Nos. 20-37 and 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.

STATE OF ARKANSAS, PETITIONER

v.

CHARLES GRESHAM, ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE FEDERAL PETITIONERS

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QUESTION PRESENTED

The Social Security Act, 42 U.S.C. 301 *et seq.*, authorizes the Secretary of Health and Human Services to approve "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid statute]." 42 U.S.C. 1315(a). The demonstration projects approved by the Secretary here test requirements designed to promote the provision of health-care coverage by facilitating the transition of Medicaid beneficiaries to employer-sponsored or federally subsidized commercial coverage and by improving their health, both of which may help States conserve resources that can be redirected to providing other coverage. The court of appeals vacated the Secretary's approvals, concluding that the "primary purpose" of Medicaid "is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage." 20-37 Pet. App. 16a. The question presented is as follows:

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

PARTIES TO THE PROCEEDING

Petitioners in No. 20-37 are Alex M. Azar II, in his official capacity as Secretary of Health and Human Services; Seema Verma, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; the United States Department of Health and Human Services; and the Centers for Medicare & Medicaid Services—all of which were defendants in the district court in Nos. 18-cv-1900 and 19-cv-773, appellants in the court of appeals in Nos. 19-5094 and 19-5293, and appellees in the court of appeals in Nos. 19-5096 and 19-5295.

Petitioner in No. 20-38 is the State of Arkansas, which intervened as a defendant in the district court in No. 18-cv-1900 and was an appellant in the court of appeals in No. 19-5096 and an appellee in No. 19-5094.

Respondents in Nos. 20-37 and 20-38 are Charles Gresham, Cesar Ardon, Marisol Ardon, Adrian McGonigal, Veronica Watson, Treda Robinson, Anna Book, Russell Cook, and Jamie Deyo, who were the plaintiffs in the district court in No. 18-cv-1900 and appellees in the court of appeals in Nos. 19-5094 and 19-5096.

Respondents in No. 20-37 additionally include Samuel Philbrick, Ian Ludders, Karin Vlk, and Joshua Vlk, who were plaintiffs in the district court in No. 19-cv-773 and appellees in the court of appeals in Nos. 19-5293 and 19-5295; and the New Hampshire Department of Health and Human Services, which intervened as a defendant in the district court in No. 19-cv-773 and was an appellant in the court of appeals in No. 19-5295 and an appellee in No. 19-5293.

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OPINIONS BELOW

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

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

[1] Unless otherwise indicated, this brief refers to the appendix to the petition for a writ of certiorari in No. 20-37.

JURISDICTION

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

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

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

The petitions for writs of certiorari in both Nos. 20-37 and 20-38 were filed on July 13, 2020. On December 4, 2020, the Court granted both petitions and consolidated the cases.

The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Pertinent statutory and regulatory provisions are reprinted in an appendix to this brief. App., *infra*, 1a-32a.

STATEMENT

A. Legal Background

1. The Medicaid program

a. The Medicaid program, enacted in 1965 as Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "is a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy

persons," *Bowen* v. *Massachusetts*, 487 U.S. 879, 883 (1988) (citation and internal quotation marks omitted). To participate in Medicaid and receive federal funding, a State must submit a plan for medical assistance that meets various statutory requirements, which must be approved by the Secretary of Health and Human Services. 42 U.S.C. 1396a(a) and (b). The State's plan, once approved, defines the categories of persons who are eligible for benefits under the plan and the types of medical services that are covered. 42 U.S.C. 1396a(a)(10) and (17). By 1982, every State had chosen to participate in Medicaid. See *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 542 (2012) (*NFIB*).

Since Medicaid's enactment in 1965, federal law has required that participating States' plans cover certain specified benefits for particular populations, while giving States the option to cover certain additional populations, additional benefits, or both. See *NFIB*, 567 U.S. at 541-542. Under the traditional Medicaid program, a State's plan is required to provide coverage for discrete categories of low-income individuals: persons who are disabled or blind, the elderly, children, parents of dependent children, and pregnant women. See *ibid.*; 42 U.S.C. 1396a(a)(10). Beyond those categories of required coverage, States also may elect—with the approval of the Department of Health and Human Services (HHS)—to cover additional individuals, additional services, or both. Historically, the majority of Medicaid spending has been for optional populations and optional benefits. In 1998, for example, by one estimate, approximately two-thirds of Medicaid spending was for optional coverage. See *The Health Care Crisis of the Uninsured: What are the Solutions?: Hearing before the Subcomm. on Public Health of the S. Comm. on Health, Education,*

Labor, and Pensions, 107th Cong., 2d Sess. 80-81, 88 (2002) (*Senate Hearing*) (statement of Cindy Mann, Senior Fellow with the Kaiser Comm'n on Medicaid & the Uninsured); see also, *e.g.*, Medicaid & CHIP Payment & Access Comm'n, *Report to Congress on Medicaid and CHIP* 2, 4, 16 (June 2017), https://go.usa.gov/xfCmY (estimating that spending on optional coverage and optional populations accounted for more than 52% of all Medicaid spending in FY2013).

Even with respect to coverage that is mandatory, the Medicaid statute affords States other forms of flexibility. For example, States have "substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985) (quoting 42 U.S.C. 1396a(a)(19)); see *ibid.* (upholding State's decision to reduce the number of annual inpatient hospital days for which the State would pay on behalf of Medicaid recipients). The statute also accords States leeway within broad parameters, subject to the Secretary's oversight, with respect to the rates they pay providers. See 42 U.S.C. 1396a(a)(30)(A) (state plan shall "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area"). The same provision authorizes and directs state plans to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary to safeguard against unnecessary utilization of such care and services." *Ibid.* Those broad standards

are enforceable only by the Secretary. See *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 324-329 (2015).

Such flexibility is particularly important in the Medicaid program because of the fiscal pressures state governments face that put their ability to provide coverage at risk. See *Senate Hearing* 79-80 (statement of Cindy Mann). As one expert (and later Director of the Center for Medicaid & CHIP Services) explained in testimony before Congress, nearly all States operate under legal constraints that generally prevent them from deficit spending. See *id.* at 79. As a result, "during economic downturns, [S]tates in particular find it difficult to fully finance their share of program costs." *Ibid.* States have "relied on" their flexibility under federal law (with HHS's approval) to "roll back in whole or in part optional eligibility expansions they have adopted," to eliminate optional services they have voluntarily chosen to cover, and to reduce provider payment rates as a means of preserving their Medicaid programs in the face of such fiscal constraints. *Id.* at 80; see *id.* at 79-82.

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

(and initially all) of the increased cost of furnishing that expanded coverage; a State that did not expand its Medicaid plan to cover that additional population could lose all of its Medicaid funds. See *NFIB*, 567 U.S. at 542 (citing 42 U.S.C. 1396c (2006); 42 U.S.C. 1396d(y)(1) (Supp. V 2011)).

In *NFIB*, however, a majority of this Court concluded that Congress could not condition a State's traditional Medicaid funding on its compliance with that new adult-eligibility expansion requirement. See 567 U.S. at 575-585 (opinion of Roberts, C.J.); *id.* at 671-689 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting (joint dissent)). In his opinion, the Chief Justice observed that Congress has authority to amend the traditional Medicaid program, but he concluded that the ACA's expansion of adult eligibility "accomplishes a shift in kind, not merely degree." *Id.* at 583. He reasoned that the ACA itself reinforced that distinction by providing that newly eligible adults receive "a level of coverage that is less comprehensive than the traditional Medicaid benefit package." *Id.* at 584.

A different majority of the *NFIB* Court concluded that the ACA provision conditioning a State's traditional Medicaid funding on its adopting the expansion was severable from the rest of the ACA. See 567 U.S. at 585-588 (opinion of Roberts, C.J.); *id.* at 645-646 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). The effect of that severability ruling was to "make the Medicaid Expansion optional." *Id.* at 690 (joint dissent). Accordingly, following *NFIB*, as States were evaluating whether to participate in the ACA's expansion of adult eligibility, HHS acknowledged that coverage of the expansion population was optional and that States have

"flexibility to start or stop the expansion." Centers for Medicare & Medicaid Servs. (CMS), HHS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* 11 (Dec. 10, 2012) (2012 CMS FAQ), https://go.usa.gov/xmN4j; see also Letter from Cindy Mann, Director, Center for Medicaid & CHIP Servs., CMS, HHS, to Mike Beebe, Governor of Ark. (Aug. 31, 2012) (19-5094 C.A. App. 170) (advising the Arkansas Governor that "[a] [S]tate may choose whether and when to expand, and, if a [S]tate covers the expansion group, it may decide later to drop the coverage").

2. Section 1315 demonstration projects

a. Although state Medicaid plans generally must comply with the requirements set forth in 42 U.S.C. 1396a, the statute includes a mechanism for testing variations from the default statutory model that might advance the statute's objectives. That mechanism, codified in 42 U.S.C. 1315(a), empowers the Secretary to authorize such an experiment and to waive otherwise-applicable statutory requirements as he or she deems necessary to facilitate the project. 42 U.S.C. 1315(a)(1).

Section 1315 provides that, "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" (as relevant here) Title XIX of the Social Security Act—*i.e.*, the Medicaid statute—"in a State or States * * * the Secretary may waive compliance with any of the requirements of section * * * 1396a of [Title 42] * * * to the extent and for the period he finds necessary to enable such State or States to carry out such project." 42 U.S.C. 1315(a)(1). In addition, Section 1315 authorizes the Secretary to treat state expenditures for an approved demonstration project as expenditures

that are eligible for federal funding even though they would not otherwise qualify. 42 U.S.C. 1315(a)(2)(A).

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

As courts recognized, Section 1315 accorded the Secretary broad substantive discretion to determine which demonstration projects to approve. See *Aguayo* v. *Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973) (Friendly, C.J.), cert. denied, 414 U.S. 1146 (1974). And federal law was largely silent on the procedures for approving demonstration projects. In *Aguayo*, for example, Chief Judge Friendly observed that the Administrative Procedure Act, 5 U.S.C. 551 *et seq.*, 701 *et seq.*, did not require the Secretary to make findings or explain the basis for approving a project. 473 F.2d at

1107; see *id.* at 1103 (noting that approval of AFDC waiver that the court upheld involved "no adversary hearing, no record, [and] no statement of the grounds for the Secretary's action"); *id.* at 1103-1108.

Congress has since established additional procedural requirements for approval of Medicaid demonstration projects, but it has left the scope of the Secretary's substantive authority unaltered. In 1997 and 2000, Congress established procedures that govern the extension of state-wide comprehensive Medicaid demonstration projects. See Balanced Budget Act of 1997, Pub. L. No. 105-33, Tit. IV, Subtit. H, Ch. 6, § 4757, 111 Stat. 527-528 (42 U.S.C. 1315(e)); Consolidated Appropriations Act, 2001, Pub. L. No. 106-554, Tit. VII, § 703, 114 Stat. 2763A-574 (42 U.S.C. 1315(f)). And in 2010, in the ACA, Congress directed the Secretary to promulgate regulations establishing new procedural requirements for the approval or renewal of a Medicaid demonstration project that "would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." ACA Tit. X, Subtit. B, Pt. I, § 10201(i), 124 Stat. 922 (42 U.S.C. 1315(d)(1) (Supp. V 2011)). Among other things, Congress directed the Secretary to provide for two periods of public comment on proposed approvals or renewals of demonstration projects—one period at the state level before an application is submitted to the Secretary, and another at the federal level after it is submitted. See 42 U.S.C. 1315(d)(2)(A) and (C). But the ACA did not alter the substantive scope of the Secretary's authority.

c. States have long relied on Section 1315 demonstration projects to test requirements designed to conserve scarce resources for cooperative-federalism benefit programs, including Medicaid. For example, the Secretary

approved a demonstration project adopting a work requirement under a State's AFDC program in 1972, and its approval was sustained by the Second Circuit in *Aguayo*, *supra*. See 473 F.2d at 1097, 1103-1108. By 1996, HHS had approved demonstration projects for dozens of States that imposed work requirements as a condition of receiving AFDC benefits. See Rebecca M. Blank, *Evaluating Welfare Reform in the United States*, 40 J. Econ. Literature 1105, 1106 (Dec. 2002) (Blank). Informed by the experience of such demonstration projects, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, which established work and work-related requirements for certain recipients of benefits under the TANF program that replaced AFDC, 42 U.S.C. 607; under the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, 7 U.S.C. 2015(*o*); and, to a limited extent, in the Medicaid statute itself, see 42 U.S.C. 1396u-1(b)(3)(A) (permitting a State to terminate the Medicaid benefits of certain adults whose TANF benefits are terminated for failure to comply with TANF's work-related requirements). The experience of the demonstration projects in which States were permitted to experiment with work-related requirements for AFDC was "a major reason why policymakers supported

work-oriented welfare reform in the 1990s." Blank 1122.[2]

Similarly, by 1997, 16 States were relying on HHS approval of demonstration projects that included waivers of the Medicaid statute's free-choice-of-providers requirement, see 42 U.S.C. 1396a(a)(23), to test mandatory managed-care programs. See Deborah M. Chasan-Sloan, *Managed Care, the Poor, and the Constitution: Are Due Process Rights Ailing under Medicaid Managed Care?*, 8 Geo. J. on Poverty L. & Pol'y 283, 288 (2001). Savings from such managed-care programs could be used to expand Medicaid eligibility. *Id.* at 287. In 1997, informed by the results of such demonstration projects, Congress authorized States to make managed-care enrollment mandatory without a waiver. *Id.* at 288; see Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (42 U.S.C. 1396u-2 to 1396u-3).

In addition, demonstration projects extending optional coverage to persons traditionally ineligible for Medicaid allowed States to provide reduced benefits to, and to increase cost-sharing for, such recipients; such projects were also subject to CMS's budget-neutrality determinations.[3] A 2001 HHS initiative called the Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA) increased state flexibility to reduce

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

[3] See generally Letter from Timothy B. Hill, Acting Director, CMS, HHS, to State Medicaid Directors (Aug. 22, 2018), https://go.usa.gov/xA58y; 59 Fed. Reg. 49,249, 49,250 (Sept. 27, 1994).

benefits and to establish cost-sharing requirements for optional enrollees, and it encouraged (but did not require) States to use the savings to extend coverage to populations not eligible for Medicaid. See Gretchen Engquist & Peter Burns, *Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States*, 3 State Coverage Initiatives Issue Brief, No. 2, at 1-5 (Aug. 2002), https://bit.ly/3nrZOs2. The HIFA projects allowed States to test the types of measures—enrollment caps, benefits reductions, and cost-sharing increases—that had been discussed but not enacted when Congress amended the Medicaid statute in the 1990s. *Senate Hearing* 92 (statement of Ronald F. Pollack, Executive Director of Families USA).

More recently, States have used Section 1315 Medicaid demonstration projects to test requirements designed to achieve savings associated with commercial health plans. For example, before the ACA's enactment, HHS approved an Indiana demonstration project to test "a model of health coverage that emphasizes private health insurance, personal responsibility, and 'ownership' of health care." Letter from Kerry Weems, Acting Administrator, CMS, HHS, to E. Mitchell Roob, Jr., Secretary, Ind. Family & Social Servs. Admin. 2 (Dec. 14, 2007) (D. Ct. Doc. 32-1, at 3, *Rose* v. *Azar*, No. 19-cv-2848 (D.D.C. Jan. 27, 2020)). HHS's 2007 approval of that project allowed Indiana to charge enrollees monthly premiums; to terminate coverage for enrollees who did not pay their premiums and to prohibit them from re-enrolling for 12 months; to eliminate retroactive eligibility; to eliminate coverage for non-emergency medical transportation; and to set an annual and lifetime limit on benefits. See *id.* at 2-3; CMS, *Special Terms and Conditions: Healthy Indiana Plan*,

No. 11-W-00237/5, at 18, 20-21, 25-26, 47-48 (D. Ct. Doc. 32-2, at 19, 21-22, 26-27, 48-49, *Rose*, *supra* (No. 19-cv-2848) (Jan. 27, 2020)).

Following the ACA's enactment, as States began to participate in the optional expansion of adult eligibility for Medicaid, some requested that HHS approve demonstration projects to test variations in the coverage offered to the newly eligible adults. For example, in January 2015, after negotiations with Indiana over its participation in the ACA expansion, HHS approved a modified version of the preexisting Indiana demonstration project. See Letter from Marilyn Tavenner, Administrator, CMS, HHS, to Joseph Moser, Medicaid Director, Ind. Family & Social Servs. Admin. 1-4 (Jan. 27, 2015) (19-5094 C.A. App. 137) (Indiana 2015 Letter). The 2015 demonstration allowed Indiana to charge newly eligible adults monthly premiums; to terminate coverage for certain enrollees who did not pay their premiums and to prohibit them from re-enrolling for six months; to eliminate retroactive eligibility; and to eliminate coverage of non-emergency medical transportation. See *ibid.*; CMS, *Waiver List: Healthy Indiana Plan (HIP) 2.0*, No. 11-W-00296/5, at 1-3 (2015) (D. Ct. Doc. 32-3, at 7-9, *Rose*, *supra* (No. 19-cv-2848) (Jan. 27, 2020)); see also Am. Compl. ¶¶ 76, 79, 81, *Rose*, *supra* (No. 19-cv-2848) (Jan. 27, 2020) (D. Ct. Doc. 32). The Secretary's approval letter explained that the demonstration project's requirements were designed "to promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care." Indiana 2015 Letter 1.

B. The Present Controversies

1. The challenged demonstration projects

During the same period following the enactment of the ACA and this Court's decision in *NFIB* rendering the ACA's Medicaid expansion optional, some States also began requesting that HHS allow them to test work and skill-building requirements (also called "community-engagement" requirements) for certain adults newly eligible for Medicaid. HHS initially denied such requests.[4] But HHS later revisited the issue and began approving demonstration projects that included work and skill-building requirements.[5] Those requirements were modeled on statutory conditions of eligibility in TANF, SNAP, and to a limited extent Medicaid itself, which in turn had been informed by the results of prior demonstration projects that had made work-related requirements a condition of AFDC benefits. See pp. 9-11, *supra*.

These cases concern amendments that HHS approved to preexisting demonstration projects in two States—Arkansas (at issue in *Gresham*) and New Hampshire (at issue in *Philbrick*)—that added such work-related and other requirements to those projects. As relevant here, both amendments sought waivers to make continued coverage of certain adults contingent on

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

[5] Some demonstration projects applied community-engagement requirements to certain adults already eligible for traditional Medicaid—such as parents and caretaker relatives. See, *e.g.*, 19-5094 Gov't C.A. Br. 9 (discussing such provisions in 2018 Kentucky project).

the performance of a specified number of hours per month of activities that include working, looking for work, job-skills training, education, and community service. Pet. App. 130a-131a (Arkansas project requiring 80 hours per month with various exemptions); *id.* at 149a-150a (New Hampshire project requiring 100 hours per month with similar exemptions). Both amendments also reduced or eliminated retroactive eligibility for certain persons under 42 U.S.C. 1396a(a)(34), which generally requires that "medical assistance under the plan * * * will be made available to" an enrollee "for care and services included under the plan and furnished in or after the third month before the month in which he made application." *Ibid.*; see Pet. App. 136a, 149a. The waivers apply only to the ACA's optional adult-expansion population, and each project includes exemptions for specified categories of beneficiaries, such as those who are pregnant or medically frail. Pet. App. 3a, 70a-71a. More than a dozen other States have similar demonstration projects that have been approved by HHS or are pending before the agency.[6]

In their submissions seeking HHS's approval of the amendments to their existing demonstration projects, both Arkansas and New Hampshire explained that the changes were designed in part to improve the sustainability of their Medicaid programs. Arkansas's submis-

[6] Specifically, this Office has been informed by HHS that similar demonstration projects have been approved for nine other States (Arizona, Georgia, Indiana, Michigan, Nebraska, Ohio, South Carolina, Utah, and Wisconsin), and eight others are pending before HHS (Alabama, Idaho, Mississippi, Montana, North Carolina, Oklahoma, South Dakota, and Tennessee). HHS also approved similar projects for Kentucky and Maine, but those States have since terminated their projects.

sion stated that it expected the changes to its demonstration project (known as Arkansas Works) to "increase the sustainability of the Arkansas Works program," to "test innovative approaches to promoting personal responsibility and work," to "encourag[e] movement up the economic ladder, and [to] facilitat[e] transitions from Arkansas Works to employer-sponsored insurance and Marketplace coverage," *i.e.*, individual coverage offered on the Arkansas Exchange established under the ACA. 18-cv-1900 Administrative Record (*Gresham* A.R.) 2057; see *id.* at 2058-2120; *King* v. *Burwell*, 576 U.S. 473, 482-483 (2015). Similarly, in seeking approval of a renewal of changes to its demonstration project (now known as Granite Advantage), New Hampshire explained that the changes were designed "to sustain and improve its Medicaid expansion for low-income adults," by "better integrating cost control and personal responsibility" and "improving beneficiary health." 19-cv-773 Administrative Record (*Philbrick* A.R.) 4378. The State explained that it sought to "retain[] health coverage for the expansion population," which under recent state legislation it would be required to discontinue without the waiver. *Ibid.*; see also 20-37 N.H. Cert. Br. 1-3.

HHS approved Arkansas's and New Hampshire's proposed amendments for periods of three and a half and five years, respectively. Pet. App. 129a-143a, 144a-171a. In its March 2018 letter approving Arkansas's proposal, HHS observed that the amendment would "facilitate transitions between and among" Arkansas's Medicaid program, employer-sponsored insurance, and commercial coverage through the ACA Exchange. *Id.* at 130a. HHS further observed that community-engagement requirements may lead to

increased health and wellness of beneficiaries. *Id.* at 133a-136a. And it explained that the limitation on retroactive eligibility is "intended to increase continuity of care by reducing gaps in coverage when beneficiaries chur[n] on and off of Medicaid or sign up for Medicaid only when sick." *Id.* at 136a; see *id.* at 142a.

HHS elaborated on those points in its November 2018 letter approving New Hampshire's renewal of its demonstration project. Pet. App. 144a-171a. By that time, a district court in related litigation involving a similar demonstration in Kentucky had vacated the Secretary's approval of the majority of that demonstration project, and in doing so the court had questioned how facilitating beneficiaries' transition to commercial coverage and improving their health would promote the Medicaid statute's objective of providing coverage to needy persons. See *Stewart* v. *Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018). Although not required by statute or regulation to provide a written explanation of its decision to approve or reject a proposed demonstration project, HHS set forth in its New Hampshire letter its reasoning at greater length to address the concerns the court in *Stewart* had raised, as well as public comments. Pet. App. 145a-170a.

HHS explained that the amendment to New Hampshire's project was designed to test whether the proposed requirements can help enable the State "to stretch its limited Medicaid resources." Pet. App. 155a. Enabling a State to conserve its resources, HHS determined, would "assist in ensuring the long-term fiscal sustainability of the program and preserving the health care safety net for those * * * residents who need it most." *Id.* at 155a-156a. Moreover, HHS observed, it

could allow a State "to provide services * * * to Medicaid beneficiaries that it could not otherwise provide." *Id.* at 156a. HHS noted, for example, the New Hampshire legislature's determination to discontinue coverage of the ACA optional adult-expansion population if the waivers were not approved. See *id.* at 155a. HHS identified two potential ways by which the requirements in New Hampshire's proposed amendment could help stretch its limited resources, and which the amended project would test: enabling beneficiaries in the expansion population to transition to commercial insurance coverage, and improving their health, both of which could help the State conserve resources that could be used to extend or preserve other coverage for needy persons. See *id.* at 150a-156a.[7]

2. Proceedings below

a. In separate actions, nine Arkansas Medicaid beneficiaries (in *Gresham*) and four New Hampshire Medicaid beneficiaries (in *Philbrick*) challenged HHS's approvals of the amendments to the demonstration projects. Arkansas and New Hampshire intervened in *Gresham* and *Philbrick*, respectively, to defend the Secretary's approvals of their amended projects. Pet. App. 33a, 75a.

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[7] Consistent with HHS's regulations, see 42 C.F.R. 431.420(d), the approval letters reserved to HHS the right to withdraw the waivers, with notice and opportunity for a hearing before the withdrawal's effective date, if it determines that the projects would no longer promote the objectives of Medicaid. Pet. App. 138a-139a, 156a; *Gresham* A.R. 20; *Philbrick* A.R. 22. HHS has informed this Office that it recently delineated more detailed procedures governing the withdrawal of waivers in letter agreements with Arkansas and other States. See Letter from Seema Verma, Administrator, CMS, HHS, to Dawn Stehle, Deputy Director for Health & Medicaid, Ark. Dept. of Human Servs. (Jan. 4, 2021).

Both cases were assigned to the same district judge presiding over the *Stewart* litigation involving the Kentucky demonstration project. See p. 17, *supra*. In that litigation, following the vacatur of the relevant parts of the Secretary's original approval of the Kentucky demonstration, the Secretary had reopened the comment period and ultimately reapproved Kentucky's project. Pet. App. 73a. The district court vacated the relevant parts of the Secretary's reapproval of the Kentucky project. *Stewart* v. *Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019) (*Stewart II*), appeal dismissed, Nos. 19-5095 and 19-5097 (D.C. Cir. Jan. 8, 2020).

Relying on its decision in *Stewart II*, the district court in these two cases (in separate decisions) vacated HHS's approvals of the Arkansas project (in *Gresham*) and the New Hampshire project (in *Philbrick*). Pet. App. 22a-63a, 64a-106a. In each decision, the court concluded that HHS had failed to consider adequately how the demonstration projects would advance what the court described as the "core objective" of the Medicaid program: "furnish[ing] health-care coverage to the needy." *Id.* at 80a; see *id.* at 49a-51a, 79a-98a.

b. The federal government and the States appealed. The court of appeals affirmed in each case. Pet. App. 1a-19a, 20a-21a.[8]

i. The court of appeals in *Gresham* concluded that Section 1315 did not authorize the Secretary to approve the amendment to Arkansas's project adding the work-related and other challenged requirements. Pet. App. 9a-16a. The court reasoned that "the principal

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[8] The federal government and Kentucky also appealed the district court's judgment in *Stewart II*, and those appeals were briefed and argued together with *Gresham*. But the *Stewart II* appeals became moot when Kentucky terminated its project. Pet. App. 7a.

objective of Medicaid is providing health care coverage," *id.* at 9a-10a (citing 42 U.S.C. 1396-1), and that the Secretary therefore may approve only demonstration projects that are "'likely to assist in promoting'" that "'objective[],'" *id.* at 10a (quoting 42 U.S.C. 1315(a)). The court stated that, in approving the changes to Arkansas's project, the Secretary had instead improperly focused on "three alternative objectives": "'improving health outcomes,'" "'address[ing] behavioral and social factors that influence health outcomes,'" and "'incentiviz[ing] beneficiaries to engage in their own health care and achieve better health outcomes.'" *Id.* at 12a (citation omitted). In the court's view, those "alternative objectives of better health outcomes and beneficiary independence are not consistent with Medicaid." *Id.* at 16a.

The court of appeals rejected the government's contention that the amendment to Arkansas's project will test requirements designed to promote the objective of providing health-care coverage by means of facilitating the transition of Medicaid beneficiaries to commercial coverage and improving their health. Pet. App. 13a-16a. As a preliminary matter, the court concluded that HHS had not sufficiently articulated that rationale in its Arkansas approval letter. *Id.* at 13a-14a. But the court proceeded to address that rationale on its merits, concluding that the Secretary could not properly "have rested his decision on" that basis. *Id.* at 14a. The court stated that "[t]he text of the statute includes one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage," and therefore the Secretary

could not approve demonstration projects aimed at those objectives. *Id.* at 16a.

Having thus "defined" "the objective of Medicaid," the court of appeals additionally held that the Secretary's approval of Arkansas's demonstration was arbitrary and capricious for failing to consider the potential effect of the work-related and other added requirements on coverage. Pet. App. 16a; see *id.* at 16a-19a.

ii. The appeals in *Philbrick* were held in abeyance pending the court of appeals' decision in *Gresham*. In light of that decision, the government moved unopposed for summary affirmance in *Philbrick*, without prejudice to seeking further review. Pet. App. 20a-21a. It observed that *Gresham* had "rejected the agency's view" that "'healthy outcomes, financial independence [and] transition to commercial coverage'" are "valid objectives for a demonstration project because they are potential means of achieving the concededly valid purpose of providing more health care coverage to the needy in a world of limited resources." 19-5293 Gov't C.A. Mot. for Summ. Affirmance 4 (citation omitted). A panel of the court, including the author of the *Gresham* decision, granted the motion, citing the government's acknowledgment that "th[e] case [wa]s controlled by" *Gresham*. Pet. App. 20a-21a.

SUMMARY OF ARGUMENT

In establishing the Medicaid program, Congress prescribed a wide range of requirements that a State's Medicaid program must satisfy. 42 U.S.C. 1396a. But in 42 U.S.C. 1315, Congress also expressly authorized the Secretary to approve experiments by States that, "in the judgment of the Secretary," are "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C.

1315(a). To that end, the Secretary may "waive compliance with any of the requirements" for state Medicaid plans set forth in Section 1396a to the extent he "finds necessary to enable" such an experiment. 42 U.S.C. 1315(a)(1).

The Secretary acted well within that broad authority in approving the amendments to the Arkansas and New Hampshire demonstration projects. Those amendments test requirements that are designed to stretch limited state resources by facilitating the transitions of adult beneficiaries to commercial coverage and improving their health. Conserving scarce resources enables the States to expand or maintain coverage, and thus promotes the Medicaid statute's undisputed objective of providing health coverage to needy persons.

In vacating the approvals, the court of appeals relied on a fundamental misunderstanding of Section 1315. The court posited that providing health-care coverage is the exclusive objective of Medicaid. From that premise, it concluded that Section 1315 does not permit projects that pursue other aims, such as "better health outcomes and beneficiary independence," Pet. App. 16a—even as *means* of advancing the goal of providing coverage. Even assuming the court's premise that providing coverage is the exclusive objective of Medicaid, and thus the only permissible ultimate aim of Section 1315 Medicaid demonstration projects, its conclusion does not follow.

Nothing in the statutory text or context precludes the Secretary from approving experiments to test measures that may indirectly advance the objective of providing coverage. To the contrary, the statutory language broadly authorizing demonstration projects that

the Secretary adjudges "likely to *assist* in promoting the objectives of" Medicaid, 42 U.S.C. 1315(a) (emphasis added), readily encompasses measures that may be intermediate means of helping States extend or preserve coverage—including by enhancing the sustainability of a State's provision of certain optional coverage. This Court, in holding that certain state work requirements were not preempted by work-related provisions of the Social Security Act, long ago recognized that requirements enabling States to stretch their limited resources promote the objectives of public-welfare programs. See *New York State Dep't of Soc. Servs.* v. *Dublino*, 413 U.S. 405, 413 (1973). That observation applies with particular force to Medicaid, where most state spending is for optional coverage.

The court of appeals' cramped reading of the statute is also irreconcilable with longstanding practice. States have long relied on Section 1315 demonstration projects to test requirements that may conserve their Medicaid resources. Aware of such projects, Congress in the ACA established new procedural requirements for Medicaid demonstration projects that "would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." 42 U.S.C. 1315(d)(1). But it did not narrow the Secretary's substantive authority to approve such projects and grant necessary waivers. Accordingly, in the years since the ACA's enactment, the Secretary has continued to approve projects that indirectly aid States' ability to provide coverage by conserving resources.

ARGUMENT

SECTION 1315 AUTHORIZES DEMONSTRATION PROJECTS TO TEST REQUIREMENTS THAT ARE DESIGNED TO PROMOTE THE PROVISION OF COVERAGE BY MEANS OF HELPING STATES TO CONSERVE SCARCE RESOURCES

A. The Secretary Has Broad Statutory Authority To Approve Demonstration Projects To Test Features That He Adjudges Likely To Assist In Promoting The Objectives Of Medicaid

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

> In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of * * * [Title XIX of the Social Security Act, *i.e.*, the Medicaid statute] * * * in a State or States—
>
> > (1) the Secretary may waive compliance with any of the requirements of section * * * 1396a of this title * * * to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

> (2)(A) costs of such project which would not otherwise be included as expenditures under section * * * 1396b of this title * * * shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans * * * .

42 U.S.C. 1315(a)(1) and (2)(A).

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

The wide latitude that Section 1315's text accords the Secretary leaves a correspondingly limited role for courts. The provision's text permitting the Secretary to approve any demonstration that, "in the judgment of the Secretary," is "likely to assist in promoting the objectives" of Medicaid, 42 U.S.C. 1315(a), and to determine the scope and duration of waivers of the statutory requirements as he "finds necessary," 42 U.S.C.

1315(a)(1), "exudes deference" to the Secretary's determination. *Webster* v. *Doe*, 486 U.S. 592, 600 (1988). And Section 1315's language referring to a demonstration project the Secretary deems "likely to assist in promoting" Medicaid's objectives (42 U.S.C. 1315(a)) calls for the "agency's predictive judgment," which this Court has long recognized "merits deference." *FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 521 (2009); see *FCC* v. *National Citizens Comm. for Broad.*, 436 U.S. 775, 813-814 (1978). The statutory text and context thus establish that any judicial review of the Secretary's determination must be highly deferential.

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

supposed to demonstrate the failings or success of such programs"). The costs and risks of such experimentation are much smaller on a time-limited basis at the state level than a permanent change of policy on a nationwide basis would be, and the experiments take place under a statute that affords States flexibility in designing their own Medicaid programs in the first place.

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

B. Section 1315 Authorizes Projects To Test Measures That The Secretary Determines Are Likely To Promote The Provision Of Health-Care Coverage By Helping States To Stretch Their Limited Medicaid Resources

The authority Congress conferred on the Secretary in the text of Section 1315 encompasses approval of demonstration projects that the Secretary adjudges likely to assist in promoting the objective of providing health-care coverage through measures that help States to conserve resources that can be used to provide coverage.

1. The court of appeals stated that "the principal objective of Medicaid is providing health care coverage." Pet. App. 9a-10a (citing 42 U.S.C. 1396-1). Assuming arguendo that providing such coverage is the exclusive objective of the Medicaid program, Section 1315 by its terms permits the Secretary to approve "any * * * demonstration project" so long as, "in [his] judgment," it is "likely to assist in promoting th[at] objective[]" of providing coverage. 42 U.S.C. 1315(a). The Secretary appropriately determined that demonstration projects that test measures designed to help States conserve resources—in turn enabling them to expand or preserve other optional coverage—satisfy that criterion.

A State's provision of health-care coverage through its Medicaid program depends on finite state resources. That is why Congress authorized federal financial assistance for States. That understanding is also reflected in the very provision, 42 U.S.C. 1396-1, on which the court of appeals relied in identifying the provision of coverage—medical assistance—as the sole objective of Medicaid. Pet. App. 9a-10a. Section 1396-1 authorizes federal funding "[f]or the purpose of enabling each State, *as far as practicable under the conditions in such State*, to furnish" both "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services," and certain "rehabilitation and other services" for "such families and individuals." 42 U.S.C. 1396-1 (emphasis added).

As this Court has long recognized, requirements that enable States to stretch and concentrate their limited resources promote the objectives of public-welfare programs. In upholding a State's work requirements in the

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

Opportunities for stretching limited state resources are particularly significant in the context of Medicaid, given the discretion the statute affords to States to tailor their Medicaid programs. "It is often said that there is no single Medicaid program, but rather 50 Medicaid programs." Cindy Mann, Kaiser Comm'n Medicaid & the Uninsured, *The New Medicaid and CHIP Waiver Initiatives* 4 (Feb. 2002) (2002 Kaiser Commission), https://bit.ly/397QQex. Although coverage of certain individuals and for certain benefits is mandatory, States are otherwise generally free to provide additional coverage. Indeed, the majority of Medicaid spending goes toward optional benefits and optional populations that States have elected but are not required to cover—including, of particular relevance here, the adult-expansion population under the ACA that became optional as a result of this Court's decision in *National Federation of Independent Business* v. *Sebelius*, 567 U.S. 519 (2012). See pp. 3-4, *supra*;

2002 Kaiser Commission 4, Fig. 1. And even with respect to coverage that is mandatory, the statute gives States substantial latitude to determine the amount, scope, and duration of coverage, see *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985), and the rates they pay providers, see 42 U.S.C. 1396a(a)(30)(A); *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 328 (2015). As HHS has observed, States thus possess "considerable flexibility in the design of their Medicaid programs," including to provide optional coverage. Pet. App. 147a n.1.

Every Medicaid dollar a State saves on one aspect of its program is thus a dollar that it can spend providing coverage for additional individuals or providing additional benefits. Savings also may enable a State that faces financial strain and is considering paring back its optional coverage to continue providing some or all of that coverage. Demonstration projects that test whether particular adjustments to the Medicaid statute's default requirements can yield such savings in a manner compatible with the broader statutory framework thus can "assist in promoting" the "objective[]," 42 U.S.C. 1315(a), of providing coverage. As HHS explained, demonstration projects "provide an opportunity for [S]tates to test policies that ensure the fiscal sustainability of the Medicaid program," in turn "better 'enabling each [S]tate, as far as practicable under the conditions in such [S]tate' to furnish medical assistance, while making it more practicable for [S]tates to furnish medical assistance to a broader range of persons in need." Pet. App. 146a (citation omitted); see *id.* at 165a.

2. The Secretary acted well within his discretion under Section 1315 in determining that the Arkansas and New Hampshire demonstration projects are likely

to assist in promoting Medicaid's objective of providing coverage by testing whether certain requirements can help the States stretch their limited resources further. Pet. App. 129a-136a, 145a-148a, 153a-156a.

a. The principal aspects of both demonstration projects that plaintiffs challenge are provisions requiring certain working-age adults not eligible for Medicaid based on a disability to engage in a specified number of hours per month of work or skill-building activities (such as job-skills training or education). See Pet. App. 130a-132a, 148a-150a. Arkansas's project, for example, requires individuals within the ACA's expansion population (subject to various exemptions) to spend at least 80 hours per month working or performing other activities such as seeking work, job-skills training or other education, or community service. See *id.* at 130a; see also *id.* at 149a-150a (New Hampshire project requiring 100 hours per month, subject to similar limitations and exemptions). Those requirements are modeled on work requirements that have been statutory conditions of eligibility since 1996 for cash assistance under the TANF program and food assistance under SNAP—conditions that Congress enacted following demonstration projects experimenting with such requirements under the AFDC program that TANF replaced. See pp. 9-11, 14, *supra*.

HHS has identified two potential ways by which work and skill-building requirements could help enable States to stretch limited Medicaid resources, which the demonstration projects would test. First, including those requirements would "help the [S]tate[s] and CMS evaluate whether" they enable non-exempt adults in the expansion population to "transition from Medicaid to financial independence and commercial insurance." Pet. App. 151a.

The requirements are designed to give covered individuals a strong incentive to acquire the skills and experience needed for sustained employment. See *id.* at 132a-136a, 145a-147a, 151a-153a, 159a. Sustained employment may in turn cause a beneficiary's income to increase above the threshold for Medicaid eligibility—approximately $17,600 for a single-person household—potentially freeing up the funds the State would otherwise spend providing coverage to that individual to provide coverage for others. See *id.* at 153a, 155a-156a; see also 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) and (e)(14)(I); CMS, HHS, *Federal Poverty Level (FPL)*, https://go.usa.gov/xwt9D.

As HHS further explained, an individual who loses eligibility for Medicaid because he or she obtains sustained employment may obtain commercial health-care coverage—either coverage sponsored by the new employer, or coverage through an Exchange established under the ACA, which Congress has heavily subsidized. Pet. App. 153a.[9] HHS determined that, if the work and skill-building requirements operate as intended—by "help[ing] individuals achieve financial independence and transition into commercial coverage"—then "the demonstration[s] may reduce dependency on public assistance while still promoting Medicaid's purpose of helping [S]tates furnish medical assistance by allowing [the States] to stretch [their] limited Medicaid resources." *Id.* at 155a.

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[9] See also *King* v. *Burwell*, 576 U.S. 473, 494 (2015) (observing that the vast majority—approximately 87%—of people who buy coverage on an Exchange do so with tax credits); Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 19-20 (Nov. 30, 2009), https://go.usa.gov/xpfCH (noting that, for individuals whose household income is below 200% of the federal poverty level, the then-proposed tax credit would cover on average approximately 80% of the premium).

Second, HHS determined that the work and skill-building requirements may lead to increased health and wellness of beneficiaries, which in turn reduces the cost of providing them health-care coverage. See Pet. App. 145a-146a, 151a-154a. As HHS explained, "research has shown" that the types of activities required by the work and skill-building requirements are "correlated with improved health and wellness." *Id.* at 133a-134a. And "measures designed to improve health and wellness," in turn, "may reduce the volume of services furnished to beneficiaries, as healthier, more engaged beneficiaries tend to receive fewer medical services and are generally less costly to cover." *Id.* at 146a. "Promoting improved health and wellness" thus "ultimately helps to keep health care costs at more sustainable levels," further enabling a State to "stretch its limited Medicaid resources." *Id.* at 155a. Moreover, an overarching purpose of "furnish[ing] medical assistance and other services to vulnerable populations" is "advancing the health and wellness of the individual receiving them." *Id.* at 145a.[10] Permitting States to experiment with requirements designed to improve beneficiaries' health also comports with Congress's own judgment in the ACA, which authorized grants for States that give Medicaid beneficiaries incentives for various "healthy behaviors," such as

[10] Research during the COVID-19 pandemic indicates that factors such as a lack of economic participation, social isolation, and other economic stressors have negative impacts on mental and physical health. See, *e.g.*, Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, Kaiser Family Found. (Aug. 21, 2020), https://bit.ly/2Lzynza. Thus, structured properly, community-engagement incentives and requirements that increase such participation may have a positive effect on beneficiary health and economic mobility.

"[c]easing use of tobacco products," "[c]ontrolling or reducing their weight," "[l]owering their cholesterol," or "[a]voiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition." ACA Tit. IV, Subtit. B, § 4108(a), 124 Stat. 561-562.

b. Another component of the demonstration projects that the plaintiffs challenge is a provision that reduces or eliminates retroactive eligibility that is otherwise required under the Medicaid statute. See Pet. App. 136a, 149a. For a number of years, HHS has approved projects that limited retroactive eligibility. See pp. 12-13, *supra* (discussing 2007 and 2015 approval of Indiana demonstration projects including such limitations). Such waivers are intended to encourage beneficiaries to enroll in Medicaid earlier and to maintain health-insurance coverage even while healthy, which in turn encourages beneficiaries to obtain preventive health care. See Pet. App. 149a. By contrast, if eligible individuals wait until they are sick to enroll in Medicaid, they are less likely to obtain preventive health services during periods when they are not enrolled. See *ibid.* Because preventive care improves beneficiary health and lowers Medicaid costs, see *ibid.*, demonstration projects often include features designed to encourage its use. See, *e.g.*, Jane B. Wishner et al., Urban Inst., *Medicaid Expansion, the Private Option, and Personal Responsibility Requirements: The Use of Section 1115 Waivers to Implement Medicaid Expansion Under the ACA* 15, Tbl. 6 (May 2015) (Urban Institute) (describing the incentive to obtain preventive services in the 2015 Indiana demonstration project). Although increased use of preventive care may raise Medicaid expenses in the short run, it may improve health and reduce utilization of medical care in the long run. See *id.* at 22.

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The Secretary thus had an ample basis to determine that the challenged work-related and retroactive-coverage provisions of the demonstration projects are likely to help the States conserve their resources, which the States may use to preserve or extend other coverage. The Secretary appropriately found that the projects are likely to assist in promoting the objectives of Medicaid.

C. The Court Of Appeals' Contrary View Of The Secretary's Approval Authority Contradicts Section 1315 And Settled Practice

The court of appeals did not question the Secretary's determinations that the particular requirements at issue here are likely to help facilitate transitions to commercial coverage and improve beneficiary health. Nor did it cast doubt on the Secretary's determination that doing so may help the States conserve resources that in turn may be used to extend or maintain other health-care coverage under Medicaid. The court nevertheless concluded that Section 1315 did not authorize the Secretary to approve either demonstration project. Pet. App. 9a-16a.[11]

The court of appeals posited that the exclusive objective of Medicaid "is providing health care coverage

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[11] Although the court of appeals in *Gresham* also stated that the Secretary's letter approving Arkansas's project had not adequately articulated the agency's position that stretching resources is a means of achieving the objective of providing coverage, Pet. App. 13a-14a, it proceeded to reach and reject that position on the merits, *id.* at 14a-16a. And in *Philbrick*, where the New Hampshire approval letter unquestionably set forth that position, the court summarily affirmed the vacatur of that approval based on *Gresham*. *Id.* at 20a-21a.

without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage," and that the Secretary therefore may not approve demonstration projects aimed at those "alternative objectives." Pet. App. 16a. The categorical language of the court's opinion makes clear, and its summary affirmance in *Philbrick* confirms, that in the court's view a demonstration project may not test measures to transition beneficiaries to commercial coverage or to improve their health even as means to the end of helping States to provide coverage. That cramped reading of Section 1315's scope has no foundation in the statutory text or context. And it cannot be reconciled with longstanding practice or with Congress's explicit determination to vest broad discretion in the Secretary and to entrust selection and oversight of Medicaid demonstration projects to his judgment.

1. Even accepting the court of appeals' premise that the Medicaid statute's sole objective is to provide health-care coverage, it does not follow that the Secretary may approve only demonstration projects that directly advance the provision of coverage—not those that may indirectly advance that goal. Section 1315's text broadly authorizes "*any* * * * demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" Medicaid. 42 U.S.C. 1315(a) (emphasis added). The text contains no exception for projects to test measures that are intermediate means of advancing the Medicaid objective of furnishing medical assistance. To the contrary, by authorizing projects the Secretary deems "likely to *assist* in promoting" Medicaid's objectives, *ibid.* (emphasis added), the text naturally encompasses measures that are means of pursuing that end.

Context reinforces that reading. Section 1315 authorizes experiments to test whether particular adjustments to the default Medicaid requirements advance the statute's aims. In that setting, it makes perfect sense that Congress allowed projects to evaluate measures one step removed from the provision of coverage itself. It is implausible, moreover, that Congress failed to appreciate the potential interplay of various aspects of a State's Medicaid program on its ability to provide coverage, or that Congress intended the Secretary to ignore those interactive effects. Cf. *Aguayo*, 473 F.2d at 1103-1104 (upholding AFDC demonstration project incorporating work requirement and explaining that "Congress must have realized" that paying benefits to families that were able to earn income would "diminish the funds available for cases where they were not").

A contrary conclusion would improperly and severely curtail the discretion that Congress expressly vested in the Secretary. Recognizing that the Secretary is best positioned to assess which experiments with variations on the default Medicaid requirements are likely to be fruitful, Congress committed to the Secretary's "judgment" the determination whether to approve a proposed project, and if so what waivers of otherwise-applicable requirements are "necessary." 42 U.S.C. 1315(a)(1). And it entrusted responsibility for ongoing oversight of approved projects to the Secretary, 42 U.S.C. 1315(d)(2)(D) and (E), who may suspend or withdraw approval of a previously approved waiver if he later finds that the project "is not likely to achieve the statutory purposes," 42 C.F.R. 431.420(d)(2). There is no basis to curtail the latitude Congress conferred on the agency with a rigid rule that would preclude the

very types of experiments that have informed prior revisions to federal benefits programs.

The court of appeals identified nothing in the text or context of Section 1315 that categorically prohibits demonstration projects that impose "any restriction geared to healthy outcomes, financial independence or transition to commercial coverage," Pet. App. 16a, even where the restriction is designed as a means to advance the objective of providing health-care coverage. The court noted that the Medicaid statute, unlike the TANF and SNAP statutes, does not itself expressly condition eligibility on working as a means of "ending the dependence of needy parents on government benefits." *Id.* at 14a (brackets and citation omitted). But the fact that Congress has not already imposed such conditions on Medicaid is beside the point. The purpose of Medicaid demonstration projects is to test *variations* from the default Medicaid model that may promote the Medicaid program's objectives (including the provision of coverage) in other ways. Indeed, those other programs' work-related requirements were themselves outgrowths of earlier AFDC demonstration projects approved under Section 1315, on which the projects at issue here are modeled.

2. Decades of administrative practice confirm that Section 1315 demonstration projects may be used to test measures that help States conserve resources, as a means of promoting the provision of coverage. Before Congress enacted the ACA, HHS had long approved such projects. And HHS has continued to do so in the years since the enactment of the ACA, which directed HHS to adopt additional procedures for approving and overseeing Medicaid demonstration projects but which

left the substantive scope of the Secretary's approval authority unaltered.

a. "Waivers have been used in good and bad economic times both to try new ways to provide coverage for the low-income population as well as to try alternative approaches to contain costs." Samantha Artiga & Cindy Mann, Kaiser Comm'n on Medicaid & the Uninsured, *New Directions for Medicaid Section 1115 Waivers: Policy Implications Of Recent Waiver Activity* 1 (Mar. 2005) (2005 Kaiser Commission), https://bit.ly/3q5gpDX. Before the ACA expansion of Medicaid eligibility, most childless adults were ineligible for Medicaid, and the only way a State could extend coverage to them was through a Section 1315 project. Kaiser Comm'n on Medicaid & the Uninsured, *A Look at Section 1115 Medicaid Demonstration Waivers Under the ACA: A Focus on Childless Adults* 4 (Oct. 2013) (2013 Kaiser Commission), https://bit.ly/3npKmwH. Under longstanding policy, however, HHS will approve Section 1315 demonstration projects only if they are budget neutral. See p. 11 & n.3, *supra*. In the 1990s, many States generated savings through waivers that allowed them to mandate that Medicaid beneficiaries enroll in managed care. See 2005 Kaiser Commission 7. In 1997, informed by the results of such demonstration projects, Congress authorized States to make managed-care enrollment mandatory without receiving a waiver. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.

Eventually, however, most States with the capacity to rely on managed care had done so. See 2005 Kaiser Commission 7. In 2001, HHS announced the HIFA initiative discussed above, see pp. 11-12, *supra*, which offered States new flexibility to reduce benefits and

charge higher cost-sharing for existing Medicaid beneficiaries, as a potential means of financing expansions of coverage. See 2005 Kaiser Commission 7. The HIFA projects allowed States to cap enrollment, to reduce benefits, and to impose new premium and cost-sharing obligations on previously eligible groups of people. See *ibid.* Savings from such reductions could be used to cover new groups, but States' implementation of those reductions was not contingent upon implementation of a coverage expansion. See *ibid.* The "combination of severe fiscal pressure on [S]tates and increased flexibility" led to a round of demonstration activity "focused on reducing coverage to relieve state fiscal pressures, affecting enrollment, benefits, and affordability of coverage and care." *Id.* at 1.

b. The HIFA projects contributed to debate about Section 1315 Medicaid projects more generally, as to both their appropriate substantive scope and the process for approving them. See, *e.g.*, *Senate Hearing* 78-82 (statement of Cindy Mann) (discussing "complex questions" of both substance and process). Congress considered those issues when it enacted the ACA in 2010.

The ACA addressed concerns that had been raised regarding demonstration-approval procedures by directing HHS to adopt regulations establishing new procedural requirements for the approval or renewal of a Medicaid demonstration project that "would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." ACA Tit. X, Subtit. B, § 10201(i), 124 Stat. 922 (42 U.S.C. 1315(d)(1) (Supp. V 2011)). Congress directed the Secretary to provide for two periods of public comment on proposed approvals or renewals of projects—one comment period at the state level before an application is submitted to the Secretary, and another

at the federal level after it is submitted. See 42 U.S.C. 1315(d)(2)(A) and (C). Congress required that each period be "sufficient to ensure a meaningful level of public input." *Ibid.* It also directed the Secretary's regulations to "provide for * * * requirements relating to" a proposed project's "goals," anticipated costs, "coverage projections," and how the State will ensure "compliance with" the Medicaid statute." 42 U.S.C. 1315(d)(2)(B). Congress also required periodic reporting to and evaluation by the Secretary. 42 U.S.C. 1315(d)(2)(D) and (E).

The ACA did not, however, narrow the Secretary's substantive authority under Section 1315 to approve demonstration projects—leaving intact the authority by which the Secretary had long approved projects that promoted the statutory objective of providing coverage by helping States to conserve resources. The regulations that HHS promulgated to implement the ACA's directions accordingly established procedural, not substantive, constraints on the submission and approval of Medicaid demonstration projects. See, *e.g.*, 42 C.F.R. 431.408, .412, .416 (addressing the state public-notice process, application procedures, and the federal review process). Moreover, although the ACA specified that the public-comment periods should be "sufficient to ensure a meaningful level of public input" on a proposed project, 42 U.S.C. 1315(d)(2)(A) and (C), it did not require the Secretary to provide a written response to public comments or a written explanation for his decision on a particular demonstration project, and the implementing regulations indicated that HHS generally would not provide responses to public comments, see 42 C.F.R. 431.416(d)(2).

c. Following the ACA's enactment, HHS has continued to approve a variety of demonstration projects that

have facilitated States' election to cover the expansion population provided for in the ACA, by permitting them to test alternative coverage models for newly eligible adults. Urban Institute 2. Because this Court's decision in *NFIB* had "effectively made Medicaid expansion optional," such projects "enabled [S]tates that were not prepared to implement a standard expansion to extend Medicaid coverage to hundreds of thousands of people who otherwise would have likely remained uninsured." *Ibid.*

Although no two States' proposals were identical, see Urban Institute 4, the alternative coverage models generally have been designed to increase continuity of care when the newly eligible individuals move between Medicaid eligibility and federally subsidized coverage for qualified health plans sold on the Exchanges, see *id.* at 2, 19-20. Such continuity ultimately helps States conserve resources by encouraging beneficiaries to obtain preventive care, which can improve beneficiaries' health. See Pet. App. 149a. Although increased use of preventive care may raise Medicaid expenses in the short run, it may reduce utilization of medical care in the long run. See Urban Institute 22.

For example, demonstration projects have allowed States to test a range of provisions modeled on commercial insurance that have the potential to generate savings for state Medicaid programs. Urban Institute 2-3. By April 2015, for example, HHS had approved projects allowing several States, including Arkansas and New Hampshire, to implement a "'private option,'" under which the State paid premiums to enroll newly eligible adults in qualified health plans sold on the Exchanges. *Id.* at 4; see *id.* at 2, 4-18; see also Pet. App. 2a. A major goal of the private option was to increase continuity of care when such adults transition between Medicaid and

eligibility for federal subsidies on the Exchanges. See Urban Institute 6, 18-19. The projects also allowed States to impose on newly eligible adults one or more "personal responsibility" requirements modeled on commercial insurance, such as charging premiums and imposing cost-sharing requirements. *Id.* at 5; see also *id.* at 20; see, *e.g.*, Arizona 2016 Letter 1-3.

Demonstration projects additionally have allowed States to create incentives for beneficiaries to engage in healthy behaviors, which in turn could lower Medicaid costs. See Urban Institute 22; see 2012 CMS FAQ 15 (CMS encouraging States to develop demonstration projects "aimed at promoting healthy behaviors" and "accountability tied to improvement in health outcomes"). For example, under an Iowa project approved in 2013, beneficiaries were excused from paying premiums if they completed certain "Healthy Behaviors." Urban Institute 10. In the first year of its implementation, that project required completion of a health-risk assessment and a wellness exam, and in future years, the State could require individuals to take steps to address unhealthy behaviors, consistent with protocols approved by HHS. See *ibid.*

* * * * *

In short, there is a settled practice, for years before the ACA and since, of approving demonstration projects to test measures that could indirectly enhance States' ability to provide coverage, including by conserving resources. That practice refutes the court of appeals' conclusion that the Secretary's authority is confined to approving projects that "provid[e] health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage." Pet. App. 16a.

CONCLUSION

The judgments of the court of appeals should be reversed.

Respectfully submitted.

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APPENDIX

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

Eligibility disqualifications

(*o*) Work requirement

(1) "Work program" defined

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

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

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

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

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

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

(2) Work requirement

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

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

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

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

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

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

(3) Exception

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

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

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

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

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

(E) a pregnant woman.

(4) Waiver

(A) In general

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

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

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

(B) Report

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

(5) Subsequent eligibility

(A) Regaining eligibility

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

(i) works 80 or more hours;

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

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

(B) Maintaining eligibility

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

(C) Loss of employment

(i) In general

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

(ii) Limitation

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

(6) Exemptions

(A) Definitions

In this paragraph:

(i) Caseload

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

(ii) Covered individual

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

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

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

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

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

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

(B) General rule

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

(C) Fiscal year 1998

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

(D) Fiscal years 1999 through 2019

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

(E) Subsequent fiscal years

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

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

(F) Caseload adjustments

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

(G) Exemption adjustments

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

(H) Reporting requirement

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

(7) Other program rules

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

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

Mandatory work requirements

(a) Participation rate requirements

(1) All families

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

If the fiscal year is:	The minimum participation rate is:
1997.....	25
1998.....	30
1999.....	35
2000.....	40

2001.....	45
2002 or thereafter.....	50.

(2) 2-parent families

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

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

(b) Calculation of participation rates

(1) All families

(A) Average monthly rate

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

(B) Monthly participation rates

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

(i) the number of families receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) that include an adult or a minor child head of household who is engaged in work for the month; divided by

(ii) the amount by which—

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

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

(2) 2-parent families

(A) Average monthly rate

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

(B) Monthly participation rates

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

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

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

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

(A) In general

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

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

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

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

(B) Eligibility changes not counted

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

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

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

(5) State option for participation requirement exemptions

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

(c) Engaged in work

(1) General rules

(A) All families

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

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

(B) 2-parent families

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

(i) the individual and the other parent in the family are participating in work activities for a total of at least 35 hours per week during the month, not fewer than 30 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d), subject to this subsection; and

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

(2) Limitations and special rules

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

(i) Limitation

Notwithstanding paragraph (1) of this subsection, an individual shall not be considered to be engaged in work by virtue of participation in an activity described in subsection (d)(6) of a State program funded under this part or any

other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title), after the individual has participated in such an activity for 6 weeks (or, if the unemployment rate of the State is at least 50 percent greater than the unemployment rate of the United States or the State is a needy State (within the meaning of section 603(b)(5) of this title), 12 weeks), or if the participation is for a week that immediately follows 4 consecutive weeks of such participation.

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

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

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

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

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

For purposes of determining monthly participation rates under subsection (b)(1)(B)(i), a recipient who is married or a head of household and has not attained 20 years of age is deemed to be engaged in work for a month in a fiscal year if the recipient—

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

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

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

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

(d) "Work activities" defined

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

(1) unsubsidized employment;

(2) subsidized private sector employment;

(3) subsidized public sector employment;

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

(5) on-the-job training;

(6) job search and job readiness assistance;

(7) community service programs;

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

(9) job skills training directly related to employment;

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

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

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

(e) Penalties against individuals

(1) In general

Except as provided in paragraph (2), if an individual in a family receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) refuses to engage in work required in accordance with this section, the State shall—

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

(B) terminate such assistance,

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

(2) Exception

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

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

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

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

3. 42 U.S.C. 1315 provides:

Demonstration projects

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

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

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

(2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall,

to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and

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

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

(b) Child support enforcement programs

(1) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of part D of subchapter IV, the project—

(A) must be designed to improve the financial well-being of children or otherwise improve the operation of the child support program;

(B) may not permit modifications in the child support program which would have the effect of disadvantaging children in need of support; and

(C) must not result in increased cost to the Federal Government under part A of such subchapter.

(2) An Indian tribe or tribal organization operating a program under section 655(f) of this title shall be considered a State for purposes of authority to conduct an experimental, pilot, or demonstration project under subsection (a) to assist in promoting the objectives of part D of subchapter IV and receiving payments under the second sentence of that subsection. The Secretary may waive compliance with any requirements of section 655(f) of this title or regulations promulgated under that section to the extent and for the period the Secretary finds necessary for an Indian tribe or tribal organization to carry out such project. Costs of the project which would not otherwise be included as expenditures of a program operating under section 655(f) of this title and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under a tribal plan or plans approved under such section, or for the administration of such tribal plan or plans, as may be appropriate. An Indian tribe or tribal organization applying for or receiving start-up program development funding pursuant to section 309.16 of title 45, Code of Federal Regulations, shall not be considered to be an Indian tribe or tribal organization operating a program under section 655(f) of this title for purposes of this paragraph.

(c) Demonstration projects to test alternative definitions of unemployment

(1)(A) The Secretary shall enter into agreements with up to 8 States submitting applications under this subsection for the purpose of conducting demonstration

projects in such States to test and evaluate the use, with respect to individuals who received aid under part A of subchapter IV of this chapter in the preceding month (on the basis of the unemployment of the parent who is the principal earner), of a number greater than 100 for the number of hours per month that such individuals may work and still be considered to be unemployed for purposes of section 607 of this title. If any State submits an application under this subsection for the purpose of conducting a demonstration project to test and evaluate the total elimination of the 100-hour rule, the Secretary shall approve at least one such application.

(B) If any State with an agreement under this subsection so requests, the demonstration project conducted pursuant to such agreement may test and evaluate the complete elimination of the 100-hour rule and of any other durational standard that might be applied in defining unemployment for purposes of determining eligibility under section 607 of this title.

(2) Notwithstanding section 602(a)(1) of this title, a demonstration project conducted under this subsection may be conducted in one or more political subdivisions of the State.

(3) An agreement under this subsection shall be entered into between the Secretary and the State agency designated under section 602(a)(3) of this title. Such agreement shall provide for the payment of aid under the applicable State plan under part A of subchapter IV of this chapter as though section 607 of this title had been modified to reflect the definition of unemployment used in the demonstration project but shall also provide that such project shall otherwise be carried out in accordance with all of the requirements and conditions of

section 607 of this title (and, except as provided in paragraph (2), any related requirements and conditions under part A of subchapter IV of this chapter).

(4) A demonstration project under this subsection may be commenced any time after September 30, 1990, and shall be conducted for such period of time as the agreement with the Secretary may provide; except that, in no event may a demonstration project under this section be conducted after September 30, 1995.

(5)(A) Any State with an agreement under this subsection shall evaluate the comparative cost and employment effects of the use of the definition of unemployment in its demonstration project under this section by use of experimental and control groups comprised of a random sample of individuals receiving aid under section 607 of this title and shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of the project conducted by the State.

(B) The Secretary shall report the results of the demonstration projects conducted under this subsection to the Congress not later than 6 months after all such projects are completed.

(d) Regulations relating to applications for or renewals of demonstration projects

(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of subchapter XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under subchapter XIX

or XXI (in this subsection referred to as a "demonstration project") shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

(2) Not later than 180 days after March 23, 2010, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(B) requirements relating to—

(i) the goals of the program to be implemented or renewed under the demonstration project;

(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with subchapter XIX or XXI;

(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

(E) a process for the periodic evaluation by the Secretary of the demonstration project.

(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

(e) Extensions of State-wide comprehensive demonstration projects for which waivers granted

(1) The provisions of this subsection shall apply to the extension of any State-wide comprehensive demonstration project (in this subsection referred to as "waiver project") for which a waiver of compliance with requirements of subchapter XIX of this chapter is granted under subsection (a).

(2) During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title), of the project.

(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waiver project would otherwise have expired.

(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.

(f) Application for extension of waiver project; submission; approval

An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) of this section (in this subsection referred to as the "waiver project") shall be submitted and approved or disapproved in accordance with the following:

(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends to

review the terms and conditions of the waiver project. A failure to provide such notification shall be deemed to be an approval of the application.

(3) Not later than 45 days after the date a notification is made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed to by the chief executive officer of the State), the Secretary shall—

(i) approve the application subject to such modifications in the terms and conditions—

(I) as have been agreed to by the Secretary and the State; or

(II) in the absence of such agreement, as are determined by the Secretary to be reasonable, consistent with the overall objectives of the waiver project, and not in violation of applicable law; or

(ii) disapprove the application.

(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title).

(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e) (taking into account the extension under this subsection with respect to any timing requirements imposed under those paragraphs).

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

Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the pur-

poses of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

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

Assuring coverage for certain low-income families

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

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

(A) Individuals receiving cash assistance under TANF

In the case of an individual who—

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

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

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

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

termination of such cash assistance because of such refusal.

(B) Exception for children

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

6. 42 C.F.R. 431.420 provides:

Monitoring and compliance.

(a) *General.* (1) Any provision of the Social Security Act that is not expressly waived by CMS in its approval of the demonstration project are not waived, and States may not stop compliance with any of these provisions not expressly waived. Waivers may be limited in scope to the extent necessary to achieve a particular purpose or to the extent of a particular regulatory requirement implementing the statutory provision.

(2) States must comply with the terms and conditions of the agreement between the Secretary and the State to implement a State demonstration project.

(b) *Implementation reviews.* (1) The terms and conditions will provide that the State will perform periodic reviews of the implementation of the demonstration.

(2) CMS will review documented complaints that a State is failing to comply with requirements specified in the special terms and conditions and implementing waivers of any approved demonstration.

(3) CMS will promptly share with the State complaints that CMS has received and will also provide notification of any applicable monitoring and compliance issues.

(c) *Post award.* Within 6 months after the implementation date of the demonstration and annually thereafter, the State must hold a public forum—

(1) To solicit comments on the progress of a demonstration project.

(2) At which members of the public have an opportunity to provide comments and in such time as to include a summary of the forum in the quarterly report associated with the quarter in which the forum was held, as well as in its annual report to CMS.

(3) The public forum to solicit feedback on the progress of a demonstration project must occur using one of the following:

(i) A Medical Care Advisory Committee that operates in accordance with § 431.412 of this subpart.

(ii) A commission or other similar process, where meetings are open to members of the public, and would afford an interested party the opportunity to learn about the demonstration's progress.

(iii) The State must publish the date, time, and location of the public forum in a prominent location on the State's public Web site, at least 30 days prior to the date of the planned public forum.

(4) [Reserved]

(d) *Terminations and suspensions.* (1) The Secretary may suspend or terminate a demonstration in whole

or in part, any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the demonstration project.

(2) The Secretary may also withdraw waivers or expenditure authorities based on a finding that the demonstration project is not likely to achieve the statutory purposes.

(3) The terms and conditions for the demonstration will detail any notice and appeal rights for the State for a termination, suspension or withdrawal of waivers or expenditure authorities.

(e) *Closeout costs.* When a demonstration is terminated, suspended, or if waivers or expenditure authority are withdrawn, Federal funding is limited to normal closeout costs associated with an orderly termination of the demonstration or expenditure authority, including service costs during any approved transition period, and administrative costs of disenrolling participants.

(f) *Federal evaluators.* (1) The State must fully cooperate with CMS or an independent evaluator selected by CMS to undertake an independent evaluation of any component of the demonstration.

(2) The State must submit all requested data and information to CMS or the independent evaluator.