607(c) (TANF); 7 U.S.C. § 2015(d)(1) (SNAP). In contrast, Congress has not conditioned the receipt of Medicaid benefits on fulfilling work requirements or taking steps to end receipt of governmental benefits.

The reference to independence in the appropriations provision and the cross reference to TANF cannot support the Secretary's alternative objective either. The

reference to "independence" in the appropriations provision is in the context of assisting beneficiaries in achieving functional independence through rehabilitative and other services, not financial independence from government welfare programs. 42 U.S.C. § 1396-1. Medicaid also grants states the "[o]ption" to terminate Medicaid benefits when a beneficiary who receives both Medicaid and TANF fails to comply with TANF's work requirements. *See* 42 U.S.C. § 1396u-1(b)(3)(A). The provision gives states, therefore, the ability to coordinate benefits for recipients receiving both TANF and Medicaid. It does not go so far as to incorporate TANF work requirements and additional objectives into Medicaid.

Further, the history of Congress's amendments to social welfare programs supports the conclusion that Congress did not intend 42 U.S.C. § 1396u-1(b)(3)(A) to incorporate TANF's objectives and work requirements into Medicaid. In 1996, SNAP already included work requirements to maintain eligibility. 7 U.S.C. § 2015(d)(1) (1994). Also in 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act, which replaced Aid to Families with Dependent Children with TANF and added work requirements. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, sec. 103, § 407, 110 Stat. 2105, 2129-34. At the same time, it added 42 U.S.C. § 1396u-1(b)(3)(A) to Medicaid. *Id.* at sec. 114, § 1931, 110 Stat. at 2177-80. The fact that Congress did not similarly amend Medicaid to add a work requirement for all recipients—at a time when the other two major welfare programs had those requirements and Congress was in the process of amending welfare statutes—

demonstrates that Congress did not intend to incorporate work requirements into Medicaid through § 1396u-1(b)(3)(A).

In short, we agree with the district court that the alternative objectives of better health outcomes and beneficiary independence are not consistent with Medicaid. The text of the statute includes one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage.

B. The Approvals Were Arbitrary and Capricious

With the objective of Medicaid defined, we turn to the Secretary's analysis and approval of Arkansas's demonstration, and we find it wanting. In order to survive arbitrary and capricious review, agencies need to address "important aspect[s] of the problem." *State Farm*, 463 U.S. at 43. In this situation, the loss of coverage for beneficiaries is an important aspect of the demonstration approval because coverage is a principal objective of Medicaid and because commenters raised concerns about the loss of coverage. *See*, *e.g.*, Ark. AR 1269-70, 1277-78, 1285, 1294-95.

A critical issue in this case is the Secretary's failure to account for loss of coverage, which is a matter of importance under the statute. The record shows that the Arkansas Works amendments resulted in significant coverage loss. In Arkansas, more than 18,000 people (about 25% of those subject to the work requirement) lost coverage as a result of the project in just five months. Ark. Dep't of Human Servs., Arkansas Works Program 8 (Dec. 2018), https://humanservices.arkansas.gov/images/

uploads/011519_AWReport.pdf. Additionally, commenters on the Arkansas Works amendments detailed the potential for substantial coverage loss supported by research evidence. Ark. AR 1269-70, 1277-78, 1285, 1294-95, 1297, 1307-08, 1320, 1326, 1337-38, 1341, 1364-65, 1402, 1421. The Secretary's analysis considered only whether the demonstrations would increase healthy outcomes and promote engagement with the beneficiary's health care. *Id.* at 3-5. The Secretary noted that some commenters were concerned that "these requirements would be burdensome on families or create barriers to coverage." *Id.* at 6. But he explained that Arkansas would have "outreach and education on how to comply with the new community engagement requirements" and that Centers for Medicare and Medicaid Services could discontinue the program if data showed that it was no longer in the public interest. *Id.* The Secretary also concluded that the "overall health benefits to the [a]ffected population . . . outweigh the health-risks with respect to those who fail to" comply with the new requirements. *Id.* at 7. While Arkansas did not have its own estimate of potential coverage loss, the estimates and concerns raised in the comments were enough to alert the Secretary that coverage loss was an important aspect of the problem. Failure to consider whether the project will result in coverage loss is arbitrary and capricious.

In total, the Secretary's analysis of the substantial and important problem is to note the concerns of others and dismiss those concerns in a handful of conclusory sentences. Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking. *See, e.g., Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932

(D.C. Cir. 2017) (critiquing an agency for "brush[ing] aside critical facts" and not "adequately analyz[ing]" the consequences of a decision); *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) (analyzing whether an agency actually considered a concern rather than merely stating that it considered the concern).

True, the Secretary's approval letter is not devoid of analysis. It does contain the Secretary's articulation of how he thought the demonstrations would assist in promoting an entirely different set of objectives than the one we hold is the principal objective of Medicaid. In some circumstances it may be enough for the agency to assess at least one of several possible objectives. *See Fresno Mobile Radio, Inc. v. FCC*, 165 F.3d 965, 971 (D.C. Cir. 1999). But in such cases, the statute lists several objectives, some of which might lead to conflicting decisions. *Id.*; *see also Melcher v. FCC*, 134 F.3d 1143, 1154 (D.C. Cir. 1998). For example, in both *Fresno Mobile Radio* and *Melcher*, the statute at issue included five separate objectives for FCC to consider when creating auctions for licenses, including "the development and rapid deployment of new technologies," "promoting economic opportunity and competition," and the "efficient and intensive use of the electromagnetic spectrum." 47 U.S.C. § 309(j)(3). In *Fresno Mobile Radio*, we recognized that these objectives could point to conflicting courses of action, so the agency could give precedence to one or several objectives over others without acting in an arbitrary or capricious manner. *Fresno Mobile Radio*, 165 F.3d at 971; *see also Melcher*, 134 F.3d at 1154; *Rural Cellular Ass'n v. FCC*, 588 F.3d 1095, 1101-03 (D.C. Cir. 2009) (explaining that an agency may not "depart from" statutory principles "altogether to achieve some other goal"). The crucial difference in

this case is that the Medicaid statute identifies its primary purpose rather than a laundry list. The primary purpose is

> to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

42 U.S.C. § 1396-1. Importantly, the Secretary disregarded this statutory purpose in his analysis. While we have held that it is not arbitrary or capricious to prioritize one statutorily identified objective over another, it is an entirely different matter to prioritize non-statutory objectives to the exclusion of the statutory purpose.

III. CONCLUSION

Because the Secretary's approval of Arkansas Works was arbitrary and capricious, we affirm the district court's judgment vacating the Secretary's approval.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19-5293
Consolidated with 19-5295
September Term, 2019
1:19-cv-00773-JEB

SAMUEL PHILBRICK, ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED, ET AL., APPELLEES

v.

ALEX M. AZAR, II, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., APPELLANTS

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES, APPELLEE

Filed: May 20, 2020

ORDER

BEFORE: HENDERSON and RAO, Circuit Judges, and SENTELLE, Senior Circuit Judge

Upon consideration of the unopposed motion for summary affirmance, it is

ORDERED that the motion for summary affirmance be granted and the district court's order filed July 29, 2019, be affirmed. The federal appellants acknowledge that the disposition of this case is controlled by Gresham

v. Azar, 950 F.3d 93 (D.C. Cir. 2020), and, accordingly, the merits of the parties' positions are so clear as to warrant summary action, see Taxpayers Watchdog, Inc. v. Stanley, 819 F.2d 294, 297 (D.C. Cir. 1987) (per curiam).

Pursuant to D.C. Circuit Rule 36, this disposition will not be published. The Clerk is directed to withhold issuance of the mandate herein until seven days after resolution of any timely petition for rehearing or petition for rehearing en banc. See Fed. R. App. P. 41(b); D.C. Cir. Rule 41.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/
Manuel J. Castro
Deputy Clerk

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Civil Action No. 18-1900 (JEB)

CHARLES GRESHAM, ET AL., PLAINTIFFS

v.

ALEX MICHAEL AZAR II, ET AL., DEFENDANTS

Filed: Mar. 27, 2019

MEMORANDUM OPINION

Adrian McGonigal is 40 years old and lives with his brother in Pea Ridge, Arkansas. He used to have a job working in the shipping department of Southwest Poultry, a food-service company located nearby, although he received no medical insurance through his employer. Like many Americans, he has several serious medical conditions. Beginning in 2014, McGonigal was able to receive medical care—including regular doctor visits and numerous prescription drugs—through the state's expanded Medicaid program. In mid-2018, however, McGonigal learned that he would be subject to new work requirements, which he would have to report online, as a condition of receiving health benefits. These were imposed by the Arkansas Works Amendments (AWA), approved by the U.S. Secretary of Health and Human Services in March 2018. Despite his lack of access to, and difficulty working with, computers, he was able to

report his employment in June 2018, but he did not know he needed to continue to do so each month. As a result, when he went to pick up his prescriptions in October, the pharmacist told him that he was no longer covered, and his medicines would cost him $800. In the absence of Medicaid, he could not afford the cost of the prescriptions and so did not pick them up. His health conditions then flared up, causing him to miss several days of work, and Southwest Poultry fired him for his absences. He thus lost his Medicaid coverage and his job.

Anna Book is 38 years old and lives in Little Rock. She currently rents a room in an apartment but was homeless for most of the last eight years. In July 2018, she got a job as a dishwasher in a restaurant, for which she works about 24 hours each week. Before that, she was unemployed for two years. She nevertheless also had health care provided through Arkansas's Medicaid program, which a local pastor helped her sign up for in 2014. Book learned last August that, pursuant to AWA, she would have to report 80 hours each month of employment or other activities to keep that coverage. While she reported her compliance in August and September with the pastor's help—she does not have reliable internet access—Book has several health conditions and worries that she will not maintain sufficient hours at her job to keep her coverage.

Russell Cook is 26 and also lives in Little Rock. He is currently homeless. While he has spent time working as a landscaper, he is not presently employed and has minimal job prospects. The state's Medicaid program has previously given him access to health care for various health conditions, including a torn Achilles tendon and serious dental problems. Cook, however, does

not believe he will be able to comply with the new AWA work requirements, which began applying to him in January 2019. Lacking access to the internet or a phone, he also worries that he will be unable to report compliance with those requirements. He thus expects to lose his Medicaid coverage.

These are three of the ten Arkansans who come to this Court seeking to undo the work requirements the state added in 2018 to its Medicaid program. They sued the Secretary of Health and Human Services in August 2018, arguing that the federal government's approval of the state's new requirements violated the Administrative Procedure Act and the Constitution.

Plaintiffs' suit does not offer an issue of first impression. Indeed, this Court just last summer considered a challenge to the Secretary's approval of very similar changes to Kentucky's Medicaid program—including work or "community engagement" requirements—in Stewart v. Azar, 313 F. Supp. 3d 237 (D.D.C. 2018) (Stewart I). There, it vacated the agency's decision because it had not adequately considered whether the program "would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." Id. at 243. Plaintiffs point to the identical deficiency in the record in this case. Despite the protestations in its (and intervenor Arkansas's) briefing, HHS conceded at oral argument that the administrative decision in this case shares the same problem as the one in Stewart I. See Oral Argument Transcript at 6-7. The Court's job is thus easy in one respect: the Secretary's approval cannot stand.

Yet a separate question remains: what is the proper remedy? In Stewart I, the Court vacated the approval

and remanded to the Secretary. Here, however, the Government argues that vacatur is improper both because, unlike Kentucky, AWA is already active and halting it would be quite disruptive, and because any error is easily fixed, just as it has been for Kentucky. The challengers disagree, positing that the deficiency in the approval is substantial and that any resulting disruption is outweighed by the ongoing harms suffered by the more than 16,000 Arkansans who have lost their Medicaid coverage. Given the seriousness of the deficiencies —which, as this Court explains in a separate Opinion issued today, the remand in Kentucky did not cure—and the absence of lasting harms to the Government relative to the significant ones suffered by Arkansans like Plaintiffs, the Court will vacate the Secretary's approval and remand for further proceedings.

I. BACKGROUND

As it did in Stewart I, the Court begins with an overview of the relevant history and provisions of the Medicaid Act. See 313 F. Supp 3d. at 243-44. It then turns to Arkansas's challenged plan before concluding with the procedural history of this case.

A. Legal Background

1. The Medicaid Act

Since 1965, the federal government and the states have worked together to provide medical assistance to certain vulnerable populations under Title XIX of the Social Security Act, commonly known as Medicaid. See 42 U.S.C. § 1396-1. The Centers for Medicare and Medicaid Services (CMS), a federal agency within the Department of Health and Human Services, has primary responsibility for overseeing Medicaid programs.

Under the cooperative federal-state arrangement, participating states submit their "plans for medical assistance" to the Secretary of HHS. Id. To receive federal funding, those plans—along with any material changes to them—must be "approved by the Secretary." Id.; see also 42 C.F.R. § 430.12(c). Currently, all states have chosen to participate in the program.

To be approved, state plans must comply with certain minimum parameters set out in the Medicaid Act. See 42 U.S.C. § 1396a (listing 83 separate requirements). One such provision requires state plans to "mak[e] medical assistance available" to certain low-income individuals. Id. § 1396a(a)(10)(A). Until recently, that group included pregnant women, children, and their families; some foster children; the elderly; and people with certain disabilities. Id. In 2010, however, Congress enacted the Patient Protection and Affordable Care Act (ACA), colloquially known as Obamacare, "to increase the number of Americans covered by health insurance." Nat'l Fed. of Indep. Business v. Sebelius, 567 U.S. 519, 538 (2012). Under that statute, states can expand their Medicaid coverage to include additional low-income adults under 65 who would not otherwise qualify. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

Generally, a state must cover all qualified individuals or forfeit its federal Medicaid funding. Id. § 1396a(a)(10)(B). That was originally so for the ACA expansion population as well. See 42 U.S.C. § 1396c. In NFIB, however, the Supreme Court held that Congress could not, consistent with the Spending Clause of the Constitution, condition previously appropriated Medicaid funds on the state's agreeing to the expansion. See 567 U.S. at 584-85. The result was that states could choose not to

cover the new population and lose no more than the funds that would have been appropriated for that group. Id. at 587. If, however, the state decided to provide coverage, those individuals would become part of its mandatory population. Id. at 585-87 (explaining that Congress may "offer[] funds under the Affordable Care Act to expand the availability of health care, and requir[e] that States accepting such funds comply with the conditions on their use"). In that instance, the state must afford the expansion group "full benefits"—*i.e.*, it must provide "medical assistance for all services covered under the State plan" that are substantially equivalent "in amount, duration, or scope . . . to the medical assistance available for [other] individual[s]" covered under the Act. See 42 U.S.C. § 1396d(y)(2)(B); 42 C.F.R. § 433.204(a)(2).

The Medicaid Act, in addition to defining who is entitled to coverage, also ensures what coverage those enrolled individuals receive. Under § 1396a, states must cover certain basic medical services, see 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a), and the statute limits the amount and type of premiums, deductions, or other cost-sharing charges that a state can impose on such care. Id. § 1396a(a)(14); see also id. § 1396*o*. Other provisions require states to provide three months of retroactive coverage once a beneficiary enrolls, see id. § 1396a(a)(34), and to ensure that recipients receive all "necessary transportation . . . to and from providers." 42 C.F.R. § 431.53. Finally, states must "provide such safeguards as may be necessary to assure" that eligibility and services "will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

2. Section 1115 of Social Security Act

Both before and after the passage of the ACA, a state is not entirely locked in; instead, if it wishes to deviate from the Medicaid Act's requirements, it can seek a waiver from the Secretary of HHS. See 42 U.S.C. § 1315. In enacting the Social Security Act (and, later, the Medicaid program within the same title), Congress recognized that statutory requirements "often stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 1589, 87th Cong., 2d Sess. 19, reprinted in 1962 U.S.C.C.A.N. 1943, 1961-62. To that end, § 1115 of the Social Security Act allows the Secretary to approve "experimental, pilot, or demonstration project[s]" in state medical plans that would otherwise fall outside Medicaid's parameters. The Secretary can approve only those projects that "in [his] judgment . . . [are] likely to assist in promoting the [Act's] objectives." 42 U.S.C. § 1315(a). As conceived, demonstration projects were "expected to be selectively approved by the Department and to be those which are designed to improve the techniques of administering assistance." *Supra* S. Rep. No. 1589 at 1962. Once the Secretary has greenlighted such a project, he can then waive compliance with the requirements of § 1396a "to the extent and for the period . . . necessary to enable [the] State . . . to carry out such project." Id. § 1315(a)(1).

While the ultimate decision whether to grant § 1115 approval rests with the Secretary, his discretion is not boundless. Before HHS can act on a waiver application, the state "must provide at least a 30-day public notice[-]and[-]comment period" regarding the proposed

program and hold at least two hearings at least 20 days before submitting the application. See 42 C.F.R. §§ 431.408(a)(1), (3). Once a state completes those prerequisites, it then sends an application to CMS. Id. § 431.412 (listing application requirements). After the agency notifies the state that it has received the waiver application, a federal 30-day public-notice period commences, and the agency must wait at least 45 days before rendering a final decision. Id. §§ 431.416(b), (e)(1).

B. Factual Background

1. Arkansas Works Amendments

Arkansas's Medicaid program dates back to 1970. For most of the program's history, the state maintained among the most stringent eligibility thresholds in the nation for adults, covering only the aged, disabled, and parents with very low incomes. See ECF 53-6, Exh. 54 (Ark. Health Care Independence Program Interim Report) at 16. That changed with the passage of the ACA. While states had a choice after NFIB not to expand Medicaid, Arkansas was one of those that opted to do so. Under its expansion program, which began January 1, 2014, Medicaid-eligible persons were given the opportunity to enroll in private insurance plans financed by the state. See AR 71. In its first two years, the program provided health coverage to more than 278,000 newly eligible individuals, helping to lower the uninsured rate from 19% to 11%. See AR 1274. The program became known as Arkansas Works in January 2017.

That month featured another significant change in the political landscape, as the Trump administration took over from President Obama. In March 2017, then-

Secretary Thomas Price and CMS Director Seema Verma sent a letter to all 50 governors announcing the administration's view that the ACA's expansion of Medicaid was "a clear departure from the core, historical mission of the program." See AR 85. They thus alerted states of the agency's "intent to use existing Section 1115 demonstration authority" to help revamp Medicaid. See AR 86. Together they promised to find "a solution that best uses taxpayer dollars to serve" those individuals they deemed "truly vulnerable." Id. Heeding HHS's call, Governor Asa Hutchinson proposed three substantial amendments to Arkansas Works under Section 1115. See AR 2057. First, he proposed to shift income eligibility for the expansion population from 133% to 100% of the Federal Poverty Line. Id. Second, he proposed to "institute work requirements as a condition" of continued Medicaid coverage. Id. Third, he proposed to eliminate retroactive health coverage. Id. The state did not estimate the effects these amendments would have on Medicaid coverage. CMS held a public-comment period from July 11 to August 10, 2017, and numerous organizations offered their views and analysis of the changes.

On March 5, 2018, the Secretary approved the work requirements and limits to retroactive coverage, concluding that they were "likely to assist in improving health outcomes" and "incentivize beneficiaries to engage in their own health care." AR 2-4. Under the new work requirements, most able-bodied adults in the Medicaid expansion population ages 19 to 49 must complete each month 80 hours of employment or other qualifying activities—or earn income equivalent to 80 hours of work. Id. Compliance was required to be reported

monthly through an online portal. See AR 29. Various groups of persons are exempt, including the medically frail, pregnant women, full-time students, and persons in drug- or alcohol-treatment programs. See AR 28. Nonexempt individuals who do not report sufficient qualifying hours for any three months in a plan year are disenrolled from Medicaid for the remainder of that year and not permitted to re-enroll until the following plan year. See AR 14, 30-31. The work requirements took effect for persons age 30 to 49 on June 1, 2018, and for persons age 20 to 29 on January 1, 2019. See ECF No. 26-3 (Arkansas Works Eligibility and Enrollment Monitoring Plan) at 7-8. As to retroactive coverage, the Secretary approved a reduction from the three months required by the Act to one month; the more drastic proposal of eliminating such coverage entirely was abandoned, as was the Governor's request to reduce eligibility down to 100% of the FPL. See AR 12, 22.

According to Arkansas's Department of Human Services, only a small percentage of the persons required to report compliance with the work requirements actually did so during the first six months of the program. In October, for example, only 12.3% (1687 out of 13653) of persons not exempt from the requirements reported any kind of qualifying activity. See ECF No. 42-1 (Arkansas Works Reports June-November 2018) at 47, 52. Since the program began, more than 16,900 individuals have lost Medicaid coverage for some period of time for not reporting their compliance. Id. at 18, 27, 36, 45. It is not known what percentage of these individuals completed the work requirements but did not report versus those who did not engage in the work itself.

2. Kentucky HEALTH

Arkansas was not the only state interested in the new administration's proposal to rethink the Medicaid Expansion. The Commonwealth of Kentucky proposed a demonstration project—called Kentucky HEALTH—with similar community-engagement requirements and cutbacks to retroactive coverage. (It also contained other elements not relevant here.) Kentucky, unlike Arkansas, did estimate the coverage effects of its project, explaining that thousands of persons would lose their Medicaid benefits over the course of the project; indeed, their estimate corresponded to about 95,000 persons losing Medicaid for one full year. As it did in Arkansas, the Secretary approved that project on the ground that it was likely to "improv[e] health outcomes" and "increas[e] individual engagement in health care decisions." Stewart I, 313 F. Supp. 3d at 258 (quoting AR 7).

Before the project took effect, several Medicaid recipients challenged the Secretary's approval in this Court. They argued, among other things, that the agency had failed to adequately explain why Kentucky HEALTH promoted the objectives of Medicaid and that approval of the project exceeded HHS's statutory authority. The Court concluded that the plaintiffs were right in one central and dispositive respect: "[T]he Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." Id. at 243. It therefore vacated the Secretary's approval and remanded the matter to the agency for further consideration. Id. at 273.

HHS has since reopened the comment period and subsequently reapproved Kentucky's project, offering

additional explanation for why the project advances the objectives of the Medicaid Act. The parties have now come back to the Court and filed cross-motions for summary judgment in that case. The Court issues a separate Opinion today resolving those motions, which it will refer to as Stewart II.

C. Procedural History

Several Arkansas residents filed this lawsuit in August 2018. They assert that the Secretary's approval of the Arkansas Works Amendments was arbitrary and capricious, in excess of his statutory authority, and in violation of the Take Care Clause of the Constitution. Because it was designated as related to Stewart I, see ECF No. 2, the case was directed to this Court. While Defendants objected to the related-case designation, see ECF No. 17, the Court determined that the cases' common legal and factual issues militated in favor of its retaining the matter. See Minute Order of Sept. 12, 2018. The State of Arkansas has since intervened as a Defendant, and numerous amici have also joined the fray. Dueling Cross-Motions for Summary Judgment are now ripe.

II. LEGAL STANDARD

The parties have cross-moved for summary judgment on the administrative record. The summary-judgment standard set forth in Federal Rule of Civil Procedure 56(c), therefore, "does not apply because of the limited role of a court in reviewing the administrative record." Sierra Club v. Mainella, 459 F. Supp. 2d 76, 89 (D.D.C. 2006); see also Bloch v. Powell, 227 F. Supp. 2d 25, 30 (D.D.C. 2002), aff'd, 348 F.3d 1060 (D.C. Cir. 2003). "[T]he function of the district court is

to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." Sierra Club, 459 F. Supp. 2d. at 90 (quotation marks and citation omitted). "Summary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [Administrative Procedure Act] standard of review." Loma Linda Univ. Med. Ctr. v. Sebelius, 684 F. Supp. 2d 42, 52 (D.D.C. 2010) (citation omitted).

The Administrative Procedure Act "sets forth the full extent of judicial authority to review executive agency action for procedural correctness." FCC v. Fox Television Stations, Inc., 556 U.S. 502, 513 (2009). It requires courts to "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). Agency action is arbitrary and capricious if, for example, the agency "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." Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).

In other words, an agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." Id. at 43 (quoting Burlington Truck Lines v. United States, 371 U.S. 156, 168 (1962)) (internal quotation marks omitted). Courts, accordingly, "do not defer to the agency's conclusory or

unsupported suppositions," United Techs. Corp. v. Dep't of Def., 601 F.3d 557, 562 (D.C. Cir. 2010) (quoting McDonnell Douglas Corp. v. Dep't of the Air Force, 375 F.3d 1182, 1187 (D.C. Cir. 2004)), and "agency 'litigating positions' are not entitled to deference when they are merely [agency] counsel's '*post hoc* rationalizations' for agency action, advanced for the first time in the reviewing court." Martin v. Occupational Safety & Health Review Comm'n, 499 U.S. 144, 156 (1991) (citation omitted). Although a reviewing court "may not supply a reasoned basis for the agency's action that the agency itself has not given," a decision that is not fully explained may, nevertheless, be upheld "if the agency's path may reasonably be discerned." Bowman Transp., Inc. v. Arkansas-Best Freight System, Inc., 419 U.S. 281, 285-86 (1974) (citation omitted).

III. ANALYSIS

The Court, as it must, first addresses whether there is subject-matter jurisdiction before proceeding to the merits of Plaintiffs' challenges.

A. Jurisdiction

Unlike in Stewart I, Defendants do not contest Plaintiffs' standing to challenge the Secretary's approval of the Arkansas Works Amendments as a whole. The Court, nevertheless, has an independent duty to assure that it has subject-matter jurisdiction in this case. See Kaplan v. Cent. Bank of Islamic Repub. of Iran, 896 F.3d 501, 509 (D.C. Cir. 2018). To establish standing under Article III, Plaintiffs must show that they have suffered a concrete injury that is fairly traceable to the challenged conduct and that is likely to be redressed by a

favorable judicial decision. See Lujan v. Defs. of Wildlife, 504 U.S. 555, 590 (1992). On review, the Court easily concludes that at least one Plaintiff has established all three elements. Consider, for example, Adrian McGonigal, whom we encountered in this Opinion's opening paragraph. He attests that he has lost his Medicaid coverage as a result of the community-engagement requirement and has thus been unable to pay for certain medical bills and prescription drugs. See ECF No. 27-3 (McGonigal Declaration). Or look to Russell Cook, also mentioned in the introduction, who avers that he will be unable to meet the community-engagement requirement once it applies to him and thus believes that loss of his health-care coverage is imminent. See ECF No. 27-7 (Cook Declaration). From these declarations and others submitted with Plaintiffs' Motion, there is little doubt that at least one Plaintiff has suffered an injury (or will suffer an injury in the future)—the loss of Medicaid coverage—that is attributable to the Secretary's approval of AWA, and that a favorable decision from the Court would redress it. See NB *ex rel.* Peacock v. District of Columbia, 682 F.3d 77, 82-83 (D.C. Cir. 2012).

While standing is thus easily established for their claim challenging the project as a whole, the state of Arkansas attacks Plaintiffs' standing to make one of their arguments. It specifically says that no Plaintiff may challenge Arkansas Works' online-only reporting requirements because the state changed its policy before this suit so as to allow reporting by phone or in person. See ECF No. 39 (Arkansas MSJ) at 34. There is no need for the Court to weigh in here. Because it resolves this case based on the challenge to the Arkansas Works Amendments writ large, the Court declines to

decide whether certain Plaintiffs have standing to challenge this particular part of the project.

B. Merits

With that threshold issue easily dispatched, the Court turns to the merits. Plaintiffs' central position is identical to that of the challengers in Stewart I: the Arkansas Works Amendments "fundamentally alter the design and purpose of Medicaid." ECF No. 27 (MSJ) at 13. They thus assail the Secretary's approval of the Amendments on similar fronts. First, with regard to the project as a whole, Plaintiffs assert that HHS did not sufficiently consider whether it would promote the objectives of Medicaid, including how it would affect the provision of medical assistance to the needy. Second, they maintain that the Secretary lacked statutory authority to approve numerous aspects of AWA. Finally, Plaintiffs posit that a letter CMS issued in January 2018 violates the APA because it did not go through notice and comment. As in Stewart I, the Court only needs to consider the first of these contentions: "whether the Secretary acted arbitrarily or capriciously in concluding that [Arkansas Works] was 'likely to assist in promoting the objectives' of the Medicaid Act." Stewart I, 313 F. Supp. 3d at 259 (quoting 42 U.S.C. § 1315(a)).

Under that deferential standard, the Court "is not empowered to substitute its judgment for that of the agency." Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971). Nor can it "presume even to comment upon the wisdom of [Arkansas's] effort at [Medicaid] reform." C.K. v. N.J. Dep't of Health & Human Servs., 92 F.3d 171, 181 (3d Cir. 1996). Still, it is a fundamental principle of administrative law that

"agencies are required to engage in reasoned decision-making." Michigan v. EPA, 135 S. Ct. 2699, 2706 (2015) (internal quotation marks omitted). This means that an agency must "examine all relevant factors and record evidence." Am. Wild Horse Pres. Campaign v. Perdue, 873 F.3d 914, 923 (D.C. Cir. 2017). At minimum, the Secretary cannot "entirely fail[] to consider an important aspect of the problem." Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983). Rather, he must "adequately analyze . . . the consequences" of his actions. See Am. Wild Horse, 873 F.3d at 932. In doing so, "[s]tating that a factor was considered . . . is not a substitute for considering it." Getty v. Fed. Savs. & Loan Ins. Corp., 805 F.2d 1050, 1055 (D.C. Cir. 1986). The agency must instead provide more than "conclusory statements" to prove it "consider[ed] [the relevant] priorities." Id. at 1057.

With that framework in mind, Plaintiffs' position is simple: "The purpose of [] Medicaid" is to enable states "to furnish health care coverage to people who cannot otherwise afford it." MSJ at 1, 15. Yet the Secretary, just as in Stewart I, "failed to consider adequately" the impact of the proposed project on Medicaid coverage. See Am. Wild Horse, 873 F.3d at 923. Indeed, he neither offered his own estimates of coverage loss nor grappled with comments in the administrative record projecting that the Amendments would lead a substantial number of Arkansas residents to be disenrolled from Medicaid. Those omissions, they urge, make his decision arbitrary and capricious.

Plaintiffs are correct. As Opening Day arrives, the Court finds its guiding principle in Yogi Berra's aphorism, "It's *déjà vu* all over again." In other words, as

the Secretary's failures here are nearly identical to those in Stewart I, the Court's analysis proceeds in the same fashion. It begins with the basic deficiencies in the Secretary's approval in this case and then examines Defendants' counterarguments.

1. The Secretary's Consideration of Medicaid's Objectives

Before approving a demonstration or pilot project, the Secretary must identify the objectives of Medicaid and explain why the project is likely to promote them. As it did in Stewart I, the Court assumes that the Secretary's identification of those objectives is entitled to Chevron deference. That is, in reviewing his interpretation, the Court must first ask whether "Congress has directly spoken to the precise question at issue," and, if not, whether "the agency's answer is based on a permissible construction of the statute." Chevron U.S.A., Inc. v. Nat'l Res. Def. Council, Inc., 467 U.S. 837, 842-43 (1984). According such deference is not of much practical significance here, however, because the Secretary agrees with the Court's understanding of a "core objective" of the Medicaid Act. See ECF No. 52 (HHS Reply) at 5.

In Stewart I, the Court explained that "one of Medicaid's central objectives" is to "furnish medical assistance" to persons who cannot afford it. See 313 F. Supp. 3d at 243, 261, 266, 273. That conclusion followed ineluctably from § 1396-1 of the Act, which provides that Congress appropriated Medicaid funds "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance . . . [to] 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." Case law discussing the program's objectives confirms as much. See, e.g., Schweiker v. Hogan, 453 U.S. 569, 571 (1982) (explaining that Congress established Medicaid "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons"); W. Va. Univ. Hosps. Inc. v. Casey, 885 F.2d 11, 20 (3d Cir. 1989) ("[T]he primary purpose of [M]edicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it.").

Defendants, as mentioned, agree that providing health coverage to the needy is a purpose of the Act. See ECF No. 37 (HHS MSJ) at 12; Ark. MSJ at 13. In Arkansas's words, "[T]hat Medicaid coverage is a Medicaid objective is readily apparent from the substantive provisions of the statute." Ark. MSJ at 13. The Secretary, in fact, refers to the provision of medical care to eligible persons as "Medicaid's core objective." HHS Reply at 5 (emphasis added). HHS nevertheless did not consider whether AWA would advance or impede that objective.

In his approval letter, the Secretary explained that he considered the following objectives of the Medicaid Act: (1) "whether the demonstration as amended was likely to assist in improving health outcomes"; (2) "whether it would address behavioral and social factors that influence health outcomes"; and (3) "whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes." AR 4. Those are substantially the same objectives HHS

considered when it first approved the Kentucky program. See Stewart I, 313 F. Supp. 3d at 261-62. What the Court said in that case thus holds true here: "While those may be worthy goals, there [i]s a notable omission from the list"—namely, whether the project would "help or hurt [Arkansas] in 'funding . . . medical services for the needy.'" Id. (quoting Alexander v. Choate, 469 U.S. 287, 289 n.1 (1985)). By his own description, the Secretary "entirely failed to consider" this question. See State Farm, 463 U.S. at 43.

The Government conceded as much at oral argument, stating that HHS's Arkansas approval letter no more addresses the program's effects on Medicaid coverage than the Kentucky approval letter before the Court in Stewart I. See Tr. at 6-7. Because this is a separate administrative decision on review in a separate case, however, a brief assessment of the deficiency is instructive. To "adequately analyze" the issue of coverage, Am. Wild Horse, 873 F.3d at 932, the Secretary needed to consider whether the demonstration project would be likely to cause recipients to lose coverage and whether it would cause others to gain coverage. He did neither.

a. *Risk to Coverage*

The Secretary's approval letter did not consider whether AWA would reduce Medicaid coverage. Despite acknowledging at several points that commenters had predicted coverage loss, the agency did not engage with that possibility. For example, after mentioning that commenters had "expressed concerns that these requirements would . . . create barriers to coverage," the Secretary responded that "[t]he state has pledged to do beneficiary outreach and education on how to comply" and has created an "easy" online reporting system.

See AR 6. He also pointed to exemptions built into the project and to Arkansas's assurances that it will allow for "reasonable modifications" for beneficiaries unable to meet the requirements. Id. But those statements did not grapple with the coverage issue. Not only did they fail to address whether coverage loss would occur as predicted, but they also ignored that commenters had projected that such loss would happen regardless of the exemptions and the education and reporting processes; indeed, some comments pinpointed online-only reporting as a source of coverage loss. See, e.g., AR 1272, 1287.

Later, HHS noted again many commenters' view that community-engagement requirements would "create barriers to coverage for non-exempt people who might have trouble accessing care." AR 6. Instead of addressing that issue, however, it merely said: "We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment." Id. That position says nothing about the risk of coverage loss those requirements create. The bottom line: the Secretary did no more than acknowledge —in a conclusory manner, no less—that commenters forecast a loss in Medicaid coverage. But "[s]tating that a factor was considered . . . is not a substitute for considering it." Getty, 805 F.2d at 1055. His decision thus falls short of the kind of "reasoned decisionmaking" the APA requires. See Michigan, 135 S. Ct. at 2706.

Defendants argue that the Secretary did not need to —and perhaps was not even able to—provide a numeric estimate of coverage loss. See HHS MSJ at 21; Ark. MSJ at 24. While producing an empirical prediction of

coverage loss does not seem like too much to ask of the expert agency tasked with supervising Medicaid programs in all 50 states, the Court does not need to decide whether such an estimate is required. Here, numerous commenters predicted that substantial coverage loss would occur; a table cataloguing the relevant comments is included at the end of this Opinion in an Appendix. See, e.g., AR 1269 (Arkansas Advocates noting that requirement "will increase the rate of uninsured Arkansans"); AR 1277 (American Congress Obstetricians and Gynecologists explaining that "[t]he experience of the TANF program . . . demonstrates that imposing work requirements on Medicaid beneficiaries would . . . lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment."); see also ECF No. 33 (Amicus Brief of Deans, Chairs, and Scholars) at 14. Under these circumstances, the agency must grapple with the risk of coverage loss. See Nat'l Lifeline Assoc. v. FCC, 915 F.3d 19, 30-31 (D.C. Cir. 2019).

The Secretary should explain, for example, whether it agrees with the commenters' coverage predictions. If so, it might elucidate whether it expects the loss to be minor or substantial, and how that weighs against the advancement of other Medicaid objectives. Nothing close to this appears in the Secretary's approval letter. That does not mean that the Government must "recit[e] and refut[e] every objection submitted in opposition to the proposed demonstration." HHS MSJ at 22. It just means that, at a minimum, the agency cannot "entirely fail[] to consider an important aspect of the problem," repeatedly raised in the comment period. See State Farm, 463 U.S. at 43.

Arkansas maintains that the Secretary did not need to consider any reduction in coverage because it—unlike Kentucky—did not predict that the project would even cause coverage loss. See Ark. MSJ at 24. But the state's failure in that respect does not alter HHS's inquiry. Under the Medicaid Act, the Secretary may approve only those demonstration projects that are "likely to assist in promoting the objectives of [Medicaid]," and the parties agree that the provision of health coverage is a "central" objective of the Act. See 42 U.S.C. § 1315(a); HHS MSJ at 12-13; Ark. MSJ at 13. Whether a state gives the Secretary excellent data or no data at all about coverage, his duty remains the same: to determine whether the proposed project will promote the objectives of the Act, including whether it advances or hinders the provision of health coverage to the needy. If it were otherwise, HHS could approve a project that would decimate Medicaid coverage without so much as addressing the issue where the state did not submit its own estimate of coverage loss. Even putting to one side the agency's affirmative obligation to address coverage loss, however, the Secretary unquestionably has a duty to consider that issue where multiple commenters provide credible forecasts that it will occur. See, e.g., AR 1269, 1277, 1285, 1294-95. Here, as has been said, the agency had and neglected that duty.

In a last attempt to resist this conclusion, the Secretary says that he did not need to consider coverage because he had no obligation to offer any explanation of his decision to approve a demonstration project. See HHS MSJ at 22-23; see also Tr. at 9. For support, HHS points to the regulations governing its approval of demonstration projects, which do not explicitly require the Secretary to respond to comments or articulate the

basis for his decision. See HHS MSJ at 22 (discussing 42 C.F.R. § 431.416). The APA, however, requires more. Where an agency decision is judicially reviewable, as the Court has already held this one is, see Stewart I, 313 F. Supp. 3d at 254-56, the Government "must give a reason that a court can measure . . . against the 'arbitrary or capricious' standard of the APA." Kreis v. Sec'y of Air Force, 866 F.2d 1508, 1514-15 (D.C. Cir. 1989); see also Coburn v. McHugh, 679 F.3d 924, 934 (D.C. Cir. 2012) ("At the very least, the Board must 'provide an explanation that will enable the court to evaluate the agency's rationale at the time of decision.'") (quoting Pension Benefit Guar. Corp. v. LTV Corp., 496 U.S. 633, 654 (1990)). HHS's regulations—which require CMS to maintain and publish an administrative record of public comments, any CMS responses, and a written approval or disapproval letter—are fully consonant with this axiomatic administrative-law requirement. See 42 C.F.R. § 431.416(f). The argument that no explanation for the Secretary's decision is required thus does not save it.

b. *Promote Coverage*

At the same time that he failed to consider the risk to coverage, the Secretary identified only one element of the Amendments that might promote health coverage. In a single sentence, he noted that "a more limited period of retroactive eligibility will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy." AR 8. Little needs to be said on this score. It is well established that "conclusory or unsupported suppositions" do not satisfy the agency's obligation to engage in reasoned decisionmaking. See McDonnell Douglas Corp. v. U.S. Dep't of Air Force, 375

F.3d 1182, 1187 (D.C. Cir. 2004). That is particularly so in the face of numerous comments taking the opposite position. As the American Congress of Obstetricians and Gynecologists, among others, explained, limiting retroactive coverage may lead "Medicaid-eligible persons [to] wait even longer to have their conditions treated to avoid incurring medical bills they cannot pay." AR 1279. And when they do eventually arrive for treatment, they will be covered for less time than they would have been before AWA took effect, by definition reducing their Medicaid coverage. See AR 1338 (National Health Law Program describing this risk). HHS's brief reference to the potential coverage-promoting effects of the changes to retroactive eligibility thus does not get it across the line.

2. Counterarguments

Defendants offer two separate reasons for the Court to overlook the Secretary's failure to consider coverage, neither of which is persuasive. They say first that the Arkansas Works Amendments promote several other important objectives of Medicaid, including the health of Medicaid-eligible persons. Second, Defendants maintain that any deficiency in the administrative record in this case is cured by the agency's subsequent approval of Kentucky's similar project on remand from the Court's decision in Stewart I.

a. *Other Objectives*

Defendants justify the proposed demonstration project on the ground that, regardless of its effect on Medicaid coverage, it advances other objectives of the Act. HHS specifically insists, as it did in Stewart I, that the Secretary was on solid ground in finding that the project

would improve health outcomes, thereby advancing the goals of Medicaid. See HHS MSJ at 17-18. Faced with this argument previously, this Court expressed skepticism that health, generally construed, was properly considered an objective of the Act. See Stewart I, 313 F. Supp. 3d at 266. It ultimately held that the agency's "focus on health is no substitute for considering Medicaid's central concern: covering health costs" through the provision of free or low-cost health coverage. Id. The Court reached the same conclusion in response to assertions that Kentucky HEALTH promoted independence and self-sufficiency. Id. at 271-72. HHS has offered no argument here that calls those conclusions into question.

Arkansas presses the point in a somewhat different way, asserting that the provision of Medicaid coverage is (1) the purpose only of Medicaid appropriations, not Medicaid, (2) in "irreconcilable tension" with other purposes of the Act, and (3) not applicable to the Medicaid expansion population. See Ark. MSJ at 10-22. At the same time, it concedes, seemingly in conflict with its other contentions, that it is "readily apparent" that providing "Medicaid coverage for Medicaid-eligible people" is "an objective of Medicaid." Id. at 13. The Court has said this before and will say it again: if, as Arkansas and HHS admit (and this Court has found), ensuring Medicaid coverage for the needy is a key objective of the Act, the Secretary's failure to consider the effects of the project on coverage alone renders his decision arbitrary and capricious; it does not matter that HHS deemed the project to advance other objectives of the Act.

While the Court might stop there, a brief foray into Arkansas's arguments is nevertheless worthwhile. As to the first, Medicaid is an appropriations statute enacted pursuant to "Congress's power under the Spending Clause." NFIB, 567 U.S. at 542. What better place could the purpose of a spending program be found than in the provision that sets up the "purpose" of its appropriations? Arkansas's second objection is even more puzzling. The Court does not understand how the objectives of a statute all agree was designed to provide free or low-cost medical care to the needy could nevertheless stand in "irreconcilable tension" with the goal of providing free or low-cost medical care to that population. The third sits on more comprehensible ground, though it yields Arkansas no more success. Addressing the purpose of the Medicaid expansion in Stewart I, the Court explained that "the Medicaid statute —taken as a whole—confirms that Congress intended to provide medical assistance to the expansion population." 313 F. Supp. 3d at 269. HHS conceded as much in that case. Id. Neither party has offered any reason to retreat from that determination.

Defendants' attempts to find refuge in other purposes of the Act and the propriety of Chevron deference as to those purposes are thus all hat, no cattle. Because they agree that the provision of low-cost medical care to Medicaid-eligible persons is a "core" purpose of the Act, see HHS Reply at 5, there is no legally significant dispute over the meaning of the Medicaid Act. What matters, instead, is the question addressed above: whether the Secretary adequately considered this issue. As has been made abundantly clear, he did not. Perhaps understanding as much, HHS largely attempts to

justify its approval of the project in this case not on the Arkansas record but on another record entirely.

b. *Kentucky Remand*

This brings the Court to the argument that leads off the Secretary's Reply Brief: that his approval of AWA "is amply justified by the reasoning in his November 20, 2018, approval of Kentucky's materially similar project." HHS Reply at 1. In particular, HHS argues that the project on review here will, like the one approved on remand in Kentucky, help adults "transition from Medicaid to financial independence," thereby enhancing "the fiscal sustainability of Arkansas's Medicaid program"—an objective of the Act. Id. at 6. The Government clarified at oral argument that this is not merely a contention against vacatur—although it was principally offered as such—but also an argument in favor of sustaining the Secretary's approval entirely. See Tr. at 8-10. The Court addresses the latter position here, leaving the remedy question for the end. In short, three weighty and independent rationales require rejecting HHS's assertion that the Amendments should be approved based on the record in the Kentucky remand proceeding.

First, it runs headlong into the "fundamental rule of administrative law" that a reviewing court "must judge the propriety of such action solely by the grounds invoked by the agency." SEC v. Chenery Corp., 332 U.S. 194, 196 (1947). Nowhere in the Secretary's approval letter does he justify his decision based on concerns about the sustainability of Arkansas's Medicaid program, or on a belief that the project will help Medicaid-eligible persons to gain sufficient financial resources to be able to purchase private insurance. And the Court "may not

accept [] counsel's *post hoc* rationalizations for agency action." State Farm, 463 U.S. at 50; see also Burlington Truck Lines, 371 U.S. at 168-69 ("Chenery requires that an agency's discretionary order be upheld, if at all, on the same basis articulated in the order by the agency itself."). The Government responded at oral argument that the Secretary did not need to provide any basis for his decision approving Arkansas's proposed project, so it does not matter on what justification his decision is judicially upheld. See Tr. at 9-10. The Court has already explained why that assertion is inconsistent with the APA, see *supra* at 20-21, and it will not spill more ink on the matter here.

HHS's argument suffers from a second and equally significant flaw. The demonstration project under consideration in Kentucky involves different considerations from the Arkansas project, and the rationales in favor of approving one may well not apply to approving the other. The Secretary said as much in opposing this case's designation as related to the Kentucky one. See ECF No. 17 ("The two cases involve two separate approvals of two distinct projects in two different States."). Consider the principal arguments the Secretary relies upon on remand in Kentucky. First, he says that the project promotes coverage because in its absence, the expansion population would have no Medicaid coverage. See Stewart v. Azar, No. 18-152, ECF No. 108 (HHS MSJ) at 18-20. A necessary ingredient of this argument appears to be that the Kentucky Governor has conditioned the Commonwealth's continued expansion of Medicaid on the Secretary's approval of the proposed project. Id. at 19. There is no suggestion that Arkansas's Governor has made any similar kind of threat with regard to the Arkansas Works Amendments. Second,

the Secretary justifies the Kentucky program on the ground that it advances the fiscal sustainability of the state's Medicaid program, which is at risk due to Kentucky's dire budgetary situation. Id. at 15-18. Yet there is no assertion that Arkansas is suffering from similar fiscal problems. The Government's argument that the Kentucky approval justifies the decision on review in this case is particularly unpersuasive considering these significant differences.

The final reason to reject this argument is the simplest: the justification the Secretary has given for sustaining Kentucky's program on remand is insufficient and the Court today rejects it in its latest Opinion in Stewart. See Stewart v. Azar, No. 18-152, Slip Opinion at 3 (Mar. 27, 2019) (Stewart II). If the explanation does not even justify affirmance of Kentucky's project, it cannot support upholding a different administrative decision approving a different state's project.

* * *

In sum, the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address—despite receiving substantial comments on the matter—whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy. Neither his consideration of other Medicaid Act objectives nor his subsequent approval of Kentucky's separate demonstration project cure that deficiency. This failure infected the Secretary's approval of AWA as a whole, such that those Amendments are invalid. The Court will thus grant Plaintiffs full relief on their arbitrary-and-

capricious claim, removing any need to address their separate statutory-authority, APA notice-and-comment, and constitutional arguments.

C. Remedy

That leaves only the question of the proper remedy, which in these circumstances is not small beer. When a court concludes that agency action is unlawful, "the practice of the court is ordinarily to vacate the rule." Ill. Pub. Telecomms. Ass'n v. FCC, 123 F.3d 693, 693 (D.C. Cir. 1997); Reed v. Salazar, 744 F. Supp. 2d 98, 119 (D.D.C. 2010) ("[T]he default remedy is to set aside Defendants' action."); Sierra Club v. Van Antwerp, 719 F. Supp. 2d 77, 78 (D.D.C. 2010) ("[B]oth the Supreme Court and the D.C. Circuit Court have held that remand, along with vacatur, is the presumptively appropriate remedy for a violation of the APA."). "[A]lthough vacatur is the normal remedy, [courts] sometimes decline to vacate an agency's action." Allina Health Servs. v. Sebelius, 746 F.3d 1102, 1110 (D.C. Cir. 2014). That decision depends on the "seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change." Allied-Signal, Inc. v. U.S. Nuclear Reg. Comm'n, 988 F.2d 146, 150-51 (D.C. Cir. 1993) (citation omitted); see also Standing Rock Sioux Tribe v. U.S. Army Corps of Engineers, 282 F. Supp. 3d 91, 103 (D.D.C. 2017) (declining to vacate when agency "largely complied" with statute and could likely substantiate prior conclusions on remand).

In Stewart I, the Court concluded that both factors supported vacatur. The Government's failure to consider an objective of Medicaid was a "major shortcoming" going "to the heart" of his decision. See 313

F. Supp. 3d at 273. And vacatur was not overly disruptive because the project had "yet to take effect" and the plaintiffs could suffer "serious harm[s]" were Kentucky HEALTH allowed to be implemented pending further proceedings. Id. While the journey is somewhat different in this case, the Court arrives at the same destination.

1. Seriousness of Deficiencies

The first factor does not favor the Government. For starters, in Stewart I, the Court concluded that the same legal error was a "major shortcoming" going "to the heart of the Secretary's decision." 313 F. Supp. 3d at 273. It explained that the D.C. Circuit has "repeatedly vacated agency actions with that flaw." Id. Defendants respond that the Secretary has cured the error identified in Stewart I on remand, so it will assuredly be able to cure this one upon remand, too. See HHS MSJ at 28-29; see also Ark. MSJ at 37-38. Not so. As explained at length in Stewart II, the Court finds that the remand has not cured this "major shortcoming." See Slip Op. at 3, 14-45. Because the agency failed to provide a legally sufficient rationale upon remand from Stewart I, the Court is even less sanguine that it will be able to do so in this case than when it vacated the Secretary's Kentucky approval the first time.

This does not mean it will be impossible for the agency to justify its approval of a demonstration project like this one. The Court's decision does not go that far. But after at least two attempts for Kentucky, it has yet to do that analysis. Indeed, HHS may find it more difficult to offer a sufficient rationale in its second attempt in this case than in Kentucky. Arkansas does not ap-

pear to face the kind of fiscal issues asserted in Kentucky; instead, the state's data suggest that the Medicaid expansion has reduced the amount Arkansas will spend on health care for this population between 2017 and 2021. See ECF No. 53-6, Exh. 55 (Final Report of Arkansas Health Reform Legislative Task Force) (explaining that if Arkansas rejects Medicaid expansion, "the negative impact to the state budget is approximately $438 [million]" during this time frame). It stands to reason that the state will have an uphill climb making the case that the expansion has pressed its annual budget, such that eligible persons should be pushed off the rolls. Such fiscal considerations would, in any event, need to be balanced against the more than 16,000 persons who have already lost their coverage because of the new requirements. See Arkansas Works Reports at 18, 27, 36, 45. The upshot is that the road to cure the deficiency in this case is, at best, a rocky one, strongly weighing in favor of vacatur.

2. Seriousness of Disruption

The second factor is a closer call. Arkansas began implementing its demonstration project in June 2018, imposing work requirements on adults ages 30-49 and implementing the changes to retroactive coverage; it began enforcing work requirements as to adults ages 19-29 in January 2019. HHS and Arkansas assert that any interruption in the project would be enormously disruptive because it would interfere with the "State's data collection efforts," HHS Reply at 22, and "undermine" its "extensive efforts to educate Arkansas Works beneficiaries" on the work requirements. See Ark. MSJ at 38-39. They emphasize that, because the Kentucky

program had not yet taken effect at the time of its vacatur, these concerns were not present in Stewart I. Id. The Court is not insensitive to the practical concerns Defendants raise about pausing enforcement of the Amendments, nor does it take lightly the effect of its ruling upon the state today. For the reasons that follow, however, it finds that the probable disruptions are not so significant as to require deviation from the ordinary rule of vacatur.

Consider first the nature and extent of the disruptions. If the Court vacates the Secretary's approval of AWA, the state would no longer condition certain Medicaid recipients' coverage on reporting 80 hours of qualifying activities each month and would restore the number of months of retroactive coverage to three. In other words, vacatur would return matters to the way they were before the project was approved. Both changes, HHS asserts, will disrupt the state's data-collection efforts. See HHS MSJ at 29. If Arkansas—as the party responsible for collecting and analyzing data from the project—has concerns about data collection in the event of vacatur, it does not say as much. See Ark. MSJ at 38-40 (mentioning only disruptive effects on education and outreach); ECF No. 45 (Ark. Reply) (same). Indeed, one amicus points out that the Secretary approved this project without "a proposed evaluation design." See Amicus Brief of Deans, Chairs, and Scholars at 19-20.

The Court assumes, however, that vacatur would interrupt the state's efforts to collect data on the effects of the work requirements and changes to retroactive coverage. While such concerns are not insignificant, they are tempered in the context of this case. Experi-

mental projects are intended to help states like Arkansas "test out new ideas" for providing medical coverage to the needy, thereby influencing the trajectory of the federal-state Medicaid partnership down the line. See *supra* S. Rep. No. 1589 at 1961. If, after further consideration or after prevailing on appeal, the Secretary and Arkansas wish to move ahead with work requirements, they will remain able to do so in the future. And if they are dissatisfied with the data gathered from the initial months of the project because of the interruption caused by vacatur, Defendants could extend the project for an additional period of time to collect more information. This is not to minimize the importance of data collection in the context of an experimental project; it is just to say that vacatur will have little lasting impact on HHS's or Arkansas's interests. That distinguishes this case from others in which the D.C. Circuit has declined to vacate on account of irreversible harms that such a remedy would inflict on the status quo. See Allied-Signal, 988 F.2d at 151.

Defendants also maintain that vacatur will harm "Arkansas's education and outreach efforts." Ark. MSJ at 39. In that regard, they explain that a decision invalidating the work requirements will be confusing to Medicaid recipients who have just recently been informed that they have to meet those requirements. Id. at 38-39. The Court grants that vacatur of work requirements that have already been implemented may send mixed messages. But any disruption in this respect is not sufficiently significant to avoid vacatur. For one thing, Defendants have expressed confidence throughout this case that they can communicate with Medicaid

recipients regarding the terms of the work requirements. See HHS MSJ at 8; Ark MSJ at 27, 34-35. If that is so, they should be able to inform them that the requirements are paused for now and, if later reapproved, that they are put back into effect. It bears mentioning here, however, that the State's outreach efforts may well be falling severely short. Notably, only 12.3% of persons not exempt from the requirements reported any kind of qualifying activity. See Arkansas Works Reports June-November 2018 at 47, 52. The numbers are even lower for several other months. Id. Arkansas might use the time while the program is paused to consider whether and how to better educate persons about the requirements and how to satisfy them. Admittedly, vacatur could make such outreach complicated. Ultimately, however, the Court finds that the harms to prior and ongoing education do not tip the scales against vacatur.

In fact, the structure of the Amendments, considered with the timing of this Opinion, renders vacatur less disruptive that might be expected. As mentioned before, Arkansas Works recipients only lose coverage after three months of non-compliance with the work requirements. See AR 31. And the three-month clock starts over at the beginning of the calendar year. Id. Because fewer than three months have elapsed in 2019, the work requirements have not yet resulted in anyone's being disenrolled, as such actions cannot take place until April 1. As a consequence, vacatur of the Amendments will not require Arkansas to re-enroll persons who have lost their coverage, with the administrative and communication-related headaches that might entail. Instead, it just requires them to communicate to provid-

ers that they should not disenroll persons moving forward on account of the requirements. The bottom line: "This is not a case in which the 'egg has been scrambled,' and it is too late to reverse course." Allina Health, 746 F.3d at 1110-11 (quoting Sugar Cane Growers Co-op of Fla. v. Veneman, 289 F.3d 89, 97 (D.C. Cir. 2002)).

Finally, the Court emphasizes that the disruptions to Arkansas's administration of its Medicaid program must be balanced against the harms that Plaintiffs and persons like them will experience if the program remains in effect. Cf. A.L. Pharma, Inc. v. Shalala, 62 F.3d 1484, 1492 (D.C. Cir. 1995) (explaining that vacatur inappropriate because "nothing in the record suggests that significant harm would result from allowing the approval to remain in effect pending the agency's further explanation"); see also Tr. at 13 (conceding that court should consider harms to Plaintiffs as part of equitable inquiry into vacatur). Arkansas's own numbers confirm that in 2018, more than 16,000 persons have lost their Medicaid. Defendants offer no reason to think the numbers will be different in 2019; indeed, once the requirements apply to persons aged 19-29, they seem likely to rise. See Arkansas Works Reports at 18, 27, 36, 45. Weighing the harms these persons will suffer from leaving in place a legally deficient order against the disruptions to the State's data-collection and education efforts due to vacatur renders a clear answer: the Arkansas Works Amendments cannot stand.

IV. CONCLUSION

For the foregoing reasons, the Court will grant Plaintiffs' Motion for Summary Judgment and deny Defend-

ants' Cross-Motions. A separate Order consistent with this Opinion will issue this day, remanding the matter to HHS.

/s/ JAMES E. BOASBERG
JAMES E. BOASBERG
United States District Judge

Date: Mar. 27, 2019

APPENDIX A

Arkansas Health Plan Component	Comments
Community-Engagement Requirement	AR 1269 (Arkansas Advocates for Children & Families) (noting that the requirement "will increase the rate of uninsured Arkansans" based on comparable effect in TANF program) AR 1277 (American Congress of Obstetricians and Gynecologists, *et al.*) ("The experience of the TANF program . . . demonstrates that imposing work requirements on Medicaid beneficiaries would . . . lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment."); AR 1285 (Families USA) ("The presence of the requirement itself will be a barrier to enrollment, causing some eligible working individuals to forego applying for coverage, and will make it more difficult for some statutorily eligible individuals to maintain coverage."); AR 1291 (AARP) (expressing concern

	that requirements would "present an unnecessary barrier to health coverage for a sector of Arkansas's population for whom coverage is critical"); AR 1294 (Cystic Fibrosis Foundation) ("We are concerned that this definition [of medically unfit] does not specify what will qualify an individual for exemption, and that people with cystic fibrosis may lose coverage because they are unable to satisfy the requirement due to health status."); AR 1308 (Arkansas Hospital Association) ("These proposed changes . . . will likely lead to increases in churn, gaps in coverage, uninsurance and uncompensated care for hospitals and other providers."); AR 1326 (Legal Aid of Arkansas) (noting that the requirement "would exclude individuals . . . who are partially employable but suffer due to chronic health conditions"); AR 1337 (National Health Law Program) ("The end result of this policy will likely be fewer people with Medicaid coverage and

	more uninsured people delaying treatment."); AR 1341 (Nat'l Alliance on Mental Illness) ("NAMI Arkansas is concerned that the implementation of mandatory work requirements could cause substantial numbers of people with mental illness to lose health coverage, making it difficult to access mental health care."); AR 1364-65 (Urban Institute Study) (detailing "coverage losses" as consideration for pending Medicaid work-related requirements nationwide and noting "potential adverse impacts on enrollees who have high health care needs but who do not qualify for disability benefits"); AR 1402 (Medicaid and CHIP Payment and Access Commission) (listing an impact on coverage as implication of Medicaid work requirement and noting almost every state proposing requirement had estimated a coverage loss). AR 1421 (Kaiser Family Foundation Issue Brief) (arguing that based on the TANF experience, "a work requirement

	might result in eligible people losing coverage").
Retroactive Eligibility	AR 1292 (AARP) (warning lack of retroactive coverage would increase debt obligations on previous beneficiaries and would "increase the burden of uncompensated care on providers"); AR 1297 (Human ARC) ("Gaps of time without medical coverage for the low-income population that are eligible and applying for Medicaid will be significant."); AR 1307 (Arkansas Hospital Association) ("AHA is concerned that the waiver of retroactive eligibility will result in unanticipated and avoidable gaps in coverage and healthcare debt."); AR 1320 (Cancer Action Network) (stating waiver of retroactive eligibility "could place a substantial financial burden on enrollees and cause significant disruptions in care"); AR 1338 (National Health Law Program) ("The entirely predictable result will be . . . more individuals experiencing gaps in coverage when some providers refuse to treat them.").

APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 19-773 (JEB)

SAMUEL PHILBRICK, ET AL., PLAINTIFFS

v.

ALEX M. AZAR II, ET AL., DEFENDANTS

Filed: July 29, 2019

MEMORANDUM OPINION

In November 2018, the Secretary of Health and Human Services approved the State of New Hampshire's proposal to impose work requirements on a significant share of its Medicaid recipients. Under the proposal, most non-disabled Medicaid beneficiaries ages 19 to 64 would be required to demonstrate that they have completed 100 hours of qualifying employment or other "community-engagement" activities each month (or show that they satisfy an exemption) or risk losing their health-care coverage. Four New Hampshire residents have challenged the Secretary's approval in this Court, arguing that it violates the Administrative Procedure Act and the Constitution.

The issues presented in this case are all too familiar. In the past year or so, this Court has resolved challenges to similar programs in Kentucky and Arkansas, each time finding the Secretary's approval deficient. See

Stewart v. Azar, 366 F. Supp. 3d 125, 131 (D.D.C. 2019) (Stewart II); Gresham v. Azar, 363 F. Supp. 3d 165, 169 (D.D.C. 2019); Stewart v. Azar, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (Stewart I). The overriding shortcoming in the agency's decisions in those cases was its failure to adequately consider the requirements' effects on Medicaid coverage. Despite conceding that providing medical care to the needy is "Medicaid's core objective," Gresham, 363 F. Supp. 3d at 176 (citation omitted), HHS did not "offer its own estimates of coverage loss or grapple with comments in the administrative record projecting that the proposal would lead a substantial number of residents to be disenrolled from Medicaid." Id. at 175 (cleaned up).

Plaintiffs argue that the Secretary's approval of New Hampshire's plan suffers from the same deficiency and thus must meet the same fate. The Court concurs. On their face, these work requirements are more exacting than Kentucky's and Arkansas's, mandating 100 monthly hours—as opposed to 80—of employment or other qualifying activities. They also encompass a larger age range than in Arkansas, which applied the requirements only to persons 19 to 49. Yet the agency has still not contended with the possibility that the project would cause a substantial number of persons to lose their health-care coverage. That omission is particularly startling in light of information before the Secretary about the initial effects of Arkansas's markedly similar project—namely, that more than 80% of persons subject to the requirements had reported no compliance information for the initial months, and nearly 16,900 people had lost coverage. The agency's rejoinders—that the requirements advance other asserted purposes

of Medicaid, such as the health and financial independence of beneficiaries and the fiscal sustainability of the safety net—are identical to those this Court rejected with respect to HHS's 2018 approval of Kentucky's program. Perhaps seeing the writing on the wall, the Government conceded at oral argument that its reasoning was deficient in these respects under the analysis in the Court's prior Opinions.

In short, we have all seen this movie before. The Secretary has significant discretion to approve demonstration projects that promote the objectives of the Medicaid Act, and it is not for the Court to second guess his policy decisions or substitute its judgment for his. "But courts retain a role, and an important one, in ensuring that agencies have engaged in reasoned decisionmaking." Judulang v. Holder, 565 U.S. 42, 53 (2011). At the heart of this review is an assessment of "whether the decision was based on a consideration of the relevant factors." Id. (citation omitted). For the fourth time, HHS has fallen short of this fundamental administrative-law requirement. The Court will, accordingly, grant summary judgment to Plaintiffs and vacate the Secretary's approval of New Hampshire's community-engagement requirements.

I. BACKGROUND

The Court begins with a now-familiar overview of the relevant history and provisions of the Medicaid Act. It then turns to New Hampshire's challenged plan before concluding with the procedural history of this case.

A. The Medicaid Act

Since 1965, the federal government and the states have worked together to provide medical assistance to

certain vulnerable populations under Title XIX of the Social Security Act, commonly known as Medicaid. See 42 U.S.C. § 1396-1. The Centers for Medicare and Medicaid Services (CMS), a federal agency within the Department of Health and Human Services, has primary responsibility for overseeing Medicaid programs. Under the cooperative federal-state arrangement, participating states submit their "plans for medical assistance" to the Secretary of HHS. Id. To receive federal funding, those plans—along with any material changes to them—must be "approved by the Secretary." Id.; see also 42 C.F.R. § 430.12(c). Currently, all states have chosen to participate in the program.

To be approved, state plans must comply with certain minimum parameters set out in the Medicaid Act. See 42 U.S.C. § 1396a (listing 86 separate requirements). One such provision requires state plans to "mak[e] medical assistance available" to certain low-income individuals. Id. § 1396a(a)(10)(A). Until recently, that group included pregnant women, children, and their families; some foster children; the elderly; and people with certain disabilities. Id. In 2010, however, Congress enacted the Patient Protection and Affordable Care Act (ACA), colloquially known as Obamacare, "to increase the number of Americans covered by health insurance." Nat'l Fed'n of Indep. Business v. Sebelius, 567 U.S. 519, 538 (2012). Of relevance here, that statute required participating states to expand Medicaid coverage to additional low-income adults under 65 who did not previously qualify. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

Generally, a state must cover all qualified individuals or forfeit its federal Medicaid funding. Id. § 1396a(a)(10)(B);

id. § 1396c. That was originally so for the ACA expansion population as well. Id. § 1396c. In NFIB, however, the Supreme Court held that Congress could not, consistent with the Spending Clause of the Constitution, condition a state's entire Medicaid funds on its agreeing to the expansion. See 567 U.S. at 584-85. As a result, states could choose not to cover the new population and lose no more than the funds that would have been appropriated for that group. Id. at 587. If the state, conversely, does decide to provide coverage, those individuals would become part of its mandatory population. Id. at 585-87 (explaining that Congress may "offer[] funds under the Affordable Care Act to expand the availability of health care, and require[] that States accepting such funds comply with the conditions on their use"). In that instance, the state must afford the expansion group "full benefits"—*i.e.*, it must provide "medical assistance for all services covered under the State plan" that are substantially equivalent "in amount, duration, or scope . . . to the medical assistance available for [other] individual[s]" covered under the Act. See 42 U.S.C. § 1396d(y)(2)(B); 42 C.F.R. § 433.204(a)(2).

The Medicaid Act, in addition to defining who is entitled to coverage, also ensures what coverage those enrolled individuals receive. Under § 1396a, states must cover certain basic medical services, see 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a), and the statute limits the amount and type of premiums, deductions, or other cost-sharing charges that a state can impose on such care. Id. § 1396a(a)(14); see also id. § 1396*o*. Other provisions require states to provide up to three months of retroactive coverage once a beneficiary enrolls, id. § 1396a(a)(34), and to ensure that recipients receive all

"necessary transportation . . . to and from providers." 42 C.F.R. § 431.53. Finally, states must "provide such safeguards as may be necessary to assure that eligibility" and services "will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

Both before and after the passage of the ACA, a state accepting federal Medicaid funds is not entirely locked in; instead, if it wishes to deviate from certain of the Act's requirements, it can seek a waiver from the Secretary of HHS. See 42 U.S.C. § 1315. In particular, Section 1115 of the Social Security Act allows the Secretary to approve "experimental, pilot, or demonstration project[s] which, in [his] judgment . . . , [are] likely to assist in promoting the [Act's] objectives." 42 U.S.C. § 1315(a). As conceived, experimental projects were "expected to be selectively approved by the Department and to be those which are designed to improve the techniques of administering assistance." S. Rep. No. 1589, 87th Cong., 2d Sess. 19, reprinted in 1962 U.S.C.C.A.N. 1943, 1962. Once the Secretary has greenlighted such a project, he can then waive compliance with the requirements of § 1396a "to the extent and for the period . . . necessary to enable [the] State . . . to carry out such project." Id. § 1315(a)(1).

While the ultimate decision whether to grant § 1115 approval rests with the Secretary, his discretion is not boundless. Before HHS can act on a waiver application, the state "must provide at least a 30-day public notice[-]and[-]comment period" regarding the proposed program and hold at least two hearings at least 20 days before submitting the application. See 42 C.F.R.

§§ 431.408(a)(1), (3). Once a state completes those prerequisites, it then sends an application to CMS. Id. § 431.412 (listing application requirements). After the agency notifies the state that it has received the waiver application, a federal 30-day public-notice period commences, and the agency must wait at least 45 days before rendering a final decision. Id. §§ 431.416(b), (e)(1).

B. Factual Background

1. New Hampshire Granite Advantage

In 2014, New Hampshire, like many states, expanded Medicaid under the ACA to previously uninsured adults whose income is 133 percent of the federal poverty line or less. See AR 17; AR 1949. More than 53,000 individuals have received coverage as a result, helping to reduce the State's uninsured rate by 45 percent. Id. at 4384. Since 2015, the State has covered this population through Section 1115 demonstration projects that deviate from traditional Medicaid delivery mechanisms—first adopting a premium-assistance model and later shifting to a managed-care system. Id. at 4379. While New Hampshire has had an interest in work requirements dating back to 2016, id. at 99, it proposed to amend its demonstration to add the work and community-engagement requirements under consideration in this suit in 2018. Id. at 4377.

As proposed, the project—now called Granite Advantage—requires most non-disabled adults aged 19 to 64 to complete 100 hours per month of employment or other community activities. Id. at 4. Certain categories of beneficiaries are exempt, including caregivers for a dependent child, pregnant women, and the medically

frail. Id. at 5. If a beneficiary does not demonstrate compliance with the work requirements in a particular month, she will be sent a notice stating that her Medicaid will be terminated the following month if she does not make up the hours or show that she qualifies for an exemption. Id. Once a beneficiary's coverage is suspended, it can be reactivated by completing 100 hours of qualifying activities or obtaining an exemption. Id. at 5, 7. Separately, New Hampshire requested as part of these amendments that HHS allow the State to eliminate all retroactive coverage. Id. at 4377.

The Secretary approved the amendments on November 30, 2018, explaining that they promoted the purposes of the Medicaid Act because they would improve the "health and wellness" of beneficiaries and enhance the "fiscal sustainability of the Medicaid program." Id. at 1-2. With respect to commenters' concerns that some beneficiaries would lose coverage, the agency responded that "the demonstration will provide coverage to individuals that the state is not required to cover"—namely, the ACA expansion population. Id. at 10. Indeed, because "the state plans to end its current coverage of the new adult group" in the event the project were not approved, HHS says, Granite Advantage necessarily increases coverage. Id. at 6, 10. The agency further explained that the requirements were "not designed to encourage" coverage loss and are "intended to [be] achievable," citing certain exemptions and safeguards that are meant to reduce the likelihood of persons improperly losing their Medicaid. Id. at 10-11.

While the new requirements could have been implemented under this approval beginning January 1, 2019, id. at 1, they have still not been put into full effect.

New Hampshire, after several initial delays, required beneficiaries to submit qualifying hours or proof of an exemption this past June. See ECF No. 1 (Complaint), ¶ 10. Under that timeframe, persons who did not satisfy the reporting obligations would lose their coverage on August 1. Id. As of July 8, 2019, however, approximately 17,000 non-exempt beneficiaries (out of about 25,000 total) had not reported any compliance information to the New Hampshire Department of Health and Human Services. See ECF No. 44-2 (Jeffrey A. Meyers Letter, July 8, 2019) at 3. Citing this consideration and emphasizing the difficulty the State has had in communicating with persons subject to the community-engagement requirements, the Department announced that it was further delaying implementation until September 30, 2019. See ECF No. 44 (Notice) at 2. Under the new implementation plan, Medicaid beneficiaries who do not report compliance with the requirements would lose coverage beginning December 1. Around the same time, the New Hampshire Legislature amended the program in several respects, including by expanding the scope of the exemptions. The State explained that it plans to seek reapproval of such amendments from CMS over the next several months. See Oral Argument Transcript (Provisional) at 3, 17.

2. Other CMS Approvals

New Hampshire is not the only state that has been interested in work requirements. As noted at the start, CMS has approved similar proposals submitted by Kentucky and Arkansas, each of which has been challenged and struck down in this Court. Kentucky's program—called Kentucky HEALTH—mirrors New

Hampshire's in many respects. As relevant here, it requires non-exempt adults aged 19 to 64 who receive coverage through the expansion to complete and report 80 hours per month of qualifying activities, such as employment, education, or job training. See Stewart I, 313 F. Supp. 3d at 246. The failure to do so or to report an exemption results in the termination of Medicaid coverage. Id. at 246-47.

Before the requirements took effect in the Commonwealth, several Medicaid recipients sought judicial review of HHS's approval. Id. at 248. They argued, among other things, that the agency had failed to adequately explain why Kentucky HEALTH promoted the objectives of Medicaid and that the approval of the project exceeded the Secretary's statutory authority. The Court agreed with Plaintiffs in one central and dispositive respect: "[T]he Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." Id. at 243. It therefore vacated the Secretary's approval and remanded the matter to the agency for further consideration. Id. at 273-74. HHS subsequently reopened the comment period and reapproved Kentucky's project on November 20, 2018. The agency reasoned, along substantially similar lines as it did ten days later when it approved New Hampshire's project, that Kentucky HEALTH advanced the Medicaid Act's objectives because it would 1) promote the health and financial independence of beneficiaries, a justification the Court had found wanting in the first round, 2) increase coverage because it allows Kentucky to cover the expansion population when it would not do so otherwise, and 3) advance the fiscal sus-

tainability of the state's Medicaid program. See Stewart II, 366 F. Supp. 3d at 138. Believing these justifications still unsatisfactory, the Bluegrass State plaintiffs returned to this Court, which again concurred. Concluding that the agency's previous rationales fared no better and that its new explanation still failed to grapple with the possibility of coverage loss, the Court vacated the approval. Id. at 138-39.

Arkansas's project, named the Arkansas Works Amendments, followed a similar, although abbreviated, path. The State proposed to require most able-bodied beneficiaries in the expansion population aged 19 to 49 to complete 80 hours of qualifying employment or other activities. See Gresham, 363 F. Supp. 3d at 172. Non-exempt individuals who did not report sufficient qualifying hours for three consecutive months in a calendar year would be disenrolled from Medicaid for the remainder of that year. Id. The Secretary approved the requirements on March 5, 2018, and their roll-out was staged through 2018 and early 2019. Id. During the first six months after implementation, however, "only a small percentage of the persons required to report compliance . . . actually did so"—in October 2018, only 12.3% reported any kind of qualifying activities—and more than 16,900 persons lost Medicaid coverage for some period of time as a result. Id. Several beneficiaries challenged the program under the APA, and, finding the Secretary's explanation deficient for the same reasons as in its first Kentucky decision, the Court vacated his approval. Id. at 175. The Court's decisions as to both of those cases are now on appeal before the D.C. Circuit. See Case Nos. 19-5094, 19-5095, 19-5096, 19-5097. No oral argument date has yet been set.

C. Procedural History

Believing with Shakespeare that what's past is prologue, four New Hampshire residents filed this lawsuit on March 20, 2019. Like the plaintiffs in Arkansas and Kentucky, they assert that the Secretary's approval of the proposed community-engagement requirements violates the APA and the Constitution. Because it was designated as related to Stewart and Gresham, the case was directed to this Court. See ECF Nos. 2-3. The State of New Hampshire has since intervened as a Defendant, and numerous *amici* have also weighed in. Dueling Cross-Motions for Summary Judgment are now ripe, and the Court held a hearing on July 23, 2019.

II. LEGAL STANDARD

The parties have cross-moved for summary judgment on the administrative record. The summary-judgment standard set forth in Federal Rule of Civil Procedure 56(c), therefore, "does not apply because of the limited role of a court in reviewing the administrative record." Sierra Club v. Mainella, 459 F. Supp. 2d 76, 89 (D.D.C. 2006); see also Bloch v. Powell, 227 F. Supp. 2d 25, 30 (D.D.C. 2002), aff'd, 348 F.3d 1060 (D.C. Cir. 2003). "[T]he function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." Sierra Club, 459 F. Supp. 2d. at 90 (quotation marks and citation omitted). "Summary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [Administrative Procedure Act] standard of review." Loma Linda Univ. Med. Ctr. v. Sebelius, 684 F. Supp. 2d 42, 52 (D.D.C. 2010) (citation omitted).

The Administrative Procedure Act "sets forth the full extent of judicial authority to review executive agency action for procedural correctness." FCC v. Fox Television Stations, Inc., 556 U.S. 502, 513 (2009). It requires courts to "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). Agency action is arbitrary and capricious if, for example, the agency "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." Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).

In other words, an agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." Id. at 43 (quoting Burlington Truck Lines, Inc. v. United States, 371 U.S. 156, 168 (1962)) (internal quotation marks omitted). Courts, accordingly, "do not defer to the agency's conclusory or unsupported suppositions," United Techs. Corp. v. Dep't of Def., 601 F.3d 557, 562 (D.C. Cir. 2010) (quoting McDonnell Douglas Corp. v. Dep't of the Air Force, 375 F.3d 1182, 1187 (D.C. Cir. 2004)), and "agency 'litigating positions' are not entitled to deference when they are merely [agency] counsel's '*post hoc* rationalizations' for agency action, advanced for the first time in the reviewing court." Martin v. Occupational Safety & Health Review Comm'n, 499 U.S. 144, 156 (1991) (citation omitted). Although a reviewing court "may not supply a reasoned basis for the agency's action that the

agency itself has not given," a decision that is not fully explained may nevertheless be upheld "if the agency's path may reasonably be discerned." Bowman Transp., Inc. v. Arkansas-Best Freight System, Inc., 419 U.S. 281, 285-86 (1974) (citation omitted).

III. ANALYSIS

Just as their predecessors did, Plaintiffs here challenge the Secretary's approval of New Hampshire's demonstration project on a number of different grounds, including that it was arbitrary and capricious, in excess of statutory authority, and in violation of the Take Care Clause of the U.S. Constitution. As in its three previous Opinions, the Court need only address the first to resolve this case. Before turning to that issue, however, it begins with jurisdiction.

A. Jurisdiction

While Defendants largely do not contest whether subject-matter jurisdiction exists in this case, the Court has an independent duty to assure as much. See Steel Co. v. Citizens for a Better Environment, 523 U.S. 83, 94-95 (1998). Two potential hurdles stand across Plaintiffs' path. The first is whether the Secretary's decision is "committed to agency discretion by law" and is therefore unreviewable under the APA. See 5 U.S.C. § 701(a)(2). HHS insisted in Stewart I that its determination to approve a Section 1115 demonstration project fell within this exception to the general presumption that administrative action is judicially reviewable. After a lengthy discussion, the Court agreed with "every court which has considered the issue" and found that the Secretary's approval was "subject to APA review." 313 F. Supp. 3d at 256 (quoting Beno v. Shalala, 30 F.3d

1057, 1067 & n.24 (9th Cir. 1994)). Apart from a couple of conclusory sentences in their Opposition and Reply, Defendants no longer press this objection, and the Court sees no reason to depart from its prior decision finding HHS's decision reviewable.

The second jurisdictional question is whether Plaintiffs have standing to bring this suit. Article III of the Constitution limits the Court's jurisdiction to "cases" or "controversies." The standing doctrine enforces this requirement, assuring that courts only decide actual disputes between parties with personal stakes in the outcome. See Clinton v. City of New York, 524 U.S. 417, 429 (1998). To establish standing, Plaintiffs must show that they have suffered (or will suffer in the future) a concrete injury that is both fairly traceable to the challenged conduct and likely to be redressed by a favorable judicial decision. See Lujan v. Defenders of Wildlife, 504 U.S. 555, 590 (1992). While Defendants disputed the basis of the plaintiffs' standing in Stewart I, in their briefing this time around, they generally leave their powder dry. Upon review, the Court can see why: at least one Plaintiff clearly has standing.

Only a few sentences are needed to show as much. Plaintiff Ian Ludders is a forty-year-old Medicaid recipient who will be subject to New Hampshire's community-engagement requirements. See ECF No. 1 (Compl.), ¶¶ 146-56; ECF No. 19-3 (Declaration of Ian Ludders); see also ECF 37-2 (Declaration of Henry Lipman) at 2. Because he maintains a "subsistence lifestyle that prioritizes living off the land" and his work is agricultural and thus largely seasonal, he does not expect that he will be able to comply with the new requirements for multiple months out of the year. See Compl., ¶¶ 147-56. Taken

together, these facts satisfy each of the three standing requirements: 1) there is a substantial risk that Ludders will lose his Medicaid coverage, thereby injuring him; 2) this risk is traceable to the Secretary's approval of the requirements; and 3) a judicial decision vacating them is likely to prevent the future injury. It may well be that Plaintiffs apart from Ludders also have standing, but there is no need to delve into that issue here. See Comcast Corp. v. FCC, 579 F.3d 1, 6 (D.C. Cir. 2009) ("[I]f one party has standing in an action, a court need not reach the issue of the standing of other parties when it makes no difference to the merits of the case.").

Defendants separately suggest that none of the Plaintiffs has standing to challenge one aspect of the Secretary's approval: his decision to allow New Hampshire to eliminate retroactive Medicaid coverage. See ECF No. 30 (HHS Cross-Mot.) at 24. As the Court explained in its prior Opinions, however, it is appropriate to "examine[] the approval of the project as a whole," given the nature of Plaintiffs' claim and the administrative action under review. Stewart I, 313 F. Supp. 3d at 253. That makes it unnecessary to decide whether any Plaintiff has standing with respect to this particular component of the Secretary's approval.

B. Merits

Turning to the merits, Plaintiffs principally submit that the Secretary's approval of the Granite Advantage project is arbitrary and capricious because it did not adequately consider the effects of the demonstration project on Medicaid coverage. The Court, as discussed above, found this argument persuasive in each of its prior three decisions, and it continues to do so. The

critical issues are thus whether the reasoning in the Secretary's approval letter meaningfully differs from the previous three, or whether attributes particular to New Hampshire's community-engagement program, as discussed in the approval, suggest coverage-loss concerns will be less significant.

Defendants' briefing does not attempt to distinguish the approval letter or the program from those in Stewart I, Stewart II, and Gresham; indeed, it marches through its arguments barely acknowledging that the Court has decided these precise issues before and adversely to HHS. At oral argument, however, the Government effectively conceded that the Secretary's reasoning in this case cannot be distinguished from his explanations in the prior ones. See Tr. at 2, 10. The Court likewise finds the records to be indistinguishable. As discussed in more detail below, CMS's approval letter mirrors the one in Stewart II, with numerous key paragraphs matching it word for word. And New Hampshire's proposed project presents, if anything, greater coverage-loss concerns than Kentucky's and Arkansas's, given the hours requirement and the age range to whom it applies.

The Court's analysis unfolds in two parts. First, it summarizes the now-familiar view that the core objective of the Medicaid Act is to furnish health-care coverage to the needy and explains why the Secretary failed to adequately consider that objective here. Turning to Defendants' counterarguments—nearly all of which were addressed at length in Stewart II—the Court will offer an abbreviated restatement of why the agency's consideration of other Medicaid Act objectives does not remedy this deficiency.

1. Coverage as Objective of the Medicaid Act

The Secretary, as outlined above, can only approve demonstration projects that are "likely to assist in promoting the objectives" of the Medicaid Act. See 42 U.S.C. § 1315(a). Before greenlighting a project, he must therefore identify the objectives of the Act and explain why the demonstration is likely to promote them. The Court has assumed that the Secretary's interpretation of those objectives is entitled to Chevron deference. See Gresham, 363 F. Supp. 3d at 176. That is, in reviewing his understanding, the Court must first ask whether "Congress has directly spoken to the precise question at issue" and, if not, whether "the agency's answer is based on a permissible construction of the statute." Chevron U.S.A., Inc. v. Nat'l Res. Def. Council, Inc., 467 U.S. 837, 842-43 (1984). Because all parties agree that "Medicaid's core objective" is to "furnish[] medical assistance" to persons who cannot afford it, according such deference would have no practical significance with respect to this objective. See ECF No. 38 (HHS Reply) at 5; ECF No. 35 (Plaintiffs' Reply) at 6; see also Stewart I, 313 F. Supp. 3d at 260-62. The Court will not repeat its discussion of why the provision of medical assistance to beneficiaries—both recipients of traditional Medicaid and members of the expansion population—is the central purpose of the Act, but instead directs interested readers to its prior Opinions. See Gresham, 363 F. Supp. 3d at 176; Stewart II, 366 F. Supp. 3d at 138; Stewart I, 313 F. Supp. 3d at 260-62.

Having correctly identified the provision of Medicaid coverage as a core objective, the agency was required to reasonably explain whether New Hampshire's proposed community-engagement requirements would advance

or impede that goal. In other words, "the Secretary needed to consider whether the demonstration project would be likely to cause recipients to lose coverage and whether it could cause others to gain coverage." Gresham, 363 F. Supp. 3d at 177. He once again neglected to do so on both counts.

a. *Risk to Coverage*

Before approving a proposed demonstration, the Secretary must address whether it creates a risk that beneficiaries will lose their Medicaid coverage. Unlike in Stewart I and Gresham, here the agency at least mentioned the possibility of coverage loss in its approval. That is step one. But "stating that a factor was considered . . . is not a substitute for considering it," Getty v. Fed. Savs. & Loan Ins. Corp., 805 F.2d 1050, 1055 (D.C. Cir. 1986); he must "adequately analyze . . . the consequences" of his actions. Am. Wild Horse Pres. Campaign v. Perdue, 873 F.3d 914, 932 (D.C. Cir. 2017). Here the Secretary fell well short.

For starters, he "never provided a bottom-line estimate of how many people would lose Medicaid" with Granite Advantage in place. Stewart II, 366 F. Supp. 3d at 140 (quoting Stewart I, 313 F. Supp. 3d at 262). In its proposal, New Hampshire estimated that the project would have no material effect on Medicaid enrollment, though it also hinted that coverage would otherwise have expanded given population growth. See AR 4386. The many commenters who addressed the issue unanimously agreed that coverage loss would be substantial. The Kaiser Family Foundation, for example, projected an enrollment loss between 6 and 17 percent, corresponding to between 2600 and 7500 people losing Medicaid. See AR 2532, 4384 (applying disenrollment

rates to 44,000 non-frail adults subject to Granite Advantage). Appendix A documents numerous comments and studies projecting the same or greater coverage losses. See, e.g., AR 1949, 1953, 2132, 2208, 2210, 2238, 2241. When the Secretary approved the project, he also had the benefit of data from the first several months of Arkansas's comparable project, which presented a stark picture. See AR 2731-47. In that time, only 12.3% of non-exempt persons "reported any kind of qualifying activity," and "16,900 individuals ha[d] lost Medicaid coverage for some period of time" as a result. Gresham, 363 F. Supp. 3d at 172 (emphasis added). Commenters explained that results were likely to be similar in New Hampshire. See, e.g., AR 2563, 2963. Indeed, because the State's requirements are more stringent than Arkansas's in key respects—*e.g.*, requiring 100 rather than 80 hours per month of activities and applying to adults aged 19 to 64 rather than 19 to 49—many projected that Granite Advantage would lead to more coverage loss than Arkansas's program. See, e.g., AR 2258, 2542, 2575, 2586.

What does the Secretary think about all this? Does he concur with New Hampshire's apparent view that coverage loss is going to be minimal, or does he agree with the commenters that it is likely to be substantial? Are the coverage losses in Arkansas likely to be replicated in New Hampshire? We have no idea, since the approval letter offers no hints. While Defendants may well be correct that HHS does not need to provide a precise numeric estimate of coverage loss, it can hardly be disputed that the agency needs to address the magnitude of that loss. That is particularly so where the comments uniformly assert—and the record evidence from similar programs strongly suggests—that the loss

will be substantial. The Secretary's "failure to address" this "salient factor" renders his decision arbitrary and capricious. See Humane Soc'y of United States v. Zinke, 865 F.3d 585, 606-07 (D.C. Cir. 2017).

HHS generally conceded at oral argument that the Secretary did not consider coverage to a greater degree in this case than in Stewart II. See Tr. at 10-11. In their briefing, however, Defendants offer several responses worthy of discussion. The agency first insists that it did consider the risk of coverage loss because it mentioned that possibility at several points in its approval letter. For example, the Secretary explained that "[t]he community engagement requirements may impact overall coverage levels if the individuals subject to the requirements choose not to comply with them." AR 6. This and statements like it butter few parsnips, for acknowledging the possibility of coverage loss is not the same as analyzing that possibility. See Getty, 805 F.2d at 1055. The letter gives no indication, as mentioned above, about the seriousness of the loss; for all the reader gleans, the project could expel 75% of prior Medicaid beneficiaries. It also neglects the possibility, likewise discussed by numerous commenters, that many beneficiaries will lose coverage merely because they are not able to satisfy the administrative burden associated with reporting their compliance. See AR 1484, 1489, 2132, 2241, 3406, 4564.

The Secretary also offers a second, more substantive response to concerns about coverage loss. He says that Granite Health was designed "to minimize coverage loss due to noncompliance," AR 11, citing the exemptions built into the project, the procedural safeguards in-

tended to prevent improper disenrollment, and the otherwise achievable nature of the requirements. Id. at 7-11. The State of New Hampshire likewise cites the broader intentions of the program and the corresponding protections put in place to prevent coverage loss. See ECF No. 37 (NH Reply) at 8. To state the obvious, however, that a project is intended to avoid coverage loss does not mean that it will do so. Similar intentions existed and corresponding protections were put in place in Kentucky, but the Commonwealth projected a coverage loss equivalent to 95,000 people losing Medicaid for one year. Same with Arkansas, yet it found that nearly 17,000 lost coverage at some point in the first six months alone. The commenters in this case explained as much, since most of the exemptions or safeguards CMS mentions were baked into their comments about the likelihood of significant coverage loss. See, e.g., AR 1484, 2132, 2241. Ultimately, the agency's explanation here comes up short—just as it did in the previous three cases—because it does not address whether and how these design attributes bear on the actual magnitude of coverage loss. See Stewart II, 366 F. Supp. 3d at 142-43.

While Defendants offer two remaining arguments as to why they have adequately considered coverage, both are more properly addressed in subsequent sections. Briefly, they assert that the project will not actually decrease coverage because it allows the State to cover a population it would not otherwise cover—namely, the ACA expansion group. The Court will analyze this argument in the ensuing section on whether the Secretary adequately considered if the project would promote coverage. See *infra* Section III.B.1.b. Defendants also maintain that any coverage loss is outweighed by the

project's promotion of other purposes of Medicaid, including health, financial independence, and fiscal sustainability. This point—which does not directly bear on whether the Secretary has ever grappled with coverage—will be addressed below in Section III.B.2.

b. *Promote Coverage*

The Secretary offers two possible reasons why Granite Advantage might improve the state's ability to furnish medical assistance to the needy. The first can be dispatched quickly. He says that the elimination of retroactive eligibility may "encourage beneficiaries to obtain and maintain health coverage, even when they are healthy." AR 12. Setting aside the equivocal nature of this assertion and the numerous comments to the contrary in the record (AR 1479-80, 4565), this possibility has nothing to do with the coverage loss the community-engagement requirements might cause. To the extent the Secretary believes that the elimination of retroactive coverage might (counterintuitively) increase coverage, he needs to weigh the promotion side of the scale against the risk-of-loss side when approving the project. That did not happen. Indeed, such a calculus would be difficult to undertake given the agency's failure, discussed at length above, to characterize the magnitude of coverage loss presented by the community-engagement requirements.

Defendants' second argument about coverage promotion is one the Court addressed at length in Stewart II: because the State will "simply de-expand Medicaid" if Granite Advantage is not approved, any coverage provided to the expansion population through the demonstration is properly understood as increasing Medicaid coverage. See 366 F. Supp. 3d at 153; see also AR 10.

In other words, "[a] demonstration that shrinks coverage may thus be coverage promoting for the purposes of § 1115 as long as the state threatens that if the demonstration is not approved, it will discontinue coverage entirely." Stewart II, 366 F. Supp. 3d at 153; see HHS Cross-Mot. at 17-18. In Stewart II, the Court addressed this point as a variant of the agency's fiscal-sustainability rationale because the ostensible reason for Kentucky to de-expand absent approval was its fiscal situation. In doing so, however, the Court noted that the argument "does not depend on a state's being in a fiscally precarious position because it does not take into account the reason the state wants to discontinue participating in the Medicaid program." Stewart II, 366 F. Supp. 3d at 154.

This case proves the point. New Hampshire has not justified its desire to de-expand absent approval of the community-engagement requirements on fiscal concerns; indeed, the State explained at oral argument that it was not facing such budgetary woes. See Tr. (Complete Transcript Pending). It ultimately does not matter how their argument is characterized; "[it] is both inconsistent with the Medicaid Act and arbitrary and capricious." Id. at 153. Before briefly restating why that is the case, the Court notes that HHS seems largely to have abandoned any robust form of this argument on appeal. See Stewart v. Azar, Case No. 19-5095, Appellant Brief at 37 (noting only that "it is permissible for HHS to take the optional character of the coverage into account when considering such applications").

As the Court explained in Stewart II, this position is unpersuasive for three interrelated reasons. To start, Defendants incorrectly assume that "a state has additional

discretion to diminish or condition eligibility for the expansion—as opposed to the traditional—population." 366 F. Supp. 3d at 153. They appear to divine this principle from the Supreme Court's decision in NFIB, where it found Congress's decision to require states to expand Medicaid unduly coercive under the Spending Clause. See 567 U.S. at 583-85. But the remedy for this constitutional problem was simply to prevent the Secretary from withdrawing "existing Medicaid funds for failure to comply with the requirements set out in the expansion." Id. at 585. After the decision, states were thus left with a choice: accept ACA funds and "comply with the conditions on their use" or decline ACA funds and keep prior federal Medicaid appropriations. Id.; see also id. at 586 (explaining that decision does not "affect the Secretary's ability to withdraw funds provided under the Affordable Care Act if a [s]tate that has chosen to participate in the expansion fails to comply with the requirements of that Act"). Since the Act otherwise places the expansion population on the same plane as the traditional population, states have no "additional discretion" in how to comply with Medicaid requirements as to the expansion group. See Stewart II, 366 F. Supp. 3d at 153.

While Defendants thus err in believing that their treatment of the expansion population is undergirded with any greater discretion than their administration of any other part of the Medicaid program, their argument about flexibility vis-à-vis the expansion population are ultimately a red herring. That is because the entire Medicaid program is optional for states. The Court does not see why—if Defendants are correct that threats to terminate the expansion program can supply the baseline for the Secretary's § 1115 review—that argument would

not be equally good as applied to traditional Medicaid. Id. at 153. Their argument must thus posit that any § 1115 program that maintains any coverage for any set of individuals promotes the objectives of the Medicaid Act as long as the state threatens to terminate all of Medicaid in the absence of waiver approval. The second problem with this position, then, is that it has no limiting principle. Under the Secretary's reasoning, states may threaten to de-expand, or indeed do away with all of, Medicaid if he does not approve whatever waiver of whatever Medicaid requirements they wish to obtain. The Secretary could then always approve those waivers, no matter how few people remain on Medicaid thereafter, because "any waiver would be coverage promoting compared to a world in which the state offers no coverage at all." Id. at 154. This reading of the Act would give HHS practically unbridled discretion to implement the Medicaid Act as "an *à la carte* exercise, picking and choosing which of Congress's mandates it wishes to implement." Id. at 153-54. Apart from the potential constitutional concerns such an interpretation would raise, cf. Clinton, 524 U.S. at 440-47 (1998), it clearly constitutes "an impermissible construction of the statute . . . because [it] is utterly unreasonable in [its] breadth." Aid Ass'n for Lutherans v. U.S. Postal Serv., 321 F.3d 1166, 1178 (D.C. Cir. 2003); see also Agape Church, Inc. v. FCC, 738 F.3d 397, 410 (D.C. Cir. 2013).

The third and final reason to reject this reading is perhaps the most important: it is inconsistent with the text of § 1115. The statute requires the Secretary to evaluate whether the project "is likely to assist in promoting the objectives" of the Act. See 42 U.S.C.

§ 1315. Against what baseline is he supposed to evaluate the project? The structure of the waiver provision assumes the implementation of the Act. It confirms that the relevant baseline is whether the waiver will promote the objectives of the Act as compared to compliance with the statute's requirements, "not as compared with a hypothetical future universe" where the Act has no force. Stewart II, 366 F. Supp. 3d at 154. This is so because the overarching provision authorizing these waivers stipulates that, if the Secretary makes a judgment that a demonstration promotes the objectives of the Act, he may then waive compliance with certain of its provisions "to the extent and for the period . . . necessary" to carry out the project. See 42 U.S.C. § 1315(a), (a)(1). That is, the provision contemplates a limited waiver from compliance with the Act's provisions. Particularly in light of what the Court has discussed above, understanding the baseline as such is the only way this provision makes sense.

For these reasons, the Secretary cannot escape his obligation to consider whether Granite Advantage poses a risk to coverage or is likely to increase coverage by emphasizing the optional nature of the expansion or by citing New Hampshire's plan to de-expand absent project approval.

2. Other Objectives of the Medicaid Act

Defendants argue that, regardless of whether the Secretary properly considered Granite Advantage's effects on coverage, he reasonably approved the project on the ground that it is likely to advance several other Medicaid objectives—namely, the health and financial independence of beneficiaries and the fiscal sustainabil-

ity of the safety net. HHS relied on those same objectives when it approved Kentucky's project the second time, and the Court addressed them at length in Stewart II. Indeed, the approval letter reviewed in that decision —which preceded New Hampshire's by only ten days— tracks the one here practically verbatim with respect to these objectives. Compare AR 1-6 with Kentucky II Approval Letter at 1-6. The agency acknowledged as much during oral argument. See Tr. at 14-15. For the same reasons the Court found that discussion wanting before, it finds it unpersuasive here.

a. *Health*

The Secretary asserts that "Granite Advantage is [] independently justified because the Secretary found that it was likely to improve the health of Medicaid recipients." Def. Cross-Motion at 16. Recognizing that this Court has found that health is not a freestanding objective of the Medicaid Act, the agency persists in the contrary view on the ground that "there is little intrinsic value in paying for services if those services are not advancing the health and wellness of individuals receiving them." Id. This position does not change the Court's mind. Assuming the Secretary's interpretation is entitled to Chevron deference, it fails at step two because it falls outside "the bounds of reasonableness." Abbott Labs v. Young, 920 F.2d 984, 988 (D.C. Cir. 1990). Medicaid, both as enacted and as later expanded by the ACA, reflects Congress's desire to "mak[e] healthcare more affordable" for "needy populations." Stewart II, 366 F. Supp. 3d at 144. Congress therefore designed a scheme "to address not health generally but the provision of care to needy populations." Id. The Secretary cannot "extrapolate the objectives of the statute to a

higher level of generality and pursue that aim in the way he prefers." Id. (citing Waterkeeper Alliance v. EPA, 853 F.3d 527, 535 (D.C. Cir. 2017)).

An example outside of the health-care context helps illustrate the problem with Defendants' interpretive leap. Say that Congress passed an education statute designed to encourage local control over education because it believed that decentralization was the best way to improve the quality of education. Implementing this view, the statute appropriates money to states that give local school districts control over their own management and curricula. Disagreeing with Congress's view about local control, however, the Secretary of Education decides she would like to fund experimental state programs that require districts to adhere to strict national education standards. She argues that this advances the purposes of the statute because, in her expertise, national standards improve education, and education must have been the statute's goal since "there is little intrinsic value in paying" for school expenses "if those services are not advancing" students' education. See AR 1. This species of argument, of course, would never fly, yet it is indistinguishable from CMS's in this case, and it exposes the weakness of HHS's position. By defining a statute's purposes up a level of generality, the Secretary can justify actions as consistent with the law even if they are clearly at odds with it. This scenario underscores that, as the Court explained in Stewart I, a statute's objectives are often bound up with the way Congress sought to solve a particular problem. See 313 F. Supp. 3d at 266-67. Ignoring as much grants largely unbounded discretion to agencies, whose exercise of that discretion can veer far afield from anything resembling the statute Congress wrote. Id. at 267-68.

In any event, even assuming Defendants were correct that health is a freestanding objective of the Act, the agency fell short "because it did not consider the health benefits of the project relative to its harms to the health of those who might lose their coverage." Stewart II, 366 F. Supp. 3d at 145. As with the second Kentucky approval, commenters here made clear that these health effects would be significant. See, e.g., AR 2131-32, 2223-24, 2242-43. The Secretary, moreover, needed to weigh the net effects on health against the effects on coverage more generally. Here he stumbled as well. His neglect to address these considerations is independently fatal to Defendants' argument that the project is supported by its effects on health alone.

b. *Financial Independence*

Defendants have previously justified the Secretary's approval on his judgment that community-engagement requirements like those in Granite Advantage improve beneficiaries' financial independence. See AR 4-5; see also Stewart II, 366 F. Supp. 3d at 145-46. This argument does not appear with much force in the Government's papers here. To the extent Defendants still press it, the Court rejects it for the reasons discussed at length in Stewart I and Stewart II—namely, that financial independence is not an independent objective of the Act and that the Secretary has not in any event adequately assessed "the benefits of self-sufficiency" and weighed them "against the consequences of coverage loss." Stewart II, 366 F. Supp. 3d at 148.

c. *Fiscal Sustainability*

The agency's principal argument this time around in favor of upholding the Secretary's decision is the same

as it was in Stewart II: that he reasonably concluded that the project would allow "New Hampshire to stretch its limited Medicaid resources." AR 6. Granite Advantage appears to enhance the fiscal sustainability of the State's safety net, according to HHS, because beneficiaries who were not previously working may transition to commercial coverage and become healthier. In Stewart II, the Court agreed that fiscal sustainability was a valid consideration in a Section 1115 project, but it found the Secretary's explanation for why the project addressed that concern to be arbitrary and capricious. See 366 F. Supp. 3d at 149-52. As the agency recognized at oral argument, HHS's explanation in approving Granite Advantage, which is practically identical to what it said in Stewart II, likewise cannot clear the bar. See Tr. at 14-15.

To start, HHS made no finding that Granite Advantage would save the state "any amount of money or otherwise make the program more sustainable in some way." Id. at 149. With respect to savings, the Court is not suggesting that the Secretary "must quantify some exact amount . . . , but he must make some finding that supports his conclusion that the project" addresses New Hampshire's fiscal concerns. Id. at 149-50. Two considerations make this analysis especially important in this case.

First, the State has represented that it neither intends for the demonstration to reduce costs nor expects it to do so. At oral argument, it explained that New Hampshire is not encountering the same fiscal concerns as Kentucky with respect to its Medicaid program and that reducing health costs is not in fact an objective of this demonstration project. See Tr. (Full Transcript

Pending). Consistent with that position, New Hampshire's waiver application projected "that spending growth in the future [under Granite Advantage] will be consistent with standard growth rates experienced in the past." AR 4399. The glaring disconnect between the Secretary's position and New Hampshire's raises substantial questions about how the agency came to believe the program would improve the State's fiscal circumstances, underscoring the need for reasoned analysis of this issue.

Second, the record in this case contains substantial reasons to doubt whether the program will save any money given administrative costs and the possible rise in uncompensated care that would accrue to the State. See AR 1480, 1949, 2206, 2241-43, 2534, 2710-11; cf. 42 U.S.C. § 1396d(y)(1) (providing that federal government shall pay between 90 and 100 percent of costs to expansion population). While the Secretary may well have arrived at a different conclusion, he needed to explain how he got there in light of the nearly uniform evidence going the other direction.

The agency does propose several potential mechanisms by which the program could save the State money. But those do not advance the ball because they are conclusory and unsupported by any evidence in the record. The Secretary never explained, for example, why he thinks that the program will transition beneficiaries to commercial coverage, given the consistent evidence before him that nearly all Medicaid recipients are already working, unable to work, or able to find only low-paying jobs that do not offer or lead to commercial coverage. See AR 1949, 2209-10, 2225, 2435; see also id. at 3587

(explaining that work requirements only expected to apply to 6% of able and non-working beneficiaries and that work opportunities for them are limited). That the community-engagement requirements can be met through education or volunteer activities, rather than employment, gives more reason to wonder why the Secretary thought the program would expand access to commercial coverage. Likewise, the agency has not explained the sort of health benefits it expected would accrue to beneficiaries as a result of the new requirements and how such benefits would save the State money.

Apart from these failings, the Secretary's fiscal-sustainability discussion suffers from another key flaw: it did not "compare the benefit[s]" to the State's safety net "to the consequences for coverage." Stewart II, 366 F. Supp. 3d at 150. The D.C. Circuit's decision in Pharmaceutical Research & Manufacturers of America v. Thompson, 362 F.3d 817 (D.C. Cir. 2004), helps illustrate how the agency fell short in this respect. There, the court upheld HHS's decision to impose a minor restriction on beneficiaries' access to prescription drugs to try to prevent borderline populations from becoming Medicaid eligible. Id. at 825. In doing so, the D.C. Circuit discussed at length whether the agency had adequately considered the burden on Medicaid recipients and reasonably explained why such imposition was necessary under the circumstances. Id. at 825-26. This is just the kind of analysis the Secretary never conducted here. He neither addressed the magnitude of coverage loss nor weighed that concern against the asserted fiscal-sustainability benefits.

This analysis is essential given the admonitions in Thompson and the Supreme Court's decision in Pharmaceutical Research & Manufacturers of America v. Walsh, 538 U.S. 644 (2003) (plurality), that projects imposing significant burdens on Medicaid recipients may not be consistent with the Act's purposes. Id. at 664-65 ("The fact that the [Program] . . . provid[es] benefits to needy persons and . . . curtail[s] the State's Medicaid costs . . . would not provide a sufficient basis for upholding the program if it severely curtailed Medicaid recipients' access to prescription drugs."); Thompson, 362 F.3d at 826 (relying on "the absence of any demonstrable significant impediment to Medicaid services"). As explained in Stewart II, "That there are limits on the extent to which fiscal sustainability can justify cuts like those outlined in these cases makes sense. Most cuts to Medicaid services would reduce the cost of Medicaid and thus advance the sustainability of the program to some extent. But it would be nonsensical to conclude that any cut therefore always promotes the Act's objectives." 366 F. Supp. 3d at 152.

In short, the Court finds that the Secretary's assertion that Granite Advantage advances the purposes of Medicaid because it would improve the fiscal sustainability of New Hampshire's Medicaid program is arbitrary and capricious, especially where the State at argument generally disclaimed such motivation. In so concluding, the Court is not questioning the agency's predictive judgments or evaluating the evidence before it on this issue. It is simply looking for what the APA requires: a reasoned explanation that considers the factors relevant to the agency's decision.

d. *Data Collection*

The Secretary has one more arrow in his quiver. He suggests that Granite Advantage advances the objectives of Medicaid regardless of what effect it has on beneficiary health and coverage because it helps the State and agency collect useful data for future policymaking purposes. See Def. Cross-Mot. at 22-3; AR 12. This one holds no water. As a textual matter, the Secretary is authorized to approve only those projects "likely to assist in promoting the objectives" of the Medicaid Act. See 42 U.S.C. § 1315(a). But no one is suggesting with a straight face that a purpose of the Medicaid Act is to collect data. A demonstration can hardly be justified, therefore, solely on data-collection grounds. The practical consequences of the Government's suggestion are also alarming. If experimentation alone could justify a project, then demonstrations with dire consequences for Medicaid beneficiaries could be approved just for the Government to gather information. Recognizing these difficulties, HHS disclaimed any such position at oral argument, confirming that any demonstration project must do more than collect data: it must also advance the purposes of the Medicaid Act, including the core objective of providing medical assistance to the needy. See Tr. at 14.

C. Remedy

That leaves only consideration of the proper remedy. Three sets of issues require attention.

First, the Court must decide whether, having arrived at the conclusions outlined above, it should issue its decision now or instead wait until November, nearer in time to when the community-engagement requirements

are set to take effect. HHS, at oral argument, maintained that the Court should stay its pen because vacating the program will substantially disrupt New Hampshire's implementation and outreach efforts and because the Court of Appeals may issue a decision in the Kentucky and Arkansas cases in the interim. See Tr. at 4-6. Neither factor, however, counsels in favor of delay. As to the former, the State of New Hampshire, which is presumably best situated to understand the consequences of a timely decision, asks the Court to issue its Opinion now rather than waiting until November. It explained at oral argument that a decision would provide further clarity to the State while it compiles an amended waiver application and considers how to implement its program moving forward. Id. (Complete Transcript Pending). Citing the uncertainty attending their circumstances and those of other Medicaid beneficiaries, Plaintiffs agree that the Court should not wait to act. As to the latter, while it is possible that the Court of Appeals will issue its decision between now and November, it is also possible that the Circuit's decision will post-date the December 1 implementation. At this point, no oral-argument date has been set. Either way, that consideration does not outweigh New Hampshire's and Plaintiffs' interests in seeking a timelier decision.

Second, the Court must consider whether to remand this matter to the agency without vacating its underlying approval of New Hampshire's demonstration. When a court concludes that agency action is unlawful, "the practice of the court is ordinarily to vacate the rule." Ill. Pub. Telecomms. Ass'n v. FCC, 123 F.3d 693, 693 (D.C. Cir. 1997); Sierra Club v. Van Antwerp, 719 F. Supp. 2d 77, 78 (D.D.C. 2010) ("[B]oth the Supreme Court and the D.C. Circuit Court have held that

remand, along with vacatur, is the presumptively appropriate remedy for a violation of the APA."). Remand without vacatur may be appropriate, however, depending on the "seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change." Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n, 988 F.2d 146, 150-51 (D.C. Cir. 1993) (citation omitted); see also Standing Rock Sioux Tribe v. U.S. Army Corps of Engineers, 282 F. Supp. 3d 91, 103 (D.D.C. 2017) (declining to vacate when agency "largely complied" with statute and could likely substantiate prior conclusions on remand).

In Stewart I, Stewart II, and Gresham, the Court concluded that both factors supported vacatur. The Secretary's failure to consider an objective of Medicaid is a "major shortcoming" going "to the heart" of his decisions. See 313 F. Supp. 3d at 273. As to Kentucky HEALTH, vacatur was not overly disruptive because the project had "yet to take effect" and the plaintiffs could suffer "serious harm[s]" were Kentucky HEALTH allowed to be implemented pending further proceedings. Id.; see also Stewart II, 366 F. Supp. 3d at 156. And as to Arkansas, while vacatur would concededly have been disruptive given that the program had already begun in part, the seriousness of this disruption—which was largely administrative in nature—had to be "balanced against the harms that Plaintiffs and persons like them will experience if the program remains in effect." Gresham, 363 F. Supp. 3d at 184.

Defendants do not dispute that vacatur is appropriate under this analysis. See HHS Cross-Mot. at 27-29 (declining to argue that Allied-Signal factors counsel

against vacatur). And for good reason. Like the prior three approvals, this one suffers from a significant deficiency: the failure to address a central factor in its decision. And vacatur will not be terribly disruptive, given that New Hampshire has not fully implemented the community-engagement requirements—indeed, the State has continued to make legislative and executive tweaks to the program since CMS approved it in late 2018.

Third, HHS argues that rather than vacating the November 2018 approval as a whole, this Court should tailor any relief solely to the four Plaintiffs and the aspects of the program that they have successfully challenged. Id. at 27-29. The Court is no more persuaded by this contention than it was in Stewart II. See 366 F. Supp. 3d at 155. In an APA case, the "ordinary result" of the Court's finding an agency action unlawful is to vacate that action—not to judicially re-write what the agency did so that it somehow does not apply to a narrow group of people or so that it persists piecemeal. See Harmon v. Thornburgh, 878 F.2d 484, 495 n.21 (D.C. Cir. 1989). The Court of Appeals, accordingly, has explained that "if the plaintiff prevails" in challenging an agency action under the APA, "the result is that the rule is invalidated, not simply that the court forbids its application to a particular individual." Nat'l Min. Ass'n v. U.S. Army Corps of Engineers, 145 F.3d 1399, 1409 (D.C. Cir. 1998) (quoting Lujan v. Nat'l Wildlife Fed., 497 U.S. 871, 913 (1990) (Blackmun, J., dissenting)).

Defendants offer no reason to deviate from the settled manner in which courts accord relief in APA cases; indeed, they do not cite a single APA case in which relief has been granted in this manner. Plaintiffs have

standing to challenge and have successfully challenged the Secretary's November 30, 2018, approval of the amendments to Granite Advantage. The proper relief, under these circumstances, is vacatur of that action.

IV. CONCLUSION

For the foregoing reasons, the Court will grant Plaintiffs' Motion for Summary Judgment and deny Defendants' Cross-Motion and Motion to Dismiss. A separate Order consistent with this Opinion will issue this day.

/s/ JAMES E. BOASBERG
JAMES E. BOASBERG
United States District Judge

Date: July 29, 2019

APPENDIX A

Comments on Coverage Consequences of Community-Engagement Requirements
AR 1484 (Disability Rights Center) ("Red tape and paperwork requirements have been shown to reduce enrollment in Medicaid and individuals coping with serious mental illness or physical impairments may face particular difficulty meeting these requirements."); AR 1489 (American Cancer Society Cancer Action Network) ("If work and community engagement is required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses could find that they are ineligible for the life-saving care and treatment services provided through the state's Medicaid program . . . The increase in administrative requirements for enrollees to attest to their working status would likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt."); AR 1949 (Rights and Democracy NH) ("[I]mposing work requirements for people who need Medicaid Expansion to gain access to health care will likely cause many people to lose coverage and increase levels of uncompensated care."); AR 1953 (Cystic Fibrosis Foundation) ("[M]any people may have trouble complying with new eligibility requirements and for someone with [cystic fibrosis], this could result in a life-threatening gap in coverage."); AR 1956 (NH Community Behavioral Health Association) ("We fear that the work requirement has the very real potential to jeopardize care for individuals with mental illness if they lose their Medicaid coverage. . . . Asking people struggling with mental illness to document their work by keeping track of

every week's pay stubs is an onerous requirement."); AR 2132 (American Diabetes Association) ("New Hampshire's proposal to limit access to Medicaid services through the implementation of work requirements will decrease access to care for low-income New Hampshire residents with and at risk for diabetes and increase state health care costs."); AR 2201 (Lung Cancer Alliance) (citing estimates that similar Iowa waiver caused that "more than 3,000 beneficiaries" to lose coverage and "become uninsured"); AR 2208 (Center on Budget and Policy Priorities & Georgetown University Center for Children and Families) ("Kaiser conservatively estimates that between 25 and 50 percent of such enrollees are at risk of losing coverage under work requirements. New Hampshire's work requirement is especially onerous, because just one month of non-compliance can lead to loss of coverage."); AR 2224-25 (American Heart Association) (asserting that work requirements will reduce "access to healthcare services both in the short and long term" for people with cardiovascular disease); AR 2238 (National Council on Aging) ("Extending work requirements would also particularly hurt the rural residents of NH," who make up 48% of NH's Medicaid population, because they are less likely to have access to the internet or transportation and therefore "risk losing coverage."); AR 2241 (Center for Law and Social Policy) ("The evidence from other programs with similar requirements is that in spite of official exemptions, in practice, individuals with disabilities are often not exempted and are more likely to lose benefits."); AR 2434 (CLASP Volatile Job Schedules and Access to Public Benefits Report) (finding that tying benefits to work requirements, especially a

specific number of hours, can be problematic because "more than 40 percent of early career hourly-workers (ages 26 to 32) receive one week or less advance notice of their job schedules. Half of these workers have no input into their schedules and three-quarters experience fluctuations in the number of hours they work, with hours varying by more than eight hours per week on average."); AR 2530 (Kaiser Family Foundation Issue Brief) (considering national effects of a Medicaid work requirement and concluding that, "[o]verall, among the 23.5 million non-SSI, non-dual, nonelderly Medicaid adults, disenrollment ranges from 1.4 million to 4.0 million under the scenarios considered"); AR 2563 (New Futures) (stating that results of Arkansas's similar program will likely reflect those of NH's program, and "[i]n the first month of implementation of the Arkansas Works work requirement (June 2018) fewer than six percent of the nearly 8,000 Medicaid enrollees who did not declare an exemption were able to satisfy the reporting requirement"); AR 2575 (Families USA) ("The coverage losses [caused by the work requirement] will result in an increase in the state's uninsured population, lost health care access, and worse health for low-income adults in New Hampshire."); AR 2696 (National Health Law Program) ("All evidence indicates that the work requirement will lead to substantial numbers of individuals losing Medicaid coverage. In Kentucky, which proposed a similar work requirement, researchers have estimated that between 45,000 to 103,000 individuals could lose coverage due to the work requirement alone."); AR 2963 (New Hampshire Fiscal Policy Institute) ("Work requirements implemented in Arkansas for certain populations starting in June 2018

. . . provide an initial indication that similar requirements may reduce enrollment significantly in New Hampshire."); AR 3372 (Kaiser Family Foundation) ("Under the Medicaid work requirement programs, the population subject to Medicaid work requirements may have access to only low-wage, unstable, or low-quality jobs to meet the weekly/monthly hours requirement[;] . . . '[p]olicies that promote job growth without giving attention to the overall adequacy of the jobs may undermine health.'"); AR 3406 (Urban Institute) ("The red tape associated with work requirements can cause people to lose access to vital supports even when they are working or should be exempt from the requirements."); AR 3584 (Philip Rocco, PhD) (citing a study about "a Florida welfare reform experiment whose benefits were conditioned on workforce participation [and] had a 16 percent higher mortality rate than comparable recipients of welfare who were not subject to work stipulations"); AR 3644 (New Hampshire Legal Assistance) ("All evidence indicates that the work requirement will lead to substantial numbers of individuals losing Medicaid coverage."); AR 4563-64 (Leukemia & Lymphoma Society) ("New Hampshire's proposal to extend its work requirement will perpetuate a return to increased bureaucracy and paperwork and, in turn, coverage losses.").

APPENDIX E

1. 7 U.S.C. 2015(*o*) provides:

Eligibility disqualifications

(*o*) Work requirement

(1) "Work program" defined

In this subsection, the term "work program" means—

(A) a program under title I of the Workforce Innovation and Opportunity Act [29 U.S.C. 3111 et seq.];

(B) a program under section 2296 of title 19;

(C) a program of employment and training operated or supervised by a State or political subdivision of a State that meets standards approved by the Governor of the State, including a program under subsection (d)(4), other than a supervised job search program or job search training program;

(D) a program of employment and training for veterans operated by the Department of Labor or the Department of Veterans Affairs, and approved by the Secretary; and

(E) a workforce partnership under subsection (d)(4)(N).

(2) Work requirement

Subject to the other provisions of this subsection, no individual shall be eligible to participate in the supplemental nutrition assistance program as a member

of any household if, during the preceding 36-month period, the individual received supplemental nutrition assistance program benefits for not less than 3 months (consecutive or otherwise) during which the individual did not—

(A) work 20 hours or more per week, averaged monthly;

(B) participate in and comply with the requirements of a work program for 20 hours or more per week, as determined by the State agency;

(C) participate in and comply with the requirements of a program under section 2029 of this title or a comparable program established by a State or political subdivision of a State; or

(D) receive benefits pursuant to paragraph (3), (4), (5), or (6).

(3) Exception

Paragraph (2) shall not apply to an individual if the individual is—

(A) under 18 or over 50 years of age;

(B) medically certified as physically or mentally unfit for employment;

(C) a parent or other member of a household with responsibility for a dependent child;

(D) otherwise exempt under subsection (d)(2); or

(E) a pregnant woman.

(4) Waiver

(A) In general

On the request of a State agency and with the support of the chief executive officer of the State, the Secretary may waive the applicability of paragraph (2) to any group of individuals in the State if the Secretary makes a determination that the area in which the individuals reside—

(i) has an unemployment rate of over 10 percent; or

(ii) does not have a sufficient number of jobs to provide employment for the individuals.

(B) Report

The Secretary shall report the basis for a waiver under subparagraph (A) to the Committee on Agriculture of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate.

(5) Subsequent eligibility

(A) Regaining eligibility

An individual denied eligibility under paragraph (2) shall regain eligibility to participate in the supplemental nutrition assistance program if, during a 30-day period, the individual—

(i) works 80 or more hours;

(ii) participates in and complies with the requirements of a work program for 80 or more hours, as determined by a State agency; or

(iii) participates in and complies with the requirements of a program under section 2029 of this title or a comparable program established by a State or political subdivision of a State.

(B) Maintaining eligibility

An individual who regains eligibility under subparagraph (A) shall remain eligible as long as the individual meets the requirements of subparagraph (A), (B), or (C) of paragraph (2).

(C) Loss of employment

(i) In general

An individual who regained eligibility under subparagraph (A) and who no longer meets the requirements of subparagraph (A), (B), or (C) of paragraph (2) shall remain eligible for a consecutive 3-month period, beginning on the date the individual first notifies the State agency that the individual no longer meets the requirements of subparagraph (A), (B), or (C) of paragraph (2).

(ii) Limitation

An individual shall not receive any benefits pursuant to clause (i) for more than a single 3-month period in any 36-month period.

(6) Exemptions

(A) Definitions

In this paragraph:

(i) Caseload

The term "caseload" means the average monthly number of individuals receiving supplemental nutrition assistance program benefits during the 12-month period ending the preceding June 30.

(ii) Covered individual

The term "covered individual" means a member of a household that receives supplemental nutrition assistance program benefits, or an individual denied eligibility for supplemental nutrition assistance program benefits solely due to paragraph (2), who—

(I) is not eligible for an exception under paragraph (3);

(II) does not reside in an area covered by a waiver granted under paragraph (4);

(III) is not complying with subparagraph (A), (B), or (C) of paragraph (2);

(IV) is not receiving supplemental nutrition assistance program benefits during the 3 months of eligibility provided under paragraph (2); and

(V) is not receiving supplemental nutrition assistance program benefits under paragraph (5).

(B) General rule

Subject to subparagraphs (C) through (H), a State agency may provide an exemption from the requirements of paragraph (2) for covered individuals.

(C) Fiscal year 1998

Subject to subparagraphs (F) and (H), for fiscal year 1998, a State agency may provide a number of exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State in fiscal year 1998, as estimated by the Secretary, based on the survey conducted to carry out section 2025(c) of this title for fiscal year 1996 and such other factors as the Secretary considers appropriate due to the timing and limitations of the survey.

(D) Fiscal years 1999 through 2019

Subject to subparagraphs (F) through (H), for fiscal year 1999 and each subsequent fiscal year through fiscal year 2019, a State agency may provide a number of exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State, as estimated by the Secretary under subparagraph (C), adjusted by the Secretary to reflect changes in the State's caseload and the Secretary's estimate of changes in the proportion of members of households that receive supplemental nutrition assistance program benefits covered by waivers granted under paragraph (4).

(E) Subsequent fiscal years

Subject to subparagraphs (F) through (H), for fiscal year 2020 and each subsequent fiscal year, a State agency may provide a number of exemp-

tions such that the average monthly number of exemptions in effect during the fiscal year does not exceed 12 percent of the number of covered individuals in the State, as estimated by the Secretary under subparagraph (C), adjusted by the Secretary to reflect changes in the State's caseload and the Secretary's estimate of changes in the proportion of members of households that receive supplemental nutrition assistance program benefits covered by waivers granted under paragraph (4).

(F) Caseload adjustments

The Secretary shall adjust the number of individuals estimated for a State under subparagraph (C), (D), or (E) during a fiscal year if the number of members of households that receive supplemental nutrition assistance program benefits in the State varies from the State's caseload by more than 10 percent, as determined by the Secretary.

(G) Exemption adjustments

During fiscal year 1999 and each subsequent fiscal year, the Secretary shall increase or decrease the number of individuals who may be granted an exemption by a State agency under this paragraph to the extent that the average monthly number of exemptions in effect in the State for the preceding fiscal year under this paragraph is lesser or greater than the average monthly number of exemptions estimated for the State agency for such preceding fiscal year under this paragraph.

(H) Reporting requirement

A State agency shall submit such reports to the Secretary as the Secretary determines are necessary to ensure compliance with this paragraph.

(7) Other program rules

Nothing in this subsection shall make an individual eligible for benefits under this chapter if the individual is not otherwise eligible for benefits under the other provisions of this chapter.

2. 42 U.S.C. 607(a)-(e) provides:

Mandatory work requirements

(a) Participation rate requirements

(1) All families

A State to which a grant is made under section 603 of this title for a fiscal year shall achieve the minimum participation rate specified in the following table for the fiscal year with respect to all families receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title):

If the fiscal year is:	**The minimum participation rate is:**
1997.....	25
1998.....	30
1999.....	35
2000.....	40
2001.....	45
2002 and thereafter.....	50.

(2) 2-parent families

A State to which a grant is made under section 603 of this title for a fiscal year shall achieve the minimum participation rate specified in the following table for the fiscal year with respect to 2-parent families receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title):

If the fiscal year is:	The minimum participation rate is:
1997.....	75
1998.....	75
1999 or thereafter.....	90.

(b) Calculation of participation rates

(1) All families

(A) Average monthly rate

For purposes of subsection (a)(1), the participation rate for all families of a State for a fiscal year is the average of the participation rates for all families of the State for each month in the fiscal year.

(B) Monthly participation rates

The participation rate of a State for all families of the State for a month, expressed as a percentage, is—

(i) the number of families receiving assistance under the State program funded under this part or any other State program funded with

qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) that include an adult or a minor child head of household who is engaged in work for the month; divided by

(ii) the amount by which—

(I) the number of families receiving such assistance during the month that include an adult or a minor child head of household receiving such assistance; exceeds

(II) the number of families receiving such assistance that are subject in such month to a penalty described in subsection (e)(1) but have not been subject to such penalty for more than 3 months within the preceding 12-month period (whether or not consecutive).

(2) 2-parent families

(A) Average monthly rate

For purposes of subsection (a)(2) of this section, the participation rate for 2-parent families of a State for a fiscal year is the average of the participation rates for 2-parent families of the State for each month in the fiscal year.

(B) Monthly participation rates

The participation rate of a State for 2-parent families of the State for a month shall be calculated by use of the formula set forth in paragraph (1)(B), except that in the formula the term "number of 2-parent families" shall be substituted for the term "number of families" each place such latter term appears.

(C) Family with a disabled parent not treated as a 2-parent family

A family that includes a disabled parent shall not be considered a 2-parent family for purposes of subsections (a) and (b) of this section.

(3) Pro rata reduction of participation rate due to caseload reductions not required by Federal law and not resulting from changes in State eligibility criteria

(A) In general

The Secretary shall prescribe regulations for reducing the minimum participation rate otherwise required by this section for a fiscal year by the number of percentage points equal to the number of percentage points (if any) by which—

(i) the average monthly number of families receiving assistance during the immediately preceding fiscal year under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) is less than

(ii) the average monthly number of families that received assistance under any State program referred to in clause (i) during fiscal year 2005.

The minimum participation rate shall not be reduced to the extent that the Secretary determines that the reduction in the number of families receiving such assistance is required by Federal law.

(B) Eligibility changes not counted

The regulations required by subparagraph (A) shall not take into account families that are diverted from a State program funded under this part as a result of differences in eligibility criteria under a State program funded under this part and the eligibility criteria in effect during fiscal year 2005. Such regulations shall place the burden on the Secretary to prove that such families were diverted as a direct result of differences in such eligibility criteria.

(4) State option to include individuals receiving assistance under a tribal family assistance plan or tribal work program

For purposes of paragraphs (1)(B) and (2)(B), a State may, at its option, include families in the State that are receiving assistance under a tribal family assistance plan approved under section 612 of this title or under a tribal work program to which funds are provided under this part.

(5) State option for participation requirement exemptions

For any fiscal year, a State may, at its option, not require an individual who is a single custodial parent caring for a child who has not attained 12 months of age to engage in work, and may disregard such an individual in determining the participation rates under subsection (a) of this section for not more than 12 months.

(c) Engaged in work

(1) General rules

(A) All families

For purposes of subsection (b)(1)(B)(i) of this section, a recipient is engaged in work for a month in a fiscal year if the recipient is participating in work activities for at least the minimum average number of hours per week specified in the following table during the month, not fewer than 20 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d) of this section, subject to this subsection:

If the month is in the fiscal year:	**The minimum average number of hours per week is:**
1997.....	20
1998.....	20
1999.....	25
2000 or thereafter.....	30.

(B) 2-parent families

For purposes of subsection (b)(2)(B) of this section, an individual is engaged in work for a month in a fiscal year if—

(i) the individual and the other parent in the family are participating in work activities for a total of at least 35 hours per week during the month, not fewer than 30 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or

(12) of subsection (d), subject to this subsection; and

(ii) if the family of the individual receives federally-funded child care assistance and an adult in the family is not disabled or caring for a severely disabled child, the individual and the other parent in the family are participating in work activities for a total of at least 55 hours per week during the month, not fewer than 50 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d) of this section.

(2) Limitations and special rules

(A) Number of weeks for which job search counts as work

(i) Limitation

Notwithstanding paragraph (1) of this subsection, an individual shall not be considered to be engaged in work by virtue of participation in an activity described in subsection (d)(6) of this section of a State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title), after the individual has participated in such an activity for 6 weeks (or, if the unemployment rate of the State is at least 50 percent greater than the unemployment rate of the United States or the State is a needy State (within the meaning of section

603(b)(5) of this title), 12 weeks), or if the participation is for a week that immediately follows 4 consecutive weeks of such participation.

(ii) Limited authority to count less than full week of participation

For purposes of clause (i) of this subparagraph, on not more than 1 occasion per individual, the State shall consider participation of the individual in an activity described in subsection (d)(6) of this section for 3 or 4 days during a week as a week of participation in the activity by the individual.

(B) Single parent or relative with child under age 6 deemed to be meeting work participation requirements if parent or relative is engaged in work for 20 hours per week

For purposes of determining monthly participation rates under subsection (b)(1)(B)(i) of this section, a recipient who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age is deemed to be engaged in work for a month if the recipient is engaged in work for an average of at least 20 hours per week during the month.

(C) Single teen head of household or married teen who maintains satisfactory school attendance deemed to be meeting work participation requirements

For purposes of determining monthly participation rates under subsection (b)(1)(B)(i) of this section, a recipient who is married or a head of

household and has not attained 20 years of age is deemed to be engaged in work for a month in a fiscal year if the recipient—

(i) maintains satisfactory attendance at secondary school or the equivalent during the month; or

(ii) participates in education directly related to employment for an average of at least 20 hours per week during the month.

(D) Limitation on number of persons who may be treated as engaged in work by reason of participation in educational activities

For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b) of this section, not more than 30 percent of the number of individuals in all families and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training, or (if the month is in fiscal year 2000 or thereafter) deemed to be engaged in work for the month by reason of subparagraph (C) of this paragraph.

(d) "Work activities" defined

As used in this section, the term "work activities" means—

(1) unsubsidized employment;

(2) subsidized private sector employment;

(3) subsidized public sector employment;

(4) work experience (including work associated with the refurbishing of publicly assisted housing) if sufficient private sector employment is not available;

(5) on-the-job training;

(6) job search and job readiness assistance;

(7) community service programs;

(8) vocational educational training (not to exceed 12 months with respect to any individual);

(9) job skills training directly related to employment;

(10) education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;

(11) satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate; and

(12) the provision of child care services to an individual who is participating in a community service program.

(e) Penalties against individuals

(1) In general

Except as provided in paragraph (2), if an individual in a family receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures

(as defined in section 609(a)(7)(B)(i) of this title) refuses to engage in work required in accordance with this section, the State shall—

(A) reduce the amount of assistance otherwise payable to the family pro rata (or more, at the option of the State) with respect to any period during a month in which the individual so refuses; or

(B) terminate such assistance,

subject to such good cause and other exceptions as the State may establish.

(2) Exception

Notwithstanding paragraph (1), a State may not reduce or terminate assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) based on a refusal of an individual to engage in work required in accordance with this section if the individual is a single custodial parent caring for a child who has not attained 6 years of age, and the individual proves that the individual has a demonstrated inability (as determined by the State) to obtain needed child care, for 1 or more of the following reasons:

(A) Unavailability of appropriate child care within a reasonable distance from the individual's home or work site.

(B) Unavailability or unsuitability of informal child care by a relative or under other arrangements.

(C) Unavailability of appropriate and affordable formal child care arrangements.

3. 42 U.S.C. 1315(a) provides:

Demonstration projects

(a) Waiver of State plan requirements; costs regarded as State plan expenditures; availability of appropriations

In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter I, X, XIV, XVI, or XIX of this chapter, or part A or D of subchapter IV of this chapter, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and

(B) costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV of this chapter and which are not included as part of the costs of projects under section 1310 of this title, shall to the extent and for the period

prescribed by the Secretary, be regarded as a permissible use of funds under such part.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such subchapters for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such subchapters and is not included as part of the cost of projects for purposes of section 1310 of this title.

4. 42 U.S.C. 1396-1 provides:

Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled 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, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

5. 42 U.S.C. 1396u-1(b)(3) provides:

Assuring coverage for certain low-income families

(b) Application of pre-welfare-reform eligibility criteria

(3) Option to terminate medical assistance for failure to meet work requirement

(A) Individuals receiving cash assistance under TANF

In the case of an individual who—

(i) is receiving cash assistance under a State program funded under part A of subchapter IV of this chapter,

(ii) is eligible for medical assistance under this subchapter on a basis not related to section 1396a(*l*) of this title, and

(iii) has the cash assistance under such program terminated pursuant to section 607(e)(1)(B) of this title (as in effect on or after the welfare reform effective date) because of refusing to work,

the State may terminate such individual's eligibility for medical assistance under this subchapter until such time as there no longer is a basis for the termination of such cash assistance because of such refusal.

(B) Exception for children

Subparagraph (A) shall not be construed as permitting a State to terminate medical assistance for a minor child who is not the head of a household receiving assistance under a State program

funded under part A of subchapter IV of this chapter.

APPENDIX F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

[Mar. 5, 2018]

Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Dear Ms. Gillespie:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas's request for an amendment to its section 1115 demonstration project, entitled "Arkansas Works" (Project Number 11-W-00287/6) in accordance with section 1115(a) of the Social Security Act (the Act).

This approval is effective March 5, 2018, through December 31, 2021, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STCs). The state will begin implementation of the community engagement requirement no sooner than June 1, 2018. The state may deviate from Medicaid

state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures.

Extent and Scope of Demonstration

The current Arkansas Works section 1115 demonstration project was implemented by the State of Arkansas ("state") in December 2016. The Arkansas Works program provides certain adult Medicaid beneficiaries with premium assistance to purchase qualified health plan (QHP) coverage through the Health Insurance Marketplace. As originally approved, Arkansas Works was designed to leverage the efficiencies and experience of the commercial market to test whether this premium assistance mode improves continuity, access, and quality for Arkansas Works beneficiaries and results in lowering the growth rate of premiums across population groups. The demonstration project also attempts to facilitate transitions between and among Arkansas Works, ESI, and the Marketplace for Arkansas Works enrollees. Approval of this demonstration amendment allows Arkansas, no sooner than June 1, 2018, to require all Arkansas Works beneficiaries ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility. Community engagement requirements will not apply to Arkansas Works beneficiaries ages 50 and older so as to ensure alignment and consistency with the state's Supplemental Nutrition Assistance Program (SNAP) requirements. The alignment is appropriate and consistent with the ultimate objective

of improving health and well-being for Medicaid beneficiaries.

CMS also is authorizing authorities for additional features, including:

- Removing the requirement to have an approved-hospital presumptive-eligibility state plan amendment (SPA) as a condition of enacting the state's waiver of retroactive eligibility;
- Clarifying the waiver of the requirement to provide new adult group beneficiaries[1] with retroactive eligibility to reflect the state's intent to not provide retroactive eligibility but for the 30 days prior to the date of application coverage; and
- Removing the waiver and expenditure authorities related to the state's mandatory employer-sponsored insurance (ESI) premium assistance program, as the state no longer intends to continue this program.

Under the new community engagement program, the state will test whether coupling the requirement for certain beneficiaries to engage in and report work or other community engagement activities with meaningful incentives to encourage compliance will lead to improved health outcomes and greater independence. CMS is approving the community engagement program based on our determination that it is likely to assist in promoting the objectives of the Medicaid program. The terms

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[1] This group includes adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

and conditions of Arkansas's community engagement requirement that accompany this approval are consistent with the guidance provided to states through State Medicaid Director's Letter (SMD 18-0002), Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued on January 11, 2018. CMS is not at this time approving Arkansas's request to reduce income eligibility for Arkansas Works beneficiaries to 100 percent of the federal poverty level (FPL).

Determination that the demonstration project is likely to assist in promoting Medicaid's Objectives

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstrations are likely to assist in promoting the objectives of Medicaid.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration programs are likely to better enable states to serve their low-income populations, through measures designed to improve health and wellness, including measures to help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore,

in making this determination, CMS considers the proposed demonstration as a whole.

In its consideration of the proposed changes to Arkansas Works, CMS examined whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes. CMS has determined that the Arkansas Works demonstration as amended is likely to promote Medicaid objectives, and that the waivers sought are necessary and appropriate to carry out the demonstration.

1. The demonstration is likely to assist in improving health outcomes through strategies that promote community engagement and address certain health determinants.

Arkansas Works supports coordinated strategies to address certain health determinants, as well as promote health and wellness through increased upward mobility, greater independence, and improved quality of life. Specifically, Arkansas Works' community engagement requirement is designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has

shown to be correlated with improved health and wellness.[2,3] As noted in CMS' SMDL: 18-0002, these activities have been positively correlated with improvements in individuals' health. CMS has long supported policies that recognize meaningful work as essential to the economic self-sufficiency, self-esteem, well-being, and improved health of people with disabilities.

Given the potential benefits of work and community engagement, we believe that state Medicaid programs should be able to design and test incentives for beneficiary compliance. Under Arkansas's demonstration, the state will encourage compliance by making it a condition of continued coverage. Beneficiaries that successfully report compliance on a monthly basis will have no disruption in coverage. It is only when a beneficiary fails to report compliance for 3 months that the state will disenroll the beneficiary for the remainder of the calendar year. Beneficiaries that are disenrolled from their plan will be able to re-enroll through Arkansas Works upon the earlier of turning age 50, qualifying for another category of Medicaid eligibility, or the beginning of a new calendar year.

Arkansas' approach is informed by the state's experience with the voluntary work-referral program in its current demonstration, which the state has not found to be an effective incentive. Since January 2017, certain

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[2] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK

[3] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper, K. Health effects of employment: a systemic review of prospective studies. BMJoumals. Occupational and Environmental Medicine. 2014:71 (10).

individuals enrolled in Arkansas Medicaid have been referred to the Arkansas Department of Workforce Services (DWS), which provides a variety of services to assist individuals in gaining employment. Through October 2017, only 4.7 percent of beneficiaries followed through with the referral and accessed DWS services. Of those who accessed DWS services, 23 percent have become employed. This result suggests that referrals alone, without any further incentive, may not be be sufficient to encourage the Arkansas Works population to participate in community engagement activities. CMS will therefore allow Arkansas to test whether the stronger incentive model is more effective in encouraging participation.

Arkansas has tailored the incentive structure to include beneficiary protections, such as an opportunity to maintain coverage for beneficiaries who report that they failed to meet the community engagement hours due to circumstances that give rise to a good cause exemption, as well as the opportunity to apply and reenroll in Arkansas Works in the beginning of the next plan year. Additionally, if Arkansas determines that a beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, the beneficiary will receive retroactive coverage to the date coverage ended without need for a new application. The impact of this incentive, as well as other aspects of the demonstration, will be assessed through an evaluation designed to measure how the demonstration affects eligibility, and health outcomes over time for persons subject to the demonstration's policies.

2. The demonstration is expected to strengthen beneficiary engagement in their personal health care.

CMS believes that it is important for beneficiaries to engage in their personal health care, particularly while they are healthy to prevent illness. Accordingly, CMS supports state testing of policies designed to incentivize beneficiaries to obtain and maintain health coverage before they become sick so they can take an active role in engaging in their personal health care while healthy. Consistent with CMS's commitment to support states in their efforts to align Medicaid and private insurance policies for non-disabled adults to help them prepare for private coverage (stated in the letter to governors on March 14, 2017), this amendment removes the requirement that Arkansas provide hospitals with an opportunity to conduct presumptive eligibility (consistent with Section 1902(a)(47)(B)) as a condition of its waiver of retroactive eligibility. It further clarifies the waiver of the requirement to provide new adult group beneficiaries with retroactive eligibility but for the 30 days prior to the date of application coverage. With respect to the waiver of retroactive eligibility, through this approval, we are testing whether eliminating 2 of the 3 months of retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries church on and off of Medicaid or sign up for Medicaid only when sick with the ultimate objective of improving beneficiary health.

Consideration of Public Comments

Both Arkansas and CMS received comments during the state and federal public comment periods. Consistent

with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all the public comments it received, when evaluating whether the demonstration project as a whole was likely to assist in promoting the objectives of the Medicaid program, and whether the waiver authorities sought were necessary and appropriate to implement the demonstration. In addition, CMS took public comments submitted during the federal comment period into account as it worked with Arkansas to develop the STCs that accompany this approval that will bolster beneficiary protections, including specific state assurances around these protections to further support beneficiaries.

Opposing commenters expressed general disagreement with efforts to modify Arkansas Works. Some offered more specific feedback regarding individual elements of the demonstration or the impact of certain provisions on distinct populations. Some commenters expressed the desire to see greater detail regarding how the program would be operationalized, particularly with respect to provisions like the community engagement requirements. Other comments expressed concerns that these requirements would be burdensome on families or create barriers to coverage. The state has pledged to do beneficiary outreach and education on how to comply with the new community engagement requirements, and intends to use an online reporting system to make reporting easy for enrollees. Further, CMS intends to monitor state-reported data on how the new requirements are impacting enrollment.

Many commenters indicated that many beneficiaries not qualifying for Medicaid on the basis of disability may still have issues gaining and maintaining employment

due to their medical or behavioral health conditions. To mitigate these concerns, Arkansas assures that it will provide these beneficiaries reasonable modifications, which could include the reduction of or exemption from community engagement hours. This is a condition of approval, as provided in the STCs.

Some commenters expressed concern that Arkansas's proposal "lacked sufficient detail to permit informed public comments." To ensure meaningful public input at the Federal level, and to facilitate the demonstration application process for States, CMS utilizes standardized demonstration application requirements so that the public, including those with disabilities, and CMS can meaningfully assess states' applications. Upon receipt of Arkansas' proposal, CMS followed its standard protocols for evaluating the completeness of the application and determined that Arkansas application was complete. We continue to believe that Arkansas submitted sufficient detail to permit meaningful public input.

Many commenters who opposed the community engagement requirement emphasized that the community engagement requirements would be burdensome for individuals and families or create barriers to coverage for non-exempt people who might have trouble accessing care. We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment. Given that employment is positively correlated with health outcomes, it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence. However, CMS has included provisions in these STCs to ensure that CMS may withdraw waivers or expenditure

authorities at any time if federal monitoring of data indicates that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and Title XXI, including if data indicates that the community engagement features of this demonstration may not adequately incentivize beneficiary participation or are unlikely to result in improved health outcomes, or that other demonstration features are not operating as intended. In efforts to support beneficiaries, CMS will require Arkansas to provide written notices to beneficiaries that include information such as how to ensure that they are in compliance with the community engagement requirements, how to appeal an eligibility denial, and how to access primary and preventive care during the non-eligibility period. The state will also implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements.

Additional comments characterized the provisions to terminate coverage for failure to participate in the community engagement process as "causing disruptions in care." CMS and Arkansas acknowledged these concerns and Arkansas will be exempting from the requirement those individuals who are medically frail, as well as those whom a medical professional has determined are unable to work due to illness or injury. The state will implement an outreach strategy to inform beneficiaries about how to report compliance with the community engagement requirements. In addition, monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities.

Several commenters expressed concern about the potential 9-month length of the non-eligibility period. This would only occur where (i) an individual fails to fulfill his or her community engagement obligations in the first month of a calendar year and then after receiving a notice from the State in the second month, fails to respond to that notice by rectifying the situation or seeking an exemption, (ii) the same individual fails to fulfill his or her community engagement obligations in the second month of a calendar year and then after receiving a notice from the State in the third month, fails to respond to that notice by rectifying the situation or seeking an exemption, and (iii) the same individual fails to fulfill his or her community engagement obligations in the third month of a calendar year and then after receiving a notice from the State in the fourth month, fails to respond to that notice by rectifying the situation or seeking an exemption. The program provides the individual with three opportunities to rectify the situation or seek an exemption. Any system that requires individuals to fulfill certain requirements as a condition of receiving benefits necessarily places some degree of responsibility on these individuals. We believe that the overall health benefits to the effected population through community engagement outweigh the health-risks with respect to those who fail to respond and who fail to seek exemption from the programs limited requirements.

Some comments pointed out that the maximum non-eligibility period is longer than what has been proposed in other state demonstration applications, and does not offer any way to regain eligibility during the non-eligibility period. CMS acknowledges this and Arkansas will be required to monitor and report to CMS certain metrics on compliance rates and health outcomes. CMS will

closely monitor this data, and retains the right to suspend, amend or terminate the demonstration if the agency determines that it is not meeting its stated objectives.

Other commenters expressed concern about Arkansas' current eligibility and application operations and their impact on beneficiaries who may reapply for eligibility after serving their disenrollment period for non-compliance with community engagement. To help mitigate these concerns, CMS has added additional assurances to the STCs and Arkansas will submit for CMS approval an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration which will allow CMS to track Arkansas' compliance with the assurances described in the STCs, including several related to eligibility and application processing systems. The state may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed the application processing monitoring plan for completeness and determined that the state has addressed all of the required elements in a reasonable manner. As part of this requirement, CMS will require that Arkansas provide status updates on the implementation of the eligibility and enrollment monitoring plan in the state's quarterly reports.

Finally, many comments expressed concern over the waiver of retroactive eligibility, citing disruptions in care for beneficiaries and potential financial burdens for both providers and beneficiaries. Arkansas had previously received approval for a conditional waiver of retroactive coverage conditioned upon the state coming into compliance with statutory and regulatory requirements

related to eligibility determinations. CMS has determined the state has met these requirements. CMS believes that a more limited period of retroactive eligibility will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. As such, with this amendment we are testing whether this limited retroactive eligibility period supports increased continuity of care by reducing gaps in coverage when beneficiaries church on and off Medicaid or sign up for Medicaid only when sick and whether this feature will improve health outcomes.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Tia Witherspoon. She is available to answer any questions concerning your section 1115 demonstration. Ms. Witherspoon's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Tia.Witherspoon@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Witherspoon and

Mr. Bill Brooks, Associate Regional Administrator, in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Mr. Bill Brooks
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
1301 Young Street, Suite 833
Dallas, TX 75202

If you have questions regarding this approval, please contact Ms. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in Arkansas, over the past months to reach approval.

Sincerely

[REDACTED]
SEEMA VERMA

Enclosures

APPENDIX G

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

11/30/2018

Henry D. Lipman
Medicaid Director
New Hampshire Department of Health and Human Services
129 Pleasant Street, Brown Building
Concord, New Hampshire 03301-3857

Dear Mr. Lipman:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend New Hampshire's section 1115 demonstration, now entitled "New Hampshire Granite Advantage Health Care Program 1115 Demonstration" (Project Number 11-W-00298/1), under authority of section 1115(a) of the Social Security Act (the Act).

The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been waived as described in the demonstration. The approval is effective through December 31, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the waivers and special terms and conditions (STCs). The state will begin implementation of the community engagement requirement and the enrollment of

eligible beneficiaries into Medicaid managed care no sooner than January 1, 2019, and only in compliance with the requirements outlined within the STCs.

Objectives of the Medicaid Program

The Secretary may approve a demonstration project under section 1115 if, in his judgment, the project is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include the appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled 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." Act § 1901. This appropriations provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing medical assistance to pay for healthcare services, is to advance the health and wellness needs of its beneficiaries and that it is appropriate for the state to structure its demonstration program in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care, and focus on interventions that drive better health outcomes and quality of

life improvements, and may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants, including by encouraging beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But, in the long term, they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services furnished to beneficiaries, as healthier, more engaged beneficiaries tend to receive fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance, including medical assistance, from the state. Such measures may en-

able states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[1] By the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 allows us to offer states more flexibility to experiment with dif-

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[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, nonelderly adult population (ACA expansion population or new adult group) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

ferent ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide coverage for more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Extent and Scope of Demonstration

In this extension package, changes have been made to the STCs and related authorities to align with New Hampshire State Legislature Senate Bill 313, requiring the state to request waivers under section 1115 needed to implement the Granite Advantage Health Care Program, which will serve beneficiaries through the state's Medicaid managed care delivery system rather than through the New Hampshire Health Protection Program (NHHPP) Premium Assistance program, which assisted beneficiaries in covering premiums to purchase qualified health plan coverage through the Health Insurance Exchange. Separately, on September 13, 2018, CMS approved New Hampshire's state plan amendment to effectuate mandatory enrollment of the new adult group population into Medicaid managed care. By transitioning all beneficiaries into a single Medicaid managed care delivery system, the state intends to streamline administration of beneficiary services and reduce administrative costs. Consistent with the STCs for this extension, the state must ensure the availability of adequate resources for implementation and monitoring of the demonstration. Approval of this demonstration extension

does not imply approval of any particular state financing approach and the state must comply with all general financial requirements under Title XIX.

As required under state law, the demonstration application includes a request for a waiver of retroactive coverage for the new adult group. This waiver does not apply to individuals who would have been eligible at any point during the otherwise available three-month retroactive eligibility period as pregnant women (including during the 60-day post-partum period), infants under 1, or children under 19, parents or caretaker relatives, or as individuals eligible in aged, blind, or disabled eligibility groups (including those who are applying for a long-term care determination). With this waiver, the state will test whether eliminating retroactive coverage will encourage beneficiaries to enroll earlier, to maintain health insurance coverage even while healthy, and to obtain preventive health care. This feature of the demonstration is designed to encourage preventive care and reduce Medicaid costs, with the ultimate objective of improving beneficiary health. If eligible individuals wait until they are sick to enroll in Medicaid, they are less likely to obtain preventive health services during periods when they are not enrolled. In addition to evaluating the effect on receipt of preventive services and on health outcomes, the state will also evaluate whether the policy increases continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick. Similar waivers for retroactive eligibility have been included in this and other prior demonstration projects.

Consistent with the approval of the state's demonstration amendment approved on May 7, 2018, this extension

allows New Hampshire, no sooner than January 1, 2019, to require all beneficiaries in the new adult group, ages 19 through 64, with certain exemptions,[2] to participate in 100 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility. Under the community engagement program, the state will test whether coupling the requirements for certain beneficiaries to engage in community engagement activities with certain meaningful incentives to encourage compliance, as detailed below, will lead to improved health outcomes, including improved health and wellness, and greater independence, while better integrating fiscal sustainability and personal responsibility into the state's Medicaid program.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

For reasons discussed below, the Secretary has determined that Granite Advantage Health Care Program is likely to assist in promoting the objectives of the Medicaid program.

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[2] If a New Hampshire Granite Advantage Health Care Program beneficiary meets one or more of the exemption criteria as described in the STCs, he or she is exempted from the community engagement requirements for the duration of his or her qualification for the exemption. Additionally, the STCs require that a non-exempt beneficiary have an opportunity to demonstrate that he or she had good cause for failing to meet the community engagement requirements for a month, and coverage and eligibility will not be suspended for failure to meet community engagement requirements for a month for which the beneficiary has established good cause for the failure.

The demonstration promotes beneficiary health and financial independence.

The New Hampshire Granite Advantage Health Care Program's community engagement requirements are designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness and increased financial independence for beneficiaries. Promoting beneficiary health and independence advances the objectives of the Medicaid program; indeed, in 2012, HHS specifically encouraged states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes."[3]

The community engagement provisions generally require adults in the new adult group to work, look for work, or engage in activities that enhance their employability, such as job training, education, or community service. The demonstration will thus help the state and CMS evaluate whether the community engagement requirement helps adults in this population transition from Medicaid to financial independence and commercial insurance, including the federally subsidized coverage that is available through the Exchanges.

Failure to comply with the community engagement requirements could result in suspension of Medicaid eligibility, and termination of Medicaid enrollment if the

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[3] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), *available at*: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

beneficiary is not in compliance with the requirements on his or her redetermination date. Beneficiaries whose Medicaid enrollment is terminated can re-apply for coverage at any time, and any prior noncompliance with the community engagement requirements will not be considered as part of their new eligibility determination. Although the state and CMS are testing the effectiveness of an incentive structure that attaches penalties to failure to take certain measures, the program is designed to make compliance with requirements achievable.

Beneficiaries can comply with the community engagement requirements by participating in a number of activities, such as subsidized or unsubsidized employment; community service; job skills training; enrollment in an accredited college or university; and substance use disorder treatment. Beneficiaries whose circumstances could make it unreasonably difficult or impossible to participate in qualifying activities are exempt from the community engagement requirements. This includes beneficiaries who are temporarily unable to participate due to illness or incapacity as documented by a licensed provider; beneficiaries who are a parent or caretaker where care of a dependent is considered necessary by a licensed provider; beneficiaries who are pregnant or 60 days or less post-partum; beneficiaries who are identified as medically frail; and beneficiaries with a disability as defined by the ADA, Section 504, or Section 1557, who are unable to comply with the requirements due to disability-related reasons. Beneficiaries have 75 days after the start date of the community engagement requirements before they must begin to meet the requirements or qualify for an exemption. Beneficiaries who do not meet the monthly community engagement re-

quirements have an opportunity to cure their noncompliance by demonstrating good cause for failing to meet the requirements; demonstrating that they qualify for an exemption; or making up the deficient hours for the month that resulted in noncompliance.

Moreover, New Hampshire has taken steps to include adequate beneficiary protections to ensure that the demonstration program requirements apply only to those beneficiaries who can reasonably be expected to meet them and to notify beneficiaries of their responsibilities under the demonstration. Any individual whose coverage is suspended or terminated for failure to meet the requirements will have the right to appeal the state's decision as with other types of eligibility terminations, consistent with all existing appeal and fair hearing protections. Furthermore, the incentives to meet the requirements, if effective, may result in individuals becoming ineligible because they have attained financial independence—a positive result for the individual. Individuals who become ineligible for Medicaid because their income has exceeded the upper limit for the new adult group may receive an offer of employer-sponsored insurance or may obtain subsidized commercial coverage through the Health Insurance Exchange, through which premium tax credits are available to help pay the plan premium for qualified individuals with income over 100 percent of the federal poverty level.

Similarly, the waiver of retroactive eligibility for the new adult group, subject to specified exceptions, is also designed to promote improved beneficiary health and wellness by encouraging continuity of coverage and care, including the receipt of preventive health services. It is designed to encourage beneficiaries to obtain and

maintain health coverage, even when healthy, and is therefore intended to reduce gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick. If eligible individuals wait until they are sick to enroll in Medicaid, they are less likely to obtain preventive services during periods when they are not enrolled, potentially resulting in worse health outcomes. CMS is requiring the state's evaluation design to include hypotheses on the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings), as well as the effects of the demonstration on health outcomes and the financial impact of the demonstration (for example, an assessment of medical debt and uncompensated care costs).

The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.

Approval of this demonstration will enable the state to continue coverage of the new adult group in the manner contemplated under state law. The state's current Medicaid expansion demonstration expires on December 31, 2018. As the state explained in its demonstration application, the Granite Advantage demonstration would extend New Hampshire's Medicaid expansion program with the objective of improving beneficiary health, while better integrating fiscal sustainability and personal responsibility into the state's Medicaid program. The state repeatedly articulated that its intention with this extension is "to continue to provide coverage for the Medicaid expansion population." Because the state is

seeking to "sustain and improve its Medicaid expansion," state law requires that if CMS does not approve the waivers necessary for the program by December 1, 2018, the state's Health Commissioner must immediately notify all program participants that the Granite Advantage demonstration program will be terminated in accordance with the current waiver STCs. If CMS were to disapprove the Granite Advantage demonstration, we recognize that the state plans to end its current coverage of the new adult group that the Granite Advantage program was designed to cover, as the state has informed CMS that, under its interpretation of state law, it would be required to terminate coverage for its expansion population should CMS not approve this demonstration extension.

New Hampshire's stated goals for the extension of the Granite Advantage demonstration program align with the goals of the Medicaid program. As discussed above, both the community engagement requirement and the waiver of retroactive eligibility for beneficiaries in the new adult group, with specified exceptions, are intended to improve beneficiary health and wellness and increase financial independence. Promoting improved health and wellness ultimately helps to keep health care costs at more sustainable levels. Moreover, to the extent that the community engagement requirements help individuals achieve financial independence and transition into commercial coverage, the demonstration may reduce dependency on public assistance while still promoting Medicaid's purpose of helping states furnish medical assistance by allowing New Hampshire to stretch its limited Medicaid resources. Helping the state stretch its limited Medicaid resources will assist in ensuring the

long-term fiscal sustainability of the program and preserving the health care safety net for those New Hampshire residents who need it most.

The community engagement requirements may impact overall coverage levels if the individuals subject to the requirements choose not to comply with them. However, the demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. It furthers the Medicaid program's objectives to allow states to experiment with innovative means of deploying their limited state resources in ways that may allow them to provide services beyond the legal minimum. Enhancing fiscal sustainability allows the state to provide services to Medicaid beneficiaries that it could not otherwise provide.

As described in the STCs, if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

Consideration of Public Comments

Both New Hampshire and CMS received comments during the state and federal public comment periods. The state's public comment period began on May 8, 2018, and lasted through June 29, 2018. The state held three public hearings in May and June 2018. New Hampshire has no federally recognized tribes or Indian health programs,

so tribal consultation was not required. New Hampshire reviewed and considered all public comments received during the public notice period. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all public comments received during the federal comment period, to determine whether the demonstration project as a whole is likely to assist in promoting the objectives of the Medicaid program, and whether the waiver authorities sought are necessary and appropriate to implement the demonstration.

Comments on Community Engagement

Many of the public comments received during the federal public comment period expressed concern that community engagement requirements would be burdensome on families and caretakers and create barriers to coverage. As CMS explained in the May 7, 2018 approval letter for the state's demonstration amendment, to mitigate some of those concerns, New Hampshire has exempted beneficiaries who are parents or caretakers where care of a dependent is considered necessary by a licensed provider; parents or caretakers of a dependent child under 6 years of age; and parents or caretakers of a dependent of any age with a disability residing with the parent or caretaker. To minimize the administrative burden of reporting, beneficiaries will be able to verify or document their compliance or exemption status via the internet, via telephone, by mail, in person, or through other commonly available electronic means as described in 42 CFR 435.907(a). CMS also intends to monitor state-reported data on how the new requirements are impacting enrollment.

Commenters specifically noted that the requirement that non-exempt beneficiaries participate in 100 hours of community engagement monthly is higher than other states with similar community engagement requirements approved to date, and may be correspondingly more difficult for beneficiaries to meet. Commenters also noted that beneficiaries whose income qualifies them for coverage in the new adult group can work unpredictable hours that vary from month to month, and often lack control over their work schedules and may involuntarily work part time. As mentioned above, to accommodate these beneficiaries irregular work schedules, the state provides beneficiaries who fail to participate in an allowable activity for 100 hours in one month with an opportunity to cure their non-compliance by making up their deficient hours in the next month, or by demonstrating good cause or qualification for an exemption, without losing coverage.

Some commenters expressed concern that, despite participating in an allowable activity or having an exempt status, beneficiaries will lose coverage due to the administrative burden of reporting compliance with the community engagement requirements. New Hampshire's system for reporting and verifying compliance is designed to minimize burden on beneficiaries. First, the state will use existing data sources, where available, to record a beneficiary's monthly participation in qualifying activities or verify his or her exempted status. Second, beneficiaries will be able to verify this information via the internet, via telephone, by mail, in person, or through other commonly available electronic means as described in 42 CFR 435.907(a). Finally, in cases where the beneficiary has to report information to the state

(that being when the state is unable to locate information in existing data systems), the beneficiary can document their compliance or exemption status via the internet, via telephone, by mail, in person, or through other commonly available electronic means as described in 42 CFR 435.907(a).

Other commenters were concerned about areas of high unemployment acting as a barrier to meeting the community engagement requirements. Through this demonstration, New Hampshire seeks to incentivize beneficiaries to obtain employment or undertake other community engagement activities by offering an array of qualifying activities, including training, education, caregiving, and community service to allow beneficiaries multiple ways to meet the requirements. Additionally, the state assures that it will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet.

Some comments expressed concern that beneficiaries with chronic or acute health conditions may not be able to meet the community engagement requirements and characterized the proposal to suspend eligibility for failure to participate in community engagement activities as having a "potentially detrimental impact on Medicaid beneficiaries' access to coverage and care." CMS acknowledged these concerns in the May 7, 2018, approval

letter, and New Hampshire will exempt from the requirements those individuals who are medically frail, as well as those individuals whom a licensed professional has certified to be temporarily unable to participate in community engagement activities due to illness or incapacity. Additionally, New Hampshire will provide multiple ways for beneficiaries to reactivate their coverage or re-enroll in Medicaid, to appropriately support individuals who have experienced a suspension of eligibility or disenrollment in regaining access to the program's benefits and resources. As stated above, beneficiaries who do not meet the monthly community engagement requirements have an opportunity to cure their noncompliance by demonstrating good cause for failing to meet the requirement; demonstrating that they qualify for an exemption; or making up the deficient hours for the month that resulted in noncompliance. Beneficiaries whose Medicaid enrollment is terminated can re-apply for coverage at any time, and any prior noncompliance with the community engagement requirements will not be considered as part of their new eligibility determination.

Commenters also raised concerns about beneficiaries with disabilities and beneficiaries who may not be eligible for Medicaid on the basis of disability but who may still have issues gaining and maintaining employment or otherwise performing qualifying activities due to their medical or behavioral health conditions. To mitigate these concerns, New Hampshire has exempted beneficiaries with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or Section 1557 of the Patient Protection and Affordable Care Act from the community engagement requirements, who are unable to comply with the requirements due to disability-related

reasons. The state must provide reasonable modifications related to meeting community engagement requirements for beneficiaries with disabilities as defined under the ADA, Section 504, or Section 1557, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. Per the STCs, the state must also provide reasonable modifications for protections and procedures, including but not limited to assistance with demonstrating eligibility for an exemption from community engagement requirements on the basis of disability; appealing disenrollments; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications. The reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the otherwise-required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

Commenters also characterized the requirement to obtain provider documentation for exemptions/exceptions as excessively burdensome. Commenters had concerns about the process involved in getting documentation of exempted or excepted status from a provider. In particular, commenters were concerned that an individual might have his or her eligibility suspended or be disen-

rolled for failure to meet the community engagement requirements, but might need documentation from a provider so that he or she can demonstrate qualification for an exemption or exception to regain Medicaid eligibility. In this case, the individual would need coverage to be able to see the provider to obtain documentation. In order to reduce administrative burden, the state will not require beneficiaries to begin meeting the community engagement requirements until the first month after that date that is 75 days after the community engagement requirements are implemented by the state. After implementation, newly eligible beneficiaries will not be required to meet the community engagement requirements until the first month after the date that is 75 days after the beneficiary's eligibility determination. This 75-day period allows individuals who may require documentation for an exemption or exception to obtain the needed documentation before the community engagement requirements begin to apply. If an individual later fails to meet the community engagement requirements for a month, he or she will be notified and will have coverage during the following month to obtain provider documentation, if needed, before eligibility suspension. Individuals whose enrollment is terminated at eligibility redetermination because their eligibility was in a suspended status for failure to meet the community engagement requirements may reapply for Medicaid at any time, and their prior noncompliance with the community engagement requirements will not be considered in making their new eligibility determination. Furthermore, beneficiaries whose eligibility is suspended or terminated may use the mechanisms in place to ap-

peal their suspension or termination and may demonstrate qualification for an exemption or exception through this process.

Some commenters noted that most Medicaid beneficiaries are already working. CMS acknowledges that many beneficiaries are already working or attending school; therefore, those activities are included as qualifying activities that meet the community engagement requirement and access to coverage should not be impacted for beneficiaries who are engaging in these activities for the required number of hours each month.

Other commenters expressed concerns that the administration of the demonstration, especially the community engagement requirement, would be burdensome and costly to state. Although such measures may have associated administrative costs, particularly at the initial stage, in the long term they may help enable beneficiaries to enjoy the many personal benefits that come with improved health outcomes and increased financial independence.

As described in the STCs, if monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, or if evaluation data for this demonstration indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers at any time it determines that continuing the waivers would no longer be in the public interest or promote the objectives of Medicaid.

Comments on Coverage Loss

Some commenters expressed concern that the Granite Advantage demonstration will lead to coverage losses. But the demonstration will provide coverage to individuals that the state is not required to cover. Any potential loss of coverage that may result from a demonstration is properly considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage for existing (but non-mandatory) populations, such as (in light of the Supreme Court's ruling in *NFIB v. Sebelius*) the ACA expansion population. As of October 2018, more than 51,000 individuals received medical assistance under the New Hampshire state plan as a result of New Hampshire's decision to participate in the ACA eligibility expansion. New Hampshire's ACA expansion population includes not only childless adults but also many parents of dependent children, who are not eligible for coverage under the New Hampshire state plan unless their household income is equal to or less than 67 percent of the federal poverty level. Under state law, however, if this demonstration were not approved, the State Commissioner of Health and Human Services would be required to report this to the State Legislature and Governor, who could then respond by seeking to scale back or even end coverage for the ACA expansion population, or other optional populations and services currently covered under the state plan. Thus, the ACA adult expansion could be eliminated if the state is unable to implement the demonstration project.

Moreover, conditioning eligibility for Medicaid coverage on compliance with certain measures is an im-

portant element of the state's efforts, through experimentation, to improve beneficiaries' health and independence and enhance programmatic sustainability. To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence. This may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the incentives included in this demonstration are not designed to encourage this result; rather, they are intended to incorporate achievable conditions of continued coverage. And any loss of coverage as the result of noncompliance must be weighed against the benefits New Hampshire hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.

It would be counterproductive to deny states the flexibility they need to implement demonstration projects designed to examine innovative ways to incentivize beneficiaries to engage in desired behaviors that improve outcomes and lower healthcare costs, as well as innovative ways to stretch limited state resources, given that states have the prerogative to terminate coverage for nonmandatory services and populations. Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment.

Some comments argued that a demonstration cannot advance the Medicaid program's objectives if the project

is expected to reduce Medicaid enrollment or Medicaid spending. We recognize that some individuals may choose not to comply with the conditions of eligibility imposed by the demonstration, and therefore may lose coverage, as may occur when individuals fail to comply with other requirements like participating in the redetermination process. But the goal of these policies is to incentivize compliance, not reduce coverage. Indeed, CMS has incorporated safeguards into the STCs intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with the state to ensure that the demonstration advances the objectives of Medicaid. Furthermore, we anticipate that some beneficiaries may dis-enroll from Medicaid if they obtain employer-sponsored or other commercial coverage and no longer qualify for the program. Finally, we note that in some cases, reductions in Medicaid costs can further the Medicaid program's objectives, such as when the reductions stem from reduced need for the safety net or reduced costs associated with healthier, more independent beneficiaries. These outcomes promote the best interests of the beneficiaries whose health and independence are improved, while also helping states stretch limited Medicaid resources and ensure the long-term fiscal sustainability of the states' Medicaid programs.

As noted above, section 1115 of the Act explicitly contemplates that demonstrations may "result in an impact on eligibility"; furthermore, the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration, if the state were unable to continue its Medicaid expansion program. Other comments predicted that Granite Advantage will fail to

achieve its intended effects. For instance, some comments argued that beneficiaries subject to the community engagement requirements will be unable to comply. To some extent, these comments reflect a misunderstanding of the nature of the community engagement requirements, which some of the comments described as a work requirement. In fact, the community engagement requirements are designed to help beneficiaries achieve success, and CMS and New Hampshire have made every effort to devise a requirement that beneficiaries should be able to meet. For example, the community engagement requirements may be satisfied through an array of activities, including education, job skills training, job search activities, and community service.

More generally, these comments reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making. As HHS previously explained, demonstrations can "influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other [s]tates." 77 Fed. Reg. at 11680. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See*, *e.g.*, *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which New Hampshire's demonstration project succeeds in achieving the

desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. As long as the Secretary determines that the demonstration is likely to assist in promoting Medicaid objectives, he is authorized to approve the demonstration notwithstanding that its ultimate outcomes cannot be known in advance.

Consistent with state law regarding coverage of the ACA expansion population, this demonstration is part of the state's plan for fiscal sustainability of its Medicaid program. In analyzing whether approval of the demonstration promotes the objectives of Medicaid, it must be understood that the alternative to coverage under this demonstration design ultimately could be reduced coverage or no coverage in the case of the ACA expansion population. This demonstration is also designed to improve health outcomes and financial independence, and reduce dependency on public assistance, by giving beneficiaries the choice either to engage in community engagement activities or to stop participating in Medicaid.

Comments on Waiver of Retroactive Eligibility

Many commenters expressed concern that the waiver of retroactive eligibility could result in unmet health needs and decreased financial security for beneficiaries, as well as increased uncompensated care costs for providers. CMS has taken these comments into consideration as part of its approval and will require the state to carefully evaluate how the waiver of retroactive eligibility is affecting beneficiaries and providers. CMS will not permit the state to waive retroactive eligibility for beneficiaries who, at any time during the otherwise applicable 3-month period of retroactive eligibility, were pregnant women (including women who are 60 days or

less postpartum), infants under age 1, children under age 19, parents or caretaker relatives, or as individuals eligible in aged, blind, or disabled eligibility groups (including those who are applying for a long-term care determination).

Commenters also asserted that there is no experimental purpose associated with the waiver of retroactive eligibility. However, as indicated in the state's application, this demonstration is designed to test whether eliminating retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy, without increasing the rate of churn in and out of the program. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, and to increase the uptake of preventive services by continuously covered beneficiaries, with the ultimate objective of improving beneficiary health.

Commenters also expressed concern that waiving retroactive eligibility does not promote the objectives of the Medicaid program. As discussed above, the waiver of retroactive eligibility is intended to incentivize beneficiaries to maintain coverage even when well, promote continuity of coverage, and encourage the receipt of preventive care, with the overall goal of improving health outcomes for beneficiaries. To increase awareness of this waiver authority and help ensure that it promotes the objectives of the Medicaid program as intended, New Hampshire will provide outreach and education to the public and to providers about how to apply for and receive Medicaid coverage. Per STC 28, no later than 90 days after approval of the demonstration, the state is

required to submit an implementation plan that includes a discussion of topics such as outreach, application assistance, and notices as they relate to the waiver of retroactive eligibility. The state will also evaluate the financial impacts of the waiver on beneficiaries and providers.

In evaluating the impact of a waiver of retroactive coverage, it is important to keep in mind that the new adult group members affected by this waiver are eligible for coverage now, and should have an incentive to obtain it, rather than waiting until they get sick to apply and having their bills retroactively covered. This entire demonstration design also will assist in making New Hampshire's Medicaid program fiscally sustainable over time, better ensuring continued coverage of individuals and services for which coverage is optional under Medicaid.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Mr. Emmett Ruff. He is available to answer any questions concerning your section 1115 demonstration. Mr. Ruff's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26

7500 Security Boulevard
Baltimore, MD 21244-1850
Email: emmett.ruff@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Ruff and Mr. Richard McGreal, Associate Regional Administrator (ARA), in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
15 Sudbury Street, JFK Federal Building
Boston, Massachusetts 02203

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in New Hampshire, over the past months to reach approval.

Sincerely,

/s/

Mary C. Mayhew
Deputy Administrator and Director

Enclosures

cc: Richard McGreal, Associate Regional Administrator, CMS Boston Regional Office