Nos. 20-37, 20-38

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.,
Respondents.

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

v.

SAMUEL PHILBRICK, ET AL.,
Respondents.

STATE OF ARKANSAS,
Petitioner,

v.

CHARLES GRESHAM, ET AL.,
Respondents.

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

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BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the Secretary's approval of Medicaid demonstration projects in Arkansas and New Hampshire that impose work requirements and limit retroactive coverage was arbitrary and capricious, in violation of the Administrative Procedure Act, because the Secretary failed to consider how the projects would affect health care coverage.

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INTRODUCTION

During a pandemic in which 50 million Americans have filed for unemployment and nearly 12 million have lost employer-sponsored health insurance, the Secretary of Health and Human Services asks this Court to revive demonstration projects that would allow States to kick people off Medicaid for failing to seek and obtain jobs that are not there. The Secretary does so by challenging a unanimous D.C. Circuit opinion written by Judge Sentelle that correctly applies settled administrative law. The Secretary does not even try to identify a split, and he glosses over the fact that his central argument was never presented to the court of appeals. To top it off, the Secretary concedes that, even if this Court were to review and reverse the decisions below, recent federal legislation would prevent implementation of these work requirements for the foreseeable future.

The Petition does not merit review. First, Judge Sentelle's decision does not break new ground or create a circuit split. Relying on the text of 42 U.S.C. § 1396-1, the D.C. Circuit identified "providing health care coverage" as the principal purpose of Medicaid, citing decisions from five other circuits that reached the same inevitable conclusion. Gov't App. 16a. It then applied textbook administrative law to vacate the Secretary's approvals because the Secretary failed to account for the loss of health care coverage except "in a handful of conclusory sentences," rendering his approvals arbitrary and capricious. Gov't App. 17a. There is no basis for the Court to review this straightforward application of settled legal principles.

Second, there is a serious vehicle problem. The Secretary defends his approvals principally on the ground that they advance the "fiscal sustainability" of Medicaid. Gov't Pet. 21-29. But the Secretary never cited that rationale in his approval for Arkansas, which is why Judge Sentelle's opinion does not address it. This Court cannot affirm the Secretary's approval on a ground he manufactured after the fact. The Secretary did raise a version of the fiscal sustainability rationale in his separate and subsequent approval for New Hampshire. But the D.C. Circuit never had the chance to address the issue. Instead, to expedite the New Hampshire case for review by this Court, the Secretary moved for summary affirmance of the District Court's decision invalidating that waiver, asserting that Judge Sentelle's opinion—which did not address fiscal sustainability—nonetheless "control[led] the disposition of this case." Having chosen for tactical reasons not to present any fiscal sustainability argument to the D.C. Circuit, and having told the D.C. Circuit that the invocation of fiscal sustainability would not change the outcome, the Secretary cannot now evade the consequences of that choice.

Third, the Petition raises no issue of "exceptional importance." The D.C. Circuit has simply remanded two waiver approvals to the Secretary for a fuller discussion. Moreover, nothing prevents the Secretary from making his fiscal sustainability argument to the D.C. Circuit. Nor does it help the Secretary to claim that the decision below "casts a shadow" on other waiver applications. Gov't Pet. 17. This Court addresses holdings, not "shadows," and the D.C. Circuit's holding (and related

reasoning) were specific to the shortcomings in these particular waivers. If the panel's decision takes root so that its "shadow" result in judicial disapproval of other waivers, the Secretary can seek review at that time.

As to practical importance, the Secretary concedes that the pandemic has changed everything. As part of the Families First Coronavirus Response Act, Congress conditioned increased Medicaid funding on an agreement not to restrict Medicaid eligibility during this public health emergency. Thus, regardless of the Secretary's approval, Arkansas and New Hampshire will not implement these demonstration projects until "public-health conditions related to the COVID-19 allow." Gov't Pet. 33. The Secretary therefore seeks an advisory opinion, asking for authority to approve projects that will not be implemented now or for the foreseeable future.

Finally, the decisions below are correct. The D.C. Circuit and five other circuits have concluded that providing health care coverage is the purpose of the Medicaid program because that is what the statute says. *See* 42 U.S.C. § 1396-1 (purpose of Medicaid appropriations is "to furnish … medical assistance"). The Secretary never addressed coverage seriously. As for "fiscal sustainability," even if the argument were properly before this Court, Judge Boasberg was correct to reject it. New Hampshire *conceded* that it neither intended nor expected its demonstration project to reduce costs, and the administrative record contained substantial reason to doubt it would do so. While Judge Boasberg acknowledged that the Secretary had discretion to conclude otherwise, he held that the

Secretary had failed "to explain how he got there in light of the nearly uniform evidence going the other direction." Gov't App. 95a. Ultimately, the Secretary's pleas for heightened deference do not excuse the serious failures in his approvals.

The Secretary's failures are unsurprising. The waivers he approved do not advance experiments intended to gather data and inform policy; instead, they are a transparent effort to undo the choices Congress has made. As the Secretary explained, his agency is "now overseeing the next great transformation in Medicaid, through our efforts to encourage work and other forms of community engagement." The Secretary has decided, in the words of Administrator Seema Verma, to "restructure the Medicaid program" because Congress's decision to expand Medicaid to "able-bodied individual[s]" "does not make sense." But that is not the agency's prerogative: whatever it thinks of Congress's decision, transforming and restructuring the social safety net are jobs for Congress through legislation, not for the Secretary in the guise of conducting a limited experiment.

The Secretary's Petition and the related Petition filed by Arkansas should both be denied.[1]

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[1] This brief responds to both Petitions (as well as the brief in support of certiorari filed by New Hampshire), and it refers to the Secretary and Arkansas collectively as "Petitioners."

STATEMENT

A. The Federal Medicaid Program

The Social Security Act establishes a number of public benefit programs to support low-income people. *See* 42 U.S.C. §§ 301 to 1397mm. Each program has its own purpose, such as welfare (cash) assistance, nutrition assistance, and housing. Title XIX of the Act establishes a health insurance program known as Medicaid. *See id.* §§ 1396 to 1396w-5. Congress enacted Medicaid "[f]or the purpose of enabling each State, as far as practicable … to furnish (1) medical assistance on behalf of" families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id.* § 1396-1.

States participating in Medicaid must provide medical assistance to individuals described in 42 U.S.C. § 1396a(a)(10)(A)(i). They also have options to cover additional populations. *See id.* § 1396a(a)(10)(A)(ii), (a)(10)(C). Initially, the covered groups included only families with dependent children and individuals who are aged, blind, or disabled. Eligibility depended in large part on being eligible for another public benefit program, such as Aid to Families with Dependent Children ("AFDC"). Beginning in the 1980s, Congress decoupled Medicaid eligibility from these welfare programs and tied it instead to income, expressed as a percentage of the federal poverty level ("FPL"). *See, e.g.*, Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(IV)).

The Affordable Care Act ("ACA") added another mandatory group, requiring States to cover adults who are under age 65, not eligible for Medicare or another Medicaid eligibility category, and have household income below 133% of the FPL. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14)). Congress thus expanded Medicaid "into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level." *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 583 (2012). Although *NFIB* prohibited the Secretary from pulling Medicaid funding from States that refuse the Medicaid expansion, *id.* at 585, the expansion population continues to be described as a mandatory coverage group in the Medicaid Act.

The Medicaid Act requires States to cover all members of a covered population group. *See* 42 U.S.C. § 1396a(a)(10)(B). States cannot restrict eligibility unless explicitly authorized. *Id.* § 1396a(a)(10)(A). The Medicaid Act also requires States to cover certain health services and gives them options to cover additional services. *Id.* §§ 1396a(a)(10)(A), 1396d(a). States must provide retroactive eligibility for care provided within three months before an enrollee's application if the enrollee would have been eligible for Medicaid at the time services were received. *Id.* §§ 1396a(a)(34), (a)(10)(A), 1396d(a). Medicaid is to be administered "in the best interest of the recipients." *Id.* § 1396a(a)(19).

Section 1115 of the Social Security Act authorizes the Secretary to "waive compliance" with particular

requirements of the Medicaid Act in certain circumstances. *See id.* § 1315(a). First, the Secretary may grant a waiver only for an "experimental, pilot, or demonstration" project. *Ibid.* Second, that project must be "likely to assist in promoting the objectives" of the Medicaid Act. *Ibid.* Third, the Secretary may waive compliance with the requirements of Section 1396a only. *Id.* § 1315(a)(1); *see id.* §§ 1396-1, 1396b to 1396w-5 (setting forth additional requirements). Fourth, the Secretary may grant a waiver only to the extent and for the period necessary to enable the State to conduct the experiment. *Id.* § 1315(a)(1). In the ACA, Congress amended Section 1115 to require the Secretary to enact regulations to ensure a transparent waiver application process. *Id.* § 1315(d). Congress envisioned that the Secretary would address "the expected State and Federal costs and coverage projections of the demonstration project." *Id.* § 1315(d)(2)(B)(ii).

B. The Administration's Use Of Section 1115 Medicaid Waivers

After he took office, President Trump vowed to "explode" the ACA, including the Medicaid expansion. Amy Goldstein & Juliet Eilperin, *Affordable Care Act Remains "Law of the Land," but Trump Vows to Explode It*, Wash. Post (Mar. 24, 2017), https://wapo.st/2Zm95Gj. Seema Verma, Administrator of the Centers for Medicare & Medicaid Services ("CMS"), declared that the ACA's decision to "move[] millions of working-age, non-disabled adults into" Medicaid "does not make sense." *Speech: Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference*, CMS.gov

(Nov. 7, 2017), https://go.cmsgov/2PELxLW. She announced that CMS would resist that change by approving state waiver projects that contain work requirements, *ibid.*, as part of an effort to "restructure the Medicaid program." *The Future of: Health Care*, Wall St. J. (Nov. 10, 2017), https://on.wsj.com/2AMeGMW.

CMS followed through on Administrator Verma's promise to "restructure" Medicaid. It issued a State Medicaid Director Letter on January 11, 2018 "announcing a new policy" allowing States to impose "work and community engagement" requirements. *Gresham v. Azar*, No. 18-cv-1900 (D.D.C. 2018), ECF No. 1-7. CMS then approved work requirements in 12 States—including Kentucky, Arkansas, and New Hampshire, discussed below. Eight additional applications are pending. *See* Gov't Pet. 8.

1. Kentucky HEALTH

The day after Administrator Verma announced the administration's "new policy," CMS approved a waiver for Kentucky to institute work requirements together with premiums, lockouts, cost-sharing, and other conditions. *See Stewart v. Azar*, 313 F. Supp. 3d 237, 245-47 (D.D.C. 2018). Kentucky estimated that its experiment, called Kentucky HEALTH, would jettison the equivalent of 95,000 Medicaid beneficiaries for an entire year. *Ibid.*

Before it was implemented, however, the United States District Court for the District of Columbia (Boasberg, J.) vacated the Secretary's approval. *See id.* at 274. The District Court held that "the 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 272. The Secretary's consideration of alternative objectives for the experiment—promoting beneficiary health and financial independence—"[wa]s no substitute for considering Medicaid's central concern: covering health *costs*." *Id.* at 266 (citation omitted).

In response, Administrator Verma declared that CMS was "very committed" to work requirements and would "push ahead with our policy initiatives and goals." Dan Goldberg, *Verma: Court Ruling Won't Close Door on Other Medicaid Work Requests*, Politico (July 17, 2018), https://politi.co/2RsJhIF. "We are undeterred," the Secretary agreed. Colby Itkowitz, *The Health 202: Trump Administration 'Undeterred' by Court Ruling Against Medicaid Work Requirements*, Wash. Post (July 27, 2018), https://wapo.st/2I6Zz4k. He vowed that the agency would effectuate "the next great transformation in Medicaid." Alex M. Azar II, Secretary, U.S. Dep't of Health & Human Servs., *Remarks on State Healthcare Innovation at the American Legislative Exchange Council Annual Meeting* (Aug. 9, 2018), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-state-healthcare-innovation.html. Months later, the Secretary again approved Kentucky HEALTH, relying on substantially the same rationale. *See* JA294.[2] The Secretary made one notable change, contending that the

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[2] "JA" refers to the Joint Appendix in *Gresham v. Azar*, No. 19-5097 (D.C. Cir. July 23, 2019).

waiver would preserve coverage because Kentucky threatened to end the expansion entirely if its waiver was not approved. *See* JA294-95.

The District Court again vacated the approval, holding that it remained arbitrary and capricious. *See* JA334. The Secretary still did not examine the effect of Kentucky HEALTH on coverage, JA304-09, and instead "continue[d] to press" his alternative justifications for approval, JA300. The District Court also rejected the Secretary's new rationale, concluding that the Secretary went too far by arguing that he "need not grapple with the coverage-loss implications of a state's proposed project as long as it is accompanied by a threat that the state will de-expand." JA288. The District Court could not "concur that the Medicaid Act leaves the Secretary so unconstrained, nor that the states are so armed to refashion the program Congress designed in any way they choose." JA289.

The Secretary initially appealed the District Court's decision but abandoned that effort after Kentucky decided to terminate the project. Gov't Pet. 8 n.4.

2. Arkansas Works Amendment

Arkansas expanded its Medicaid program effective January 1, 2014. Through a Section 1115 project, Arkansas enrolled most individuals in private health plans, with Medicaid covering their premiums and cost-sharing. In 2014 and 2015, more than 278,000 Arkansans received medical assistance through the Medicaid expansion, reducing Arkansas's uninsured rate from 19 percent to 11 percent. Gov't App. 29a.

Governor Hutchinson then submitted a request to the Secretary to amend the project, by that time called Arkansas Works. Ark. App. 85a. The Arkansas Works Amendment ("AWA") generally mandates 80 hours of work activities each month for individuals aged 19 to 49; those who fail to document their compliance for any three months of the calendar year lose coverage and are not permitted to re-enroll until the next year. AWA also limits retroactive coverage to one month. Gov't App. 30a-31a. Arkansas did not provide coverage loss projections, but numerous organizations submitted comments predicting substantial gaps in and loss of coverage. Gov't App. 60a-63a.

The Secretary nevertheless approved AWA on March 5, 2018. In the approval letter, which closely mirrored the original letter approving Kentucky HEALTH, CMS stated that it examined three questions: "whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes." Gov't App. 133a. However, the approval did not address whether AWA would reduce coverage. While acknowledging that many comments expressed concerns about coverage loss, the approval said only: "We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment." Gov't App. 138a. The approval—which predated the District Court's initial Kentucky

HEALTH decision—did not invoke any "fiscal sustainability" rationale.

In June 2018, Arkansas began implementing the work requirement, starting with individuals ages 30 to 49. By the end of the year, Arkansas had terminated the Medicaid coverage of well over 16,900 people for failure to meet the work requirement. Gov't App. 30a-31a.

Arkansas Works enrollees then challenged the approval. The District Court held that, as with Kentucky, the Secretary "entirely failed to consider" whether the project would "help or hurt [Arkansas] in funding … medical services for the needy." Ark. App. 39a (internal quotation marks and bracket omitted). The Secretary's failure to consider coverage—which he acknowledged as the "core objective" of Medicaid—was fatal. Gov't App. 40a-41a. The District Court vacated the approval but confirmed that its decision "does not mean it will be impossible for the agency to justify its approval of a demonstration project like this one." Gov't App. 53a.

3. New Hampshire Granite Advantage

New Hampshire expanded its Medicaid program effective January 1, 2014. Over 53,000 people gained coverage as a result, reducing the uninsured rate by 45 percent. Gov't App. 70a.

In 2018, New Hampshire submitted a proposal for a demonstration project called the Granite Advantage Health Care Program ("Granite Advantage"). *Ibid.* Granite Advantage conditions coverage for most non-disabled adults aged 19 to 64 on completion of 100 hours per month of work or other community activities. Gov't

App. 150a. Those who do not comply are required to make up hours or prove an exemption; otherwise, they lose coverage. Gov't App. 70a. Granite Advantage also eliminates retroactive coverage. *Ibid.* New Hampshire's proposal for Granite Advantage estimated that it would have no material effect on Medicaid enrollment, but commenters disagreed. One commenter projected enrollment loss at 6-17%—meaning 2,600 to 7,500 people—and others forecasted even greater losses. Gov't App. 82a-83a. Commenters also cited the substantial coverage loss during the first months of Arkansas's project, which had imposed less stringent requirements and applied them to a narrower age range. Gov't App. 83a.

The Secretary approved Granite Advantage in November 2018. Gov't App. 144a. The Secretary acknowledged "that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations." Gov't App. 145a. Yet according to the Secretary, that objective had "little intrinsic value" unless the medical assistance promoted health, wellness, and financial independence. *Ibid.* Thus, the Secretary concluded, advancing health and wellness must be a separate objective of Medicaid. *Ibid.* The Secretary found that Granite Advantage was likely to promote that objective. Gov't App. 151a.

The Secretary conceded that the work requirement might "impact overall coverage levels," Gov't App. 156a, and recognized comments expressing concerns and predictions about coverage loss, Gov't App. 164a. Yet the approval dismissed those comments, stating that it was not the intent of the project to reduce coverage; that

the actual impact on coverage could not be determined in advance; and that approval could ultimately promote coverage in the sense that the State might otherwise eliminate coverage for expansion populations altogether. Gov't App. 164a-168a. The Secretary provided no indication of the expected magnitude of coverage loss and no assessment of the various projections offered in the comments.

The District Court concluded that the Secretary's consideration of coverage loss was once again insufficient. Gov't App. 82a-85a. Although the Secretary acknowledged the possibility of coverage loss, there was no analysis. Gov't App. 84a. That omission was "particularly startling" since the work requirement at issue was even more exacting than the one approved in AWA, which had quickly caused significant coverage loss. Gov't App. 65a. Indeed, New Hampshire reported that within the first months of implementation, approximately 17,000 non-exempt beneficiaries (out of a total of 25,000) had not documented their compliance. Gov't App. 71a-72a.

The District Court also considered the Secretary's arguments that Granite Advantage would promote coverage. The Secretary claimed that any continued coverage qualified as increased coverage because, without the work requirement, New Hampshire would "simply de-expand Medicaid." Gov't App. 86a (quotation marks omitted). The court disagreed. It explained, "the entire Medicaid program is optional for states," meaning the Secretary's argument had no limit: "if Defendants are correct that threats to terminate the expansion program can supply the baseline for the Secretary's

§ 1115 review," the same would be true "as applied to traditional Medicaid." Gov't App. 88a-89a. And that would mean any State could obtain a waiver by threatening to de-expand or eliminate Medicaid, arguing that some coverage is better than none. Gov't App. 89a. "This reading of the Act would give HHS practically unbridled discretion to implement the Medicaid Act as 'an *à la carte* exercise, picking and choosing which of Congress's mandates it wishes to implement.'" *Ibid.* (citation omitted).

Finally, the District Court addressed the argument that Granite Advantage legitimately promoted other objectives. Gov't App. 90a. With respect to beneficiary health and financial independence, the court explained those were not independent objectives of the Act, and at any rate the Secretary failed to weigh them against the consequences for coverage. Gov't App. 90a-93a. As for fiscal sustainability, the court agreed with the agency that it "was a valid consideration in a Section 1115 project." Gov't App. 94a. But the agency's explanation for why Granite Advantage promoted fiscal sustainability was unreasonable. New Hampshire represented that it neither intended nor expected to save costs, and the Secretary did not make any finding that it would. *Ibid.* This "glaring disconnect between the Secretary's position and New Hampshire's raise[d] substantial questions about how the agency came to believe the program would improve the State's fiscal circumstances, underscoring the need for reasoned analysis of this issue." Gov't App. 95a. Compounding the problem, the agency failed to weigh any supposed cost-savings against the project's effect on coverage.

Gov't App. 96a-97a. The District Court thus vacated the approval.

C. Decisions Below

The Secretary appealed both the Arkansas and New Hampshire decisions. In *Gresham*, the D.C. Circuit (Sentelle, Edwards, and Pillard, JJ.) upheld the District Court's decision on AWA in a unanimous opinion authored by Judge Sentelle. Gov't App. 1a-2a. The court began with the "indisputably correct" conclusion "that the principal objective of Medicaid is providing health care coverage." Gov't App. 9a-10a. The court relied on the statutory text that articulates the reasons for appropriating Medicaid funds, which starts with "furnish[ing] medical assistance," 42 U.S.C. § 1396-1, defined as "payment of part or all of the cost of the following care and services or the care and services themselves," *id.* § 1396d(a). The court explained that three other circuits had relied on these provisions to hold 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.'" Gov't App. 11a (citations omitted). Other courts, including this Court, had identified the same primary purpose even without relying on the text of the statute. *Ibid.* As a result, the court explained, it was bound to give effect to Congress's "unambiguously expressed intent." Gov't App. 12a.

The court rejected the Secretary's argument that he had reasonably concluded that AWA was likely to promote alternative objectives. While the court acknowledged "[t]here might be secondary benefits that the government was hoping to incentivize, such as

healthier outcomes for beneficiaries or more engagement in their health care," it explained that "the 'means [Congress] has deemed appropriate' is providing health care coverage." *Ibid.* (quoting *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994) (bracket in original)). Thus, the three alternative objectives listed in the approval letter (*see supra* 11) could not sustain the approval: they "all point[ed] to better health outcomes as the objective of Medicaid, but that alternative objective lacks textual support." *Ibid.* And while the Secretary claimed that AWA also advanced yet another objective of "transitioning beneficiaries away from governmental benefits through financial independence or commercial coverage," the court rejected that claim as a post hoc rationalization, since the approval letter did not mention it. Gov't App. 13a-14a.

Having established Medicaid's primary purpose, the court held the Secretary's approval of AWA was arbitrary and capricious. "In this situation," the court explained, "the loss of coverage for beneficiaries is an important aspect of the demonstration approval because coverage is a principal objective of Medicaid and because commenters raised concerns about the loss of coverage." Gov't App. 16a. The agency therefore needed to address loss of coverage, yet it failed to do so. That failure was notable given the extensive comments in the administrative record predicting coverage loss, which were borne out when nearly a quarter of those subject to the work requirement lost coverage within the first five months. Gov't App. 16a-17a. The D.C. Circuit

therefore affirmed the District Court's judgment vacating the Secretary's approval of AWA.[3]

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

REASONS FOR DENYING THE PETITIONS

Petitioners ask this Court to review and reverse Judge Sentelle's unanimous, splitless opinion, and to do so principally on the basis of an argument that the Secretary prevented the D.C. Circuit from considering. Worse still, the Secretary concedes that the resolution of this question will have little or no practical effect for the foreseeable future as a result of legislation Congress enacted in response to the pandemic. Gov't Pet. 33. The

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[3] The D.C. Circuit also correctly held that the agency's approvals are reviewable. Gov't App. 8a. The Secretary no longer contests reviewability.

decisions below were correct, and their consequences are narrowly confined. The Petitions should be denied.

I. The Question Presented Does Not Warrant Review.

A. There Is No Conflict Of Authority.

The D.C. Circuit rendered a straightforward decision applying unchallenged APA principles and invoking the well-established purpose of Medicaid. There is no circuit conflict about any aspect of the court's opinion.

Judge Sentelle's opinion applied three tenets of administrative law. First, citing *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the court held that Congress clearly expressed its intent when it enumerated specific purposes for Medicaid. Gov't App. 12a; *see* 42 U.S.C. § 1396-1. Second, the court explained that an agency is bound not just by the ultimate congressional purpose but also by the means that Congress specified. Gov't App. 12a-13a (citing *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994)). In this case, the court explained, "[t]he means that Congress selected to achieve the objectives of Medicaid was to provide health care coverage to populations that otherwise could not afford it." Gov't App. 13a. Finally, the court applied the familiar standard that agency action is "arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, [or] offered an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43

(1983). The court relied on these constraints when it held that coverage loss was "an important aspect of the problem" that the Secretary neglected to consider. Gov't App. 17a. Petitioners identify no conflict over these basic principles of administrative law.

Most importantly, Petitioners identify no conflicting authority about Medicaid's purpose. That is no surprise, as Medicaid's primary purpose is well-established. As Judge Sentelle explained, Gov't App. 11a, at least five other federal appellate courts have concluded 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. Rsch. & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) (quoting 42 U.S.C. § 1396 (2000)), *aff'd sub nom. Pharm. Rsch. & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003); *see Price v. Medicaid Dir.*, 838 F.3d 739, 742 (6th Cir. 2016); *Virginia ex rel. Hunter Labs., L.L.C. v. Virginia*, 828 F.3d 281, 283 (4th Cir. 2016); *Univ. of Wash. Med. Ctr. v. Sebelius*, 634 F.3d 1029, 1031, 1034-35 (9th Cir. 2011); *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991). Similarly, in *Arkansas Department of Health & Human Services v. Ahlborn*, this Court described Medicaid as a program providing "joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs." 547 U.S. 268, 275 (2006). These decisions present a consistent view of the statutory purpose, and neither Petition cites any precedent to the contrary.

The Secretary acknowledged this purpose below. He called the provision of medical care to eligible persons

"Medicaid's *core* objective." *See* Gov't App. 40a (emphasis in original). He could hardly argue otherwise, having stated in the approval for Granite Advantage that "an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations." Gov't App. 145a (citing 42 U.S.C. § 1396-1).

Similarly, Arkansas conceded in its briefing below that this objective "is readily apparent from the substantive provisions of the statute." Gov't App. 40a. In this Court, Arkansas reverses course, devoting the majority of its Petition to a novel and elaborate explanation for why the purpose specified in the statute does not elucidate Medicaid's objective. Ark. Pet. 13-23. No court has adopted Arkansas's understanding of the Act, and for good reason: it ignores the statutory text and misreads the precedent. *See infra* 27-34. Arkansas's untested argument—which the Secretary does not endorse—is no basis for review.

B. The Petitions Have A Fatal Vehicle Problem.

The Secretary asks this Court to grant certiorari on a question the D.C. Circuit never had occasion to address. The centerpiece of the Secretary's Petition is his argument that he was justified in approving these projects because they might "help States stretch their Medicaid dollars." Gov't Pet. 21-29; *see also* Ark. Pet. 23. That argument was not aired in the D.C. Circuit, and the Secretary cannot leapfrog appellate court review.

The Secretary's fiscal sustainability argument did not appear anywhere in his approval for AWA. Gov't

Pet. 129a-143a. As a result, Judge Sentelle's opinion did not consider it. That forbearance was compelled by the "fundamental rule of administrative law" that an agency's action must be judged "solely by the grounds invoked by the agency." *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947). Accordingly, the Secretary's argument about "stretching limited state resources" has no place in the discussion of Arkansas's program.[4]

The Secretary did invoke some version of fiscal sustainability in his approval of Granite Advantage. Gov't App. 154a-156a. Due to the Secretary's own litigation choices, however, the D.C. Circuit never considered that rationale. Just as the government had done in the DACA litigation, *see DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1908 (2020) (describing machinations surrounding Nielsen Memo), the government here cut procedural corners to expedite review. The Secretary moved for summary affirmance of the District Court's decision vacating approval of Granite Advantage. Unopposed Motion for Summary Affirmance, *Philbrick v. Azar*, No. 19-5293 (D.C. Cir. Mar. 12, 2020); *see also* Gov't App. 20a. In his motion, the Secretary "acknowledge[d] that the disposition of [*Philbrick*] is controlled by *Gresham*"—referring to Judge Sentelle's opinion, which did not consider (and

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[4] The fiscal sustainability rationale was briefed in the D.C. Circuit, because the Kentucky and Arkansas appeals were consolidated and the Secretary had invoked a version of the fiscal sustainability rationale in his re-approval of Kentucky HEALTH. But Kentucky terminated its project while the appeal was pending, leaving only AWA before the D.C. Circuit. That court thus had no reason to consider—and did not consider—any fiscal sustainability rationale.

could not have considered) fiscal sustainability. *See* Gov't App. 20a.

To be clear, Respondents believe the invocation of fiscal sustainability cannot salvage the Secretary's approval. *See infra* 31-34 (addressing Secretary's shifting and flawed fiscal sustainability rationales). But the key point here is simpler: having made a tactical litigation decision not to present his fiscal sustainability rationale to the D.C. Circuit (or any other court of appeals), and having conceded that the rationale would make no difference to the outcome, the Secretary cannot evade the consequences of those choices by asking this Court to uphold the waivers under a fiscal sustainability rationale.

C. This Court's Intervention Is Unnecessary.

Lacking any real basis for certiorari, Petitioners sound the alarm on problems supposedly caused by the decisions below. If those decisions stand, Petitioners claim, they will "cast shadows" over other demonstration projects, prevent any State from ever testing work requirements, and deprive the federal government of important data that might inform policy changes on a national scale. *See* Gov't Pet. 33-35; Ark. Pet. 26-30. These claims are baseless.

First and foremost, the Secretary concedes that neither project will be implemented unless or until "public health conditions related to COVID-19 allow." Gov't Pet. 33. That is because Section 6008 of the Families First Coronavirus Response Act has conditioned increased federal Medicaid funding on an agreement by the States to a maintenance-of-effort

provision that will remain in place throughout the public health emergency. Pub. L. No. 116-127, div. F, § 6008(a), (b), 134 Stat. 178, 208-09 (2020). Each State has accepted the increased funding and thereby agreed not to effectuate any "eligibility standards, methodologies, or procedures"—including through a demonstration project—that are more restrictive than those in effect on January 1, 2020. *Id.* § 6008(b)(1); *see also id.* § 6008 (b)(3) (conditioning funding on maintaining eligibility for individuals enrolled during pandemic). That has halted previously approved demonstration projects for the length of the pandemic. Petitioners are effectively asking this Court for an advisory opinion.

Even absent the present constraints, it is hard to understand how the Secretary could rationally implement work requirements that reduce coverage while the nation's economy struggles amidst the worst pandemic in a century. The rate of unemployment stands at 7.7 percent,[5] and over 50 million Americans have filed for unemployment benefits since late March.[6] Even before the pandemic, the number of Americans without health insurance was on the rise, at an estimated

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[5] Dep't of Labor, News Release, *Unemployment Insurance Weekly Claims* (Oct. 15, 2020), https://www.dol.gov/ui/data.pdf.

[6] Rachel Garfield & Jennifer Tolbert, *What We Do and Don't Know About Recent Trends in Health Insurance Coverage in the US*, Kaiser Family Foundation (Sept. 17, 2020), https://www.kff.org/policy-watch/what-we-do-and-dont-know-about-recent-trends-in-health-insurance-coverage-in-the-us/.

29.6 million people[7]—and studies show that over 12 million Americans have lost employer-sponsored health insurance during the pandemic.[8] Independent of the arbitrariness identified by the courts below, it would be entirely irrational to kick Americans off health coverage now for failing to find jobs that do not exist.[9]

Regardless, if and when the Secretary and the States proceed, the decisions below do not preclude approvals. The D.C. Circuit did not outlaw work requirements. Nor did it forbid limitations on retroactive coverage. Petitioners over-read the decisions below as holding that the Secretary can *never* use his waiver authority to approve demonstration projects with these features. *See* Gov't Pet. 34; Ark. Pet. 26-27. Judge Sentelle's opinion held only that the Secretary must comply with the most basic constraints on administrative action when

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[7] Katherine Keisler-Starkey & Lisa N. Bunch, Rep. No. P60-271, U.S. Census Bureau, Health Insurance Coverage in the United States: 2019 (Sept. 15, 2020), https://www.census.gov/library/publications/2020/demo/p60-271.html.

[8] Josh Bivens & Ben Zipperer, *Health Insurance and the COVID-19 Shock*, Econ. Pol'y Inst. (Aug. 26, 2020), https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/.

[9] On October 15, 2020, the Secretary approved a Section 1115 waiver in Georgia that included, among other components, work requirements. The Secretary acknowledged that the comment period for that project closed prior to declaration of the COVID-19 public health emergency. *See* Letter from Seema Verma, Administrator, Center for Medicare & Medicaid Services, to Frank W. Berry, Commissioner, Georgia Department of Community Health (Oct. 15, 2020), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf.

he considers and approves waiver applications. The D.C. Circuit left open the possibility that the Secretary could cure the deficiencies in the approvals by performing the analysis that Section 1115 requires. Gov't App. 16a-19a. The District Court did likewise. Gov't App. 53a.

Granted, Respondents expect that analysis would demonstrate significant or even fatal shortcomings with the demonstration projects. This is presumably why the Secretary has steadfastly refused to do what Section 1115 requires. But the Secretary's refusal is not a basis for this Court to grant certiorari. Moreover, Respondents believe the Secretary's approvals effect (as advertised) a major transformation and restructuring of Medicaid contrary to the statute and beyond the power of the Executive Branch. But the lower courts have not yet addressed these arguments. If a lower court were to render an opinion that outlaws work requirements, the Secretary could petition for review at that time.

Finally, the claims about experimentation ring hollow. The Secretary complains that the decisions below deprive him "of the lessons and experience that th[e] experiments may yield." Gov't Pet. 33. And Arkansas insists that "much of national healthcare policy as we know it began its life as a State's Section 1115 Medicaid experiment." Ark. Pet. 30. Yet the Secretary has already set policy on a national scale. In 2018, HHS announced a "new policy" embracing work requirements, as part of the administration's effort to "fundamentally transform Medicaid" and "explode" the ACA. *See supra* 7-9. When, the very next day, HHS approved the first demonstration project containing work requirements, it cited the agency's new policy as

the basis for doing so. And the waivers have been open to all comers; no requested waiver has yet been denied. In other words, the outcome of this "experiment" was preordained; the Secretary and the States now claim to need data to formulate and implement a national policy that, in fact, is already in place. Regardless, the decisions below do not impede innovation. They require only that the Secretary consider Medicaid coverage before he blesses an experiment that could deprive tens or hundreds of thousands of needy people of access to health care. That commonsense conclusion does not warrant the Court's review.

II. The Decisions Below Are Correct.

A. The Secretary Had To Consider The Program's Core Objective.

The courts below correctly held that the principal objective of Medicaid is providing health care coverage—meaning that a project's effect on coverage is an important aspect of the problem that the Secretary needed to consider. This conclusion is consistent with the statutory text and history. The alternative objectives urged by Petitioners are not.

Start with the text. The text makes clear that the Secretary can approve a waiver only when he concludes it is "likely to assist in promoting the objectives" of the Act. 42 U.S.C. § 1315(a). As for those objectives, Section 1396-1 authorizes the appropriation of funds for Medicaid, and it expressly provides that the appropriated funds are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, *to furnish (1) medical assistance* …." 42

U.S.C. § 1396-1 (emphasis added). What more need be said? Or, as the District Court observed, "[w]hat better place could the purpose of a spending program be found than in the provision that sets up the '*purpose*' of the appropriations?" Gov't App. 48a (emphasis in original).

By establishing this purpose, Congress distinguished Medicaid from the other forms of assistance that the Secretary invokes. Although Congress included work requirements in SNAP and TANF, it chose not to add them to Medicaid. Beginning in the 1980s, Congress deliberately set Medicaid apart from these programs by decoupling participation in one program from eligibility for the other. *See, e.g.*, Medicare Catastrophic Coverage Act of 1988, § 302, 102 Stat. at 750 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(IV)). Even recently, Congress declined to add work requirements to Medicaid. *See* American Health Care Act of 2017, H.R. 1628, 115th Cong., §117 (2017); Medicaid Reform and Personal Responsibility Act of 2017, S. 1150, 115th Cong. (2017). Despite the Secretary's attempt to cast Medicaid as just another public welfare program like AFDC or TANF, Gov't Pet. 8, 24-25, Medicaid is a fundamentally different program Congress developed to target a fundamentally different problem.

Notwithstanding the clarity of the text, the Secretary focused on a different slate of objectives: improving beneficiary health and independence, Gov't App. 12a-13a, and, for New Hampshire, conserving state resources to improve the long-term fiscal sustainability of Medicaid, Gov't App. 93a-97a. But Congress did not authorize those objectives, which have little to do with furnishing medical assistance to needy individuals, and

it is not the Secretary's role to redefine Medicaid's very purpose.

Promoting Health. Although the Secretary relied heavily on "improving health outcomes" when he approved both projects, Gov't App. 133a, 145a-146a, the Secretary no longer defends that supposed objective.[10] While improving health outcomes is clearly a desirable *result* of furnishing medical assistance, the Secretary lacks authority to isolate that desired outcome. Agencies "are bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994). "To the extent Congress sought to 'promote health' and 'well-being' here, it chose a specific method: covering the *costs* of medical services." *Stewart*, 313 F. Supp. 3d at 267. Improving beneficiary health, without regard to coverage of medical services or the cost of those services, is not an objective in and of itself.

Were it otherwise, the Secretary could approve any policy he concludes may improve health and wellness. He could, for example, authorize States to require individuals to eat certain vegetables, adopt certain exercise regimens, or live in certain areas. *See Stewart*, 313 F. Supp. 3d at 267-68. Surely that is not the law. Nor does the ACA's authorization of grants to incentivize

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[10] The Secretary argues only that stretching Medicaid dollars is part of providing health care coverage, and that promoting health might serve that objective by reducing services and attendant costs. Gov't Pet. 27-28. Arkansas, by contrast, continues to press "health" as "the ultimate objective" of Medicaid. Ark. Pet. 20.

"healthy behaviors" support this objective. *See* Gov't Pet. 28-29 (citing ACA, § 4108, 124 Stat. at 561-64 (codified at 42 U.S.C. § 1396a note)). That provision has nothing to do with Section 1115 demonstrations. In fact, Congress carefully defined the scope of these initiatives such that they *cannot* affect Medicaid eligibility. ACA, § 4108(e), 124 Stat. at 564.

Financial Independence. Promoting "financial independence" and facilitating the transition of low-income adults from Medicaid to commercial coverage are not freestanding objectives of Medicaid. The Secretary no longer disputes that fact. Yet Arkansas continues to argue that independence is an objective of Medicaid, even though the Secretary's approval of AWA did not invoke it. Gov't App. 13a-14a. Arkansas's post hoc rationalization is based on a misreading of Section 1396-1's reference to "independence," which, in context, refers to *functional* independence, not *financial* independence. *See* JA315 (interpreting "independence" to mean financial independence "is an unreasonable reading of the relevant provision because it is incompatible with the surrounding statutory language and aims").

Arkansas's reliance on other social welfare programs is also misplaced. Ark. Pet. 22; *see also* Gov't Pet. 24-25. In 1996, Congress established TANF, a cash assistance program, with a stated purpose "to end the dependence of needy parents on government benefits programs by promoting job preparation, work, and marriage." 42 U.S.C. § 601(a)(2). To that end, Congress included work requirements in the TANF statute, *see id.* § 607, as it had in the predecessor program (AFDC), *see id.*

§ 602(19) (1996), and added to the work requirements in SNAP, 7 U.S.C. § 2015(d), (o). Notably, Congress did *not* impose work requirements in Medicaid to mirror SNAP and TANF and did *not* amend Medicaid's objectives to mirror those in TANF.[11] Petitioners cannot ignore this important distinction by importing requirements from other public welfare programs, simply because they disagree with Congress's choices.

Long-Term Fiscal Sustainability. Finally, even if the Secretary's principal argument about fiscal sustainability were properly before the Court, it would fail. The Secretary now attempts to recast the various objectives that he actually considered in his approvals as part of an overarching goal to help States improve the fiscal sustainability of their Medicaid programs. That argument lacks merit for several reasons.

To begin, the Secretary's fiscal sustainability argument is a moving target. When used to approve Granite Advantage, the Secretary invoked fiscal sustainability in the specific and narrow sense that, without the waiver, the State could "simply de-expand Medicaid" based on financial concerns, such that "any coverage provided to the expansion population through the demonstration is properly understood as increasing Medicaid coverage." Gov't App. 86a. The District Court correctly concluded that this hostage scenario could not justify the Secretary's approval: because Medicaid is a

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[11] Congress enacted one provision—Section 1396u-1—that permits States to coordinate eligibility for Medicaid and TANF. This provision does not transform the core objectives of Medicaid. Instead, it reflects Congress's desire to avoid conflicts and facilitate coordination among the two programs.

voluntary program, the Secretary's theory would allow—indeed require—the Secretary to approve any project if a State threatened to cut any population or "do away with all of Medicaid" without the approval. Gov't App. 87a-90a. The States could effectively pick and choose among Medicaid's statutory requirements so long as their resulting mix-and-match coverage left some number of individuals receiving some level of benefits.

The District Court similarly rejected another version of this fiscal sustainability argument that the Secretary advanced in his briefing—namely, that the project would allow New Hampshire to stretch limited resources. As the District Court explained, the record indicated that New Hampshire would *not* capture savings from the demonstration project, and the State itself disclaimed any goal or expectation of doing so. *See supra* 15.

In his Petition, the Secretary tries yet another version of this fiscal sustainability argument. He contends that the objectives he actually relied upon in approving the waivers—like beneficiary health and financial independence—are means to an end (fiscal sustainability) that is part of the Medicaid program's objectives. Under this view, anything that might theoretically advance fiscal sustainability is itself a basis to approve a waiver. This view allows the Secretary to smuggle a wide range of extra-statutory objectives into his approval authority, all under the guise of promoting fiscal sustainability. This novel concept of fiscal sustainability has no discernible limit.

Each version of this argument suffers from an even deeper flaw. Regardless of whether the Secretary may properly consider fiscal concerns when evaluating

Section 1115 proposals, he cannot place saving money on par with the Medicaid Act's primary objective of furnishing medical assistance. Section 1396-1's requirement for a State to furnish assistance "as far as practicable" does not alter the analysis. At most, that provision "qualif[ies] … the extent to which states must furnish medical assistance." JA321 (internal quotation marks omitted). It does not give the Secretary free rein to pursue fiscal sustainability at the expense of coverage. To hold otherwise would mean that any Section 1115 project that cut Medicaid costs, even by slashing eligibility or reducing benefits, would promote the objectives of the program. That cannot be correct.

Neither of the cases the Secretary cites support his argument. Gov't Pet. 22. *New York State Department of Social Services v. Dublino* arose from implementation of work requirements in the AFDC program, not Medicaid. 413 U.S. 405, 408 (1973). This Court focused on the text of the AFDC statute, which—in stark contrast to the Medicaid Act—included work requirements and listed promoting work as a purpose of the program. *Id.* at 419-20. Although the Court acknowledged that a State may consider fiscal sustainability, it stated that such considerations cannot lead to "interpret[ing] federal statutes to negate their own stated purposes." *Id.* Thus, per *Dublino*, a State may *not* pursue fiscal sustainability at the expense of the program objectives established by Congress. The plurality in *Pharmaceutical Research & Manufacturers of America v. Walsh* reached the same conclusion. It stated that providing cheaper drugs to individuals not enrolled in Medicaid and cutting Medicaid costs "would

not provide a sufficient basis for upholding the [supplemental drug rebate] program if it severely curtailed … recipients' access to" Medicaid services. 538 U.S. 644, 664-65 (2003). That curtailed access is precisely why the courts below found that the Secretary's approvals were arbitrary and capricious.

B. The Secretary's Failure To Consider Coverage Violated The APA.

The Secretary did not reasonably conclude that either AWA or Granite Advantage "is likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). Each record contains substantial evidence showing that the proposed project would strip Medicaid coverage from significant numbers of low-income people. The Secretary's failure to consider that evidence is no surprise since his approvals were based principally on the desire to advance a different slate of objectives. But given that the core objective of Medicaid is to furnish medical assistance to needy individuals, the Secretary had to assess whether each proposed project would affect coverage, either by causing loss or gain. The Secretary failed to do so, rendering the approvals arbitrary and capricious.

The Secretary does not dispute that he failed to address coverage loss; he argues only that he did consider potential coverage promotion. Yet the Secretary's failure to address coverage loss is fatal. It would be like advancing an experimental drug to human trials based on a hypothesis that it might be inexpensive and accessible for patients, without weighing those potential benefits against compelling evidence that the drug causes serious and even deadly side effects.

While the Secretary does not make excuses for this failure, Arkansas does. It says the Secretary cannot be faulted because he "could not predict the precise outcome of Arkansas's experiment." Ark. Pet. 25. That argument is a strawman. None of the courts below held that the Secretary needed to pinpoint the amount of coverage loss. The problem was his failure to engage at all with credible forecasts—which proved accurate—that the projects would cause significant coverage loss. Alternatively, Arkansas claims that the Secretary fulfilled his responsibility by acknowledging the concern and gesturing at "beneficiary protections" that might minimize coverage loss. Ark. Pet. 25-26; *see* Ark App. 71a. There is no dispute that these "protections" were in the AWA application, *see* Gov't App. 42a, meaning that commenters made their estimates of massive coverage loss with these features in mind. Still, the Secretary offered no response.

The Secretary's discussion of coverage loss in his approval for Granite Advantage fares no better. While the Secretary acknowledged that the work requirement "may impact overall coverage levels," that statement is insufficient: "acknowledging the possibility of coverage loss is not the same as analyzing that possibility." Gov't App. 84a (emphasis and internal quotation marks omitted). The Secretary gave no indication of the magnitude of coverage loss, and while he stated that procedural safeguards were *intended* to mitigate any loss, the Secretary did not assess the likelihood they would actually do so, particularly after similar "safeguards" did not prevent substantial losses in Arkansas. Gov't App. 84a-85a.

Given these shortcomings in addressing coverage, the Secretary's consideration of other objectives cannot save the approvals. To be sure, "the Secretary's approval letter is not devoid of analysis," Gov't App. 18a; both approval letters addressed whether the projects might advance other objectives. Even setting aside the serious deficiencies in the Secretary's reasoning, *see* Gov't App. 46a-49a, 90a-98a, there was no way to evaluate whether the projects were likely to advance the stated and primary objective of the Medicaid program without considering coverage loss. No matter how persuasively the Secretary addressed other objectives, that omission was fatal. *See* Gov't App. 18a-19a.

Finally, even accepting the Secretary's central argument that stretching Medicaid dollars is part and parcel of the program's primary objective, the approvals still fail. Judge Sentelle's opinion correctly refused to consider post hoc rationalizations that were not included in the Secretary's approval letter for AWA. Gov't App. 13a-14a (citing *State Farm*, 463 U.S. at 50). While the Secretary did address fiscal sustainability in his approval of Granite Advantage, he did not rationally conclude that the project was likely to promote that objective. The State itself represented that it neither intended nor expected to save money, and, as Judge Boasberg observed, the Secretary simply failed to explain why he believed such cost-savings might result. Gov't App. 94a-95a; *see supra* 15.

C. Pleas For Heightened Deference Cannot Save The Secretary's Waivers.

The Secretary's position is not improved by his plea for heightened deference. This plea relies on the

Secretary's supposed exercise of "predictive judgment" in the context of projects the results of which are supposedly unpredictable and unknowable. Gov't Pet. 19-21. Yet Judge Sentelle's opinion did not reject the Secretary's "predictive judgment." Gov't Pet. 20. Instead, it rejected the Secretary's failure to consider coverage—the core objective of the Medicaid Act—and record evidence indicating the projects would result in massive coverage loss. Gov't App. 16a-19a. In other words, the Secretary simply made no "predictive judgment" as to whether the waivers were "likely to assist in promoting" that core objective. *See* 42 U.S.C. § 1315(a).

Nor does *Aguayo v. Richardson*, Gov't Pet. 21, support a more deferential standard here. 473 F.2d 1090 (2d Cir. 1973). *Aguayo* predated *State Farm*, which rejected the application of rational basis review to agency action. 463 U.S. at 42-44 & n.9. As in *State Farm*, the traditional arbitrary-and-capricious standard applies here. Regardless, the Secretary misconstrues *Aguayo*. Even if "a lower threshold for persuasion" applies to the Secretary's exercise of his waiver authority, Gov't Pet. 21, the D.C. Circuit did not hold that the Secretary's analysis of coverage loss was unpersuasive; it held that the Secretary effectively conducted no analysis at all. Gov't App. 17a-18a.

CONCLUSION

The Petitions for a writ of certiorari should be denied.

Respectfully submitted,

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