Nos. 20-37 & 20-38

In the Supreme Court of the United States

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.
Petitioners,
v.
CHARLES GRESHAM, *et al.*,
Respondents.

STATE OF ARKANSAS,
Petitioner,
v.
CHARLES GRESHAM, *et al.*,
Respondents.

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

REPLY BRIEF OF PETITIONER STATE OF ARKANSAS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

OTHER AUTHORITIES Page(s)

REPLY BRIEF

Medicaid is a healthcare program, not simply a program that pays for healthcare costs. Indeed, to the extent there is one theme that ties all of Medicaid's various provisions together it is the goal of improving beneficiary health. That means that the Secretary could consider whether Arkansas's demonstration project was likely to assist in promoting health, and the decision below holding that he could only consider coverage cannot stand.

Respondents first try to avoid that commonsense conclusion by urging the Court to not decide this case. But even with the Government's sudden *volte-face*, Respondents' arguments for dismissal amount to little more than a renewal of their arguments for denying certiorari.

Alternatively, on the merits, Respondents largely stake their case on an assertion that Section 1115's authorization to waive existing Medicaid requirements so that states can experiment with new ways of promoting Medicaid's objectives only permits tinkering with—not actually waiving—those existing requirements. Aside from conflicting with the plain text of the statute, that claim also cannot be squared with the history of Medicaid waivers.

Moreover, even if the Secretary could only consider coverage, the judgment below still couldn't stand because Arkansas's community-engagement requirements will promote coverage by transitioning able-bodied adults to other, non-Medicaid coverage and making Medicaid sustainable. And there's no dispute that the Secretary expressly found Arkansas's waiver limiting retroactive eligibility would promote coverage by encouraging people to get covered before they

need expensive treatment. The judgment below should be reversed.

I. The question presented remains just as pressing as when the Court granted review.

Respondents begin with a thinly veiled plea for dismissal, arguing the question presented is no longer cert-worthy. Resp. Br. 26-27. The Government, meanwhile, now claims these cases are no longer appropriate vehicles to decide the question presented and seeks vacatur. But the question presented is just as pressing as when the Court granted certiorari, and these cases remain appropriate vehicles to resolve it.

Respondents and the Government principally rely on the Government's proposed revocation of one aspect of Arkansas and New Hampshire's—and many other States'—waivers. Yet the Government hasn't proposed to revoke Arkansas and New Hampshire's waivers of retroactive eligibility, so whether those waivers were permissible will remain a fully live question. And as to community-engagement waivers, the coming cascade of litigation over the Government's unprecedented revocations of approved waivers will only make the questions these cases present more salient, not less.

A. To begin with, neither Respondents nor the Government suggest these cases are moot or are on the verge of becoming moot. After the Government moved for vacatur, CMS notified Arkansas that it had revoked its approval of the state's community-engagement requirement.[1] Letter from Elizabeth Richter, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Dawn Stehle, Deputy Dir. for Health &

[1] Though CMS proposed revocations of 11 States' waivers, so far it has only revoked Arkansas and New Hampshire's.

Medicaid, Ark. Dep't of Hum. Servs. (Mar. 17, 2021).[2] But that revocation does not become effective until April 16 and is subject to administrative appeal thereafter, *id.* at 16, so it is not final and therefore does not moot these cases.

Nor, for two reasons, would it moot these cases once final. First, CMS has only purported to revoke *half* of Arkansas's waiver: the half authorizing community-engagement requirements. It has not revoked the Secretary's waiver of retroactive eligibility, which the decisions below vacated, Pet.App. 44a, 53a, and which is included within the questions presented. *See* Ark. Pet. i (asking whether Arkansas's waiver in its entirety was lawful); Gov't Pet. 16, 34-35 (addressing the retroactive-eligibility issue). And even on Respondents' theory that the sole objective of Medicaid is maximizing coverage, that waiver is unproblematic.

Second, even CMS's half-revocation is extremely vulnerable to procedural and substantive challenge, *see* Ark. Opp'n to Mot. to Vacate 3-4, and so long as it could be vacated the validity of the underlying waivers would remain a live question. The Government counters that whether its revocation would survive judicial review is premature, Mot. Reply 5, but the Court needn't forecast whether revocation challenges would succeed. The point is that so long as they might, it isn't "impossible . . . to grant [Arkansas] any effectual relief whatever." *Chafin v. Chafin*, 568 U.S. 165, 172 (2013).

B. Unable to claim impending mootness, Respondents and the Government claim that changed circumstances have made the question presented less cert-

[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-ca2.pdf.

worthy, or these cases less appropriate vehicles to address it. But that isn't the case either.

Respondents and the Government make much of pandemic-response legislation that temporarily holds Arkansas and New Hampshire's community-engagement requirements in abeyance during the current public-health emergency. Resp. Br. 27; Mot. to Vacate 3-4. But as the Government formerly explained, that provision's temporary bar doesn't make the question presented any less consequential, Cert. Reply 8, and given the growing pace of vaccinations, Respondents' prediction that it will last until "at least the end of 2021," Resp. Br. 27, seems willfully pessimistic.

Next, Respondents and the Government argue that the partial revocation of Arkansas's waiver makes plenary review unwarranted. That's incorrect because, as already noted, whether the Secretary can waive retroactive eligibility remains a live and cert-worthy question in itself. Indeed, administrations of both parties have frequently waived retroactive eligibility, Gov't Pet. 34 (citing examples), and eight States currently have approved retroactive-eligibility waivers. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, Kaiser Fam. Found. (Feb. 25, 2021).[3]

Moreover, even as to community-engagement requirements, the Government's revocation won't make the question of the permissibility of such waivers any less salient. To the contrary, the Government's unprecedented proposal to revoke eleven States' waivers in eight different regional Circuits, *see* Mot. to Vacate 4, Gov't Br. 15 n.6, will only create a cascade of

[3] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state.

litigation over community-engagement requirements that will inevitably require resolution by this Court.

The Government responds that these cases are the wrong vehicles to resolve the questions that litigation will spawn. Mot. Reply 5. But whether community-engagement requirements are permissible is a threshold question that will need to be resolved before courts can decide whether the Government reasonably exercised its discretion in rescinding them, *cf. Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891 (2020), and these cases squarely present that question, with the benefit of full briefing focused solely on that issue.

Because the question presented remains pressing, this Court should decide these cases.

II. The Secretary enjoys broad authority to grant Section 1115 waivers.

Section 1115 authorizes the Secretary to "waive compliance with any of the requirements" of Section 1902, the guts of the Medicaid statute, "[i]n the case of any experimental, pilot, or demonstration project which, in [his] judgment . . . is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. 1315(a). Respondents contend that broad language only authorizes the Secretary to expand existing coverage or tinker with its delivery, Resp. Br. 9, not to test new means of furthering Medicaid's objectives. That gets Section 1115 fundamentally wrong.

A. Respondents' core claim is that Section 1115 doesn't mean what it says. That provision says the Secretary may waive Medicaid's requirements if he believes doing so is likely to assist in promoting Medicaid's objectives. Yet Respondents insist that

"the Secretary lacks authority to" do exactly that. Resp. Br. 41.

Instead, Respondents argue that the Secretary can only test ways to expand coverage or enhance its delivery, not whether conditioning coverage on healthy behavior might further Medicaid's goals. *See id.* They argue that's because agencies are "bound not only by the ultimate purposes Congress has selected, but by the means it has . . . prescribed, for the pursuit of those purposes," and, on their view, Medicaid's prescribed means is coverage. *Id.* (quoting *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 231 n.4 (1994)). Thus, they reason, the Secretary acted unlawfully here because Arkansas's program could limit Medicaid coverage. *See id.*

That claim is flatly contradicted by Section 1115. While it's certainly true that agencies are bound by the means Congress has chosen to achieve its purposes, Respondents misapply that principle. Section 1115 makes *experimentation* a means of pursuing Medicaid's objectives. And far from limiting that experimentation to technical details or coverage expansion, that provision empowers the Secretary to waive *any* of Section 1902's existing requirements—including the details of Medicaid's existing coverage regime. Indeed, lower courts have long rejected the argument that Section 1115 "does not permit the Secretary to waive any requirement . . . which might result in the curtailment or denial of assistance," concluding that "the only limitation imposed on the Secretary was that he must judge the project to be 'likely to assist in promoting the objectives' of the designated parts of the Social Security Act." *Aguayo v. Richardson*, 473 F.2d 1090, 1104-05 (2d Cir.

1973) (Friendly, J.) (citing *Cal. Welfare Rts. Org. v. Richardson*, 348 F. Supp. 491 (N.D. Cal. 1972)).

Past agency practice also underscores that the Secretary's authority to waive requirements is broader than Respondents suggest. As the Obama administration explained, many demonstrations "have constrained eligibility or benefits in ways otherwise not permitted by statute," whether by "provid[ing] for a more limited set of benefits than the statute requires," "implement[ing] cost-sharing at levels that exceed statutory requirements, or includ[ing] enrollment limits." Medicaid Program: Review and Approval Process for Section 1115 Demonstrations, 77 Fed. Reg. 11678, 11678 (Feb. 27, 2012). And multiple administrations have used that authority to condition expanded coverage on healthy behavior and to fund any number of health-promoting services that have nothing to do with health care coverage as traditionally understood. Ark. Br. 6-8.

In fact, Respondents themselves cite (Resp. Br. 9) a secondary source that concludes that 70 of the 87 *pre-Trump-administration* Section 1115 waivers on which information is available did not merely tinker with technical details and delivery methods, but "limit[ed] access to medical assistance" below what Medicaid law normally requires, whether by imposing cost-sharing, eliminating retroactive eligibility, or cutting benefits. Alexander Somodevilla et al., *How Far do Section 1115 Medicaid Experiments Designed to Restrict Eligibility and Enrollment Veer from the Norm? A 25-Year Perspective*, GW Health Pol'y & Mgmt. Matters (June 13, 2019).[4]

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[4] http://gwhpmmatters.com/blog-how-far-do-section-1115-medicaid-experiments-designed-restrict-eligibility-and-enrollment-veer.

Furthermore, to the extent that there was ever any doubt about the Secretary's ability to approve broader programs that impact coverage, recent amendments to Section 1115 underscore Congress's recognition that approved waivers may "result in an impact on eligibility, enrollment, benefits [and] cost-sharing." 42 U.S.C. 1315(d). The Court should therefore reject Respondents' attempt to graft additional limitations onto the Secretary's authority to approve waivers.

B. Relatedly, Respondents also misapprehend the role of courts in reviewing such waivers. Both the Second Circuit, through Judge Friendly, and the Third Circuit have held that—given the agency's historic and permissible practice of making few if any formal findings when granting waivers—when reviewing a Section 1115 approval the question is whether "the Secretary rationally could have determined that [the waiver] was 'likely to assist in promoting the objectives'" of the program at issue. *C.K. v. N.J. Dep't of Health & Hum. Servs.*, 92 F.3d 171, 183 (3d Cir. 1996); *see Aguayo*, 473 F.2d at 1105 (asking "whether the Secretary had a rational basis for determining that the programs were 'likely to assist in promoting the objectives'" of the program at issue there). Subject to the proviso that, when the Secretary does offer reasoning, it cannot be contrary to law or unreasonably determine the facts, that is the correct standard here.

Respondents would consign those precedents to the ash can and require the Secretary to affirmatively address all relevant factors and respond to significant comments. Resp. Br. 29, 37-38. Their basis for toppling that precedent is that it preceded the recent Section 1115 amendments noted above that require the Secretary to solicit comments. Resp. Br. 32. They argue that process "generat[es] the robust administra-

tive record" that was supposedly "absent in *Aguayo*." *Id.* But *Aguayo* and *C.K.* were not premised on an absence of *record*. In fact, Judge Friendly praised the "extensive" and "impressive" materials commenters submitted to the agency, *Aguayo*, 473 F.2d at 1097, 1106, and the Third Circuit described similar commentary in the record before it, *C.K.*, 92 F.3d at 180. Rather, they were premised on the informality of the Secretary's approvals. *Id.* at 183 (citing *Aguayo*, 473 F.2d at 1103).

That informality has not changed. Rather, in a regulation promulgated by the Obama administration in response to the amendments discussed above, the Secretary said he would "not provide written responses to public comments," 42 C.F.R. 431.416(d)(2), because he did "not believe it is feasible to explain considerations regarding conclusions reached with respect to a particular component of a demonstration." Medicaid Program: Review and Approval Process for Section 1115 Demonstrations, 77 Fed. Reg. at 11685.

Respondents do not challenge those regulations, and the Secretary was entitled to promulgate them because while Section 1115 approvals involve notice-and-comment procedures, they are not notice-and-comment rulemakings. Therefore, the strictures this Court has found implicit in the APA's provisions governing notice-and-comment rulemaking, including "respon[se] to significant comments," *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 96 (2015) (citing 5 U.S.C. 553(c)), do not apply. And the Court should reject Respondents' attempt to interpose such a requirement here.

III. The Secretary correctly interpreted Medicaid's objectives.

A. Maximizing Medicaid coverage is not Medicaid's sole purpose.

If the parties agree on anything, it is that the Medicaid statute is "lengthy and complex," Resp. Br. 41 n.11—and that's an understatement. As anyone who's attempted to read this "aggravated assault on the English language" knows, *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 n.14 (1981), the statute strikes an ornate, "delicate balance . . . between competing interests" that "belies [any] efforts to distill from it a single purpose." *Pharm. Rsch. & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 676 (2003) (Thomas, J., concurring in the judgment).

Despite that complexity, Respondents insist Medicaid has a single exclusive purpose: providing coverage to eligible beneficiaries. To make that argument, they dismiss as "cherry-pick[ing] from a lengthy and complex statute," Resp. Br. 41 n.11, countless provisions aimed at fostering independence and improving health. Yet they rest their entire argument on a cherry-picked snippet in a single sentence of an appropriations provisions that was enacted a half-century before the Medicaid expansion program at issue here. And even that provision contradicts Respondents' claim that coverage is the expansion's sole objective.

That provision, Section 1901, says that, "[f]or *the purpose* of enabling each State" to provide medical assistance to Medicaid's original beneficiaries, "there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the *purposes* of this subchapter." 42 U.S.C. 1396-1 (emphasis added).

Respondents argue that the "purpose" stated in the preamble to that provision is Medicaid's—and by extension, the expansion's—sole purpose. That argument fails for four reasons.

First, Section 1901 isn't a purpose section; it's an authorization of appropriations. Such provisions play a merely parliamentary role, and rather than appropriating funds, or telling agencies how to spend them, such enactments merely satisfy Congress's own requirement that it authorize appropriations before enacting an appropriations bill. *See* Ark. Br. 33-34.

Respondents don't dispute that limited function. Instead, they retort, "what better place" could there be for stating a spending program's purpose than its appropriations section? Resp. Br. 34 (alteration omitted) (quoting Pet.App. 46a). That question, however, answers itself: Had Congress wished to codify an exhaustive list of Medicaid's objectives, it could have enacted a purpose section. That's what Congress has done with other social welfare programs. *See* Ark. Br. 33 (citing examples). And Congress's failure to do so here underscores—as Justice Thomas explained in *Walsh*—that Medicaid's objectives cannot be so neatly distilled into a single fraction of a sentence.

Second, Section 1901 doesn't say anything about the expansion's purposes. At best, it only states a purpose of the original Medicaid program, one that is limited to Medicaid's original beneficiaries, "families with dependent children" and "aged, blind, or disabled individuals." 42 U.S.C. 1396-1. Indeed, if the "purpose" stated in Section 1901 were Medicaid's only purpose, the expansion itself—a program for childless, nondisabled adults—would exceed Medicaid's purposes.

Respondents counter that health care coverage is undoubtedly a purpose of the expansion, even if Section 1901 might not say so. Resp. Br. 35-36. But that misses the point. Respondents can't prevail merely by showing that coverage is *a* purpose of the expansion; it certainly is. Rather, they must show that coverage is the expansion's sole purpose to the exclusion of health. And Respondents don't point to anything demonstrating that's the case. Nor could they since other expansion provisions evince any number of other objectives. *See* Ark. Br. 20-25.

Third, on its face, Section 1901 doesn't purport to be an exhaustive statement of Medicaid's objectives. Instead, it authorized appropriations "to carry out the purposes," plural, "of this subchapter," as they might develop over time. That language, as explained at length in Arkansas's opening brief, would make no sense, if, as Respondents argue, Section 1901 itself contained an exhaustive list of objectives. And recognizing as much, Respondents—like the courts below, Pet.App. 11a, 38a—tellingly avoid quoting Section 1901 in its entirety. Resp. Br. 34 (only quoting its preamble).

Fourth and last, Congress has rejected Respondents' coverage-only theory of Medicaid's objectives. Respondents make much of the ACA's having amended Section 1115 to require the Secretary to obtain, where feasible, "the expected . . . costs and coverage projections" of proposed demonstration projects. Resp. Br. 10 (quoting 42 U.S.C. 1315(d)(2)(B)(ii)). That provision, however, merely suggests Congress thought coverage—*and* cost—was one relevant consideration in reviewing waiver applications. It doesn't suggest coverage is the only thing the Secretary may consider.

Instead, far more telling is the ACA's amendment requiring the Secretary to provide additional process where a Section 1115 waiver "would result in an impact on eligibility, enrollment, benefits [or] cost-sharing." 42 U.S.C. 1315(d)(1). If coverage were Medicaid's sole objective, then the Secretary could never have approved projects with such an impact in the first place and that amendment would make little sense. Thus, contrary to Respondents' claim, coverage is merely *an* objective of Medicaid, not its only or overriding one.

B. Health is an objective of Medicaid.

Respondents claim that "beneficiary health and financial independence . . . are not objectives of Medicaid." Resp. Br. 2. Yet aside from their claim that Section 1901 announced Medicaid's exclusive purposes for all time, Respondents don't point to anything suggesting that "better health outcomes . . . are not consistent with Medicaid." Pet.App. 16a.

1. Improving beneficiaries' health is Medicaid's chief objective. And that shouldn't be debatable. Medicaid, as Respondents stress, is a healthcare coverage program; it funds "medical care for individuals who cannot afford to pay their own medical costs." Resp. Br. at 34 (quoting *Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006)). The reason people obtain coverage for medical care, or that the government pays for it, is that medical care promotes health. If medical care didn't promote health, the government wouldn't pay for it—and indeed, Medicaid doesn't pay for care that doesn't promote health. *See* Ark. Br. 22; *Walsh*, 538 U.S. at 677 (Thomas, J., concurring in the judgment).

Respondents answer that improved beneficiary health is merely Medicaid's "desirable *result*," or Congress's "desired outcome," not its "independent objective." Resp. Br. 41. At best, this is empty word-play. The "objective" of a program, in ordinary speech, *is* its desired outcome. *See* Objective, Merriam-Webster English Dictionary (defining "objective" as "something toward which effort is directed: an aim, goal, or end of action").[5] At worst, it's simply nonsensical. To say that coverage is Medicaid's sole objective and health is merely Medicaid's fortuitous byproduct is like saying that the point of welfare is cash assistance itself, not reducing poverty. Indeed, as Respondents acknowledge, healthcare coverage is but "the *means* Congress has prescribed to promote health and wellness." Resp. Br. 41 (emphasis added). And that means' end is health.

2. That health is Medicaid's ultimate objective is so intuitive one almost needn't read the statute to know it. But reading the statute makes that even clearer.

With no small irony, after claiming a single half-century-old provision holds the key to Medicaid's one and only purpose, Respondents dismiss the dozens of health-seeking provisions cited in Arkansas's opening brief, Ark. Br. 20-25, 28, as a mere "handful" of provisions "cherry-picked from a long and complex statute." Resp. Br. 41 n.11. Yet absent reprinting the entire thousand-odd-page law, those provisions offer a fair cross-section of the program and its health-centric focus. Collectively, those provisions illustrate that:

(1) Medicaid is designed to improve patient level health outcomes, Ark Br. 20, 25;

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[5] https://www.merriam-webster.com/dictionary/objective.

(2) Medicaid services, and especially Medicaid-expansion services, are designed to optimize health outcomes, not simply minimize expenses, Ark. Br. 21-23;

(3) Medicaid doesn't simply cover care if it's available, but promotes well-being by guaranteeing access to care, Ark. Br. 23-24;

(4) Medicaid strives to enhance care quality and thereby improve patients' outcomes, Ark. Br. 24-25; and

(5) Medicaid requires the Secretary to test healthy-behavior incentives, including ones that condition enhanced coverage on demonstrating healthy behaviors, Ark. Br. 28.

Thus, the Secretary was entitled to consider whether Arkansas's project was likely to assist in promoting health.

3. In response, Respondents argue that health can't be an objective because if it were, the Secretary could authorize waivers that require beneficiaries to "eat certain vegetables." Resp. Br. 42. That is not a realistic concern.

The past three administrations all approved Medicaid healthy-behavior incentives under Section 1115, Ark. Br. 7, and no State has asked the Secretary for authority to condition coverage on broccoli consumption. What they have sought—and obtained—are waivers conditioning coverage, in whole or part, on not smoking, or—as here—on community engagement. Ark. Br. 8. And multiple administrations have approved demonstration programs on the grounds that they "strengthen[] coverage" and improve "health outcomes for low-income individuals." Letter from

Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Thomas Betlach, Dir., Ariz. Health Care Cost Containment Sys. 2 (Sept. 30, 2016).[6] Thus, as before, the Secretary properly relied on health in approving Arkansas's project.

C. Independence is an objective of Medicaid.

Even if Section 1901 were an exhaustive statement of the expansion's purposes, that provision recognizes that independence is a Medicaid objective. *See* 42 U.S.C. 1396-1 (authorizing Medicaid appropriations "[f]or the purpose" of furnishing "rehabilitation or other services to help" beneficiaries "attain or retain capability for independence or self-care"). The Secretary, therefore, could rely on it here.

1. Respondents acknowledge that independence is a Medicaid objective. They argue, however, that "independence" in Section 1901 means functional independence or, what they describe as "the capacity to accomplish the various activities of daily living,

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[6] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf; *see also* Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to John McCarthy, Medicaid Dir., Ohio Dep't of Medicaid 1 (Sept. 9, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/healthy-ohio-program/oh-healthy-oh-program-disapproval-ltr-09092016.pdf (same); Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., to Cynthia B. Jones, Medicaid Dir., Va. Dep't of Med. Assistance Servs. 2 (Dec. 30, 2016) (approving waiver on ground it would "foster improved care and health outcomes"), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/Governors-Access-Plan-GAP/va-gov-access-plan-gap-appvl-amdmnt-12152016.pdf.

such as feeding, dressing, and bathing." Resp. Br. 43. That reading cannot be squared with Section 1901's reference to attaining "independence *or self-care*" since it would render those terms synonymous. Nor for that matter is Respondents' reading consistent with the reminder of Section 1901 since it's unlikely that Congress meant to state a purpose of helping "families" attain the capability to feed themselves, dress and bathe. *See* 42 U.S.C. 1396-1 (stating a purpose of "help[ing] such families . . . attain or retain capability for independence").

Rather than address those problems with their reading, Respondents suggest that Section 1901's earlier reference to "rehabilitation and other services" means that the statute must be about functional, not financial, independence. Resp. Br. 42. Yet there's no reason that rehabilitation and other Medicaid services cannot be designed to help foster both the kind of self-care that Respondents allude to and financial independence. Indeed, the program does exactly that. *See* 42 U.S.C. 1396n(c)(5)(B), (i)(1) (authorizing prevocational and supported employment services). Respondents' strained reading thus cannot be squared with Section 1901's text.

2. The rest of Medicaid also leaves little doubt that helping beneficiaries attain financial independence is a goal of the program. Since 1965, Congress has enacted multiple provisions explicitly designed to incentivize work and help beneficiaries transition from government assistance. Ark. Br. 40-41.

Those provisions include imposing work requirements for beneficiaries who also receive TANF assistance, providing services that help beneficiaries gain employment, and extending temporary eligibility to beneficiaries whose earnings would otherwise

make them ineligible for Medicaid. And tellingly, those provisions are explicitly designed to "enable [beneficiaries] to maintain employment" and "reduce their dependency" on government assistance. Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. No. 106-170, sec. 2(b), 113 Stat. 1860, 1863 (1999).

Respondents all but ignore those provisions. Their only response is that the incorporation of TANF's work requirements isn't relevant because that coordination only "ensure[s] that the two programs do not conflict." Resp. Br. 44 n.12. But Congress didn't need to import TANF's work requirements into Medicaid to avoid a conflict; providing Medicaid coverage to TANF beneficiaries who don't work wouldn't have diluted TANF's work requirements to receive cash assistance.

Rather, that incorporation demonstrates that Congress thought financial independence was an objective worth pursuing *in Medicaid*. And just as importantly, it underscores that work requirements aren't inconsistent with Medicaid. As this Court wrote in *New York State Department of Social Services v. Dublino*, the fact that a welfare program contains "partial" work requirements and job "training opportunities" doesn't imply it "prevent[s] States from undertaking supplementary efforts toward this very same end," 413 U.S. 405, 419 (1973); it means those supplementary efforts further the "stated purposes" of the program. *Id.* at 420.

D. Health and independence promote fiscal sustainability.

Respondents concede that "the Secretary may consider costs when he reviews [Section 1115] waiver applications." Resp. Br. 51. That's consistent with both the statutory text and this Court's conclusion

that cost control is an objective of Medicaid. Ark. Br. 43-44. It follows that the Secretary was allowed to consider whether Arkansas's program would control costs by improving beneficiary health and encouraging those who could work to gain employment and transition to other coverage.

Recognizing that making beneficiaries healthier and helping them transition to other coverage controls costs, Respondents attempt to sidestep sustainability. They argue that the Court cannot consider sustainability because, they say, the Secretary did not explicitly rely on it. Yet even if it were true that the Secretary didn't explicitly discuss sustainability, that wouldn't preclude its consideration here because fiscal sustainability isn't a new, freestanding rationale for the approval.

Rather, fiscal sustainability is simply a *legal* reason why—even if they aren't separate objectives—health and independence matter. *Chenery* does not forbid agencies from expanding on the legal reasoning that supports their original grounds for action; if it did, government briefing in administrative-law cases would be limited to a copy-and-paste job. *See Mass. Trs. of E. Gas & Fuel Assocs. v. United States*, 377 U.S. 235, 246-47 (1964) (holding it "irrelevant" under *Chenery* that an agency failed to identify "the correct source of its authority" when it correctly determined it had it). Respondents therefore cannot simply sidestep fiscal sustainability.

Knowing that, Respondents also argue that the Secretary isn't permitted to pursue cost savings through supposedly "impermissible objectives," like health or independence. Resp. Br. 52. Respondents don't offer any support for their suggestion that the Secretary may only pursue cost savings by directly

cutting costs. Nor could they, since this Court has previously upheld far more "circuitous" (*id.*) fiscal sustainability rationales. For instance, *Walsh* held that States could use their Medicaid programs to lower drug prices for non-Medicaid beneficiaries—surely not a Medicaid objective in itself—because doing so would help keep those individuals out of Medicaid and thus make Medicaid coverage more sustainable. *See Walsh*, 538 U.S. at 663 (plurality opinion). Thus, the Secretary can pursue cost control by any means that promotes it.

Lastly, Respondents assert that "cutting costs cannot come at the expense of substantial coverage loss" and the Secretary cannot just "slash[]" his way to sustainability. Resp. Br. 52. But that's not what happened here. Far from simply imposing "eligibility restrictions and benefit cuts in the name of saving money" (*id.*), the Secretary denied Arkansas's request to reduce eligibility to 100% of the poverty level. Pet.App. 68a. Instead, the Secretary only approved those elements of Arkansas's program that he determined were meetable, would improve health, and would help beneficiaries gain employment and transition to other non-Medicaid coverage. And while Respondents may quibble with the Secretary's prediction that Arkansas's project would be successful, that disagreement does not support their assertion that the project was simply a benefits cut.

IV. The Secretary's approval was not arbitrary and capricious.

Because health and independence are Medicaid objectives, the Secretary's approval was not arbitrary and capricious. The Secretary predicted that Arkansas's waiver would likely promote health and independence.

Neither court below found that prediction unreasonable. The approval therefore must stand.

Respondents say that the Secretary's approval was nevertheless arbitrary and capricious because he "failed to . . . address[] potential coverage loss at all." Resp. Br. 38. That's not true. Instead, what Respondents really mean is that the Secretary did not say enough to satisfy them.

A. In approving Arkansas's community-engagement requirements, the Secretary did not ignore coverage loss. To the contrary, the Secretary acknowledged that the "health-risks" associated with losing coverage were relevant to his decision. Pet.App. 76a. But he predicted that, on balance, the "health benefits" of incentivizing community engagement (and limiting retroactive eligibility) would outweigh those risks. *Id.*

1. In reaching that conclusion, he pointed to multiple features of Arkansas's project that he believed would mitigate coverage loss. For instance, the Secretary pointed to Arkansas's robust outreach and notification program, the fact that beneficiaries would only become ineligible after failing to comply for three months, and the extensive list of exemptions. Pet.App. 75a-76a. And the Secretary explained that his decision to approve the program ultimately rested on his prediction that the community-engagement requirement would "adequately incentivize beneficiary participation." Pet.App. 75a.

Faced with that extensive discussion, Respondents argue that the Secretary failed to adequately discuss "the magnitude of coverage loss he anticipated." Resp. Br. 38. In the case of a rulemaking such a critique would arguably carry the day.

But this case doesn't involve rulemaking—or even long-term agency action. Rather, it involves a short-term experiment that's supposed to determine whether community-engagement requirements promote beneficiary health and independence. Thus, unlike a rulemaking, where an agency must forecast a rule's impact in advance, the point of the agency action here is to find out what its impact will be. As Judge Friendly put it, "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," *Aguayo*, 473 F.2d at 1103, particularly given that "[a]scertainment by actual demonstration" whether a waiver will achieve its stated aims is "a legitimate objective" itself. *Id.* at 1106.

Respondents' criticism that the Secretary did not show all of his work thus falls flat. Instead, the only question for review here is whether the Secretary could reasonably predict that the community-engagement requirement's health benefits would exceed its costs, given the evidence before him.

2. Respondents ultimately don't point to anything suggesting that conclusion was unreasonable. At best, they cite comments vaguely predicting coverage loss. Resp. Br. 37. Yet those comments, the most salient parts of which are quoted in the appendix to the district court's opinion, Pet.App. 57a-58a, hardly gave any "sense of the magnitude of coverage loss" (Resp. Br. 38) either. They simply said that, based on the history of dissimilar social welfare programs, *some* loss would occur. The Secretary was not obliged to defer to such vague predictions or to offer any "special justification" for reaching a different conclusion. *Dep't of Com. v. New York*, 139 S. Ct. 2551, 2571 (2019)

(holding Commerce Secretary was not required to defer to, or offer any special justification for rejecting, the considerably more informed predictions of the Census Bureau concerning the effects of asking certain census questions).

Moreover, the handful of commenters that did say something about the significance of coverage loss didn't predict the community-engagement requirements themselves would cause such losses. They argued instead that those requirements were unnecessary because most beneficiaries *already* worked or qualified for an exemption. *See* AR 1269 (arguing the requirements would affect *too few* people because 75% of beneficiaries were in working families and another 20% would likely be exempt). And Respondents' amici paint a similar (albeit post-hoc) picture, claiming that "95% of Medicaid recipients in Arkansas . . . either have sufficient hours of work or qualifying activities or would be exempt from reporting." Texas Medical-Legal Partnerships Amicus Br. 33; *see also* Leukemia & Lymphoma Society Amicus Br. 24 (citing a post-approval study predicting a 3-6% coverage loss in States that adopted community-engagement requirements).

Instead, the comments largely argued that reporting issues—and not an inability to comply—caused "the substantial possibility of lost coverage." Texas Medical-Legal Partnerships Amicus Br. 34; *see* AR 1285 (predicting reporting difficulties would cause working beneficiaries to lose coverage); AR 1287, 1292 (faulting electronic reporting methods). But if, as the commenters predicted, it was reporting that would be the overwhelming source of any coverage loss, the Secretary addressed those concerns and disagreed.

For instance, the Secretary concluded that several features of Arkansas's project would mitigate such losses, including the State's robust efforts to educate beneficiaries on reporting, its provision of assistance to beneficiaries who needed help reporting, and the multiple opportunities the State would give beneficiaries to remedy non-reporting. Pet.App. 75a-76a. And the mere fact that some commenters had a different view of the likely efficacy of those protections, Resp. Br. 38, does not, contrary to Respondents' suggestion, make the Secretary's view unreasonable.

Further, as to the sliver of beneficiaries for whom non-compliance was a risk, the Secretary predicted that the requirement would "adequately incentivize" compliance. Pet.App. 75a. That was a reasonable view of the record. Indeed, most relevantly, the record contained a detailed report by the non-partisan Medicaid and CHIP Payment and Access Commission discussing TANF's work requirements. That report advised the Secretary that while (as commenters claimed) the number of people receiving TANF assistance shrank after work requirements became law, beneficiary employment also rose and that much of the decline in enrollment was due to increased employment rather than noncompliance and disenrollment. AR 1403-04. And while the commenters (and Respondents) are free to disagree about whether welfare reform worked as intended, nothing barred the Secretary from taking one side of that debate.

B. Respondents make even less of an effort to defend the decisions below vacating the Secretary's approval of Arkansas's waiver limiting retroactive coverage. *See* Pet.App. 44a, 53a. That's not surprising, since the Secretary predicted that reducing retroactive eligibility from three months to one would

increase coverage by "encourag[ing] beneficiaries to obtain and maintain health coverage, even when they are healthy," rather than "sign[ing] up for Medicaid only when sick." Pet.App. 72a-73a.

The district court, however, rejected the Secretary's conclusion on the grounds that reducing retroactive eligibility "by definition reduc[es]" coverage to a shorter period of time. Pet.App. 44a. (The court of appeals, without offering any reasoning, affirmed that conclusion.) But that's only true if one assumes the Secretary's prediction that shortening retroactive eligibility would likely cause beneficiaries to sign up earlier is wrong, and the district court did not point to anything suggesting that prediction was unreasonable. Thus, the Secretary's approval must stand, and at a minimum, this Court should reverse the vacatur of that portion of the approval.

CONCLUSION

This Court should reverse the court of appeals' judgment.

Respectfully submitted,

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