UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM, et al. **PLAINTIFFS**

v. **No. 1:18-cv-01900JEB**

ALEX M AZAR, et al. **DEFENDANTS**

STATE OF ARKANSAS **DEFENDANT-INTERVENOR**

ARKANSAS'S MOTION FOR SUMMARY JUDGMENT & RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

For the reasons explained in the attached brief, the Court should grant Arkansas's motion for summary judgment and deny Plaintiffs' motion for summary judgment. Fed. R. Civ. P. 56.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that November 30, 2018, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which shall send notification of such filing to any CM/ECF participants.

/s/ *Dylan L. Jacobs*

Dylan L. Jacobs

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BRIEF IN SUPPORT OF ARKANSAS'S MOTION FOR SUMMARY JUDGMENT & RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

INTRODUCTION

This case is about Arkansas's Medicaid expansion program, Arkansas Works, and concerns whether the Secretary of Health and Human Services acted arbitrarily and capriciously when he approved a demonstration program requiring program participants to work or participate in volunteer activities. Like similar programs approved in 4 other states, Arkansas's demonstration program is designed to encourage healthy outcomes and increase program sustainability.

Arkansas's program took effect in April of this year, and in August, Plaintiffs filed this lawsuit seeking to disrupt Arkansas's demonstration program. They base their challenge on a disagreement with the Secretary's reasonable interpretation of the objectives of the Medicaid Act and they ask this Court to second-guess (and substitute its judgment for) the Secretary's consideration of those objectives in approving the Arkansas Works Amendment. In doing so, they purport to rely on *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018), but they grossly mischaracterize that case and—in arguing that case is controlling here—ignore profound differences between the administrative record in this case and that one. Plaintiffs' claims are meritless, and this Court

should deny Plaintiffs' summary judgment motion and instead grant summary judgment in favor of the Defendants.

FACTUAL BACKGROUND

In September 2013, Arkansas became the first state in the country to receive approval from CMS for a Section 1115 demonstration waiver to provide coverage to the Medicaid expansion population through a private option plan. Instead of providing benefits on a traditional fee-for-service model, enrollees are, with few exceptions, enrolled into private insurance plans, with the state paying the premiums on behalf of enrollees.

Arkansas Works was first created in 2016 as an amendment to Arkansas's Medicaid demonstration project. The program sought to increase community engagement among Medicaid expansion enrollees, particularly by incentivizing enrollees to seek employment. Franklin Decl. ¶ 4. In January 2017, the Arkansas Department of Human Services (DHS) implemented a program to refer all individuals enrolled in Arkansas Works to the Arkansas Department of Workforce Services, allowing enrollees to voluntarily seek assistance with job training and job placement. But that program did not work as hoped. By October 2017, only 4.7 percent of enrollees acted upon the referral and used the offered services. Franklin Decl. ¶ 5. Of those that utilized the services, 23 percent became employed. *Id*.

In order to further the goal of incentivizing participation in work and community engagement activities, Arkansas submitted an amendment to the Arkansas Works demonstration project requiring certain non-disabled adults without dependents in work and community engagement requirements. *Id*. ¶¶ 6–7. Enrollees who are subject to the requirement must engage in, and report, 80 hours of qualifying activities each month. If they have income that is *consistent* with working 80 hours a month at a minimum wage, they are deemed to satisfy the requirement. (AR 20 n.2 and

accompanying text). Thus, for example, a beneficiary who works only forty hours a month and is paid twice the hourly minimum wage satisfies the requirement through her work activities alone.

CMS acknowledged Arkansas's experience that "referrals alone, without any further incentive, may not be sufficient to encourage the Arkansas Works population to participate in community engagement activities." (AR 4–5). CMS therefore approved Arkansas's plan to "require all Arkansas Works beneficiaries ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility." (AR 2). That requirement has been in effect since June 2018. Nevertheless, Plaintiffs bring this lawsuit challenging the Secretary's approval of the Arkansas Works amendment.

ARGUMENT

I. The Secretary reasonably interpreted Section 1115's reference to the "objectives" of Medicaid.

Section 1115 of the Social Security Act authorizes the Secretary to "waive compliance with any of the requirements of section . . .1396a of . . . title [42]," "[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 subchapter . . . XIX" of the Social Security Act, i.e., Medicaid. 42 U.S.C. 1315(a). The Secretary, finding that Arkansas's proposed amendment to its existing section 1315 demonstration project was "likely to promote [the] Medicaid objectives" (AR 4), as he understood Medicaid's objectives, of "improving health outcomes" (*id.*), "strengthen[ing] beneficiary engagement in their personal health care" (AR 5), "promot[ing] beneficiary independence" (AR 6), and "the ultimate objective of improving health and well-being for Medicaid beneficiaries" (AR 2),

waived the relevant requirements of Section 1396a and approved the Arkansas Works Amendment.

Plaintiffs argue that the Secretary failed to consider whether the Amendment would promote Medicaid coverage gains or cause Medicaid coverage loss, *see* Pls.' Mem. 18–24, and unreasonably determined that the Amendment would promote the non-coverage objectives of health and independence he found it would. *See* Pls.' Mem. 24–29. But most fundamentally, Plaintiffs argue that the Medicaid objectives the Secretary found the Amendment would promote are not Medicaid objectives at all. *See* Pls.' Mem. 14–18.

Rather, relying on *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018), they claim that Medicaid's objectives are solely paying the costs of medical services for Medicaid-eligible persons, and providing services that promote "functional" independence, a term by which Plaintiffs mean "the capacity to accomplish the various activities of daily living, such as feeding, dressing, and bathing." Pls.' Mem. 17. Improving health outcomes or larger notions of independence, Plaintiffs insist, are not objectives of Medicaid at all, but at most "might be a desirable *result*," *id.* at 15 (emphasis in original), of the narrow objectives Plaintiffs identify: state provision of healthcare coverage and certain rehabilitative services that promote bodily self-care. On this view, any demonstration project that reduces, even if slightly, the numbers of persons covered by Medicaid, or even the contributions a state Medicaid plan makes towards beneficiaries' services, cannot promote Medicaid's objectives—no matter how much it might improve Medicaid beneficiaries' health, hasten their financial independence from the program, or encourage them to make wise choices in their care.

Plaintiffs' understanding of Medicaid's objectives, and the exaggerated characterization of *Stewart* from which Plaintiffs claim to derive that understanding, are seriously mistaken. The

Secretary is entitled to *Chevron* deference to his interpretation of Section 1115's oblique reference to "the objectives" of Medicaid, so his gloss of that reference may only be rejected if the latter is unambiguous or the former is unreasonable. But there is nothing unambiguous about what "the objectives" of Medicaid, as contemplated by Section 1115, are. Section 1115 does not list Medicaid's objectives, or cross-reference a section of the Medicaid subchapter that does. There is no purposes section of Medicaid, or provision of Medicaid denominated as a statement of the program's purposes.

Instead, Plaintiffs—like *Stewart*—locate the requisite unambiguous statement of Medicaid's purposes needed to defeat the Secretary's interpretation in a prefatory purpose clause of Medicaid's *appropriations* section. This clause undeniably references some of Medicaid's "objectives." But, as explained below, it does not unambiguously or even plausibly describe *all* of the objectives of Medicaid, especially as expanded. Rather, a reading of the whole statute shows that Medicaid has many purposes in addition to, and even arguably at odds with, those listed in its appropriations section, including the ones identified by the Secretary.

A. The Secretary's interpretation of Medicaid's "Objectives" is entitled to *Chevron* deference.

In finding that Arkansas's Amendment was "likely to promote Medicaid objectives" (AR 4), as required by Section 1115, he had to render an interpretation of what "the objectives" of Medicaid are. 42 U.S.C. 1315(a). *Stewart* "assume[d]" that the Secretary "should receive deference in interpreting [Medicaid's] 'objectives'" under Section 1115, *Stewart*, 313 F. Supp. 3d at 260, and that assumption is doubtlessly correct for several reasons.

First, the Secretary's interpretation of Section 1115 was rendered, as Congress required, in a notice-and-comment procedure, *see* 42 U.S.C. 1315(d)(2)(C), automatically triggering *Chevron*

deference. *See United States v. Mead Corp.*, 533 U.S. 218, 230 (2001) ("It is fair to assume generally that Congress contemplates administrative action with the effect of law when it provides for a relatively formal administrative procedure," such as "notice-and-comment"); *see also City of Arlington v. FCC*, 569 U.S. 290, 306 (2013) (clarifying that a grant of notice-and-comment rulemaking authority and its use automatically triggers *Chevron* deference under *Mead*).

Second, the Supreme Court has specifically held that *Chevron* applies to interpretive questions about what the purposes of a statute are. In *Pension Benefit Guaranty Corp. v. LTV Corp.*, 496 U.S. 633 (1990), where the agency had authority to restore terminated ERISA plans conditioned on whether doing so would "further[] the statutory purposes" of a title of ERISA, *id.* at 648, the Court observed that the stated purposes of that title were silent on the question at issue and deferred under *Chevron* to the agency's interpretation of those purposes. *See id.* at 649–52.

Third and lastly, the D.C. Circuit has specifically held that the Secretary's "authority to review and approve state Medicaid plans" is an "'express delegation of specific interpretive authority'" to interpret the statutory requirements to which those plans must conform, and that the "interpretations of the Medicaid Act" he renders in approving Medicaid plans "are therefore entitled to *Chevron* deference." *Pharm. Research & Mfrs. Am. v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004) (second quotation quoting *Mead*, 533 U.S. at 229). Indeed, the court found this delegation so explicit that it brushed aside concerns that the Secretary's interpretations were "not the result of a formal administrative process," were inconsistent with past interpretations, and were "developed solely in response" to litigation. *Id.* at 521. Likewise, the Secretary's authority to approve state Medicaid demonstration projects and determine whether, "in the judgment of the Secretary, [they are] likely to assist in promoting the objectives" of Medicaid, 42 U.S.C. 1315(a), is an express delegation of specific interpretive authority as to what the objectives of Medicaid are.

B. The Secretary's interpretation of Medicaid's "objectives" was permissible.

With that said, the question here, as in any *Chevron* case, is whether the Secretary's interpretation of Section 1115's reference to "the objectives" of Medicaid was unambiguously foreclosed or unreasonable. Section 1115 itself does not specify the objectives of Medicaid, or tell the Secretary where to look to find them. And unlike many other subchapters and parts of the Social Security Act, which contain purpose sections that courts have relied on to review Section 1115 approvals under those subchapters and parts, the Medicaid subchapter has no purposes section—at least, none expressly denominated as such.[1] In the absence of a Medicaid purposes section, Plaintiffs, like *Stewart*, rely on Medicaid's "Appropriations" section, Section 1901 of the Act, which appropriates funds for Medicaid on a standing basis and, in a prefatory clause, states "the purpose" for which those funds are appropriated. 42 U.S.C. 1396-1.

Section 1901 undeniably states *some* purposes of Medicaid, but in arguing that it unambiguously states Medicaid's sole purposes to the exclusion of the ones the Secretary recognized, Plaintiffs badly overreach. For a host of reasons, the statute is best read as containing more purposes

[1] *Cf.* 42 U.S.C. 601 ("Purpose" section of Aid to Families with Dependent Children (AFDC) part, stating "[t]he purpose of this part"); *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 184 (3d Cir. 1996) (relying on this statement of purpose in addressing whether the Secretary reasonably determined a Section 1115 AFDC demonstration project was likely to further the objectives of AFDC); *Beno v. Shalala*, 30 F.3d 1057, 1069–70 (9th Cir. 1994) (same); *Aguayo v. Richardson*, 473 F.2d 1090, 1104 (2d Cir. 1973) (same); 42 U.S.C. 621 ("Purpose" section of child welfare services subpart, stating "[t]he purpose of this subpart"); 42 U.S.C. 629 ("Purpose" section of Promoting Safe and Stable Families subpart, stating "[t]he purpose of this program"); 42 U.S.C. 670 ("Congressional declaration of purpose" of federal foster care and adoption assistance program); 42 U.S.C. 1381 ("Statement of purpose" section of Supplemental Security Income subchapter); 42 U.S.C. 1397 ("Purposes of division" section of social services block grants division); 42 U.S.C. 1397aa ("Purpose" section of State Children's Health Insurance Program subchapter, stating "[t]he purpose of this subchapter"); 42 U.S.C. 1397n ("Purposes" section of social impact demonstration projects division, stating "[t]he purposes of this division").

than those set out in Section 1901, and it is at the very least ambiguous whether the purposes of Medicaid in its present form are limited to Section 1901's stated purposes.

1. Courts have not traditionally looked to Section 1901 to limit the Secretary's discretion under Section 1115.

In explaining its use of Section 1901 to fill the gap in Section 1115's "ambiguous" reference to the objectives of Medicaid, *Stewart* reasoned that "courts have traditionally looked to [Section 1901] . . . to discern those objectives." *Stewart*, 313 F. Supp. 3d at 260. This is true in a sense, but not in the relevant sense. Courts have, indeed, often looked to Section 1901 for guidance on Medicaid's objectives, but usually for far more impressionistic purposes than deciding whether the Secretary unambiguously erred in construing those objectives.

For example, in the sole case *Stewart* cited for its proposition of traditional reliance on Section 1901, the First Circuit looked to Section 1901 to decide whether a state statute was at odds with "the . . . purpose of [Medicaid] as a whole" and thus impliedly preempted by Medicaid. *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) (internal quotation marks omitted) (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 98 (1992)). *Stewart* also cited a student note on Medicaid and Section 1115 waivers for the proposition, *see* 313 F. Supp. 3d at 260, but the additional case that note cites on the point, besides *Concannon*, looked to Section 1901 for the same purpose as *Concannon*—that is, deciding an issue of implied conflict preemption. *See Pharm. Research & Mfrs. of Am. v. Meadows*, 304 F.3d 1197, 1208 (11th Cir. 2002).

Tellingly, the note, while urging courts to apply Section 1901 in reviewing Section 1115 waivers, cites no case that did, and until *Stewart*, few courts did so, and fewer still conceived of Section 1901 as a complete statement of Medicaid's objectives. In *California Welfare Rights Or-*

ganization v. Richardson, 348 F. Supp. 491 (N.D. Cal. 1972), the first major Section 1115 Medicaid case, the court found some guidance in Section 1901, but reasoned that several other sections of the Act "would also seem to furnish the basis for deriving an objective of the title." *Id.* at 496. Subsequent cases gleaned general purposes from different Medicaid provisions to the exclusion of Section 1901, *see Georgia Hospital Ass'n v. Department of Medical Assistance*, 528 F. Supp. 1348, 1355 (N.D. Ga. 1982), or gave absolute deference to the Secretary's judgment of what Medicaid's objectives were. *See Crane v. Mathews*, 417 F. Supp. 532, 539 (N.D. Ga. 1976).

Most recently, in *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011), the Ninth Circuit reviewed a demonstration project that expanded Medicaid to beneficiaries who were statutorily ineligible for Medicaid but for the Secretary's Section 1115 authority.[2] *See id.* at 376. By definition, that project could not advance the purposes stated in Section 1901, namely, "furnish[ing] (1) medical assistance" to enumerated classes of Medicaid-eligible beneficiaries, "and (2) rehabilitation and other services to help *such* families and individuals[.]" 42 U.S.C. 1396-1 (emphasis added). In lieu of considering the purposes stated in Section 1901, the Ninth Circuit deferred to the Secretary's judgment that one of Medicaid's objectives was "ensur[ing] wider health benefit coverage to low-income populations" beyond the populations statutorily eligible for Medicaid coverage at the time, *Newton-Nations*, 660 F.3d at 381 (internal quotation marks omitted), and ultimately faulted the Secretary for inadequately considering this objective, stated nowhere in the statute. *See id.* (faulting the Secretary for saying too little to allow "review [of] the

[2] This Court is familiar with such demonstration projects. *See Cooper Hosp./ Univ. Med. Ctr. v. Burwell*, 179 F. Supp. 3d 31, 45 (D.D.C. 2016).

agency's consideration of the impact Arizona's demonstration project would have on the economically vulnerable").[3]

2. Section 1901 states only the purpose of Medicaid appropriations, not the purpose of Medicaid.

Moreover, Plaintiffs' claim has little to recommend it as a matter of first principles. First, the supposed unambiguous and exhaustive statement of Medicaid's objectives that plaintiffs identify is not contained in a purposes section, as one might expect, but in Medicaid's standing appropriations provision. This is an awkward fit. Appropriations "measures have the 'limited and specific purpose of providing funds for authorized programs,'" *Donovan v. Carolina Stalite Co.*, 734 F.2d 1547, 1558 (D.C. Cir. 1984) (quoting *TVA v. Hill*, 437 U.S. 153, 190 (1978)), and while they "can substantively change existing law, there is a very strong presumption that they do not." *Calloway v. D.C.*, 216 F.3d 1, 9 (D.C. Cir. 2000) (internal quotation marks omitted) (quoting *Bldg. & Contr. Trades Dep't., AFL-CIO v. Martin*, 961 F.2d 269, 273 (D.C. Cir. 1992)). Thus, "when appropriations measures arguably conflict with the underlying authorizing legislation, their effect must be construed narrowly." *Id.* (quoting *Donovan*, 734 F.2d at 1558).

[3] There are a small handful of recent district court decisions, besides *Stewart*, that purport to equate Section 1115's reference to Medicaid's objectives with the purposes stated in Section 1901. But none did so dispositively, none did so en route to rejecting the Secretary's understanding of Medicaid's objectives at *Chevron* Step One, none did so to the exclusion of other Medicaid objectives, and some ultimately accepted objectives at odds with those contained in Section 1901. *See Wood v. Betlach*, 922 F. Supp. 2d 836, 848 (D. Ariz. 2013) (claiming that "[t]he purpose of the Medicaid Act" was that stated in Section 1901, but reading Section 1901 so broadly as to contemplate "extend[ing] medical assistance to expansion populations," i.e., the statutorily "Medicaid ineligible," *id.* at 839); *Wood v. Betlach*, No. CV-12-08098-PCT-DGC, 2013 WL 3871414, at *8–9 (D. Ariz. July 26, 2013) (again identifying a Medicaid purpose of extending medical assistance to the Medicaid-ineligible, in irreconcilable tension with Section 1901); *G. v. Hawaii*, 676 F. Supp. 2d 1006, 1017 (Haw. 2009) (holding that "*[o]ne* of the primary purposes of the Medicaid Act" was the purpose set forth in Section 1901 and that a Section 1115 approval advanced that purpose) (emphasis added).

As explained below, Section 1901 cannot be read to limit Medicaid's purposes to those mentioned there because this would create irreconcilable conflict with much of the Medicaid Act. But even were that not so, Section 1901's authorization of appropriations for Medicaid would still be the wrong place to look for a substantive limit on the Secretary's discretion to approve Medicaid demonstration projects. Section 1901, like all appropriations measures, has the "limited and specific purpose of providing funds for [an] authorized program[]," *Andrus v. Sierra Club*, 442 U.S. 347, 361 (1979) (quoting *Hill*, 437 U.S. at 190), namely Medicaid, not of substantively narrowing that program's purposes or limiting the Secretary's discretion under it.

To be sure, like all appropriations measures, Section 1901 states the purpose of its appropriation. *See Nevada v. Dep't of Energy*, 400 F.3d 9, 13 (D.C. Cir. 2005) (noting that by definition a continuing appropriation is one that is always available for a "specified purpose[]"). But that only serves to say what Medicaid funds are appropriated for and prohibit them from being spent on something else, not to limit the Secretary's discretion in every Medicaid-policymaking exercise that calls upon him to divine the objectives of Medicaid.

The Secretary, for example, could not use Medicaid funds to simply subsidize the purchase of broccoli, because Section 1901 does not appropriate funds for the free-ranging promotion of health; it appropriates funds for states to furnish medical assistance, rehabilitation, and other services to certain populations. But it does not follow that in exercising his statutory discretion to approve or disapprove states' methods of providing medical assistance to those populations, he may not pursue Medicaid's obvious objective of improving those populations' health—including, even, by allowing states to offer Medicaid beneficiaries reduced cost-sharing or enhanced coverage to incentivize their purchase of broccoli. *But see Stewart*, 313 F. Supp. 3d at 267–68 (claiming that reading Section 1901 to permit the Secretary to approve demonstration projects "conditioning

Medicaid coverage on consuming more broccoli" or "enroll[ing] in pilates classes" would be a "bizarre result[]"). Indeed, each of the last three administrations has approved multiple Medicaid plans and demonstration projects that conditioned reduced cost-sharing or enhanced coverage on various healthy behaviors.[4] Evidently, these administrations too believed that incentivizing healthy behaviors at the risk of reduced coverage furthered the objectives of Medicaid.

Looking to Section 1115 for complete insight into Medicaid's objectives becomes even more obviously misplaced when one considers the details of the purpose stated in Section 1115. That is because Medicaid's full definition of "medical assistance" provides for "payment of part or all of the cost of the *following* care and services," 42 U.S.C. 1396d(a) (emphasis added), and proceeds to list, by a conservative count, thirty-nine distinct types of care or services, *see* 42 U.S.C. 1396d(a)(1)–(30), including such detailed items as "counseling and pharmacotherapy for cessation of tobacco use by pregnant women" (itself a defined term), 42 U.S.C. 1396d(a)(4)(D), "prescribed . . . dentures," 42 U.S.C. 1396d(a)(12), and eyeglasses so long as they are "prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select." *Id.* So "furnish[ing] . . . medical assistance" to Medicaid populations means, by definition, the payment of part or all of the cost of dentures, eyeglasses, methadone treatment for opioid use, counseling for pregnant smokers, and dozens of other minutely detailed and defined services. To find

[4] *See* MACPAC, *The Use of Healthy Behavior Incentives in Medicaid*, at 2 (August 2016), https://tinyurl.com/yam48hm8 (discussing four Section 1115 waivers that included healthy behavior incentives under the previous administration, one such waiver under the Bush administration, and two alternative benefit plans including healthy behavior incentives approved by the last two administrations under the Secretary's alternative-benefit-plan-approval power, discussed below); Hannah Katch & Judith Solomon, Ctr. On Budget & Pol'y Priorities, *Are Medicaid Incentives an Effective Way to Improve Health Outcomes?* (2017), https://tinyurl.com/yafs2nuf (policy paper, cited on comments relied upon by Plaintiffs, *see* Pls. Mem. 18 (citing AR 1268), discussing a mix of Medicaid incentives and penalties engineered to incentivize healthy behaviors that were approved by the prior two administrations under the Secretary's Section 1115 and alternative benefits powers).

an unambiguously exhaustive statement of Medicaid's "objectives" in this list of appropriated services is like equating the purpose of a new building to the specifications of the work orders given to the various subcontractors that build it.

To be clear, this is not to suggest that Medicaid coverage for Medicaid-eligible people is not *an* objective of Medicaid; that Medicaid coverage is a Medicaid objective is readily apparent from the substantive provisions of the statute. What it is to say is that Section 1901's list of appropriated services is the wrong place to look for a comprehensive statement of Medicaid's objectives. Rather, Section 1901's prefatory clause merely says what Medicaid funds are appropriated for.

3. Section 1901's stated purposes are in irreconcilable tension with post-1901 amendments to Medicaid, which reveal broader purposes.

Even if Section 1901's specification of a purpose for Medicaid appropriations could be mistaken for a broader statement of Medicaid objectives, it could not plausibly be read as a complete statement of those objectives. Section 1901 was enacted as part of the original Medicaid Act in 1965; it was last substantively amended in 1973, and then only modestly. *See* Pub. L. 93-233, 13(a)(1), 87 Stat. 947, 960 (1973) (amending Section 1901's reference to the "permanently and totally disabled" to a reference to the "disabled").[5] Medicaid has evolved dramatically since, and in particular, has evolved past the "purpose" stated in Section 1901.

At the time Medicaid and Section 1901 were enacted, Medicaid was characterized by a "'defined benefit' approach to coverage," Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. Health Care L. & Pol'y 5, 40 (2006); the Medicaid entitlement "consist[ed] of an entitlement to coverage encompassing a broad array

[5] A single subsequent technical amendment corrected Section 1901's reference to the Secretary of Health, Education and Welfare. *See* Pub. L. 98-369, 2663(j)(3)(C), 98 Stat. 494, 1171 (1984).

of specified benefits[.]" *Id.* at 41. These benefits were specified and defined in the definition of "medical assistance" discussed above, which in a real sense functioned at the time as the engine of the entire statute. *See id.* at 13. "[I]ndeed, the detailed nature of benefit specification [wa]s such that much of the Medicaid litigation . . . [in the] four decades" after its enactment focused on the details of the "medical assistance" definition. *Id.* at 41.

During that time, it may have made sense to say that Medicaid's purpose was the furnishing of medical assistance, as defined in the Act, to Medicaid beneficiaries. But that changed in 2006. That year, the Deficit Reduction Act of 2005 ("DRA"), which "mark[ed] a new chapter in the life of the Medicaid program," was signed into law. *Id.* at 35. The most dramatic change ushered in by the DRA was giving states the option to—with respect to certain Medicaid populations, including what would subsequently become the Medicaid expansion population—opt out of providing "medical assistance" as defined in the Act altogether and instead provide Medicaid beneficiaries what Congress called "benchmark coverage." 42 U.S.C. 1396u-7(a)(1)(A)(i).

As the name would suggest, such coverage was not defined by the services it covered, but by its equivalence to various acceptable "benchmarks" in the non-Medicaid market. Those benchmarks included the coverage offered to state employees, 42 U.S.C. 1396u-7(b)(1)(B), the coverage offered by a state's largest HMO, *see* 42 U.S.C. 1396u-7(b)(1)(C), or most dramatically vis-à-vis Medicaid's former defined-benefit approach to coverage, "[a]ny other health benefits coverage that the Secretary determines . . . provides appropriate coverage[.]" 42 U.S.C. 1396u-7(b)(1)(D). As one leading academic in the field put it, "this section authorize[d], for affected [populations], a shift from the 'defined benefit' approach to coverage that historically has characterized Medicaid to a 'defined contribution' system under which a state program would pay premium support for a

coverage product, with almost no specifications regarding the terms of coverage . . . [and] almost total discretion over actual benefit design[.]" Rosenbaum, *supra*, at 40–41.

The DRA also gave states the "option . . . [to] impose premiums and cost sharing" on certain classes of Medicaid beneficiaries, 42 U.S.C. 1396o-1(a)(1), with permissible coinsurance rates of up to twenty percent. *See* 42 U.S.C. 1396o-1(b)(2)(B). Congress further added that the limitations it placed on premiums and cost sharing should not be construed as limiting the Secretary's "authority . . . through waiver to modify [those] limitations," expressly contemplating and blessing Section 1115 demonstration projects in which the Secretary might permit even more cost sharing than Congress initially allowed. 42 U.S.C. 1396o-1(b)(6)(B). Finally, Congress mandated the Secretary to approve demonstration programs under which up to ten states would experiment with health opportunity accounts. *See* 42 U.S.C. 1396-8(a)(1)–(2)(A). Under these programs, Medicaid beneficiaries would pay a high deductible before obtaining any Medicaid benefits, *see* 42 U.S.C. 1396u-8(c)(1)–(2), after which they would use state-contributed funds in their account to pay for services. These programs were required to "[c]reat[e] patient awareness of the high cost of medical care," 42 U.S.C. 1396u-8(a)(3)(A), "[e]nabl[e] patients to take responsibility for health outcomes," 42 U.S.C. 1396u-8(a)(3)(D), and most tellingly for these purposes, "[p]rovid[e] incentives to patients to seek preventive care services," 42 U.S.C. 1396u-8(a)(3)(B), including by offering "additional account contributions for an individual demonstrating healthy prevention practices." 42 U.S.C. 1396u-8(a)(3).

In the Affordable Care Act, which enacted the Medicaid expansion, Congress called for further experimental incentives of healthy behavior in Medicaid. In the Medicaid Incentives for Prevention of Chronic Disease program, Congress required the Secretary to award states grants to give incentives to Medicaid beneficiaries for various "healthy behaviors," Pub. L. 111-148,

§ 4108(a)(1)(A)(ii), 124 Stat. 119, 561 (codified at 42 U.S.C. 1396a note)), including "[c]easing use of tobacco products," "[c]ontrolling or reducing their weight," "[l]owering their cholesterol," or successfully "[a]voiding the onset of diabetes[.]" Pub. L. 111-148, 4108(a)(3)(A), 124 Stat. 119, 561. Under this congressionally mandated arm of Medicaid, states paid Medicaid beneficiaries graded cash incentives if they lost seven to ten percent of their body weight, Centers for Medicare & Medicaid Services, *Medicaid Incentives for Prevention of Chronic Diseases: Final Evaluation Report* 41–42 (2017), https://downloads.cms.gov/files/cmmi/mipcd-finalevalrpt.pdf, hit specific blood pressure, blood sugar, or cholesterol levels, *id.* at 41, 44, reduced fat and caloric intake, *id.* at 42, or exercised a certain number of hours per week, *id.*, proved they had quit smoking by passing a carbon monoxide breathalyzer test, *id.* at 40, or joined Weight Watchers. *Id.* at 43–44.

Given these changes to Medicaid, Medicaid's objectives clearly are not limited to the purposes Congress listed when it enacted Section 1901 over fifty years ago. Medicaid cannot be plausibly described as solely concerned with "furnish[ing] . . . medical assistance" as defined in the Act, 42 U.S.C. 1396-1, when states now have the flexibility to offer alternate benefits that bear no resemblance to the Act's definition of medical assistance. Medicaid cannot be plausibly described as solely concerned with the maximization of coverage for the Medicaid-eligible when states now have the flexibility to require beneficiaries to pay large premiums, copays, and coinsurance payments. Most importantly, Medicaid cannot be plausibly described as solely concerned with the maximization of coverage to the exclusion of the broader pursuit of health when Congress *repeatedly mandated the Secretary to approve demonstration programs incentivizing Medicaid beneficiaries to act in the pursuit of their health*, including in ways that have nothing to do with the consumption or coverage of medical services.

As explained above, to the extent the purposes stated in Section 1901—an appropriations provision—conflict with the evident purposes of the substantive provisions of the Act, that conflict must be resolved in favor of the Act's substantive provisions. Those purposes do conflict. Therefore, Section 1901, however vital it may remain as a rough limit on the use of Medicaid funds, can no longer limit the Secretary's policy choices to those that would further Section 1901's stated "purpose." In short, Section 1901, however completely it may have spoken to Medicaid's purposes when it and Medicaid were enacted in 1965, plainly does not exhaust Medicaid's purposes today.

4. Section 1901 cannot be an unambiguous limit on the "objectives" of the Medicaid expansion because its stated purposes exclude the Medicaid expansion.

In addition to Section 1901's being a non-substantive appropriations provision, and the mismatch between the purposes of Medicaid appropriations listed in Section 1901 and the purposes of the program as a whole as it has evolved since the DRA, there is another and perhaps more basic reason that whether Section 1901 exhaustively states Medicaid's objectives is at least ambiguous. That, of course, is that Section 1901 says nothing about the purposes of the Medicaid expansion.

Rather, Section 1901 calls for "furnish[ing] (1) medical assistance on behalf of [traditional Medicaid populations covered by the program on the date of the section's enactment in 1965], and (2) rehabilitation and other services to help *such* families and individuals attain or retain capability for independence or self-care[.]" 42 U.S.C. 1396-1 (emphasis added). It simply does not state the purposes of Medicaid with respect to the Medicaid expansion population; as far as Section 1901 is concerned, Medicaid has no purpose to serve the Medicaid expansion population at all. Therefore, Section 1901 is simply not a place to look for unambiguous guidance at Chevron Step One on the Medicaid expansion's objectives.

Stewart admittedly rejected a variant of this argument. To the extent *Stewart* merely held that "the Medicaid statute . . . confirms that Congress intended to provide medical assistance to

the expansion population," *Stewart*, 313 F. Supp. 3d at 269, notwithstanding its failing to say so in Section 1901, Arkansas agrees. Just as it is clear from the substantive provisions of the Act that Medicaid has more objectives than those stated in Section 1901, it is equally clear from the Act's substantive provisions that *an* objective of the Medicaid expansion is the provision of medical assistance to the expansion population. Arkansas would also agree that Section 1901 is "inartfu[ly] draft[ed]," *id.* at 260 (quoting *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015)), and indeed contains a plain drafting error, inasmuch as it suggests that Medicaid appropriations cannot be spent on Medicaid expansion beneficiaries and other groups that have been made Medicaid-eligible since Section 1901's enactment.

Arkansas disagrees, however, with *Stewart*'s suggestion that the Medicaid expansion's purposes are somehow plainly *exactly the same* as those stated with respect to the original Medicaid populations in Section 1901, and therefore can be divined from a statute that says nothing about the Medicaid expansion at all. That is to say, Congress's failure to amend Section 1901 to cover the Medicaid expansion population is a plain drafting error, as was its failure to say that *a* purpose of Medicaid expansion appropriations is medical assistance. But whether Congress would have stated new purposes for the Medicaid expansion (or indeed for Medicaid as a whole) in addition to those listed in Section 1901 had it seen fit to amend 1901 is altogether unclear.

In this regard, Arkansas disagrees with *Stewart*'s declaration that "it is inconceivable that Congress intended to establish separate Medicaid programs, with differing purposes, for each" class of beneficiaries that Congress has added to Medicaid since Medicaid's enactment. *Stewart*, 313 F. Supp. 3d at 270. *Stewart* did not explain why a divergence in purpose between traditional Medicaid and the Medicaid expansion is inconceivable, and it seems quite conceivable in light of

the Supreme Court's holding in *NFIB v. Sebelius* that the Medicaid expansion *is* "a new health care program," 567 U.S. 519, 584 (2012), not just "a modification of the existing" one. *Id.* at 582.

In sum, though it is correct that Congress plainly committed drafting error in failing to state *some* appropriations purpose for the Medicaid expansion, and though it is correct too that furnishing medical assistance is plainly a component of that purpose, it cannot be inferred that had Congress corrected the error, it clearly would have simply interpolated the Medicaid expansion population into Section 1901 without any adjustment to the purposes stated there. Precisely what a statement of purpose for the Medicaid expansion would have looked like is unknowable. The Medicaid expansion's purposes can only be judged, not by assuming that Congress must have had just the same purposes for it that Congress stated for its precursor program in 1965, but by a review of the whole statute. Such a review reveals that though Congress plainly intended to provide insurance coverage to the Medicaid expansion population, it also generally sought to make them healthier, including by incentivizing them to engage in healthy behaviors apart from their consumption of covered medical services.

5. The Secretary reasonably interpreted Section 1901's stated purposes to encompass the objectives he identified.

Finally, even if Section 1901's statement of appropriations purpose for traditional Medicaid were an unambiguously exhaustive statement of the policy objectives of the Medicaid expansion, the fact remains that even those purposes can be reasonably read to underwrite the objectives the Secretary recognized. Section 1901 states *two* purposes, one of which is "furnish[ing] . . . rehabilitation and other services to help [traditional Medicaid populations] attain or retain capability for independence or self-care[.]" 42 U.S.C. 1396-1. The Secretary reasonably understood this language to state an objective of "economic self-sufficiency" (AR 4) and "beneficiary independ-

ence" (AR 6); *see also* AR 74 (noting, in letter to state Medicaid directors, that work and community-engagement requirements can help beneficiaries "rise out of poverty and attain independence, also in furtherance of Medicaid program objectives").

Plaintiffs have two responses to the Secretary's interpretation. The first is that "independence or self-care" unambiguously refers only to the ability to independently dress, bathe, and the like without assistance, given the context in which those terms are used. *See* Pls.' Mem. 17. Plaintiffs do not explain precisely what about the context of Section 1901 so limits these capacious terms, but presumably it is plaintiffs' view that because they are mentioned alongside medical assistance, they must take on some limited medical meaning.

This may be *an* interpretation that a differently led agency could reasonably advance, though Plaintiffs cite no case or agency pronouncement ever construing the terms their way. But it is far from unambiguously mandated by the terms' proximity to medical assistance. An equally contextual reading, and one supported by some law, is that "independence or self-care" means independence *from* needing state-furnished medical assistance because one's "income and resources are insufficient to meet the costs of necessary medical services," and "self-care" in the sense that one pays for one's healthcare oneself. 42 U.S.C. 1396-1.

Indeed, two circuits, in interpreting AFDC's former purpose section's eerily similar reference to "'self-support and personal independence,'" 42 U.S.C. 601 (1994), read it to state the purpose of "aid[ing] AFDC recipients in 'slaying their own personal welfare dragon,'" *C.K. v. N.J. Department of Health & Human Services*, 92 F.3d 171, 184 (3d Cir. 1996) (quoting *C.K. v. Shalala*, 883 F. Supp. 991, 1006 (D.N.J. 1995)), or advancing "the ideal . . . situation in which the

family 'breadwinner' would win the needed bread[.]"[6] *Aguayo v. Richardson*, 473 F.2d 1090, 1104 (2d Cir. 1973) (Friendly, J.) These courts did so notwithstanding that AFDC's purpose section also, in language reminiscent of Section 1901, stated the cross-cutting purpose of "furnish[ing] financial assistance and rehabilitation and other services . . . to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life[.]" 42 U.S.C. 601 (1994).

Plaintiffs also argue, following *Stewart*, that Section 1901's stated purpose "clearly limits its objectives to helping States furnish rehabilitation and other services that might promote self-care and independence," and that it "does not follow that limiting access to medical assistance would further the same end." *Stewart*, 313 F. Supp. 3d at 271 (emphasis in original). *Stewart* was quite right to observe that Section 1901's stated purpose is the furnishing of services that promote self-care and independence, not the promotion of self-care and independence by any means whatsoever. And *Stewart* was also correct inasmuch as its reasoning suggests that simply denying coverage to Medicaid beneficiaries in an effort to induce them to work for *employer* coverage would not be the provision of a service that promotes independence.

But what does not follow, respectfully, is that *conditioning access to state medical assistance* on independence-promoting behaviors (namely work and volunteering) is not, itself, the furnishing of a service "to help [Medicaid beneficiaries] attain or retain capability for independence or self-care[.]" 42 U.S.C. 1396-1. Rather, by offering a valuable service, namely Medicaid, that is conditioned on work or volunteering, Arkansas offers a service that encourages beneficiaries to attain or retain the capability for independence or self-care. Just as a school that expels students

[6] Both courts did so in the context of reviewing Section 1115 waivers, and in the instance of Judge Friendly's opinion, did so in the context of reviewing and upholding the approval of an experimental AFDC work requirement.

for violations of its strict honor code offers a service, education, that promotes the honesty of its students, and just as an insurer that kicks off its insureds if they smoke offers a service, insurance, that promotes tobacco abstinence, Arkansas offers a service, Medicaid, that promotes the community engagement that is a condition of its receipt.

II. The Secretary did not act arbitrarily or capriciously in determining that the Arkansas Works Amendment was likely to assist in promoting the objectives of the Medicaid Act.

A. The Secretary adequately examined whether the Arkansas Works amendment met the Section 1115 conditions.

Section 1115 allows the Secretary to approve a demonstration project if, "in the judgment of the Secretary," it "is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. 1315(a). As *Stewart* concluded, "Section 1115(a) asks whether a 'project' would promote the Act's objectives, not whether each component, 'viewed in isolation,' would." *Stewart*, 313 F. Supp. 3d at 260 (quoting *Wood v. Betlach*, 922 F.vSupp.2d 836, 843 (D. Ariz. 2013)). "While it may be relevant to the Secretary's determination whether any given component is consistent with the Act's objectives, he must ultimately determine whether, on balance, the project as a whole passes muster." *Id*.

Due to the inherently experimental nature of Medicaid demonstration projects, the Secretary is ultimately tasked with making a predictive judgment of whether a given project will assist in promoting the objectives of Medicaid. "The 'arbitrary and capricious' standard is particularly deferential in matters implicating predictive judgments[.]" *Rural Cellular Ass'n v. F.C.C.*, 588 F.3d 1095, 1105 (D.C. Cir. 2009). This is because, where an agency "must make predictive judgment about" the effects of a proposal such as the Arkansas Works Amendment, "certainty is impossible." *Id*. In circumstances involving agency predictions of uncertain future events, "complete factual support in the record for the [agency's] judgment or prediction is not possible or required,"

since "'a forecast of the direction in which future public interest lies necessarily involves deductions based on the expert knowledge of the agency.'" *Melcher v. FCC,* 134 F.3d 1143, 1151 (D.C. Cir. 1998) (quoting *FCC v. Nat'l Citizens Comm. for Broad.*, 436 U.S. 775, 813–14 (1978)*; see also BellSouth Corp. v. FCC,* 162 F.3d 1215, 1221 (D.C. Cir. 1999) ("When . . . an agency is obliged to make policy judgments where no factual certainties exist or where facts alone do not provide the answer, our role is more limited; we require only that the agency so state and go on to identify the considerations it found persuasive.") (quoting *Melcher*, 134 F.3d at at 1152).

Given the considerable uncertainty involved in an experimental demonstration project such as Arkansas Works, the Secretary's predictive judgment that the project would assist in promoting the objectives of Medicaid, and the assumptions involved in making that judgment, are entitled to enormous deference. *See* Jacob Gersen & Adrian Vermuele, *Thin Rationality Review*, 114 MICH. L. REV. 1355, 1406 (2016) (the Supreme Court's decision in *Baltimore Gas & Electric Co. v. NRDC*, 462 U.S. 87, 98–106 (1983), "made clear (1) that it is generally sufficient that an agency states the nature of its uncertainty—not that it resolve it; (2) that agencies are entitled to adopt any rational assumptions to cope with uncertainty, including highly optimistic assumptions, which are just as rational as highly pessimistic ones; and (3) that courts may not demand the impossible by requiring agencies to explain why they have chosen the assumptions they have, as opposed to other assumptions"). Under this deferential standard, the Secretary's approval easily passes muster.

1. Viewed in the light of the administrative record in this case—and not the administrative record in *Stewart*—the Secretary adequately analyzed the issue of coverage loss and promotion.

Plaintiffs, largely relying on *Stewart*, argue that the Secretary failed to adequately consider coverage loss and promotion. Their reliance is misplaced because of the differences between the administrative record in this case and that in *Stewart*. In *Stewart*, this Court held that the Secretary

"'entirely failed to consider' Kentucky's estimate that 95,000 persons would leave its Medicaid rolls" on account of Kentucky's work requirement. *Stewart*, 313 F. Supp. 3d at 260 (quoting *Motor Vehicles Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). In this case, Arkansas did not predict that its community-engagement requirement would cause significant coverage loss. In the absence of any prediction of significant coverage loss by the state, and unpersuasive, speculative comments from commenters predicting coverage loss for reasons that had little to do with the specifics of Arkansas's proposed demonstration project, the Secretary reasonably predicted that Arkansas's community engagement requirement for a valuable benefit would in the main successfully incentivize beneficiaries to gain employment.

In *Stewart*, in the face of Kentucky's own estimate that its "project would cause more than 95,000 people to leave its Medicaid rolls," *id.* at 262, the Secretary "never once mention[ed] the estimated 95,000 people who would lose coverage, which g[a]ve[] the Court little reason to think that he seriously grappled with the bottom-line impact on healthcare" of Kentucky's demonstration project. *Id.* at 263. The Court, therefore, had little difficulty concluding that the Secretary failed to consider an important aspect (coverage loss) of the problem before it.

Here, Arkansas made no projection of significant coverage loss. Commenters did predict coverage loss, however, *see* Pls. Mem. 18 (citing comments), and the Secretary acknowledged their predictions, writing that "[m]any commenters who opposed the community engagement requirement emphasized that the community engagement requirements would be burdensome for individuals and families or create barriers to coverage for non-exempt people who might have trouble accessing care." (AR 6). The Secretary responded, however, that he believed "the community engagement requirements create appropriate incentives for beneficiaries to gain employment." (*Id.*) He noted that the agency would "require Arkansas to provide written notices to

beneficiaries that include information [on] how to ensure that they are in compliance with the community engagement requirements" (*id.*), and that Arkansas would "implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements." (AR 7).

Then, responding to comments "express[ing] concern about the potential 9-month length of the non-eligibility period," the Secretary pointed out that such a sustained period of non-eligibility "would only occur" where an individual thrice failed to satisfy the requirement after receiving three monthly notices of non-compliance, and doubted that many beneficiaries would fail "to rectify" their non-compliance after being given "three opportunities" to do so. (AR 7). Ultimately, the Secretary predicted that "the overall health benefits to the effected population through community engagement outweigh the health-risks with respect to those who fail to respond and who fail to seek exemption from the program's limited requirements." (*Id.*). And the Secretary wrote that if this were not so, "including if data indicates that the community engagement features of this demonstration may not adequately incentivize beneficiary participation" (AR 6), or if "the agency determines that [the demonstration] is not meeting its stated objectives" (AR 7), the agency could suspend or terminate the demonstration at any time—obviously implying that the Secretary believed the community engagement requirement *would* adequately incentivize beneficiary participation. In short, the Secretary predicted that, contrary to the predictions of the commenters, Arkansas's community-engagement requirement was an "appropriate" and "adequate" incentive to successfully incentivize beneficiary participation in the main, such that the "health benefits [of] community engagement" for those that were successfully incentivized to engage would "outweigh the health-risks [for] those who fail" to satisfy the requirement and lost coverage.

Plaintiffs' submission to this Court is that that prediction was unreasonable.[7] But the comments on which Plaintiffs rely gave the Secretary little reason to conclude that Arkansas's powerful incentive to work or volunteer—the carrot of free health coverage, coupled with the stick of temporary disenrollment—would fail to, in most cases, have its intended and expected effect. For example, comments cited policy papers on weaker Medicaid incentives that were poorly publicized, merely tinkered with levels of cost-sharing, and were unrelated to community engagement (AR 1268), or papers that studied work requirements in welfare and acknowledged mixed opinion on their success or failure (AR 1269). Comments repeatedly pointed out (*e.g.*, AR 1278–79) that studies show many Medicaid beneficiaries who are unemployed report that illness, disability, taking care of sick family members, or full-time-student status are the reasons for their unemployment—but this was irrelevant to whether Arkansas Works beneficiaries would fail to comply with the community engagement requirement, given that the requirement exempts the medically frail, the disabled, full-time students, and people who are caring for the incapacitated. (AR 28). Commenters feared that beneficiaries suffering from chronic conditions might not be exempted (*e.g.*,

[7] Plaintiffs complain, in part, that this prediction fails for lack of specificity, and that the Secretary should have calculated a numerical estimate of precisely how many beneficiaries would lose coverage. But neither the state nor commenters provided him with such an estimate or data from which one could be derived. The Secretary cannot be faulted for failing to do the impossible. "It is one thing to set aside agency action under the [APA] because of failure to adduce empirical data that can readily be obtained. It is something else to insist upon obtaining the unobtainable." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009) (internal citation omitted). Moreover, this Court did not hold in *Stewart* that an estimate of this kind is required generally in a Section 1115 approval that might cause coverage loss. The reason that the Court faulted the Secretary for not creating such an estimate was due to Kentucky's estimate that 95,000 beneficiaries would lose coverage. *See Stewart*, 313 F. Supp. 3d at 263 (faulting the Secretary for relying on certain "guardrails" to minimize the effects of Kentucky's work requirement, but "never revis[ing] Kentucky's estimate on coverage loss with th[o]se [guardrails] in mind"). Here, there was no concrete estimate in the record that the Secretary was obligated to revise to find that Arkansas's program would promote Medicaid objectives.

AR 1290–92, 1294), but the agency specifically addressed these concerns by requiring (AR 28), as several commenters suggested (AR 1294, 1319), Arkansas to exempt the medically frail as that term is defined in 42 C.F.R. 440.315(f) to include "individuals with serious and complex medical conditions."

Finally, a number of commenters pessimistically predicted that the difficulties of monthly reporting would cause some individuals to lose coverage after failing to report compliance with the requirement for three months straight, *see* Pls. Mem. 19 (collecting comments), but gave little reason to support these dire predictions. In sum, nothing in the record made it unreasonable for the Secretary to predict, as he did, that the community engagement requirement would adequately incentivize community engagement for most recipients, with the result that the health effects of work and volunteering on the part of the successfully incentivized would outweigh the health costs of coverage loss on the part of those beneficiaries who failed to comply with the requirement over a protracted period of time.

Plaintiffs will no doubt argue, and already have, that post-approval data shows the Secretary erred in making that prediction. Post-approval data, however, is entirely legally irrelevant to whether the Secretary reasonably predicted that the community engagement requirement would adequately incentivize beneficiaries on the record before him. *See Fresno Mobile Radio, Inc. v. FCC*, 165 F.3d 965, 971 (D.C. Cir. 1999) ("Fresno makes no showing that the Commission's decision was unreasonable *ex ante*; rather, its argument is that the Commission's belief in the efficacy of bidding credits appears *ex post* to have been mistaken. Because this argument is not a challenge to the reasonableness of the agency's decision on the basis of the record then before it, Fresno's claim must fail."); *Rural Cellular*, 588 F.3d at 1107 ("[W]e judge the reasonableness of an agency's decision on the basis of the record before the agency at the time it made its decision.

Whether an agency's decision turns out to be mistaken *ex post* is of limited significance."). If Plaintiffs believe the Secretary's prediction was mistaken in light of post-approval data, their remedy is to request the Secretary to terminate or suspend the demonstration program in light of that data, as the Secretary said he could do if he determined the program was not working as he anticipated. (AR 6–7).

Plaintiffs also fault the Secretary for not specifically pointing out the aspects of the Arkansas Works Amendment that would *promote* coverage. *See* Pls.' Mem. 23–24. It is true that the Secretary's only specific reference to promoting coverage was his prediction that the waiver of retroactive coverage will encourage beneficiaries to maintain health coverage year-round, instead of waiting to sign up until they are sick. (AR 8). However, even this was not necessary, and certainly nothing more was required of the Secretary, under *Stewart*'s rationale. This is because Kentucky's 95,000 coverage loss estimate was central to *Stewart*'s faulting the Secretary for failing to consider coverage promotion. *See Stewart*, 313 F. Supp. 3d at 265. Noting that the Secretary was required to determine "that on balance the objectives [of Medicaid] considered together were likely to be advanced[,]" *Stewart* reasoned that the Secretary's relatively brief discussion of promoting coverage did not outweigh the agency's failure, as the Court saw it, to grapple with the issue of coverage loss as presaged by Kentucky's own projections. Here, Arkansas did not project significant coverage loss, the Secretary reasonably predicted that coverage losses would be limited and would be outweighed by the health benefits of community engagement on the part of those beneficiaries for whom the community engagement requirement worked as intended, and it was therefore unnecessary for the Secretary to find that coverage promotion would outweigh the costs of coverage losses.

2. The Secretary reasonably concluded that the Arkansas Works amendment would further the objectives of Medicaid.

In disputing the Secretary's conclusion that the Arkansas Works amendment would further the objectives of Medicaid, Plaintiffs seek to attack specific aspects of the Arkansas Works program, nitpicking the evidence in the record to substitute their judgment for the Secretary's. In doing so, they miss the forest for the trees. As *Stewart* concluded, "Section 1115(a) asks whether a 'project' would promote the Act's objectives, not whether each component, 'viewed in isolation,' would." *Stewart*, 313 F. Supp. 3d at 260 (quoting *Wood v. Betlach*, 922 F. Supp. 2d 836, 843 (D. Ariz. 2013)). The Secretary's conclusion that the Arkansas Works Amendment furthers the objectives is more than reasonable.

Work and community engagement requirement. First, Plaintiffs claim that the "literature Defendants cited does not show that working causes individuals' health to improve." Pls.' Mem. at 25. Yet with the exception of a citation to a single page of the Waddell study and two general characterizations of the Van der Noordt study, Plaintiffs do not engage with the literature on which the Secretary relied, instead simply contending that the Secretary should have been persuaded by different studies. In reality, both studies that the Secretary found persuasive provide ample support for the health benefits of working. *See, e.g.*, AR 1759 (Waddell) ("[T]here is a strong association between worklessness and poor health"); AR 1772 (Waddell) ("There is a strong, positive association between unemployment and . . . [i]ncreased rates of overall mortality and, mortality from cardiovascular disease, lung cancer and suicide."); AR 1774 (Waddell) ("The mortality rate of unemployed young people is significantly higher[.]"); AR 1780 (Waddell) (finding that a meta-analysis of work/health studies showed that "re-employment leads to improved health in all age groups," that eight of eleven high-quality studies indicated this correlation was not a function of

health selection effects, and that "the balance of the evidence is that health improvements are (at least to a large extent) a direct consequence of re-employment") (citations omitted); AR 1689 (Van der Noordt) ("All six high-quality studies [reviewed[. . . found a significant protective effect of employment on depression[.]"); AR 1690 (Van der Noordt) ("Six studies examined the relationship between the employment and general mental health, and all four high-quality studies found a positive effect of employment, leading to strong evidence."). The administrative record also contains evidence regarding the benefits of volunteering, which Plaintiffs ignore. *See* (AR 1703–04, 1719).

Second, Plaintiffs engage in further cherry-picking regarding the effect of work requirements on employment, ignoring the evidence that contradicts their position and relying on largely repetitive comments that often rely on the same underlying studies. *See* AR 1269 (linking to CBPP paper which acknowledges arguments that work requirements in TANF "have been a huge success");[8] AR 1400 (MACPAC paper writing that TANF's work requirements helped increase employment). *Third*, Plaintiffs criticize the Secretary's ultimate predictive judgment that "the overall health benefits to the effected population through community engagement outweigh the health-risks with respect to those who fail to respond and who fail to seek an exemption from the programs limited requirements." Pls.' Mem. 26–27 (citing AR 7). But Plaintiffs' criticism is nothing more than an argument that the Secretary should have taken their view of the evidence in the record.

Retroactive coverage. Plaintiffs also claim that the Secretary lacked a rational basis to approve a waiver of retroactive coverage. In approving this component of Arkansas Works, the Secretary predicted that it will "encourage beneficiaries to obtain and maintain health coverage, even when healthy." (AR 8). The Secretary intended to test whether this will "increase continuity

[8] https://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf

of care by reducing gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick[.]" (*Id.*) This straightforward reasoning adequately establishes the Secretary's rational basis for waiving retroactive coverage. Plaintiffs' argument that the Secretary failed to respond to comments about how waiving retroactive coverage could create gaps in Medicaid coverage and create financial problems for would-be enrollees, Pls.' Mem. 29, ignores the Secretary's response on this point, including his predictive judgment about the expected outcome of waiving retroactive coverage, as well as the fact that the entire point of a demonstration project is to put such predictions to the test.

B. The Secretary had statutory authority to approve the Arkansas Works Amendment.

In addition to arguing that the Secretary misidentified the objectives of Medicaid in approving the Arkansas Works Amendment, that the Secretary failed to adequately consider coverage loss, and that the Secretary arbitrarily found that the Amendment would further the objectives of Medicaid the Secretary identified, Plaintiffs argue that the various features of the Amendment were simply beyond the Secretary's power to approve under Section 1115. Plaintiffs are mistaken in each instance.

1. The Secretary has ample authority to approve work requirements.

Plaintiffs first argue that the Secretary lacked Section 1115 authority to approve the community-engagement requirement. Their first reason for this conclusion is textual; the Secretary, Plaintiffs say, only has authority to negatively "waive compliance" with certain requirements of the Medicaid Act, 42 U.S.C. 1315(a)(1), not to approve the imposition of new requirements external to the Act. Pls.' Mem. 30.

In the first place, it is unclear that the Secretary's Section 1115 authority is limited to merely waiving compliance with select provisions of the Act, as opposed to approving "any experimental, pilot, or 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). Arkansas would read 1115's provision authorizing the Secretary to waive compliance with the requirements of 42 U.S.C. 1396a as a feature of the Secretary's demonstration-project-approval power, not as a limit on it to such waivers (though it does mean that his *waiver* power is limited to waiving Section 1396a requirements).

That said, the Secretary's approval of the community-engagement requirement was a waiver of compliance with Section 1396a requirements. The Secretary explained (AR 12) that in approving the community-engagement requirement, he was waiving the requirements of 42 U.S.C. 1396(a)(8) and (a)(10), which provide that medical assistance must be made available "to all eligible individuals." 42 U.S.C. 1396(a)(8). What the Secretary permitted Arkansas to do was to provide medical assistance to only a subset of those individuals—members of the Medicaid expansion population who satisfied the community-engagement requirement, or were exempt from it. That was a waiver of the requirement that, insofar as a state opts into the Medicaid expansion, it must provide medical assistance to *all* members of the Medicaid expansion population. In the past administration, the Secretary similarly approved at least three Section 1115 demonstration projects under which Medicaid expansion beneficiaries would be disenrolled if they failed to pay premiums. *See* Sidney D. Watson, *Premiums and Section 1115 Waivers: What Cost Medicaid Expansion?*, 9 St. Louis U.J. Health L. & Pol'y 265, 272, 277, 279–80 (2016). Under Plaintiffs' theory, these projects would also be unlawful because the Secretary approved requirements for coverage extrinsic from the Act's eligibility requirements.

Plaintiffs also claim that the Secretary's waiver authority does not permit him to, even on an experimental basis, "'transform' or 'restructure' the scheme Congress has enacted," Pls.' Mem. 31, and that had Congress wished to give the Secretary that authority, it would have done so expressly. But that is exactly what Congress did; Congress expressly gave the Secretary the authority to, on an experimental basis, "waive compliance with *any of the requirements*" of the central provision of the Act, 42 U.S.C. 1396a. 42 U.S.C. 1315(a)(1) (emphasis added). The Secretary may not, of course, restructure the program on a permanent basis nationwide, but he may approve an individual state's experimental "restructuring" of the program so long as such restructuring does not entail waiver of the Act's requirements contained in provisions other than Section 1396a.

Plaintiffs next rely on the Supreme Court's decision in *MCI Telecommunications Corp.* for the proposition that the power to waive any of the Act's requirements is not a power to experimentally "transform" Medicaid, but of course, *MCI* famously held that the phrase "*modify* any requirement," 47 U.S.C. 203(b)(2) (emphasis added), only permitted the FCC, as a matter of common dictionary definitions, "to change [any requirement] moderately or in minor fashion." *MCI Telecomm. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 225 (1994). "Waive," by contrast, is defined in the context of waiving rules, as Plaintiffs themselves note, as refraining from requiring compliance with a rule—which is to say, suspending a rule altogether. *See* Pls. Mem. 30.

Plaintiffs next point out that Congress has included work requirements in other entitlements and chose not to include them in Medicaid. *See* Pls. Mem. 31–33. Quite so; no one would suggest that work requirements are presently a feature of Medicaid generally, which is why the Secretary had to *waive the requirements* of the Act to approve Arkansas's. And that is precisely the point: Section 1115 demonstration projects are all about the approval of state Medicaid programs that are in some respect non-compliant with the Act absent a waiver of its requirements.

Finally, Plaintiffs claim that the Secretary has previously "interpret[ed] . . . work requirements as *outside* [his] own Section 1115 waiver authority[.]" Pls.' Mem. 34. This is incorrect. What the Section 1115 disapprovals Plaintiffs cite, *see id.* at 34 n.19, all said was that the proposed work requirements "could undermine access to care and do not support the objectives of the program[.]" Letter from Andrew M. Slavitt, Acting Adm'r, Cntrs. For Medicare & Medicaid Servs., HHS to Thomas Betlach, Dir. Az. Health Care Cost Containment Sys. (Sept. 30, 2016), http://bit.ly/2PHb0Ek. Rather than saying he lacked legal authority to approve work requirements, the Secretary merely said that in his judgment the *particular* work requirements proposed would not support the program's objectives, which implicitly assumes the Secretary *does* have Section 1115 authority to approve them, notwithstanding their "restructuring" of the program, so long as the Secretary found as a factual matter that they would promote Medicaid objectives. New agency leadership, making a different predictive judgment about the health effects of community-engagement requirements, simply made a different judgment in this case.

2. The Secretary had authority to approve the online-only reporting requirement, and Plaintiffs lack standing to challenge it.

Plaintiffs also claim that the Secretary lacked authority to approve the online reporting requirement. Besides joining in the Secretary's defense on the merits of his approval of that requirement, Arkansas believes the Plaintiffs lack standing to challenge it. In May 2018, several months *before* Plaintiffs filed this action, Arkansas elected to allow Arkansas Works beneficiaries to report compliance with, or exemptions from, the community-engagement requirement by phone to registered reporters with their insurance carriers, or in person at county offices of the state Department of Human Services. *See* Franklin Decl. at ¶¶ 11–15. The injury Plaintiffs claim the Secretary's approval of online-only reporting has caused them is that they cannot report or can only report with difficulty because they cannot report online or find online reporting difficult, but

thanks to Arkansas's implementation choices, that is simply not the case; they may report by telephone or in person. And while Plaintiffs claim that Arkansas is required by statute to permit reporting by mail, as well as in person, online, or by telephone, *see* Pls. Mem. 34, not one of the Plaintiffs has complained that they cannot report for want of a mail reporting option. Rather, each of their declarations that touches on reporting solely complains of difficulties with online reporting[9]—an injury the Secretary's approval has not caused them, because Arkansas does not require online reporting.

3. The Secretary has authority to waive the retroactive coverage requirement.

Finally, Plaintiffs claim that the Secretary lacks the authority to waive Medicaid's requirement of three months of retroactive coverage. In making that argument, they really make two arguments—that the Secretary could not waive the retroactive coverage requirement and that he unwittingly failed to. In arguing that he could not waive the requirement, Plaintiffs say that the Secretary's Section 1115 waiver authority is limited to the requirements of Section 1396a, that "medical assistance" is defined to require three-month retroactive coverage, *see* 42 U.S.C. 1396d(a) (defining medical assistance to require coverage "in or after the third month before the month in which the recipient makes application for assistance"), and that the Secretary can therefore not waive the retroactive coverage requirement. The problem with that argument is that the inert definition of medical assistance does not by itself require retroactive coverage. Rather, on Plaintiffs' own view, it is the operative provisions of Section 1396a that require the furnishing of medical assistance as defined in section 1396d that require retroactive coverage. The Secretary *does* have authority to waive *those* provisions.

[9] *See* Docs. 27-2 ¶ 11, 27-3 ¶ 8, 27-4 ¶ 15, 27-5 ¶ 9, 27-6 ¶ 8, 27-7 ¶ 10, 27-8 ¶ 8, 27-9 ¶ 10. Many of these declarations acknowledge that various plaintiffs own phones, albeit ones with limited Internet access.

Plaintiffs also claim that the Secretary failed to waive section 1396(a)(a)(10), which requires the provision of medical assistance as defined in section 1396d, with respect to retroactive coverage. The Secretary, however, *did* waive Section 1396a(a)(34) (AR 12), which is the sole provision of Section 1396a that requires retroactive coverage by its own express terms. Plaintiffs claim that is insufficient. On Plaintiffs' view, 1396a(a)(34) is a total redundancy given 1396a(a)(10)'s implicit incorporation of the definition of medical assistance. Even were Plaintiffs correct about that, it is clear that the Secretary intended to waive such provisions of Section 1396a as had to be waived to permit a reduction in retroactive coverage, clear that the Secretary had the power to do so, and any inadvertent failure to waive provisions of Section 1396a that redundantly require retroactive coverage should be treated as harmless given his waiver of the 1396a provision that primarily speaks to that requirement.

III. The proper remedy for any deficiency in the Secretary's approval of Arkansas Works is a remand without vacatur.[10]

Even if this Court determines that the Secretary's decision to approve the Arkansas Works amendment is deficient, the Court should remand to the agency without vacating the approval. As *Stewart* recognized, even where an agency decision is remanded to the agency, remand without vacatur may be appropriate in some circumstances, *see Stewart*, 313 F. Supp. 3d at 273—circumstances present here. This Court applies the two-factor test in *Allied-Signal, Inc. v. U.S. Nuclear Regulatory Commission*, which measures the "seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change." 988 F.2d 146, 150–51 (D.C. Cir. 1993) (citation omitted). Both factors favor a remand without vacatur.

[10] Arkansas concurs with the Federal Defendants' arguments regarding the challenge to the SMD Letter and under the Take Care Clause. *See* DOJ Br. at 29–33.

In some cases, the first factor clearly counsels in favor of vacatur. Vacatur is, of course, warranted where an agency "cannot arrive at the same conclusions reached" in its first decision "because the actions taken were not statutorily authorized." *Children's Hosp. Ass'n of Tex. v. Azar*, 300 F. Supp. 3d 190, 211 (D.D.C. 2018) (quoting *Humane Soc'y of the United States v. Jewell*, 76 F. Supp. 3d 69, 136 (D.D.C. 2014)). As explained above, the decision to approve the Arkansas Works Amendment was well within the Secretary's statutory authority. *See supra* at § I. Even *Stewart* did not go so far as to hold that "the Secretary can never approve demonstration projects" of the kind at issue here. *Stewart*, 313 F. Supp. 3d at 273.

However, where "[c]orrecting" the "flaw" in its decision merely requires that the agency "better articulate [its] reasoning[,]" courts decline to grant vacatur. *Standing Rock Sioux Tribe v. U.S. Army Corps of Eng'rs*, 282 F. Supp. 3d 91, 98 (D.D.C. 2017). This flows from the principle that agencies should "be 'afforded a reasonable opportunity to provide a reasoned explanation' of their choices." *Id.* (quoting *Am. Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 242 (D.C. Cir. 2008)) (alterations omitted). Even where the deficiency of an agency decision is "not insignificant[,]" remand without vacatur is appropriate where there is a "serious possibility" that the agency can adequately explain its decision on remand. *Milk Train, Inc. v. Veneman*, 310 F.3d 747, 756 (D.C. Cir. 2009) (quoting *Allied Signal*, 988 F.2d at 151).

That the Secretary can correct any deficiencies identified by the Court is demonstrated by the reapproval of Kentucky HEALTH following *Stewart*. After *Stewart* held that the Secretary "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens," *Stewart*, 313 F. Supp. 3d at 243, CMS opened a new 30-day comment period to allow stakeholders an opportunity to weigh in on the issues raised in the Court's decision. On November 20, 2018, CMS once again approved Kentucky HEALTH, providing a

more robust explanation for its conclusion that approval will further the objectives of Medicaid. The Court can be confident that any deficiencies found in the Secretary's approval if the Arkansas Works can be similarly addressed on remand. This factor therefore weighs against vacatur while they agency has the chance to address any deficiencies on remand.

The second *Allied-Signal* factor also strongly weighs against vacatur. In determining that vacatur was warranted, *Stewart* relied exclusively on the fact that Kentucky HEALTH had yet to take effect for the proposition that vacatur would not "be particularly disruptive." 313 F. Supp. 3d at 273. On the other hand, *Stewart* indicated that allowing the program to take effect would be disruptive for the plaintiffs in that case. *Id*. Thus, *Stewart* was merely "preserving the status quo" by vacating the approval while the Secretary gave further consideration to the program. *Id*.

Here, on the other hand, Arkansas began implementing Arkansas Works in June 2018. By the time this Court rules on the motions for summary judgment in this case, the program will have been in effect for at least the better part of a year, if not longer. The balance of disruption is the exact opposite as in *Stewart*, as vacatur would put on hold a program that state officials have expended considerable time and energy implementing, while allowing the program to continue would preserve the status quo.

Vacatur would have seriously detrimental effects on Arkansas's implementation of Arkansas Works. State officials have engaged in extensive efforts to educate Arkansas Works beneficiaries on the work and community engagement requirements, including whether particular beneficiaries are required to report compliance or are exempt from the requirements, and how to report compliance. These efforts have been ongoing since shortly after the Arkansas Works amendment was approved.

Vacating the approval while the Secretary revisits the decision on remand would be disastrous for Arkansas's education and outreach efforts. If the program is vacated, and the work and community engagement requirements put on hold, state officials will be tasked with informing beneficiaries of the changed circumstances. Once the program is reapproved after remand, state officials would be forced to start all over in informing beneficiaries of the work requirements, sowing confusion among those who would be told that the requirements are no longer in effect, before being told that those same requirements once again apply. That confusion cannot be undone; once that "egg has been scrambled[,]" state officials cannot simply "restore the status quo" with further outreach efforts. *Sugar Cane Growers Co-op. of Fla. v. Veneman*, 289 F.3d 89, 97 (D.C. Cir. 2002).

Vacatur would not only tax the resources of state officials; it would undermine the education and outreach efforts of the community and professional organizations the state has partnered with in implementing Arkansas Works. *See* Franklin Decl. at ¶¶ 18–20. Further, unlike the program at issue in *Stewart*, Arkansas Works provides coverage through private insurers by paying premiums on behalf of beneficiaries. These insurers are not only involved in Arkansas Works by providing health insurance to beneficiaries, but also serve as registered reporters in order to assist beneficiaries with complying with the work and community engagement requirements. Franklin Decl. ¶¶ 12–13.

If any deficiencies are found in the Secretary's decision to approve the Arkansas Works amendment, the Court should, as it did in *Stewart*, keep the status quo in place while the Secretary addresses those deficiencies. Here, that requires remand without vacatur. The drastic disruptive consequences that would otherwise inure are unwarranted in light of the fact that any deficiency

in the Secretary's approval of the Arkansas Works amendment would doubtlessly be remedied on remand, as shown by the Secretary's recent reapproval of Kentucky HEALTH.

CONCLUSION

For the reasons explained above, the Court should deny Plaintiffs' motion for summary judgment and grant Arkansas's motion for summary judgment.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that November 30, 2018, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which shall send notification of such filing to any CM/ECF participants.

/s/ *Dylan L. Jacobs*

Dylan L. Jacobs

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM, et al. **PLAINTIFFS**

v. **No. 1:18-cv-01900JEB**

ALEX M AZAR, et al. **DEFENDANTS**

STATE OF ARKANSAS **DEFENDANT-INTERVENOR**

DECLARATION OF MARY FRANKLIN

The undersigned, Mary Franklin, having been duly sworn, states upon oath and affirmation as follows:

1. I am over 18 years of age, of sound mind and capable of making this Affidavit.

2. I am employed with the Arkansas Department of Human Services for twenty six years, and have been the Director of County Operations for the Arkansas Department of Human Services ("DHS") since 2016. In the course of my employment, I have overseen the operational implementation of the Arkansas Works program.

Medicaid Expansion in Arkansas

3. In September 2013, Arkansas became the first state in the country to receive approval from CMS for a Section 1115 demonstration waiver to provide coverage to the Medicaid expansion population through a private option plan. Instead of providing benefits on a traditional fee-for-service model, enrollees are, with few exceptions, enrolled into private insurance plans, with the state paying the premiums on behalf of enrollees. Health plans that participate in Arkansas's Medicaid expansion are known as Qualified Health Plans ("QHP").

4. Arkansas Works was first created in 2016 as an amendment to Arkansas's Medicaid demonstration project. The program sought to increase community engagement among Medicaid expansion enrollees, particularly by incentivizing enrollees to seek employment. As relevant here, beginning in January 2017, each month, DHS referred everyone who had been approved or renewed in Arkansas Works to the Arkansas Department of Workforce Services, allowing enrollees to voluntarily seek assistance with job training and job placement.

5. The results of the work referral program were disappointing. By October 2017, only 4.7 percent of enrollees acted upon the referral and used the offered services. Of those that did, 23 percent became employed through the process.

6. In an effort to further incentivize participation in community engagement activities, Arkansas submitted an amendment to its demonstration waiver requiring certain able-bodied adults without dependents to participate in work and community engagement ("WCE") requirements. CMS, in approving Arkansas's waiver amendment, recognized that "referrals alone, without any further incentive, may not be sufficient to encourage the Arkansas Works population to participate in community engagement activities."[1]

7. CMS therefore approved Arkansas's plan to "require all Arkansas Works beneficiaries ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility."[2]

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[1] Doc. 1-3 at 3–4.

[2] *Id.* at 1.

Work and Community Engagement Reporting

8. I understand that Plaintiffs have taken issue with various aspects of the reporting procedures for reporting WCE activities and exemptions, the online portal system in particular. I wish to clear up a number of misconceptions about the program.

9. DHS submitted, and CMS approved, an online-only reporting system for WCE activities and exemptions. DHS implemented an online reporting system through the Access Arkansas portal.[3] This portal is used to apply for or renew enrollment in a number of state programs, including Supplemental Nutrition Assistance Program (SNAP), Transitional Employment Assistance (TEA, also known as Arkansas's TANF Program), and traditional Medicaid, in addition to Arkansas Works. Through the Access Arkansas portal, Arkansas Works beneficiaries are able to report WCE activities and exemptions. This portal is accessible via a computer, in addition to most smartphones and tablets.

10. DHS has provided beneficiaries with detailed, step-by-step guides for creating an account on the Access Arkansas website, logging information into the website, and reporting WCE activities and exemptions online.[4] To improve accessibility for those with limited access to personal computers, smartphones, or tablets, DHS maintains an online directory of publically-accessible computers.[5]

11. Shortly after CMS approved the Arkansas Works demonstration project, DHS expanded the reporting options for beneficiaries beyond online-only reporting, inasmuch as Arkansas Works beneficiaries have options for reporting CWE activities and exemptions other than logging into the Arkansas Works portal themselves to report.

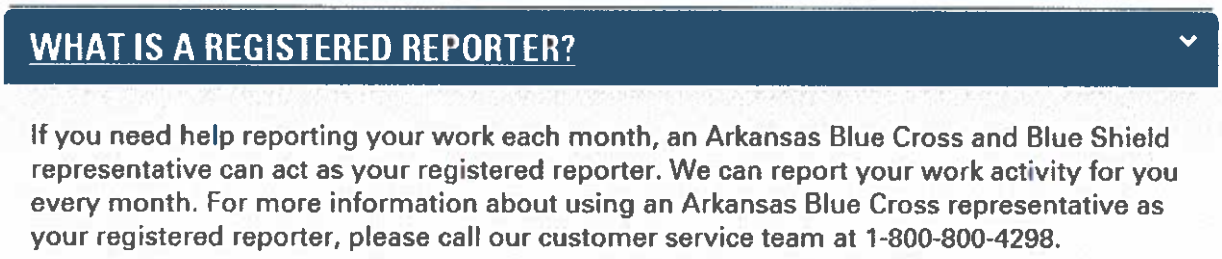
[3] https://access.arkansas.gov

[4] https://ardhs.sharepointsite.net/ARWorks/default.aspx

[5] http://agio.maps.arcgis.com/apps/webappviewer/index.html?id=2dfe5be5db6844f2b8a2f6dcd7338388

12. A beneficiary may designate another individual as a registered reporter—an authorized representative who may report WCE activities and exemptions through the online portal on behalf of the beneficiary.[6] Individuals complete two online training modules in order to become registered reporters. Participating health plans, in addition to some providers, have individuals on staff who serve as registered reporters for Arkansas Works beneficiaries. There are currently over 240 registered reporters in the state.

13. Beneficiaries may contact their health plan via telephone and report WCE activities and exemptions to a registered reporter on staff. For example, Arkansas BlueCross BlueShield, an Arkansas Works QHP, has the following information on its website:[7]



Thus, even beneficiaries who do not have access to a computer, or even a smartphone or tablet, are able to report WCE activities and exemptions through their insurance carrier. Carriers have a strong incentive to assist their customers in meeting WCE reporting requirements because the carrier no longer receives premiums paid on behalf of individuals who are disenrolled from Arkansas Works for failure to comply with WCE requirements.

14. A beneficiary may visit a DHS county office, where kiosks are available and staff can assist the beneficiary in reporting WCE activities and exemptions. Staff can walk beneficiaries through each step of the process of creating an account on the Access Arkansas website, logging information into the website, and reporting WCE activities and exemptions

[6] *See* 42 CFR 435.945(a) (allowing agencies to accept attestations from "an authorized representative").

[7] https://www.arkansasbluecross.com/members/arkansasworks.aspx

online through the portal. Staff are also available at 86 county offices across the state via telephone to answer any questions beneficiaries may have between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday. In addition to these hours DHS operates a call center between the hours of 7:00 a.m. and 9:00 p.m. seven days per week.

15. Finally, in the case of exemptions, certain changes in status that result in exemptions are recorded automatically. Medicaid beneficiaries, both traditional and Arkansas Works, are required to report, within 10 days, changes in circumstances that may affect program eligibility, such as a change in employment, increase in wages, change in household composition, or the addition or reduction of dependents, among others. Beneficiaries may submit these changes in person, via phone, fax, email, or by paper form. When DHS staff loads this data into DHS' system, that information is automatically updated in the Arkansas Works portal and visible to the beneficiary when he or she logs in.

16. Many of these changes in circumstances also impact whether a beneficiary is exempt from the WCE requirement. If a beneficiary reports any change in circumstances that results in him or her being exempt from the monthly WCE reporting requirement, that exemption is automatically processed and updated in the Arkansas Works portal. The beneficiary need not separately log in to the Arkansas Works portal to report this exemption. Additionally, beneficiaries who are also enrolled in SNAP have no additional reporting requirements to report separately to the Arkansas Works Program. In other words, beneficiaries who meet the work requirement in SNAP need not do anything further to satisfy the WCE requirement in Arkansas Works. This is possible because DHS shares system data between SNAP and Arkansas Works.

Outreach and Educational Efforts

17. In its approval of Arkansas Works, CMS required the state to "implement an outreach strategy to inform beneficiaries how to report compliance" with WCE requirements.[8]

18. Beginning March 15, 2018, DHS has engaged in extensive outreach efforts to educate Arkansas Works beneficiaries on the WCE requirements and how to report compliance. In doing so, DHS has partnered with the Qualified Health Plans who serve Arkansas Works beneficiaries under Arkansas's private-coverage scheme. These providers have an incentive to ensure that their customers maintain compliance with the WCE requirements. DHS has also partnered with the Arkansas Department of Workforce Services to assist with outreach and education, provide career assessments, job-search assistance, and referrals for training as appropriate. Additionally, DHS has engaged with numerous professional and community organizations. Finally, DHS has contracted with Arkansas Foundation for Medical Care ("AFMC") to provide outreach services for Arkansas Works beneficiaries.

19. During the April – June 2018 quarter, DHS and its partners outreach efforts have included:[9]

a. Press releases and media advisories to the public;

b. Letters sent to Arkansas Works enrollees whose WCE requirements were to start in June, followed by multiple other mailings, along with texts and emails;

c. Outbound telephone calls by AFMC to Arkansas Works beneficiaries whose WCE requirements were beginning and for whom reporting would be required, totalling over 86,000 calls;

d. Informational flyers and materials;

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[8] *See* Doc. 1-3 at 6.

[9] *See* Arkansas Works Quarterly Report, April 1, 2018 – June 30, 2018, *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-qtrly-rpt-apr-jun-2018.pdf

e. Presentations, webinars, and trainings with community organizations, advocacy groups, higher education institutions, professional and medical associations, librarians, and other state governmental agencies;

f. Information and videos posted online through social media as well as a public Arkansas Works SharePoint site.

20. DHS sends a weekly file to AFMC and the Department of Workforce Services that includes every Arkansas Works beneficiary and the beneficiary's WCE status. DHS also sends a weekly file to each Qualified Health Plan specific to the Arkansas Works beneficiaries who are covered in their plan. In addition, DHS also sends a daily file to AFMC that includes new Arkansas Works beneficiaries who were enrolled the previous day. DHS sends these files to facilitate and assist them with tailoring outreach and education efforts

21. In sum, DHS has made every effort to ensure that Arkansas Works beneficiaries are aware of the WCE requirements and how to report compliance.

Work and Community Engagement Exemptions

22. I understand that the Plaintiffs have criticized the approval of the Arkansas Works program due to certain subsets of the population who have certain medical conditions having difficulties meeting WCE requirements, claiming that comments to this effect were ignored by CMS.[10] In fact, CMS did address this concern. In its approval, CMS required DHS to exempt those Medicaid Expansion beneficiaries who meet the criteria for being "medically frail"—as defined by federal regulations— from WCE requirements,[11] among a myriad list of required exemptions. The definition of "medically frail" includes, among other things, "individuals with serious and complex medical conditions."[12]

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[10] *See* Doc. 27-1 at 21–22.

[11] *See* Doc. 1-3 at 27, ¶ 49 (requiring exemptions for "[b]eneficiaries identified as medically frail (under 42 CFR 440.315(f) and as defined in the alternative benefit plan in the state plan)).

[12] *See* 42 CFR 440.315(f).

23. CMS also required DHS to allow reporting of exempt populations in accordance with federal regulations, which allows for "attestation of information needed to determine eligibility" by the individual, an adult in the same household, or a family member.[13] Thus, those who meet the criteria for being "medically frail" may attest to this through the online reporting system (or as described above) and qualify as exempt from the WCE requirements. No supporting documentation is required at the time a beneficiary reports an exemption, although DHS does engage in quality-control efforts to verify beneficiaries' exemption status.

Procedures Regarding Noncompliance

24. When a beneficiary who is subject to the WCE requirement fails to report qualifying WCE activities or an exemption, he or she is deemed noncompliant for that month. The beneficiary will receive notices from DHS notifying him or her of the noncompliance, including information on how to report WCE activities and exemptions. Additionally, the beneficiary will be the target of outreach efforts discussed above.

25. If a beneficiary accrues three months of noncompliance with the WCE requirement, he or she is disenrolled from Arkansas Works. The individual is ineligible for Arkansas Works during the same calendar year he or she is disenrolled, but is eligible for coverage again the following January. Thus, any beneficiaries who have currently been disenrolled, assuming they still qualify for the program, may restart coverage in January 2019 and comply with the WCE requirements.

26. Generally, disenrolled beneficiaries must wait until January 1 of the following year, when they are again eligible for Arkansas Works, to be enrolled into the program. However, when the open enrollment period for the Arkansas Insurance Marketplace begins each year, DHS will process applications from individuals who were previously disenrolled from

[13] 42 CFR 435.945(a).

Arkansas Works, and if approved, coverage will automatically begin on January 1 of the following year. Thus, the individual does not need to wait until January 1 to actually apply. In 2018, the open enrollment period began on November 1, 2018.

27. Even where a beneficiary is disenrolled for noncompliance, he or she has a number of options including an appeal or requesting a good cause exemption.[14] If a beneficiary demonstrates good cause for failing to meet the WCE hours required for a noncompliant month, and the beneficiary is granted a good cause exemption, DHS will retroactively remove the noncompliance for that month.

28. As an illustration, Plaintiff Adrian McGonigal sought and received a good cause exemption. This resulted in reenrollment in Arkansas Works retroactive to October 1, 2018. McGonigal will be classified as medically frail as of December 1, 2018, and will be exempt from WCE requirements. In other words, McGonigal is currently receiving coverage through the Arkansas Works program, is exempt from the WCE requirement, and will continue to be exempt so long as McGonigal's medically frail status does not change.

29. DHS also sends an informational letter to all Arkansas Works beneficiaries whose coverage ends due to noncompliance with the WCE requirements explaining healthcare options through the good cause exemption process, other Medicaid categories, the Federally Facilitated Marketplace, Federally Qualified Health Centers, or other community health centers.

FURTHER AFFIANT SAYETH NOT.

[14] The bases for a good cause exemption can be found in STC ¶ 53(a) of Arkansas's waiver approval. Doc. 1-3 at 29.

Mark Franklin

11/30/2018

Date

Subscribed and Sworn before me a Notary Public this 30th day of November, 2018.

Kitten L. Dixon

NOTARY PUBLIC

Official Seal
Kitten L. Dixon
Notary Public - Arkansas
Pulaski County
Commission #12389970
My Commission Expires 09/25/2022

My Commission Expires: 9/25/22

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM, et al. **PLAINTIFFS**

v. **No. 1:18-cv-01900JEB**

ALEX M AZAR, et al. **DEFENDANTS**

STATE OF ARKANSAS **DEFENDANT-INTERVENOR**

[PROPOSED] ORDER

This matter is before the Court on the motion of the State of Arkansas for summary judgment and the motion of Plaintiffs for summary judgment. The Court GRANTS Arkansas's motion for summary judgment and DENIES Plaintiffs' motion for summary judgment. Plaintiffs' claims are DISMISSED WITH PREJUDICE.

SO ORDERED this ____ day of _____, 2018.

_____
HON. JAMES E. BOASBERG
UNITED STATES DISTRICT JUDGE