UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 1:18-cv-152 (JEB)
	)	
	)	
ALEX M. AZAR II, *et al.*,	)	
	)	
Defendants.	)	

COMMONWEALTH OF KENTUCKY'S MEMORANDUM IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT & RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

This case is an unprecedented attack on a waiver approved under Section 1115 of the Social Security Act. Although Plaintiffs accuse the Secretary and the Commonwealth of Kentucky of using Section 1115 to fundamentally alter Medicaid, it is Plaintiffs' arguments that, if adopted, would drastically rewrite Section 1115 and Medicaid more generally. Almost every challenged component of Kentucky HEALTH has been approved before under Section 1115, most several times. And Plaintiffs' objections to the central aspect of Kentucky HEALTH—its community-engagement program—are largely policy disagreements couched as legal arguments. For Plaintiffs to prevail, the Court would have to second-guess the Secretary's judgment, bypass the deference due to the Secretary, ignore the Social Security Act's plain language, and call into question numerous other Section 1115 waivers.

Even if Plaintiffs' claims had merit, Plaintiffs lack standing to challenge all or most of Kentucky HEALTH. Most fundamentally, Plaintiffs cannot establish that prevailing here will redress their alleged injuries. To the contrary, if Plaintiffs win, Kentucky will stop participating in expanded Medicaid, which will cause Plaintiffs to lose what they sued to protect—their Medicaid coverage. In addition, Plaintiffs have not established that most of Kentucky HEALTH's requirements will cause them an actionable injury.

FACTUAL BACKGROUND

On August 24, 2016, Governor Matthew G. Bevin submitted Kentucky's Section 1115 waiver application for Kentucky HEALTH to the Secretary of the Department of Health and Human Services (the "Secretary"). (AR 5432.) Governor Bevin explained that circumstances unique to Kentucky drove the need for and content of Kentucky HEALTH. (AR 5433.) From the outset, Governor Bevin made clear that approval of Kentucky HEALTH, a program that almost

exclusively affects Kentucky's Medicaid expansion population, was how the Commonwealth could continue participating in expanded Medicaid. (*See* AR 5432.)

On January 12, 2018, the Secretary approved Kentucky HEALTH. (AR 1–10.) In its approval letter, CMS concluded that "Kentucky HEALTH is designed to address the unique challenges the Commonwealth is facing as it endeavors to maintain coverage and promote better health outcomes among its residents." (AR 4.) To that end, the Secretary approved a community-engagement program, which will get enrollees into their communities in a variety of ways, a premium requirement, which will encourage personal responsibility and mirror commercial coverage by requiring enrollees to invest modest amounts in their health care, and a *My Rewards* account for each enrollee, which will incentivize healthy behaviors to unlock enhanced benefits. (*See* AR 2–10.) The Secretary approved Kentucky HEALTH because he concluded that—in his judgment—it likely will assist in advancing the objectives of Medicaid. These objectives include, among others, "assist[ing] in improving health outcomes," "address[ing] behavioral and social factors that influence health outcomes," "incentiviz[ing] beneficiaries to engage in their own health care and achieve better health outcomes," and "familiariz[ing] beneficiaries with a benefit design that is typical of what they may encounter in the commercial market." (*E.g.*, AR 4.)

On the same day that the Secretary approved Kentucky HEALTH, Governor Bevin issued an executive order on the subject, explaining:

> [T]he Commonwealth will not be able to afford to continue to operate its Medicaid expansion program as currently designed in the event any one or more of the components of Kentucky's Section 1115 Waiver and the accompanying Special Terms and Conditions are prevented by judicial action from being implemented within the demonstration period set forth in the Special Terms and Conditions.

(ECF 25-1 at 3.) Governor Bevin thus ordered that if any aspect of Kentucky HEALTH is ultimately enjoined by a court, the responsible state officials are "directed to take the necessary

actions to terminate Kentucky's Medicaid expansion program." (*Id.*) In other words, if this case ultimately is successful in whole or in part, expanded Medicaid in Kentucky will be no more.

Nevertheless, on January 24, Plaintiffs filed this putative class action. (ECF 1.) Their 408-allegation complaint is a broadside attack on Kentucky HEALTH that primarily raises objections to seven of its components. (*Id.* ¶¶ 346–84.) The federal government moved to transfer this action to Kentucky, which the Commonwealth, not yet a party, supported. (ECF 6, 25.) With summary judgment briefing underway, the Commonwealth intervened to protect Kentucky HEALTH in the event that the Court denied transfer, which it ultimately did. (Minute Order 3/30/18; ECF 42.)

ARGUMENT

I. Plaintiffs lack standing.

For Plaintiffs to have standing, the Constitution requires "an injury-in-fact," "that the injury is fairly traceable . . . to the challenged agency action," and "that it is likely as opposed to merely speculative that the injury will be redressed by a favorable decision of the court." *Klamath Water Users Ass'n v. F.E.R.C.*, 534 F.3d 735, 738 (D.C. Cir. 2008). "[S]tanding is not dispensed in gross." *Lewis v. Casey*, 518 U.S. 343, 358 n.6 (1996). This means that Plaintiffs must establish that one of them has standing to challenge each of Kentucky HEALTH's objected-to components. *See DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006). They have not done so.

A. Plaintiffs have not established redressability.

Redressability asks whether, if a plaintiff prevails in court, such a victory "will likely alleviate the particularized injury alleged by the plaintiff." *West v. Lynch*, 845 F.3d 1228, 1235 (D.C. Cir. 2017) (citation omitted). Plaintiffs have not established that prevailing here likely will redress their alleged injuries. To the contrary, if Plaintiffs win, they no longer will receive Medicaid.

Plaintiffs ask the Court to invalidate the Secretary's approval of Kentucky HEALTH. (ECF 1, Prayer for Relief ¶¶ 3–4.) Plaintiffs' theory is that securing this relief will cause Kentucky to continue its status quo with respect to expanded Medicaid. However, if Plaintiffs prevail in this action, the Commonwealth will not continue participating in expanded Medicaid. From the moment that Kentucky submitted its Section 1115 waiver application, Governor Bevin made clear that Kentucky HEALTH was how the Commonwealth could continue participating in expanded Medicaid. (AR 5432.) Governor Bevin gave this conclusion the force of law on the same day that the Secretary approved Kentucky HEALTH. As discussed above, in his January 12 executive order, Governor Bevin directed that if any aspect of Kentucky HEALTH is ultimately invalidated by a court, then Kentucky will promptly "un-expand" from expanded Medicaid. (ECF 25-1 at 3.)

Governor Bevin is well within his rights to order Kentucky to remove itself from expanded Medicaid. *See Nat'l Fed'n of Independent Bus. v. Sebelius*, 567 U.S. 519, 587 (2012) ("Some States may indeed decline to participate, either because they are unsure they will be able to afford their share of the new funding obligations, or because they are unwilling to commit the administrative resources necessary to support the expansion."). Important for present purposes, Kentucky began participating in expanded Medicaid at the unilateral direction of then-Governor Steve Beshear, whose Cabinet for Health and Family Services submitted a Medicaid plan amendment to that effect on or about October 1, 2013. This decision was challenged in Kentucky state court as an unlawful executive action, and then-Governor Beshear prevailed. *Adams v. Commonwealth of Ky.*, 13-CI-00605 (Franklin Circuit Court Sept. 3, 2013) (attached as Exhibit 1). If Kentucky can participate in expanded Medicaid through discretionary executive action, as it has done for more than four years, it follows that Governor Bevin can direct the Cabinet for Health and Family Services to remove the Commonwealth from expanded Medicaid through a state plan

amendment. In fact, around the time that then-Governor Beshear adopted expanded Medicaid for Kentucky, his administration recognized that expansion could later be unwound. (Exhibit 2 at 2.)

The fact that Governor Bevin already has ordered expanded Medicaid to be undone in the event that Plaintiffs prevail here makes it impossible for them to establish redressability. A plaintiff lacks standing where the "redress for its injury depends entirely on the occurrence of some other, future event made no more likely by its victory in court." *Teton Historic Aviation Found. v. U.S. Dep't of Defense*, 785 F.3d 719, 726 (D.C. Cir. 2015). Where, as here, a third party "can exercise 'broad and legitimate discretion the courts cannot presume either to control or to predict,' a court is generally unable to redress the alleged injury and, accordingly, standing is found wanting." *Nyambal v. Mnuchin*, 245 F. Supp. 3d 217, 224 (D.D.C. 2017) (citation omitted); *see also Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 42–43 (1976).

This rule has been applied to deny standing where the requested relief would not remedy the alleged injury without the independent actions of state government. *See DaimlerChrysler Corp.*, 547 U.S. at 344. *Klamath Water Users Association v. F.E.R.C.* nicely illustrates this point. There, a nonprofit organization sought to challenge F.E.R.C.'s decision not to include a contract setting low power rates as part of a license. The Court found no standing because the states "have independent authority to fix the rates charged by the operator to its retail customers, and each [state] *has already held that it will not be bound by the contract rates*." 534 F.3d at 736 (emphasis added). That is to say, the Court found no standing because the ultimate relief sought by the plaintiff rested in the state's hands and the state had already spoken on the issue. *See id.* at 738–40; *see also U.S. Ecology, Inc. v. U.S. Dep't of Interior*, 231 F.3d 20, 21 (D.C. Cir. 2000) (dismissing for lack of standing because the plaintiff's "alleged injury would not be redressable unless and until California accepted transfer of the disputed land and elected to proceed with

the . . . project"). Analogous to *Klamath Water Users Association*, Governor Bevin has ordered that Kentucky will not participate in expanded Medicaid if any aspect of Kentucky HEALTH is invalidated by this action. Plaintiffs therefore cannot establish redressability.

B. Plaintiffs have not established an injury-in-fact.

Plaintiffs challenge seven components of Kentucky HEALTH, but they have not established an injury-in-fact from at least five of them.[1] Under Article III of the Constitution, Plaintiffs must establish a "concrete and particularized" injury.[2] *See Food & Water Watch, Inc. v. Vilsack*, 808 F.3d 905, 914 (D.C. Cir. 2015). To be actionable, an injury must have either transpired or be imminent. *NO Gas Pipeline v. F.E.R.C.*, 756 F.3d 764, 767 (D.C. Cir. 2014).

Starting with Kentucky HEALTH's redetermination and reporting requirements, Plaintiffs admit that applicable law requires them to timely participate in the Medicaid redetermination process and to report any changes affecting Medicaid eligibility. (Memo. at 34.) Kentucky HEALTH does not alter this regime, but merely adds an additional consequence for failing to comply with it—being dis-enrolled from Kentucky HEALTH for at least six months, with allowance made for a good-cause exception and the option of early re-enrollment. (AR at 27, 30.) Stated differently, Kentucky HEALTH does not require Plaintiffs to do anything new or different.

In their affidavits, Plaintiffs counter that they are "worried" or "concerned" that in the future they may fail to comply with the redetermination and reporting requirements, which could

[1] Kentucky reserves the right to object to Plaintiffs' standing to challenge the other two components of Kentucky HEALTH (community engagement and premiums) for lack of Article III standing once the Commonwealth determines whether Plaintiffs will be subject to these two requirements.

[2] Although the Commonwealth largely leaves to the federal government the task of directly opposing Plaintiffs' challenge to the January 11, 2018 letter to state Medicaid directors, and likely will incorporate that analysis by reference, Plaintiffs lack standing to object to that letter because it has not injured them in a concrete and particularized manner.

lead to them being dis-enrolled for up to six months. (ECF 33-2 at 2, 33-6 at 2, 33-7 at 2, 33-9 at 2, 33-12 at 2, 33-13 at 2, 33-16 at 3, 33-17 at 2.) These worries and concerns are speculative, and they come nowhere close to showing that a concrete and particularized injury is "certainly impending and immediate—not remote, speculative, conjectural, or hypothetical." *Food & Water Watch*, 808 F.3d at 914 (citation omitted). In addition, Plaintiffs' injuries are within their control; to avoid injury, they merely need to follow the existing redetermination and reporting requirements, as current law requires. This further erodes any suggestion of imminence. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 564 n.2 (1992).

Plaintiffs also lack standing to challenge the Secretary's waiver of requirements regarding non-emergency medical transportation ("NEMT"). None of Plaintiffs' affidavits state that they have used NEMT in the past or that they plan to use it in the future. In fact, according to the Commonwealth's records, Plaintiffs have not used NEMT before. (Exhibit 3 ¶ 7(c), Affidavit of Jennifer Hix.) To be sure, several Plaintiffs state that they do not have a car or cannot drive. But only two Plaintiffs even mention NEMT in their affidavits: One of them notes that her mother drives her to medical appointments (ECF 33-14 at 3), and the other uses public transportation to get to the doctor (ECF 33-8 at 3). Both Plaintiffs, moreover, discuss using NEMT in a purely hypothetical sense. (*Id.* ("Under the waiver, non-emergency medical transportation will not be covered, which *could* be a problem for me *at some point*." (emphases added)); ECF 33-14 at 3 ("Under the waiver, I am *concerned* that I will not be able to go to medical appointments because medical transportation is not a covered benefit." (emphasis added).) With respect to NEMT, Plaintiffs simply have not evinced an injury that is "certainly impending and immediate" as opposed to one that is "remote, speculative, conjectural, or hypothetical." *See Food & Water Watch*, 808 F.3d at 914 (citation omitted).

Plaintiffs likewise have failed to establish an injury-in-fact with respect to how Kentucky HEALTH will treat non-emergency use of the emergency room. As explained more fully below, if an enrollee receives non-emergency treatment at the emergency room, Kentucky will decrease the amount in the enrollee's *My Rewards* account. (AR at 34.) Important for present purposes, an enrollee who goes to the emergency room for a non-emergent condition will be told *before* receiving treatment "the name and location of an available and accessible alternative non-emergency services provider." (*Id.* (incorporating 42 C.F.R. § 447.54(d)(2).) If an enrollee nevertheless receives care at the emergency room, then that care is the product of his or her informed choice, thus weakening any contention of an imminent injury. *See Lujan*, 504 U.S. at 564 n.2. Further destroying imminence, none of Plaintiffs allege that they would receive non-emergency care at the emergency room even after being informed of an accessible alternative place for medical care.

Lastly, Plaintiffs have not established an injury-in-fact from Kentucky HEALTH's waiver of retroactive coverage. Absent a waiver, retroactive coverage applies to individuals who receive medical treatment while they do not have Medicaid coverage but are eligible for it and then apply for Medicaid coverage within three months and ultimately receive it. *See* 42 U.S.C. § 1396a(a)(34). However, Plaintiffs alleged in their complaint that they are current Medicaid enrollees. (ECF 1 ¶¶ 12–26.) The Commonwealth's records confirm as much as of April 2018. (Exhibit 3 ¶ 7(a), Affidavit of Jennifer Hix.) As such, Plaintiffs' challenge to Kentucky HEALTH's waiver of retroactive coverage is undeniably hypothetical and speculative. Plaintiffs lack standing to object to what could occur if the following events transpire: they (i) happen to lose Medicaid coverage, (ii) happen to fail to secure early re-enrollment under Kentucky HEALTH (AR at 41) (iii) happen to receive medical treatment before they can re-up coverage, and (iv) happen to be eligible for

coverage at the time of the medical treatment but for Kentucky HEALTH's dis-enrollment provisions. Plaintiffs' injuries in this regard are obviously "remote, speculative, conjectural, or hypothetical." *See Food & Water Watch*, 808 F.3d at 914 (citation omitted).

II. Approving Kentucky HEALTH was well within the Secretary's judgment.

Section 1115 of the Social Security Act enables the Secretary to "waive compliance with any of the requirements of section . . . 1396a" for "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)(1). Section 1115 grants "broad power to the Secretary to authorize projects which do not fit within the normal [Medicaid] guidelines." *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 493 (N.D. Cal. 1972); *Crane v. Mathews*, 417 F. Supp. 532, 539 (N.D. Ga. 1976) (similar). Judge Friendly correctly labeled the Secretary's Section 1115 waiver authority as "extensive." *Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973).

The key component of Section 1115 is that it vests the Secretary and no one else with the "judgment" to determine whether a project is "likely to assist in promoting the objectives" of Medicaid. In 50 pages of briefing, Plaintiffs never once quote Section 1115's allowance of "judgment" by the Secretary. Section 1115 "speak[s] in terms of an otherwise unfettered 'judgment'" for the Secretary and "does not require that, before the Secretary approves an experiment, every i must be dotted and t must be crossed." *Id.* at 1107. More to the point, "[t]he requirements of § 1115 do not require certainty much less prescience, on the Secretary's part as to the results." *Richardson*, 348 F. Supp. at 497.

In reviewing the Secretary's judgment under the Administrative Procedure Act ("APA"), the question is simply "whether the Secretary had a **rational basis**" for approving a Section 1115 waiver. *Aguayo*, 473 F.2d at 1105 (emphasis added). Or, as the Third Circuit framed the "central

question," does "the record disclose[] that the Secretary **rationally** could have determined that . . . [the] program was 'likely to assist in promoting the objectives'" of Medicaid? *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 183 (3d Cir. 1996) (emphasis added); *see also Cooper Hosp./Univ. Med. Center v. Burwell*, 179 F. Supp. 3d 31, 51 (D.D.C. 2016) ("[C]ourts have vacated § 1115 waiver projects where they have found that the agency could not rationally have determined that such a program advances the objectives of Medicaid."). In applying this standard, the Court is not to act as a social scientist, scientific critic, or policymaker, nor is it to "comment upon the wisdom" of the waiver. *See C.K.*, 92 F.3d at 181; *Richardson*, 348 F. Supp. at 497–98. Put more succinctly, "[t]he court is not empowered to substitute its judgment for that of the [Secretary]." *Aguayo*, 473 F.3d at 1107 (quoting *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971)).

Under this deferential standard of review, the Court must defer to the Secretary's judgment that Kentucky HEALTH as a whole likely will assist in promoting the objectives of Medicaid. Plaintiffs' brief attacks Kentucky HEALTH piece by piece, never directly asking whether there is a rational basis for the program as whole. Section 1115, however, speaks in terms of the Secretary exercising judgment as to "any experimental, pilot, or demonstration *project*," not to the individual parts of such a project. 42 U.S.C. § 1315(a) (emphasis added). As one court put it:

> The Secretary is required to make a judgment that *a project* proposed under § 1115 is "likely to assist in promoting the objectives" of the title. That judgment could rationally be made with respect to *a project* which was directed to promoting one of several objectives, even if another objective would suffer by reason of *the project's* operation, so long as the Secretary concluded that *on balance* the objectives considered together were likely to be advanced.

Richardson, 348 F. Supp. at 497 (emphases added, except the last); *see also C.K.*, 92 F.3d at 185 (considering a Section 1115 waiver "in the aggregate").

Under no circumstances can the Court conclude that the Secretary lacked a rational basis for finding that Kentucky HEALTH as a whole is likely to assist in promoting the objectives of Medicaid. CMS's January 12 approval letter and the accompanying Special Terms and Conditions ("STCs"), which together account for over 80 pages, amply demonstrate the Secretary's considered judgment. In its January 12 approval letter, CMS concluded that "Kentucky HEALTH is designed to address the unique challenges the Commonwealth is facing as it endeavors to maintain coverage and promote better health outcomes among its citizens." (AR at 4.) One of the primary components of Kentucky HEALTH, which Plaintiffs' brief barely mentions, is an enrollee's *My Rewards* account, which accumulates virtual funds for healthy behaviors that can be used to receive enhanced benefits. This responds to the fact that, in 2015, "fewer than 10 percent of beneficiaries [in Kentucky] received an annual wellness or physical exam." (*Id.*)

As mentioned above, Kentucky HEALTH also has a community-engagement program, which requires non-exempt enrollees to spend 80 hours per month in their communities, whether through volunteering, working, taking classes, or many other options. (AR 42–43.) CMS reasoned that, among other things, this requirement "is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that research has shown to be correlated with improved health and wellness." (AR at 4.)

CMS also concluded that Kentucky HEALTH as a whole likely will increase beneficiary engagement in health care. CMS observed that "[p]rior evaluations of demonstration projects with beneficiary engagement components have shown promise that these strategies can have a positive impact on beneficiary behavior." (AR at 5.) Kentucky HEALTH's beneficiary-engagement provisions include beneficiary-directed accounts, redetermination and reporting requirements, and non-retroactive coverage. (AR at 5–6.) These provisions, CMS concluded, likely will "strengthen

beneficiary engagement in their personal health care plan and provide an incentive structure to support responsible consumer decision-making." (AR at 5.) They also will "encourag[e] responsible utilization of services, promot[e] continuity of care by reducing gaps in coverage, and improv[e] program integrity." (AR at 6.)

CMS also concluded that Kentucky HEALTH seeks to "remov[e] potential obstacles to a successful transition from Medicaid to commercial coverage." (*Id.*) In asking for a waiver of various Medicaid provisions to further this objective, Kentucky relied on a study estimating that "approximately half of adults with income below 200% FPL will move between Medicaid eligibility and Marketplace coverage at least once a year, while 25% will move between the two programs more than once." (AR at 5444.) To reduce this "churning" problem, Kentucky HEALTH approximates commercial coverage by requiring premiums, having limited enrollment windows, and providing experience with a deductible. (AR at 6–7.)

Even the foregoing abbreviated discussion of the highlights of Kentucky HEALTH suffices to establish that the Secretary possessed a rational basis for concluding that Kentucky HEALTH as a whole likely will assist in promoting the objectives of Medicaid.

III. Plaintiffs' arguments about the scope of Section 1115 and Medicaid's objectives are demonstrably wrong.

Plaintiffs' lead arguments for invalidating Kentucky HEALTH are that the Secretary cannot "fundamentally restructure" Medicaid through Section 1115 and that the Secretary has rewritten the purposes of Medicaid by approving Kentucky HEALTH.

A. Section 1115 is not just for tinkering with Medicaid.

Plaintiffs first claim that the Secretary and the Commonwealth have "sought to fundamentally alter the design and structure of Medicaid" through Kentucky HEALTH, which they claim is inconsistent with the text of Section 1115. (Memo. at 12–13.) However, Section

1115, as written, plainly contemplates waivers that are big, small, and anywhere in between. It allows the Secretary to waive "*any* of the requirements of section . . . 1396a." 42 U.S.C. § 1315(a)(1) (emphasis added). It does not, as Plaintiffs contend, say that the Secretary can only waive requirements as long as the Secretary modifies Medicaid around the edges.

Plaintiffs base their argument on *MCI Telecommunications Corp. v. American Telephone & Telephone Co.*, 512 U.S. 218 (1994). Their reliance on this case shows just how wrong they are. *MCI Telecommunications* was not a Section 1115 case; it instead dealt with a statute that allowed an agency to "modify any requirement" of the statute. *Id.* at 224. To state the obvious, allowing an agency to "modify any requirement" of a statute is altogether different from enabling the Secretary to "waive compliance with any of the requirements" of a statute. As the *MCI Telecommunications* Court explained, "[t]he word 'modify'—like a number of other English words employing the root 'mod' . . . such as 'moderate,' 'modulate,' 'modest,' and 'modicum'—has a connotation of increment or limitation. Virtually every dictionary we are aware of says that 'to modify' means to change moderately or in minor fashion." *Id.* at 225. The word "waive," by contrast, is not inherently limited in any way. To "waive" something is "to refrain from pressing or enforcing it" or to "dispense with" it. *Webster's Third Int'l Dictionary* 2570 (1976). Whereas the word "modify" has a "connotation of increment or limitation" built into it, the word "waive" does not.[3]

[3] In passing, Plaintiffs press the argument that "waiv[ing] any of the requirements" of Medicaid does not allow the Secretary to modify, amend, or change statutory provisions. (Memo. at 14.) Their argument appears to be that waiver is an on-off proposition, and the Secretary has fashioned a new program via Section 1115. Plaintiffs can cite no court decision that has interpreted Section 1115 this way. With good reason. Section 1115 envisions a state submitting an "experimental, pilot, or demonstration project" to the Secretary, which the Secretary can then approve by waiving contrary provisions of the Medicaid statute as necessary. *See Phoenix Baptist Hosp. & Med Center v. United States*, 728 F. Supp. 1423, 1428 (D. Ariz. 1989), *aff'd* 937 F.2d 452 (9th Cir. 1991) ("The Secretary's decision to waive requirements involves a policy decision to allow a state the opportunity to develop its own alternative to traditional medicaid programs which can provide information helpful to furthering the objectives of the Medicaid program.").

One final point: Plaintiffs' cramped view of the Secretary's waiver authority—namely, that it is just for tinkering with Medicaid—is incompatible with how Section 1115 has been interpreted for decades. For example, Arizona's entire Medicaid program has operated under a Section 1115 waiver since 1982.[4] Tennessee and Rhode Island likewise have received global Section 1115 waivers to operate their Medicaid programs.[5] Compared to these global waivers, Kentucky HEALTH is modest. In addition, states have used Section 1115 waivers to accomplish far more fundamental changes to Medicaid than Kentucky HEALTH. Arkansas, for example, expanded Medicaid by using a Section 1115 waiver, under which Medicaid expansion enrollees are placed into private insurance plans, rather than receiving Medicaid.[6] The takeaway is clear: If Plaintiffs' constrained view of the Secretary's waiver authority is sustained, which would be a judicial first, the Court will call into question decades of Section 1115 waivers, many of which are in place now.

B. Plaintiffs conceive far too narrowly of Medicaid's objectives.

Plaintiffs also challenge Kentucky HEALTH on the basis that the objectives it pursues are not the objectives of Medicaid. As evidence, they cite 42 U.S.C. § 1396-1, which appropriates Medicaid funds to do the following:

> [F]urnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other

[4] Schubel, Senate Health Bill Would Penalize Arizona for Its Innovative and Efficient Medicaid Program (July 19, 2017), *available at* https://www.cbpp.org/research/health/senate-health-bill-would-penalize-arizona-for-its-innovativ e-and-efficient-medicaid (last visited Apr. 24, 2018).

[5] Tennessee Approval & STCs, at 12 (Feb. 1, 2018), *available at* https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf (last visited Apr. 25, 2018); Rhode Island Comprehensive Demonstration STCs, at 10 (Oct. 20, 2016), *available at* http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/1115Waiver/RISTCswTCs120216.pdf (last visited Apr. 25, 2018).

[6] Maylone, *et al.*, Evidence from the Private Option: The Arkansas Experience (Feb. 22, 2017), *available at* http://www.commonwealthfund.org/publications/issue-briefs/2017/feb/private-option-arkansas-experience (last visited Apr. 24, 2018).

> services to help such families and individuals attain or retain capability for independence or self-care.

42 U.S.C. § 1396-1. According to Plaintiffs, Kentucky HEALTH ignores these two purposes. This is both irrelevant and wrong.

Plaintiffs' reliance on Section 1396-1 is irrelevant because, with very limited exception, Kentucky HEALTH only applies to the Medicaid expansion population.[7] Section 1396-1 dates to well before Medicaid expansion occurred, and by its terms, Section 1396-1 only governs traditional Medicaid. Section 1396-1 lists four categories of persons that are subject to it: those who are "aged, blind, or disabled" and "families with dependent children." 42 U.S.C. § 1396-1; *see Sebelius*, 567 U.S. at 583 ("The original [Medicaid] program was designed to cover medical services for four particular categories of the needy . . . ."). The four categories of persons listed in Section 1396-1, however, are not part of expanded Medicaid. The Medicaid expansion is a "new health care program" designed "to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level." *Id.* at 583–84. So, because Section 1396-1 only discusses the four needy populations covered by traditional Medicaid, this statutory provision says little about the objectives of expanded Medicaid. Plaintiffs try to obscure this point through a misleading quotation of Section 1396-1, swapping the four categories of needy persons listed in Section 1396-1 with the word "individuals." (Memo. at 16.) That rewrites Section 1396-1.

The objectives of expanded Medicaid are not cabined to the two purposes listed in Section 1396-1. Enrollees in Kentucky HEALTH will be distinct in many ways from participants in traditional Medicaid. Whereas participants in traditional Medicaid are "aged, blind, or disabled" or "families with dependent children," Kentucky HEALTH enrollees will be able-bodied adults.

[7] These limited instances need not be dealt with here because Plaintiffs are part of the expansion population. (Exhibit 3 ¶ 7(b), Affidavit of Jennifer Hix.)

The objectives of Medicaid are rather different for that population than for the categorically needy. *See Sebelius*, 567 U.S. at 584 ("[T]he manner in which the expansion is structured indicates that while Congress may have styled the expansion as a mere alteration of existing Medicaid, it recognized it was enlisting the States in a new health care program.").

In applying section 1115 to the Medicaid expansion population, the Secretary determined that the objectives of the Medicaid statute are, among other things, (i) "improving health outcomes," (ii) "address[ing] behavioral and social factors that influence health outcomes," (iii) "incentiviz[ing] beneficiaries to engage in their own health care and achieve better health outcomes," and (iv) "familiariz[ing] beneficiaries with a benefit design that is typical of what they may encounter in the commercial market and thereby facilitat[ing] smoother beneficiary transition to commercial coverage."[8] (AR at 4.) This interpretation of Section 1115 as applied to the Medicaid expansion population is entitled to *Chevron* deference and is a reasonable construction of Section 1115 and the Medicaid statute. *See Pharm. Res. & Mfrs. Am. v. Thompson*, 362 F.3d 817, 821–22 (D.C. Cir. 2004) (applying *Chevron* deference to the Secretary's approval of a state Medicaid plan). In fact, Plaintiffs' memorandum cites no instance where Congress has "directly spoken to the precise question at issue"—namely, the objectives of Medicaid expansion for purposes of Section 1115. *See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842 (1984).

Even if Section 1396-1 can be said to apply to the Medicaid expansion population, Section 1396-1 recognizes that Medicaid is designed to provide "rehabilitation and other services to help such families and individuals attain or retain capability for *independence* or self-care." 42 U.S.C.

[8] The Secretary interprets the objectives of Medicaid for purposes of Section 1115 to include six objectives. *See* https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Apr. 21, 2018).

§ 1396-1 (emphasis added). The word "independence" is key. *See* Webster's Third Int'l Dictionary 1148 (1976) (defining "independence" to mean "the quality or state of being independent" and defining "independent" to mean "not subject to control by others" and "not requiring or relying on something else"). The Secretary relied on numerous independence-based objectives in approving Kentucky HEALTH, such as "promot[ing] individual independence and reduc[ing] reliance on public assistance by creating incentives for individuals to obtain and maintain coverage through private, employer-sponsored insurance." (*E.g.*, AR at 5.)

Plaintiffs essentially ask the Court to conclude that interpreting "independence" in Section 1396-1 to mean "independence" is an unreasonable reading of the statute. According to Plaintiffs, "it is clear that 'independence' [in Section 1396-1] refers to *functional* (not financial) independence; that is, the capacity to accomplish the various activities of daily living, such as feeding, dressing, and bathing." (Memo. at 17.) Plaintiffs cite no source that has ever interpreted Section 1396-1's use of the word "independence" in this narrow, artificial manner. Indeed, Plaintiffs' interpretation of "independence" as limited to "feeding, dressing, and bathing" amounts to essentially "self-care," which also is mentioned as a purpose in Section 1396-1. To interpret "independence" to mean "self-care" would render the former statutory term superfluous. *See Corley v. United States*, 556 U.S. 303, 314 (2009).

More fundamentally, defining "independence" for the Medicaid expansion population to mean only "feeding, dressing, and bathing" renders the statutory term irrelevant. For some in the traditional Medicaid population, independence may well mean "feeding, dressing, and bathing." However, for the expanded Medicaid population—many of whom are able-bodied—independence cannot mean just "feeding, dressing, and bathing," which is something that they are capable of regardless of whether they receive Medicaid. For the able-bodied population, "independence" must

mean something more. Thus, the Court must define "independence" with reference to the able-bodied participants in expanded Medicaid, which is exactly what the Secretary did in approving Kentucky HEALTH. "Independence" for the able-bodied participants in expanded Medicaid means, among other things, learning healthy behaviors, engaging in their communities, finding meaningful work, getting the skills and education they need, and successfully transitioning to commercial coverage.

Plaintiffs' discussion of the objectives of Medicaid contains the suggestion that the Secretary's and the Commonwealth's real objective with Kentucky HEALTH is "to knock people off Medicaid and undermine the Medicaid expansion enacted by Congress." (Memo. at 17.) There, of course, is no evidence of this. Instead, Plaintiffs are trying to re-frame perversely Kentucky's good-faith attempt to make expanded Medicaid sustainable for the Commonwealth going forward, rather than abruptly ending expanded Medicaid, which the Commonwealth has every right to do. Thus, rather than using Section 1115 to "knock people off Medicaid," the Commonwealth is using Section 1115, in part, *to ensure that expanded Medicaid still exists for Kentuckians*, including Plaintiffs.[9] Surely one of the objectives of Medicaid is making it affordable enough that the states can continue participating in it. *See Richardson*, 348 F. Supp. at 496–97 (upholding waiver where "[t]he stated purposes of the . . . experiment might be expressed as an attempt to see how imposition of some cost-sharing will decrease utilization of the program benefits, and, consequently, costs"); *Crane*, 417 F. Supp. at 540 ("The public purse, both that of the state and even of the United States, is not absolutely unlimited. Accordingly, public officials must make some effort to provide the greatest good possible at the least possible costs. That appears to be the

[9] This eviscerates Plaintiffs' assertion that Kentucky HEALTH is something "only Orwell could love." (Memo. at 17.)

underlying motive behind this project, and it is one to be commended, and not one to be criticized.").

IV. Kentucky HEALTH's community-engagement program likely assists in promoting the objectives of Medicaid.

Plaintiffs challenge what they call Kentucky HEALTH's "work requirements" without ever explaining what they actually do. (Memo. at 11, 18.) To be clear, Kentucky HEALTH does not contain "work requirements." Kentucky HEALTH instead has a community-engagement program, and performing 80 hours of work per month is *one of many ways* that enrollees can become engaged in their communities. (AR at 42–43.) Enrollees also can satisfy the community-engagement requirement by doing 80 hours per month of any one or combination of the following: job-skills training; job-search activities; education related to employment; general education; vocational education and training; community work experience, community service, or public service; caregiving services for a non-dependent relative or other specified person; or participation in substance use disorder treatment. (AR at 42.)

Plaintiffs also fail to mention that Kentucky HEALTH goes out of its way to exclude all but the able-bodied from its community-engagement initiative. Those exempt from the community-engagement program include: pregnant women; primary caregivers of a dependent; those who are medically frail; those who are "diagnosed with an acute medical condition that would prevent them from complying with the requirements"; full-time students; former foster care youth; and enrollees under the age of 19 or over the age of 64. (*Id.*) Kentucky HEALTH also contains a good-cause exemption from the community-engagement requirement. (AR at 44.) These

numerous, careful exclusions confirm a simple point: Kentucky HEALTH's community-engagement initiative only applies to the most able-bodied participants in Medicaid.[10]

A. The Secretary had authority to approve Kentucky HEALTH's community-engagement program.

Plaintiffs claim that allowing community-engagement requirements exceeds the Secretary's Section 1115 waiver authority. Their lead argument is that "Congress has demonstrated time and again that Medicaid is a medical assistance program, not a work program." (Memo. at 18.) Their primary evidence is two recent bills introduced in Congress that contained work requirements but failed to pass. American Health Care Act, H.R. 1628, 115th Cong., § 117 (2017)[11]; Medicaid Reform & Personal Responsibility Act of 2017, S. 1150, 115th Cong. (2017). These proposed bills, however, are irrelevant to the Secretary's authority to approve Kentucky HEALTH. For one thing, they contained work requirements different in many respects from Kentucky's community-engagement program. And more importantly, the Supreme Court has held that "failed legislative proposals are 'a particularly dangerous ground on which to rest an interpretation of a prior statute.'" *Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps. of Eng'rs*, 531 U.S. 159, 169–70 (2001) (citation omitted).

Next, Plaintiffs claim that Kentucky HEALTH's community-engagement requirements are unlawful simply because SNAP and TANF both mention work requirements, whereas the Medicaid state does not. (Memo. at 19.) Plaintiffs are confusing the inquiry. The question is not whether the Medicaid statute as currently written contains a work requirement or a community-

[10] If an able-bodied person nevertheless fails to meet the community-engagement requirement in a given month, Kentucky HEALTH provides an opportunity in the following month to cure non-compliance to avoid suspension from the program. (AR at 44.)

[11] This bill was a comprehensive proposal of which work requirements were a very small part.

engagement requirement. The applicable question is whether Section 1115 permits a waiver of Medicaid's requirements for a community-engagement trial run.

If anything, the work requirements in SNAP and TANF bolster the Secretary's decision to approve Kentucky HEALTH's community-engagement program. As Plaintiffs acknowledge, before 1996, neither SNAP nor TANF contained work requirements. Those work requirements came about as part of the welfare reform package that President Clinton signed in 1996. *See* Personal Responsibility & Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996). Important for present purposes, prior to 1996, many states had received waivers—issued under Section 1115—to allow work requirements in TANF's predecessor program, AFDC. These pre-1996 waivers were an impetus for enacting welfare reform in 1996:

> Growing dissatisfaction with AFDC . . . led an increasing number of states to seek waivers from the AFDC rules. These waivers were mostly designed to allow states to more stringently enforce work requirements for welfare recipients. Such waivers had started under President Ronald Reagan, but the Clinton Administration actively encouraged more expansive statewide waiver programs. As a result, by the time [the 1996 welfare reform] passed, 27 states had major state-wide waivers in place.

Blank, Evaluating Welfare Reform in the United States, *Journal of Economic Literature*, Vol. 40, No. 4, at 1106 (Dec. 2002). Indeed, these pre-1996 waivers "were a major reason why policymakers supported work-oriented welfare reforms in the 1990s." *Id.* at 1122. That is, the states' experimentation with AFDC work requirements in the 1980s and 1990s led to Congress's passage of work requirements for TANF and SNAP in 1996.

This is an important point. Waivers allow states to experiment with innovative programs, and they allow others, including Congress, to track the success or failure of those programs while considering permanent changes to Medicaid. The 1996 changes to SNAP and TANF demonstrate that work requirements have been tested through waivers before and have culminated in real policy changes. Thus, the two failed bills mentioned by Plaintiffs, which show that at least some members

of Congress are actively considering work or community-engagement requirements, actually underscore the necessity of a Section 1115 waiver like Kentucky HEALTH.

Plaintiffs also argue that Kentucky HEALTH's community-engagement program violates the APA simply because it is unprecedented, claiming that "[i]n the 50-plus years of Medicaid, CMS has not previously approved a work requirement as a condition of Medicaid eligibility." (Memo. at 20.) Plaintiffs, however, conveniently omit to mention that, for nearly 50 of those years, expanded Medicaid did not exist. As summarized above, the Medicaid expansion was a sea change for Medicaid, bringing into the program an entirely new class of enrollees. *See Sebelius*, 567 U.S. at 583–84. From 1965 until the Medicaid expansion, Medicaid served only "four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children." *Id.* at 584. In light of the demographics of this population, it should come as no surprise that the Secretary did not approve a mandatory work requirement from 1965–2014.

Plaintiffs further note that, during the prior administration, the Secretary denied several waiver requests to impose work requirements on Medicaid recipients. (Memo. at 20–21 n.6.) These denials, Plaintiffs urge, undermine the deference owed to the Secretary's decision to approve Kentucky HEALTH. This is wrong for at least four reasons.

First, because expanded Medicaid became effective in 2014, the prior administration was the first one to interpret Section 1115 as it applies to the Medicaid expansion population. The prior administration is not entitled to a monopoly on the meaning of Section 1115, especially in light of the discretion afforded to the Secretary. As one district court has held, "it seems quite plain that the sort of experimental projects which are going to be approved [under Section 1115] may be much more closely related to the political and sociological orientation or general policy, of the

Administration then in power than with its understanding of what the statute authorizes." *Richardson*, 348 F. Supp. at 496.

Second, this Court has held that the Secretary's decisions regarding Section 1115 waivers are "case-by-case, fact-based determinations" in which "courts appropriately defer to the agency entrusted by Congress to make such policy determinations." *Cooper Hosp.*, 179 F. Supp. 3d at 51 (citation omitted). That is to say, Section 1115 waivers generally are not susceptible to challenge on the basis that the Secretary has reversed positions because Section 1115 waivers are inherently fact bound. This is especially true here. The work programs that the prior administration declined to approve differ in meaningful respects from Kentucky HEALTH's community-engagement initiative. For example, Arizona's proposed waiver required enrollees to be employed, actively seeking employment, or attending school or a job-training program. *See, e.g.*, A.R.S. § 36-2903.09(A)(1). New Hampshire's waiver proposal, which the prior administration rejected days before the 2016 presidential election, is similarly distinguishable. Among other things, New Hampshire's proposal required 30 hours per week of defined activities (as opposed to 80 hours per month).[12]

The Section 1115 waivers rejected by the prior administration differ from Kentucky HEALTH in one other significant respect: the population affected by the waiver. Perhaps more than any other state, Kentucky and its population are ideally situated to test a community-engagement program. As Governor Bevin explained in Kentucky's initial waiver submission, Kentucky's unique situation drove the need for a Section 1115 waiver:

[12] New Hampshire Waiver Request, at 4–5 (Aug. 10, 2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-state-application-081016.pdf (last visited Apr. 24, 2018).

> The need for change [in Kentucky] is urgent. Almost twenty percent of our residents live in poverty, we are 47th in the nation for median household income, nearly one-third of Kentuckians are on Medicaid, and our workforce participation is among the worst in the nation at less than 60 percent. Kentucky also ranks third in the nation for drug related fatalities.

(AR 5432.) These troubling statistics make Kentucky a particularly good fit for testing a community-engagement program. At a minimum, it is a reasonable construction of Section 1115 and a valid exercise of the Secretary's judgment to conclude that this is so.

Third, the prior administration did allow states to conduct voluntary work programs, albeit outside of Section 1115. For example, in 2014, the Secretary allowed Pennsylvania to pursue a voluntary work program "outside the demonstration."[13] Similar programs followed in Indiana and Arkansas.[14] However, the available data from these voluntary work programs showed *exceptionally low participation rates*. For example, Indiana's results showed that:

> 244,000 HIP members were unemployed, while an additional 58,000 members were working fewer than 20 hours per week. Despite these numbers, with a voluntary Gateway to Work initiative, members are not properly incentivized to actively seek employment, resulting in only 580 Gateway to Work orientations being attended during the first fifteen (15) months of the program.[15]

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[13] Pennsylvania Approval Letter & STCs, at 2 (Aug. 28, 2014), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-ca.pdf (last visited Apr. 21, 2018).

[14] Indiana Approval Letter & STCs, at 3 (Jan. 27, 2015), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appvl-01272015.pdf (last visited Apr. 21, 2018); Arkansas Approval Letter & STCs, at 4 (Mar. 5, 2018), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf (last visited Apr. 21, 2018).

[15] Indiana Amendment Request, at 7 (July 20, 2017), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-07202017.pdf (last visited Apr. 21, 2018).

Arkansas's voluntary work program was similarly ineffective from a participation perspective, with only 4.7 percent of beneficiaries referred to the work program following through and accessing the work-referral services.[16] CMS specifically relied on these anemic participation rates in approving Kentucky HEALTH's mandatory community-engagement initiative, reasoning that "[w]e understand from some states that these incentives have not been strong enough to influence individual beneficiary behavior. CMS and Kentucky believe that Kentucky HEALTH's community engagement initiative is likely to be more effective than other incentives or referrals to employment services, as it provides for the consequence of eligibility suspension for non-compliance." (AR at 4–5.) In sum, Kentucky HEALTH's community-engagement program is not a reversal in agency position so much as it is a natural and logical next step from voluntary work programs, which proved altogether ineffective at getting participation.

And fourth, not every change by an agency automatically renders deference to the Secretary's decision inappropriate. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016). Where, as here, the change in position did not upset long-settled expectations, "[a] summary discussion" of the change may suffice. *Id.* at 2126. To the extent that the waiver denials during the prior administration can be characterized as a reversal, the Secretary has given a reasoned explanation for the change. In its January 12 letter, CMS recognized that it "has not previously approved a community engagement requirement as a condition of eligibility" and that "CMS has rejected similar proposals in the past." (AR at 4, 8.) CMS offered several reasons for approving Kentucky HEALTH's community-engagement requirement, including (among others):

- "CMS has long supported policies that recognize meaningful work as essential to the economic self-sufficiency, self-esteem, well-being, and improved health of people with disabilities." (AR at 4.)

[16] Arkansas Waiver Approval & STCs, at 4–5, *supra* note 14.

- Previous work-incentive programs, which were purely voluntary, "may not have been strong enough to influence individual beneficiary behavior." (AR at 4–5.)

- CMS concluded that Kentucky's community-engagement program responded to public commenters' concerns by including "important protections for vulnerable individuals." (AR at 8.)

This summary is more than sufficient for the Secretary's judgment to warrant deference. *See Navarro*, 136 S. Ct. at 2126 (holding that an agency must "display awareness that it is changing position" and "show that there are good reasons for the new policy" (citation omitted)).

CMS's January 11 letter to state Medicaid directors provides even further justification for the Secretary's position. The January 11 letter cites numerous studies that support the Secretary's decision. (AR at 91.) CMS admitted that its willingness to approve programs like Kentucky HEALTH "is a shift from prior agency policy regarding work and other community engagement as a condition of Medicaid eligibility or coverage, but it is anchored in historic CMS principles that emphasize work to promote health and well-being." (AR at 92.) CMS further observed that it "has long assisted state efforts to promote work and community engagement and provide incentives to disabled beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work." (AR at 91.) CMS concluded that the "successes of all these programs [that CMS has historically supported] suggest that a spectrum of additional work incentives . . . could yield similar outcomes while promoting these same objectives." (AR at 92.)

B. The Secretary had a rational basis to approve Kentucky HEALTH's community-engagement program.

In arguing that the Secretary lacked a rational basis to approve Kentucky HEALTH's community-engagement program, Plaintiffs proffer mostly policy-based objections. They devote their arguments in large part to the alleged consequences of imposing work requirements. This is

a straw-man tactic: Plaintiffs cannot validly claim that the Secretary lacked a rational basis with respect to a community-engagement program, so they make Kentucky HEALTH into something it is not, a work program. Thus, virtually all of Plaintiffs' arguments opposing Kentucky HEALTH's community-engagement program can be summarily dismissed as focusing on something that Kentucky HEALTH is not.

Although Plaintiffs urge that a work requirement is refuted by study after study[17] and comment after comment, Plaintiffs acknowledge that the Secretary relied on research to support his decision to approve a community-engagement program. In fact, the administrative record is replete with research that supports the Secretary's decision. (*E.g.*, AR 4761, 4765–66, 4824–25, 4840–43, 5054–60, 5072–73, 5112–368, 5369–85, 5386–91, 5392–408.) In this vein, CMS concluded that Kentucky HEALTH "is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that research has shown to be correlated with improved health and wellness." (AR at 4.) CMS expounded on this point in its January 11 letter. (AR at 91 (collecting sources).) Although Plaintiffs try to find something to disagree with in this research, the Court need not wade into this social-science dispute. *See Richardson*, 348 F. Supp. at 498 ("This Court does not, however, function as a scientific critic . . . ."). The aforementioned body of research plainly gave the Secretary a rational basis to test a community-engagement program as likely to improve health outcomes, among other things. Plaintiffs' only rebuttal is to argue that, in their view, it is a "leap that defies logic" to go from research showing

[17] The studies cited in footnotes 7–12 of Plaintiffs' brief, which Plaintiffs describe as being referenced in the administrative record rather than actually part of it, were not before the Secretary and thus need not be considered in determining whether the Secretary had a rational basis to approve Kentucky HEALTH. *See Marcum v. Salazar*, 751 F. Supp. 2d 74, 80 (D.D.C. 2010) (holding that "references to documents in the administrative record do not prove that the documents were 'before' the deciding agency"); *Cape Hatteras Pres. Alliance v. U.S. Dep't of Interior*, 667 F. Supp. 2d 111, 114 (D.D.C. 2009) (similar).

positive outcomes associated with community engagement to requiring 80 hours per month of community-engagement activities for a carefully specified group. (Memo. at 24.) That judgment, however, is vested with the Secretary, not the Plaintiffs or this Court. *See* 42 U.S.C. § 1315(a).

Plaintiffs also argue that the Secretary did not adequately respond to comments in the administrative record that oppose his judgment. A Section 1115 waiver, however, need not contain "a specific recitation and refutation of objections submitted in opposition . . . ." *C.K.*, 92 F.3d at 185; *see Cooper Hosp.*, 179 F. Supp. 3d at 54. CMS noted in its January 12 letter that it reviewed all submitted comments, and it specifically discussed many of them. (AR at 7–9.) And many more comments, although not specifically mentioned in the January 12 letter, are directly addressed through unique aspects of Kentucky HEALTH's STCs that minimize or eliminate the issues raised by the comments. (AR at 8.)

Plaintiffs nevertheless claim that the Secretary did not respond to comments about how Kentucky HEALTH will affect Medicaid enrollees who are working and simply rely on Medicaid for health insurance. (Memo. at 23.) Kentucky HEALTH directly addresses this subset of enrollees by, among other things, deeming those who work 120 hours per month as satisfying the community-engagement requirement without requiring them to actively report their activities. (AR at 8, 43.) And even if the enrollees who are already working do not work 120 hours per month, they simply need to work 80 hours per month or perform other qualifying activities to achieve compliance. (AR at 43.) Plaintiffs also mention comments arguing that enrollees do not lack motivation but rather face market and structural barriers to employment. (Memo. at 23.) Kentucky HEALTH, in response, allows enrollees to satisfy their community-engagement obligation by doing various tasks to overcome such barriers, such as education, skills training, vocational training, and community service. (AR at 42.) Plaintiffs also argue that the Secretary failed to

consider the lesser alternative of a voluntary work program. (Memo at 24.) However, as discussed above, CMS expressly mentioned this alternative but opted against it because previous voluntary programs had extremely low participation rates.[18] (AR at 4–5.)

Plaintiffs also mention comments in the administrative record about Kentucky's community-engagement program being administratively complex for participants. (Memo. at 23–24.) CMS's January 12 letter, however, noted that Kentucky was committed to, and had taken meaningful steps toward, streamlining operations. (*See* AR at 9.) The STCs also contain an assortment of "state assurances" to ensure that enrollees are fully aware of how to satisfy their community-engagement obligations. (AR 45–47.)

V. The Secretary validly approved Kentucky HEALTH's premiums.

Plaintiffs next challenge the Secretary's approval of premiums as part of Kentucky HEALTH. In so doing, Plaintiffs mischaracterize the applicable STCs, which actually work as follows: Non-exempt enrollees[19] with incomes of greater than 100 percent of FPL are required to pay modest premiums of at least $1 per month but not to exceed 4 percent of household income. (AR at 38.) For enrollees with incomes of less than 100 percent of FPL, they have the option of paying premiums to unlock the full benefits of Kentucky HEALTH. (AR at 39–40.) If they fail to pay these optional premiums, they are not dis-enrolled from Kentucky HEALTH; instead, they continue receiving all of its benefits except the optional benefits that come with the *My Rewards*

[18] Plaintiffs also argue that the Secretary failed to address a comment that they characterize as arguing that the community-engagement program "may" (as opposed to "will") violate the Fair Labor Standards Act. (Memo. at 24.) An agency, however, has no obligation to respond to speculative comments like this. *Public Citizen, Inc. v. F.A.A.*, 988 F.2d 186, 197 (D.C. Cir. 1993). Any such concerns, moreover, can be addressed on a case-by-case basis in the future.

[19] Pregnant women, former foster care youth, and the medically frail are not required to pay premiums. (AR at 38.)

account and must make copayments "equal to the copayments schedule in the Kentucky Medicaid state plan." (*Id.*)

A. The Secretary had legal authority to impose premiums.

Plaintiffs claim that the Secretary cannot waive Section 1396a's limitation on premiums. Plaintiffs face an uphill battle here. In addition to Kentucky HEALTH, the Secretary has approved some version of premiums under Section 1115 in Arizona, Arkansas, Indiana, Iowa, Michigan, and Montana.[20]

Plaintiffs nevertheless contend that the Secretary has been wrong all along because Medicaid's limitation on premiums is not part of Section 1396a and thus cannot be waived under Section 1115. This could not be more wrong. Section 1396a(a)(14), which is part of Section 1396a, states that "[a] State plan for medical assistance must . . . provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title."[21] To waive Section 1396a(a)(14), as the Secretary has done, logically means that a state can impose premiums without complying with Section 1396o. Not only is that a reasonable construction of Sections 1115 and 1396a(a)(14) sufficient to warrant deference, but it is the correct reading of the statutes: not having to comply with Section 1396o as it pertains to premiums necessarily follows from waiving Section 1396a(a)(14).

[20] *See* Musumeci, *et al.*, Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers (Mar. 8, 2018), *available at* https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/ (last visited Apr. 23, 2018).

[21] Plaintiffs posit that Section 1396a(a)(14)'s language "only as provided in" conveys that the Secretary cannot waive the limitation on premiums. (Memo at 27–28.) Section 1115, as written, allows the Secretary to waive "any" requirement of Section 1396a. The language "only as provided in" does not *sub silentio* overrule Section 1115's broad language. It simply directs the reader to the provision concerning premiums, if a waiver of Section 1396a(a)(14) has not been granted.

Plaintiffs resist this conclusion by pointing to Section 1396o-1, which they argue "also prohibits states from imposing premiums on enrollees with income below 150% of FPL" and which they note is not referenced in Section 1396a. (Memo. at 26.) Section 1396o-1 itself definitively refutes this argument. Section 1396o-1(b)(6)(B)—a provision that Plaintiffs fail to mention—states that "[n]othing in this section shall be construed . . . as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost-sharing under this section." Thus, section 1396o-1 unambiguously states that it does not limit the Secretary's waiver authority, which is exactly what Plaintiffs are asking the Court to use it for. The legislative history of Section 1396o-1 likewise conveys that it does not alter Section 1115. *See* Conf. Rep. No. 109-262, at 312 (2005) ("The bill further specifies that these provisions would not prevent states from further limiting cost-sharing, affect the authority of the Secretary to waive limits on premiums or cost-sharing, nor affect waivers in effect before the date of enactment.").

Plaintiffs' argument about Section 1396o-1, if sustained, renders the Secretary's ability to waive Section 1396a(a)(14) meaningless with respect to premiums. According to Plaintiffs, Sections 1396o and 1396o-1 are redundant in prohibiting the Secretary from imposing premiums on anyone with an income below 150 percent of FPL. (Memo. at 26.) Plaintiffs' position, then, is that in order for the Secretary to impose premiums, he must separately waive *both* overlapping provisions. This elevates form over substance. If the Secretary can waive Section 1396o's limitations on premiums, it cannot be the case that Section 1396o-1's overlapping provisions nonetheless stand in the way of the Secretary's waiver authority. Otherwise, Section 1115 would be meaningless with respect to Section 1396a(a)(14)'s limitation on premiums.

Plaintiffs also observe that Section 1396o has its own waiver provision in subsection (f), with the implication being that it supplants Section 1115. (Memo. at 27.) However, this limited

waiver provision, by its terms, *does not apply to premiums*. It states: "No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary . . . unless [five requirements are met] . . . ." 42 U.S.C. § 1396o(f). As written, Section 1396o(f) in no way modifies the Secretary's Section 1115 waiver authority with respect to premiums. It applies to a "deduction, cost sharing, or similar change" and nothing else. Moreover, Section 1396o(f) does not state, or even imply, that the Secretary can only waive requirements of Section 1396o through Section 1396o(f). To the contrary, by using the language "under any waiver authority of the Secretary," Section 1396o(f) expressly recognizes that the Secretary has waiver authorities other than Section 1396o(f) *that continue to exist*, and it modifies those other authorities *only as to* a waiver of a "deduction, cost sharing, or similar charge." To conclude otherwise would be to find that the Secretary's ability to waive Section 1396a(a)(14) under Section 1115 is all but meaningless—that is, the Secretary technically can waive Section 1396a(a)(14) under Section 1115, but in actuality he cannot waive premium limitations at all and he can only waive cost-sharing restrictions consistent with Section 1396o(f).

Next, Plaintiffs rely on *Pharmaceutical Research & Manufacturers of America v. Thompson*, 251 F.3d 219 (D.C. Cir. 2001), which stated in *dicta* that Section 1115 "does not authorize [the Secretary] to waive . . . the requirement that Medicaid beneficiaries contribute no more than a 'nominal' amount to the cost of medical benefits they receive."[22] *Id.* at 222. Plaintiffs read this to hold broadly that "Section 1115 does not authorize the Secretary to waive the premium and cost-sharing limits." (Memo. at 26.) Plaintiffs are wrong. *Thompson*'s *dicta* was carefully limited to the Secretary's inability under Section 1115 to waive the requirement that beneficiaries

[22] This aspect of *Thompson*'s decision was *dicta* because the Court specifically declined to consider the underlying alternative argument. 251 F.3d at 226.

only contribute a "nominal" amount toward their medical benefits. That requirement comes from Section 1396o(a)(3), which states that "any deduction, cost sharing, or similar charge imposed under the plan . . . will be nominal in amount . . . ." Section 1396o(a)(3) does not apply to premiums—only to "any deduction, cost sharing, or similar charge." Although *Thompson* did not say so, its *dicta* was grounded in Section 1396o(f), which as discussed above provides a separate waiver authority for a "deduction, cost sharing, or similar charge."

Plaintiffs also claim that how the Medicaid Act has been amended over time, allegedly in response to two district court decisions, demonstrates that Congress intended to make it impossible for the Secretary to waive Medicaid's limit on premiums. (Memo at 28–29.) This is a stretch. Both cited district court decisions dealt with cost sharing, not premiums. *Crane*, 417 F. Supp. at 537; *Richardson*, 348 F. Supp. at 493–95. This simple fact eviscerates Plaintiffs' favored narrative. In addition, the excerpted legislative history on which Plaintiffs rely says nothing about limiting the Secretary's ability to waive the limitation on premiums (as opposed to limiting his ability to waive restrictions on cost sharing). *See* S. Rep. 97-757, at 6 (1982) ("The Committee notes that a large number of States have sought waivers of current law relating *to the imposition of cost-sharing* under the demonstration authority at section 1115 of the Act. The Committee believes that this bill gives the States sufficient flexibility *in this regard* to make further exercise of the Secretary's demonstration authority unnecessary." (emphases added)).

B. The Secretary had a rational basis to approve Kentucky HEALTH's premiums.

Plaintiffs also claim that the Secretary lacked a rational basis to approve premiums as part of Kentucky HEALTH. The Commonwealth had sound reasons to request, and the Secretary had a reasonable basis to approve, premiums. As Kentucky explained in its waiver application, in any given year, a significant number of Kentucky Medicaid recipients "churn" back and forth between

Medicaid and commercial coverage. More specifically, Kentucky relied on data estimating that "approximately half of adults with income below 200% FPL will move between Medicaid eligibility and Marketplace coverage at least once a year, while 25% will move between the two programs more than once." (AR at 5444.) Part of Kentucky's hypothesis, which the Secretary agreed was worth testing in light of the above-cited data, is that Kentucky HEALTH enrollees need to experience the unique aspects of marketplace coverage to decrease the churn rate between commercial coverage and Medicaid. (AR at 6, 5444.)

Plaintiffs split hairs by claiming that commercial premiums and Kentucky HEALTH premiums are different in certain respects (for example, commercial premiums are deducted from a participant's paycheck not paid directly[23] and commercial premiums do not vary throughout the year). But commercial premiums and Kentucky HEALTH premiums are identical in the most important respect: enrollees pay their own money on a monthly basis to get health care. At a minimum, the Secretary had a rational basis to conclude that this important similarity made premiums worth testing as part of Kentucky HEALTH.

Plaintiffs make much of studies that, in their view, show that previous Section 1115 demonstration projects with premiums have caused a significant loss in coverage. (Memo. at 30.) To begin with, none of the studies they cite are actually in the administrative record, as opposed to merely being referenced in the record. This is not enough. *See Marcum*, 751 F. Supp. 2d at 80; *Cape Hatteras Pres. Alliance*, 667 F. Supp. 2d at 114.

Plaintiffs principally rely on Indiana's recent experience with premiums in which they say "premiums created substantial barriers to coverage." (Memo. at 31 (citing AR 4962–69).) Here

[23] Not all commercial premiums are automatically deducted from an enrollee's paycheck. For example, private market coverage not through an employer typically requires monthly payments.

again, Plaintiffs' brief cites a mere reference to Indiana's data, not the actual data. In any event, the Indiana data sharply undercuts Plaintiffs' position on premiums. Only 5 percent of participants in Indiana's program were dis-enrolled for non-payment of premiums.[24] Plaintiffs' statement that 55 percent of Indiana enrollees failed to pay their premiums is deceptive, as enrollees for whom payment of a premium was optional accounted for 88 percent of the non-payers. POWER Account, at 8. In addition, while Indiana's data showed that 23 percent of enrollees did not make their initial premium payment, the data also suggested that half or so of those enrollees either reapplied for the program and paid the premium or were enrolled in another Medicaid category. *Id.* at 12, 22.

In addition to distorting the data about premiums and enrollment, Plaintiffs fail to mention a crucial aspect of Indiana's data about premiums, which is in the administrative record. As Kentucky explained in its waiver application, premiums in Indiana have been positively correlated with healthy behavior:

> [P]remium payments are critical to member engagement, as studies have shown that making regular monthly premiums may actually lead to better health outcomes for members. In Indiana, where Medicaid eligible adults are required to pay monthly premiums equal to 2% of income, members making contributions had higher satisfaction rates, higher primary and preventative care utilization, higher drug adherence, and lower emergency room use than those who did not.

(AR 5464–65; *see also, e.g.*, AR 4934, 4947 (providing this data).) All of this goes to show that Plaintiffs' views about the negative effects of premiums are strongly contested in the administrative record.

Even so, the Secretary took at least two specific steps to respond to concerns about premiums and coverage. *First*, in its approval letter, CMS noted that Kentucky HEALTH limits

[24] Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, at 10 (Mar. 31, 2017), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf (last visited Apr. 23, 2018).

dis-enrollment due to premium non-payment by providing an "'on-ramp' that enables these individuals [*i.e.*, those who lose coverage due to non-payment of premiums] to regain eligibility and successfully access all of the benefits, resources, and tools of the Kentucky HEALTH program, without waiting until the end of the non-eligibility period." (AR at 7.) This refers to Kentucky HEALTH's early re-enrollment process, which allows an enrollee who loses coverage due to premium non-payment to re-enroll, once a year, *before* his six-month ineligibility period runs. (AR at 41.) This early-enrollment process minimizes the number of enrollees who will lose coverage for any meaningful length of time for failing to pay premiums. *Second*, so as to limit the number of individuals who lose coverage due to non-payment of premiums, CMS noted that "Kentucky has taken steps to protect beneficiaries [from being dis-enrolled due to premium nonpayment] by exempting certain vulnerable populations, such as pregnant women and individuals who are medically frail . . . as well as by allowing temporary good cause exemptions in certain circumstances . . . ." (AR at 7.) Similarly, Kentucky does not require enrollees under 100 percent of FPL to pay their premiums, further decreasing the likelihood that enrollees will be dis-enrolled for not paying their premiums. (AR at 39–40.) In these ways, the Secretary directly responded to the public comments in the record suggesting that penalties for non-payment of premiums result in coverage problems.

Plaintiffs also argue that the real purpose of premiums is to reduce overall enrollment in Kentucky HEALTH. (Memo. at 32.) But if that were true, why does Kentucky HEALTH include early re-enrollment provisions for those who fail to pay premiums? Why does Kentucky HEALTH make premiums optional for those under 100 percent of FPL? And why does Kentucky HEALTH go out of its way to exempt the medically frail from paying premiums and provide a good-cause exemption? Plaintiffs' brief has no answer to these questions.

Plaintiffs lastly argue that the Secretary failed to address various comments about premiums in the administrative record. The Secretary's burden in responding to comments in the administrative record is not "particularly demanding." *Cooper Hosp.*, 179 F. Supp. 3d at 54 (quoting *Public Citizen, Inc. v. F.A.A.*, 988 F.2d 186, 197 (D.C. Cir. 1993)); *see also C.K.*, 92 F.3d at 185 ("We will not assume that the Secretary ignored the materials presented in contravention of the state's position simply because, in the end, she was not persuaded by them."). The most relevant and significant pushback that the Secretary received related to premiums concerned how many enrollees will lose Medicaid coverage if premiums are imposed, a topic that, as discussed above, CMS directly addressed. *See Public Citizen*, 988 F.2d at 197. The 80-plus page approval package for Kentucky HEALTH more than enables the Court to "see what major issues of policy were ventilated . . . and why the agency reacted to them as it did." *Id.* (citation omitted).

VI. The Secretary appropriately waived retroactive eligibility.

Plaintiffs next claim that the Secretary lacks the authority to waive Medicaid's guarantee of retroactive eligibility, which the Secretary has now done in some fashion in Indiana, Arkansas, Iowa, and New Hampshire, in addition to Kentucky. *See* Musumeci, *supra*. On this issue, Plaintiffs cannot overcome the simple fact that Medicaid's retroactivity requirement is located in Section 1396a(a)(34), a provision that is undeniably waivable under Section 1115. Plaintiffs contend that two other provisions, taken together, refute this self-evident fact. Plaintiffs rely on (i) Section 1396a(a)(10), which requires a state plan to "mak[e] medical assistance available" to certain individuals and (ii) Medicaid's definitions section, which defines "medical assistance" as payment for care and services "if provided in or after the third month before the month in which the recipient makes application for assistance . . . ." 42 U.S.C. § 1396d(a). Plaintiffs' argument is nothing more than a simplistic attempt at "gotcha." Plaintiffs fail to mention that the retroactivity provision in

Section 1396(a)(34) also uses the term "medical assistance." It follows that, in waiving Section 1396a(a)(34), the Secretary logically waived the requirement that Kentucky provide "medical assistance" retroactively. At a minimum, that is a reasonable construction of the statute.

Plaintiffs also claim that the Secretary lacked a rational basis to approve a waiver of retroactive coverage. In approving this component of Kentucky HEALTH, CMS concluded that it "encourages beneficiaries to obtain and maintain health coverage, even when healthy. This is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick." (AR at 6.) CMS also observed that, by waiving retroactive coverage, Kentucky HEALTH mirrors commercial coverage, where enrollees receive coverage once it is initiated. (AR at 6–7.) CMS's easy-to-follow reasoning adequately establishes the Secretary's rational basis for waiving retroactive coverage.

Plaintiffs counter 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. (Memo. at 38.) Three points in response: First, CMS directly responded to these types of concerns in the January 12 letter by stating that "where an individual experiences a period of non-eligibility, Kentucky is providing opportunities to return to eligibility"—*i.e.*, the early re-enrollment provisions discussed above. (AR at 9, 41.) This more than suffices under the APA. *See Public Citizen*, 988 F.2d at 197 ("[T]he agency's response to public comments need only 'enable us to see what major issues of policy were ventilated . . . and why the agency reacted to them as it did.'" (citation omitted)); *see also C.K.*, 92 F.3d at 185. Second, CMS further responded to any concerns about the lack of retroactive coverage by requiring automatic ex parte renewals for at least 75 percent of Kentucky HEALTH beneficiaries. (AR at 28.) This will minimizes the number of enrollees with gaps in coverage. (*See* AR 5478–79.) Third, CMS

recognized that any gaps in coverage and resulting financial burdens due to the lack of retroactive coverage would pale in comparison to what would occur if Kentucky "un-expanded" its Medicaid. (AR at 5 ("Without fundamental, sustainable reforms, the Commonwealth expressed that it would be unable to maintain access for currently enrolled populations."). Thus, CMS approved a waiver of retroactive coverage with the recognition, at least in part, that the Commonwealth may well entirely discontinue its participation in expanded Medicaid without a waiver.[25] *See Richardson*, 348 F. Supp. at 496.

VII. Kentucky HEALTH's provisions regarding non-emergency use of the emergency room comply with the APA.

Plaintiffs next challenge Kentucky HEALTH's method of incentivizing enrollees not to use the emergency room for non-emergency treatment. Federal law already allows hospitals to require Medicaid enrollees to pay modest amounts each time they engage in this inefficient behavior. *See* 42 U.S.C. § 1396o-1(e). However, in 2015, nearly 125,000 Medicaid enrollees in Kentucky went to the emergency room for a non-emergent condition. (AR 5463.)

Recognizing that the current framework leaves much to be desired, Kentucky HEALTH links non-emergency use of the emergency room to an enrollee's *My Rewards* account, which an enrollee can use for enhanced benefits, like paying for dental and eye care. (AR at 33–35.) An enrollee's *My Rewards* account accumulates virtual dollars when the enrollee engages in healthy

[25] Plaintiffs also claim that the Secretary failed to respond to comments about Kentucky HEALTH creating financial losses for Medicaid providers. These speculative comments are of limited relevance and required no response. *See Home Box Office, Inc. v. F.C.C.*, 567 F.2d 9, 35 n.58 (D.C. Cir. 1977); *Public Citizen*, 988 F.2d at 197; *see also C.K.*, 92 F.3d at 185. To the extent a response is required, the STCs adequately address any such issues. Plaintiffs further claim that the Secretary failed to respond to comments raising administrative concerns about waiving retroactive coverage. To the extent those comments are not speculative and otherwise require a response, *see Public Citizen*, 988 F.2d at 197, the Secretary adequately addressed any relevant and significant concerns about administrative issues in the STCs.

behavior. (A.R. 5461–63.) However, the opposite also is true: When an enrollee uses the emergency room for non-emergency treatment, his or her *My Rewards* account decreases—by $20 for the first visit, $50 for the second visit, and $75 for every visit thereafter. (A.R. 5463.) To be clear, the *My Rewards* account is not comprised of actual money. In reality, the virtual dollars in a *My Rewards* account are the equivalent of points that fluctuate up and down. Kentucky HEALTH chooses to express those points as virtual dollars to approximate for enrollees a commercial insurance experience. (AR at 4, 6.)

Plaintiffs claim that this incentive structure violates Medicaid's restrictions on cost sharing, which the Secretary did not waive with respect to Kentucky HEALTH. But decreasing the virtual dollars in an enrollee's *My Rewards* account is not cost sharing. At a minimum, it is a reasonable construction of Section 1396o to reach this conclusion. For one thing, enrollees do not contribute money to their *My Rewards* accounts, such that it is deducted from them when they receive non-emergency treatment at an emergency room. And if Plaintiffs lose coverage, they cannot take their *My Rewards* balances with them. (*See* AR at 33, 5463.) Plaintiffs nevertheless ask the Court to collapse the differences between taking money out of an enrollee's pocket—cost sharing—and reducing the amount of virtual money available in an enrollee's *My Rewards* account. As justification, Plaintiffs cite the definition of cost sharing as "any deduction, copayment, or similar charge," 42 U.S.C. § 1396o-1(a)(3)(B), and urge that a reduction in a *My Rewards* account is either a "deduction" or a "similar charge."

However, analyzing Sections 1396o and 1396o-1 as a whole, it is unmistakable that cost sharing means amounts that an enrollee directly pays. *See Rehab. Ass'n of Va., Inc. v. Kozlowski*, 42 F.3d 1444, 1454 (4th Cir. 1994) ("Without getting into much detail, 42 U.S.C. § 1396o relates

to a state's ability to *impose certain charges on certain plan participants* for certain services." (emphasis added)). For example, Section 1396o(e) states:

> The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's *inability to pay* a deduction, cost sharing, or similar charge. The requirements of this subsection *shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.*

Id. (emphases added). The italicized portions of Section 1396o(e) establish that a "deduction, cost sharing, or similar charge" is something that an enrollee directly pays as opposed to something that is taken from a *My Rewards* account for which the enrollee did not pay in the first instance. Section 1396o-1(d)(2) likewise envisions "*the payment* of any cost sharing authorized to be imposed under this section with respect to such care, items, or services." *Id.* (emphasis added). In sum, when Sections 1396o and 1396o-1 talk about cost sharing, they refer to making the enrollee actually pay money to someone else, which is distinguishable from reducing virtual dollars in a *My Rewards* account.

In fact, Kentucky HEALTH itself distinguishes between cost sharing and reducing the amount in an enrollee's *My Rewards* account. More specifically, Kentucky HEALTH permits an enrollee to carry a negative balance in his or her *My Rewards* account. (AR at 34.) However, even if an enrollee's *My Rewards* account has a negative balance, the enrollee is not required to reimburse the deficit. (AR at 35; *see also* AR at 5463.)

VIII. The Secretary appropriately waived Medicaid's redetermination and reporting requirements.

Plaintiffs also contest Kentucky HEALTH's consequences for enrollees who fail to participate in the redetermination process for Medicaid eligibility or who fail to timely report changes that affect Medicaid eligibility. Applicable law already requires enrollees to do both of

these things. Kentucky HEALTH merely adds teeth to the existing requirements. Specifically, after failing to complete the redetermination process, Kentucky HEALTH enrollees will have an additional 90 days to rectify the problem before they are dis-enrolled from the program for up to six months, with allowance made for a good-cause exception and early re-enrollment. (AR at 27.) As to the reporting requirement, Kentucky HEALTH enrollees must report changes affecting their Medicaid eligibility during the required reporting period to avoid losing Medicaid eligibility for up to six months, with allowance made for a good-cause exception and early re-enrollment. (AR at 30.)

Plaintiffs challenge these requirements on the basis that, during the previous administration, the Secretary rejected Indiana's request for a waiver related to Medicaid's redetermination requirements. As discussed above, whether or not to approve a waiver request is based upon "case-by-case, fact-based determinations," *Cooper Hosp.*, 179 F. Supp. 3d at 51, and appropriately can be tied to "the political and sociological orientation or general policy, of the Administration then in power," *Richardson*, 348 F. Supp. at 496; *C.K.*, 92 F.3d at 187. Thus, in light of the experimental, fact-found nature of waivers, Plaintiffs' reliance on the Secretary's reversal from Indiana to Kentucky does not add up to much.

Plaintiffs nonetheless claim that the Secretary did not adequately explain his shift from Indiana's denial to Kentucky's approval. All that the Secretary needed to do, however, was display awareness of the change, which he did (AR at 7), and establish that "there are good reasons for the new policy," which he also did. *See Navarro*, 136 S. Ct. at 2126 (citation omitted). As for the latter showing, CMS gave three primary reasons for approving Kentucky HEALTH's redetermination component: (i) it "strengthen[s] beneficiary engagement in their personal health care plan" (AR at 5); (ii) it "encourages individuals to maintain compliance with beneficiary responsibilities

requirements . . . that also protect program integrity" (AR at 6); and (iii) it helps enrollees understand what commercial coverage is like (AR at 7). As to why the Secretary approved Kentucky's application but not Indiana's, CMS explained that "this policy should be evaluated and is likely to support the objectives of Medicaid to the extent that it prepares individuals for a smooth transition to commercial health insurance coverage and ensures that resources are preserved for individuals who meet eligibility requirements." (*Id.*) The foregoing explanation is more than enough under the APA. *See Navarro*, 136 S. Ct. at 2126.

Plaintiffs also claim that the Secretary did not adequately respond to the comments opposing Kentucky HEALTH's redetermination and reporting requirements. As mentioned above, the Secretary's job in this regard is "not particularly demanding." *Cooper Hosp.*, 179 F. Supp. 3d at 54 (citation omitted). To the extent that the comments Plaintiffs point to are not speculative, *see Public Citizen*, 988 F.2d at 197, CMS adequately responded to any relevant and significant comments about potential risks associated with consequences for enrollees who violate longstanding reporting and redetermination requirements. *See Cooper Hosp.*, 179 F. Supp. 3d at 54; *see also C.K.*, 92 F.3d at 185. As mentioned above, CMS's January 12 letter underscored how important early re-enrollment was to the Secretary's approval of Kentucky HEALTH. (AR at 5, 9.) In addition, the Secretary required an ex parte re-approval rate of at least 75 percent, which further responds to the comments cited by Plaintiffs. (AR at 28.) These aspects of the Secretary's reasoning constitute a more than adequate response to the comments. *See Cooper Hospital*, 179 F. Supp. 3d at 54; *Public Citizen*, 988 F.2d at 197; *C.K.*, 92 F.3d at 185.

IX. The Secretary's waiver of NEMT requirements must be upheld.

Plaintiffs also challenge the Secretary's waiver of Medicaid's NEMT requirements. Similar waivers have been approved in Indiana and Iowa. *See Musumeci*, *supra*. Kentucky

requested a waiver of NEMT requirements, in part, to allow enrollees in Kentucky HEALTH to experience something like the commercial marketplace, which does not offer NEMT. (AR at 5454.) Plaintiffs concede (Memo. at 41 (citing AR at 116)) that the Secretary relied upon this rationale in approving the NEMT waiver for Kentucky HEALTH. *Cf. Aguayo*, 473 F.2d at 1103, 1106. The Secretary had a rational basis to approve NEMT as part of the larger package of components of Kentucky HEALTH that mirrors a commercial experience. (AR at 6–7.)

In arguing that the Secretary lacked a rational basis to approve this component of Kentucky HEALTH, Plaintiffs argue that the Secretary should have relied on data from Iowa and Indiana, both of which are operating with a NEMT waiver, to find that such a waiver in Kentucky is inappropriate.[26] In Plaintiffs' view, the Iowa and Indiana data show that NEMT waivers restrict access to care.[27] However, the data actually shows that those without NEMT actually miss *fewer* medical appointment than those with NEMT.[28] In Indiana, only 6 percent of those *without* NEMT reported missing a medical appointment because of transportation, while 10 percent of those *with* NEMT reported missing a medical appointment because of transportation. (AR 4908.) Kentucky

[26] Plaintiffs do not cite the location of the Iowa data in the administrative record, but instead argue that it is "incorporate[d]" therein. (Memo. at 40.) As discussed above, the mere fact that data is referenced in the record does not mean it is before the agency. *See Marcum*, 751 F. Supp. 2d at 80; *Cape Hatteras Pres. Alliance*, 667 F. Supp. 2d at 114. The same goes for the studies mentioned in footnotes 17 and 18 of Plaintiffs' brief, which were not before the Secretary.

[27] Plaintiffs cite AR 3870 for the alleged proposition that "the data from Iowa show that eliminating NEMT disproportionately affects women, people of color, and enrollees with significant health needs." However, the cited source makes this statement with no analysis of how the relevant Iowa data shows this, while in the same breath admitting that the analysis of the Iowa project is not complete. Absent more, this part of the administrative record need not factor into the Secretary's decision. *See, e.g.*, *Home Box Office*, 567 F.2d at 35 n.58.

[28] Some of the Indiana data can be found at AR 4908, while the Iowa data can be found at Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan, at 22 (March 2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-nemt-rpt-mar-2016.pdf (last visited Apr. 25, 2018).

specifically raised these points in its waiver application. (AR 5478.) It cannot be said that the Secretary lacked a rational basis to approve a NEMT waiver as part of a holistic attempt to create a commercial experience for enrollees, especially in light of the data referenced in Kentucky's application.

Plaintiffs argue in passing that the Secretary failed to take account of purported evidence that waiving NEMT could increase enrollees' non-emergency use of the emergency room. All of the cited excerpts from the administrative record are conclusory and speculative, and none of them include data as part of the administrative record that the Secretary could evaluate to test any alleged correlation between the lack of NEMT and increased use of the emergency room for non-emergency purposes. *See Public Citizen*, 988 F.2d at 197; *Home Box*, 567 F.2d at 35 n.58. Any such data, in any event, would have to overcome the above-discussed results from Indiana and Iowa.

CONCLUSION

The Court should grant the Commonwealth's motion for summary judgment and deny Plaintiffs' motion.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on April 25, 2018 I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to the following:

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