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 REPLY IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

This renewed challenge to Kentucky HEALTH invites the Court to take a series of extreme positions *en route* to substituting its judgment for that of the Secretary. At bottom, the Plaintiffs ask the Court to hold that the Medicaid Act is concerned with paying for health care for as many people as possible *and nothing else*. The Medicaid Act, in the Plaintiffs' view, cares not about whether Medicaid actually improves the health and well-being of recipients. Nor, argue the Plaintiffs, is the Medicaid Act concerned with whether Medicaid is financially sustainable for the States or with whether Medicaid recipients have the ability to improve their means and move off of public assistance. These arguments, which are irreconcilable with the purposes, history, and text of the Medicaid Act, should be rejected, and Kentucky HEALTH should be upheld as a legitimate exercise of the Secretary's judgment under Section 1115.

ARGUMENT[1]

I. The Secretary's interpretation of the objectives of Medicaid receives deference.

The Plaintiffs lead off by arguing that *Chevron* deference does not apply here. (Pls. Br. at 2-3.) The Court has already assumed that *Chevron* deference applies to the Secretary's interpretation of the "objectives" of Medicaid under Section 1115, *see Stewart v. Azar*, 313 F. Supp. 3d 237, 260 (D.D.C. 2018), and the Court has acknowledged that "the 'objectives' of Section 1115 may be ambiguous," *id.* The Plaintiffs have offered no reason for the Court to depart from this line of reasoning.

[1] The Commonwealth incorporates by reference the Federal Defendants' arguments regarding Counts 1 and 9 of the Plaintiffs' Amended Complaint. In addition, the Commonwealth incorporates by reference the Federal Defendants' arguments opposing the Plaintiffs' requested relief (ECF No. 107 at 41-42 & n.11) while noting the effect of Governor Bevin's January 12, 2018 executive order (ECF No. 25-1).

The Plaintiffs argue otherwise by claiming that Kentucky HEALTH concerns a question of "deep 'economic and political' significance that is central to [a] statutory scheme" under *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). However, unlike the permanent, nationwide reforms at issue in *King*, Kentucky HEALTH is a time-limited waiver that primarily affects participants in expanded Medicaid in a single state. Further differentiating *King* is the fact that the agency involved in that case, the Internal Revenue Service, had "no expertise" in the health policy issue at stake. *Id.* The Secretary, by contrast, has undisputed expertise in the issues raised here. And perhaps most importantly, *King*'s rule does not apply where Congress clearly gives an agency discretion over a matter. *See id.* ("[H]ad Congress wished to assign that question to an agency, it surely would have done so expressly."); *Util. Air Regulatory Grp. v. E.P.A.*, 573 U.S. 302, 324 (2014) ("We expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'"). Congress has done so here. In Section 1115, Congress expressly concluded that the determination of whether "any experimental, pilot, or demonstration project" is "likely to assist in promoting [Medicaid's] objectives" is made "*in the judgment of the Secretary*." 42 U.S.C. § 1315(a) (emphasis added). Through this "express delegation of specific interpretive authority," *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001), Congress made clear that the Secretary's interpretation of Section 1115, and more specifically his interpretation of the objectives of Medicaid, should have the force of law. *See, e.g.*, *Pharm. Res. & Mfrs. Am. v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004) (applying *Chevron* deference where "Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments").

Nor does the *Utility Air Regulation Group* decision get the Plaintiffs around *Chevron* deference. The Plaintiffs rely on a passage from that decision stating that "[w]hen an agency claims

to discover in a long-extant statute an unheralded power to regulate 'a significant portion of the American economy,' we typically greet its announcement with a measure of skepticism." 573 U.S. at 324 (internal citation omitted). The Secretary has not found an "unheralded power" here. Instead, like previous Secretaries, he has used Section 1115 to waive requirements in the Medicaid Act to the extent necessary to test out an "experimental, pilot, or demonstration project." 42 U.S.C. § 1315(a). The fact that the Secretary is testing a program that differs from those tried by previous Secretaries does not make his use of Section 1115 "unheralded." After all, that is the whole point of Section 1115—to foster innovation by allowing the States to try *new* ideas, which may provide a template for new policies at the federal level. The Plaintiffs cannot help but agree. (*See* Pls. Br. at 22 ("Plaintiffs do not contest that Congress enacted Section 1115 to allow states to carry out time-limited demonstrations designed to test novel ideas . . . .").) Nor does the Secretary's approval of Kentucky HEALTH give him the power to regulate "a significant portion of the American economy," as in *Utility Air Regulation Group*. To reiterate the point from above: Kentucky HEALTH is a temporary program that only affects certain Medicaid recipients in Kentucky.

II. The Secretary reasonably discerned the "objectives" of the Medicaid Act.

The Plaintiffs again argue that the Secretary improperly discerned the "objectives" of the Medicaid Act under Section 1115. (Pls. Br. at 8-20.) The Plaintiffs, however, cannot overcome the *Chevron* deference to which the Secretary is entitled on these questions. Nor can they show that the Secretary actually misread the Medicaid Act in determining its objectives. Reduced to its core, the Plaintiffs' argument is that the Medicaid Act only cares about paying for health care for as many people as possible. That argument should be rejected with or without *Chevron* deference.

Fiscal sustainability. According to the Plaintiffs, the fiscal sustainability of the Medicaid program "is not a legitimate objective under Section 1115." (Pls. Br. at 9.) Taken to its logical conclusion, this means that the Medicaid Act cares not one iota about whether states choose to participate in the Medicaid program or, more specifically, in the Medicaid expansion. That is a hard argument to press for a cooperative federal-state program like Medicaid that requires the participation of *both* the federal government and the States. The fact that the federal government pays for a high, albeit decreasing-over-time, percentage of expanded Medicaid suffices to refute the Plaintiffs' assertion that the Medicaid Act takes no account of whether the States are in a financial position to participate. *See* 42 U.S.C. § 1396d(y)(1). More to the point, if the States' financial positions were irrelevant to the Medicaid Act, why did Congress offer them a higher initial share of federal funding? This point also can be seen in 42 U.S.C. § 1396-1, which provides that Medicaid appropriations (at least for the four populations listed) are to enable each State to provide medical assistance "as far as practicable under the conditions in such State." Section 1396-1's mention of practicability is an unmistakable endorsement of Medicaid's sustainability rationale.

The Plaintiffs' sustainability arguments also are foreclosed by precedent. The Plaintiffs cannot distinguish the Supreme Court's and D.C. Circuit's binding holdings in *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003), and *Pharmaceutical Research & Manufacturers of America v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004). Both of these decisions convey that advancing the sustainability of Medicaid is in fact an objective of the Medicaid Act. *Thompson*, for example, upheld as "reasonable on its face" the Secretary's conclusion that the challenged provision would "further the goals and objectives of the Medicaid program" by preventing borderline populations from becoming Medicaid eligible, thereby

preserving scarce state resources. *See id.* at 824-25 (quoting Fed. Gov't Br.). The Plaintiffs' lead argument to the contrary is that "*Walsh* addressed a preemption challenge to a state Medicaid program and did not purport to define or determine the objectives of the Medicaid Act for the purpose of Section 1115." (Pls. Br. at 9.) It is true that *Walsh* was not a Section 1115 case. Neither was *Thompson*. Those cases, however, discussed the "purposes," "goals," and "objectives" of Medicaid. *Walsh*, 538 U.S. at 663; *id.* at 687 (O'Connor, J., concurring in part & dissenting in part) (discussing the "Medicaid goal" of "stretching available resources to the greatest effect"); *Thompson*, 362 F.3d at 824-25. It is splitting hairs to write off *Walsh* and *Thompson* for the simple reason that they did not concern Section 1115. *Thompson*'s and *Walsh*'s language about the "purposes," "goals," and "objectives" of Medicaid obviously parallels the language in Section 1115 about the "objectives" of Medicaid. The Plaintiffs also distinguish *Walsh* because the program there, in their judgment, "is the kind of fiscally sound policy that also promotes the provision of medical assistance." (Pls. Br. at 9.) In so arguing, the Plaintiffs invite the Court to adopt their favored policy preferences when Section 1115 leaves such "judgment" exclusively to the Secretary.

The Plaintiffs also challenge the Secretary's conclusion, and the position of the Obama administration, that Kentucky has the discretion to "un-expand" Medicaid.[2] They do so to dispute the Secretary's commonsense conclusion that Kentucky HEALTH furthers the provision of

[2] The Plaintiffs claim that "states, such as Kentucky, that opted-in understood the bargain" of not being able to opt-out. (Pls. Br. at 11.) That is demonstrably wrong. As Kentucky has explained, before it expanded, it specifically reserved its right to "un-expand." (ECF No. 50-3 at 2.) And well before Kentucky expanded Medicaid, the prior administration unambiguously informed States that they can leave expanded Medicaid, if they so choose. (Ky. Op. Br. at 13-14.) The Plaintiffs dismiss the Obama administration's conclusion as meaningless, while in the same breath repeating their mantra that the current administration is using Kentucky HEALTH to "'explode' the ACA's Medicaid expansion." (Pls. Br. at 8.) They cannot have it both ways.

medical assistance because the demonstration project enables Kentucky to continue participating in expanded Medicaid for the next five years. (AR at 6731.) The Plaintiffs' argument for why expanded Medicaid is forever mandatory once a state opts in boils down to the fact that the ACA describes the expanded Medicaid population as mandatory. (Pls. Br. at 11.) But that issue was resolved in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012) ("*NFIB*"). The question there was whether Congress could compel States to participate in expanded Medicaid (by making it a mandatory population) under the threat of losing Medicaid funding. The Court squarely held that Congress "cannot . . . withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion." *Id.* at 585. The position that the Plaintiffs are currently pressing is irreconcilable with *NFIB*: by using the word "mandatory," the Plaintiffs argue, Congress *can* in fact "withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion." At base, the Plaintiffs' argument about a state's inability to "un-expand" cannot coexist with *NFIB*. *See id.* at 587 ("*States may now choose to reject the expansion*; that is the whole point . . . . Some states may indeed decline to participate . . . *because they are unsure they will be able to afford their share of the new funding obligations* . . . ." (emphasis added)).

The Plaintiffs next criticize what they characterize as Governor Bevin's alleged "threat" to end expanded Medicaid in Kentucky. (Pls. Br. at 1.) To be clear, the Governor's policy judgment about whether Kentucky continues to participate in expanded Medicaid, which Kentucky law leaves to his judgment and which is reflected in an executive order, is not a "threat." (*See* ECF 25-1.) The Governor's executive order is the law of Kentucky, and it reflects his policy judgment as the Commonwealth's duly elected chief executive that Kentucky will not be able to afford expanded Medicaid going forward absent Kentucky HEALTH. *See* Ky. Const. § 69. The Plaintiffs,

it should be noted, do not dispute that the Governor's executive order is in fact the law of Kentucky. Indeed, in rejecting the Federal Defendants' request for transfer, the Court concluded that this case does *not* raise questions of Kentucky law. *See Stewart v. Azar*, 308 F. Supp. 3d 239, 249 (D.D.C. 2018) ("[A] federal court need not wade into any particulars of state law to decide whether the Secretary can, under federal laws and regulations, permit certain state Medicaid proposals.").

Although the Plaintiffs do not challenge Governor Bevin's executive order on state-law grounds, they do urge that "there is no evidence in the record that Kentucky in fact lacks the funding to maintain coverage of the expansion population (or other optional groups or services) without Kentucky HEALTH." (Pls. Br. at 14.) As a threshold matter, this assertion ignores the reality on the ground in Kentucky. After the Court's remand, the Commonwealth, for a time, had a projected Medicaid shortfall for this biennium of nearly $300 million. *See, e.g.*, Lisa Gillespie, *Ky. Officials Warn of Shortfall, Consider Ending Medicaid Expansion* (Aug. 30, 2018), *available at* https://wfpl.org/ky-officials-warn-of-shortfall-consider-ending-medicaid-expansion/ (last visited Feb. 28, 2019). This is fully consistent with Kentucky's description of its budgetary predicament in its waiver application.[3] (AR at 5439 (stating that the growing costs of expanded Medicaid "have the potential to challenge the overall state budget and could create funding issues for other programs, such as education, pensions, and infrastructure, as well as also jeopardize

[3] In addition, the massive unfunded liability associated with Kentucky's public pension system, which is among the worst funded in the nation, is a matter of public record. *See, e.g.*, *Bevin v. Commw. ex rel. Beshear*, 563 S.W.3d 74, 78 (Ky. 2018) ("In response to the inadequate funding of Kentucky's public employee pension systems and a rising concern about the ability of those systems to meet future obligations, the Kentucky General Assembly opened its 2018 session with ambitious plans to address *the looming financial threat* by reforming the public pension systems." (emphasis added)). In fact, that unfunded liability could be as high as $84 billion. *See* Special Session Proclamation (Dec. 17, 2018), *available at* http://apps.sos.ky.gov/Executive/Journal/execjournalimages/2018-PROC-258725.pdf (last visited Mar. 1, 2019).

funding for the traditional Medicaid program that covers the aged, blind, disabled, pregnant women and children").)

Regardless, it cannot be the case that a state must submit budgetary worksheets before the Secretary can agree to a Section 1115 waiver to further the sustainability of Medicaid. There is nothing irrational about the Secretary relying on Governor Bevin's executive order in the absence of budgetary worksheets. In determining that expanded Medicaid in Kentucky is at risk so as to justify Kentucky HEALTH, the Secretary did not rely on the offhand remark of a mid-level government official who is not the final authority on whether Kentucky will "un-expand" in the absence of Kentucky HEALTH. Instead, the Secretary relied on the final decision of the duly elected official in Kentucky who is charged with making this policy decision under state law and who has reduced that decision to a written executive order. *Cf. NFIB*, 567 U.S. at 587 (holding that states may choose not to participate in expanded Medicaid merely because "they are unsure they will be able to afford their share of the new funding obligations").

The Plaintiffs also attack the Secretary's sustainability rationale on the ground that, if sustained, it allegedly "would make Section 1115 authority virtually limitless." (Pls. Br. at 12.) That is a vast overstatement. In the Plaintiffs' view, "any proposed project that cuts spending would then pass muster under Section 1115 so long as the state continued to cover some populations and/or services." (*Id.*) To begin with, Kentucky HEALTH is not a program that merely "cuts spending." It is an innovative, first-of-its-kind program that advances several of Medicaid's objectives, only one of which is making expanded Medicaid more sustainable for Kentucky. To dismiss Kentucky HEALTH as merely cutting spending is to ignore, for example, its groundbreaking community-engagement program and *My Rewards* accounts. Also, if Kentucky HEALTH solely concerns "cutting spending," why does it provide access to optional services

(benefits for which Kentucky is under no obligation to foot part of the bill), like dental and vision care and prescription drugs? And why does the umbrella KY HEALTH waiver guarantee non-Medicaid benefits like SUD treatment to enrollees? The Plaintiffs have no answer to these questions. Consequently, if the Court upholds Kentucky HEALTH under the Secretary's sustainability rationale, as it should, the Court will not be opening the door to any Section 1115 waiver that merely cuts costs.

The Plaintiffs also assert that upholding Kentucky HEALTH will facilitate the "slicing and dicing [of] coverage in any way the Secretary would allow." (Pls. Br. at 13.) To the contrary, Section 1115 is being used *to expand medical assistance* beyond what Kentucky can otherwise provide. Virginia's recent experience with expanded Medicaid nicely illustrates this point. Virginia recently agreed to cover the new adult population, but as a condition of expansion, required the submission of a Section 1115 waiver application that, among other things, contains a community-engagement program. 2018 Va. Acts 1st Sp. Sess. Ch. 2 (HB 5002), at 306-07 (2018); *see also* Virginia Waiver Application (Nov. 20, 2018), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-pa4.pdf (last visited Feb. 28, 2019). Viewed through Virginia's lens, Section 1115 is a means for expanding medical assistance that otherwise would not exist. Kentucky's situation is the flip side of the same coin. Whereas Virginia would not have expanded Medicaid without a Section 1115 waiver, Kentucky cannot keep expanded Medicaid absent a Section 1115 waiver. In both states, making expanded Medicaid a reality equally justifies the respective Section 1115 waivers (assuming Virginia's application is granted).

Health and Well-Being. The Plaintiffs continue to argue that promoting health and well-being is not a permissible objective of the Medicaid Act. (Pls. Br. at 15-16.) In their view, the

Medicaid Act is all about paying for health care for as many people as possible without any consideration of whether that health care actually improves the health and well-being of these people. That argument cannot be squared with the Medicaid Act's purposes, history, and plain language. In fact, to state that argument is to refute it.

The Plaintiffs claim that the "Defendants cite no authority" on the health and well-being point, but the point is self-evident for a program that provides health care. In any event, the Plaintiffs do not mention the fact that Medicaid's definition of "medical assistance" expressly incorporates health and well-being as an objective of Medicaid, as does the Medicaid Act's requirement that medical assistance be provided with "reasonable promptness." (Ky. Op. Br. at 6-8.) Their silence on these points is telling. As Kentucky explained, and as the Plaintiffs did not dispute, the Medicaid Act defines the "medical assistance" that Medicaid provides as including *both* the "payment of part or all of the cost of the following care and services *or the care and services themselves*, or both." 42 U.S.C. § 1396d(a) (emphasis added). This provision confirms that the Medicaid Act is just as concerned with paying for health care as it is with the health care itself. In light of the Medicaid Act's focus on health care separate and apart from paying for that health care, it was a permissible, and indeed the correct, construction of Section 1115 for the Secretary to conclude that an objective of the Medicaid Act is promoting health and well-being. The Medicaid Act's requirement that a state plan must ensure that medical assistance is furnished with "reasonable promptness" underscores this point. *See* 42 U.S.C. § 1396a(a)(8). If the Medicaid Act is only concerned with paying for health care for as many people as possible, as the Plaintiffs contend, why does it have a state-plan requirement that health care be provided with "reasonable promptness"? Under the Plaintiffs' narrow view of Medicaid's objectives, the Medicaid Act is internally inconsistent.

Rather than address this point, the Plaintiffs fall back on criticizing the alleged "sheer breadth" of the Secretary's position. (Pls. Br. at 15.) In this regard, they reference the Court's previous statement that if "the Secretary could exercise his waiver authority solely to promote health . . . . [n]othing could stop him from conditioning Medicaid coverage on consuming more broccoli (at least on an experimental basis)." *See Stewart*, 313 F. Supp. 3d at 267-68. Several points in response: First, even if a "broccoli mandate" is permissible under Section 1115, the Plaintiffs' argument presupposes that only an Article III court can stop it. The political processes would almost certainly step in long before the "broccoli mandate" made it to a courtroom. The judicial branch, it must be remembered, is not the only check on the Secretary's Section 1115 waiver authority. If Congress does not like a Section 1115 waiver, it of course has the power to modify Section 1115 accordingly. And even if Congress does not stop the waiver, the People can respond by electing a President with a new Secretary who will not approve a "broccoli mandate." The People also can choose to elect new state decisionmakers who will not request a "broccoli mandate" from the Secretary under Section 1115.

Second, a judgment upholding Kentucky HEALTH will not pave the way to a "broccoli mandate." The Court's careful language about this issue confirms as much. The Court noted that, in its view, this hypothetical might arise if "the Secretary could exercise his waiver authority *solely to promote health*." *See id.* (emphasis added). As the italicized language demonstrates, the "broccoli mandate" hypothetical only comes into play if the Secretary approves a Section 1115 waiver *solely* to promote health and well-being. As has been thoroughly explained in this matter, the Secretary identified other objectives that Kentucky HEALTH also advances, such as Medicaid sustainability, independence, and providing optional services to enrollees. Presumably, a proposed

"broccoli mandate," like that mentioned by the Court, would not advance the other objectives identified by the Secretary in this matter.

Third, Kentucky HEALTH obviously takes a much more nuanced, and appropriate, approach to promoting health and well-being than does a simple "broccoli mandate." A "broccoli mandate" addresses only physical health, and it would be next-to impossible for a state to operationalize such that enrollees' broccoli consumption can be tracked and audited. Kentucky HEALTH, by contrast, can be effectively implemented (as Kentucky has spent considerable time doing), and it approaches health and well-being from the more refined, research-based perspective of encouraging enrollees to participate in their communities, which (Kentucky expects) will lead to better mental and physical health and well-being and will give enrollees the tools and knowledge they need to improve their circumstances. To compare Kentucky HEALTH's holistic approach to improving health and well-being with a simplistic "broccoli mandate" is to equate a Bach concerto to a nursery rhyme. If the Court upholds Kentucky HEALTH based upon its objective of improving Kentuckians' health and well-being, a subsequent court will have ample latitude to reject a rudimentary "broccoli mandate" in the unlikely event it ever makes it through the political processes.

Independence. The Plaintiffs' response mainly reiterates their position that promoting independence from Medicaid is not an objective of the Medicaid Act. In essence, the Plaintiffs believe that the Medicaid program generally, and expanded Medicaid in particular, takes no account of whether enrollees actually have the ability to move beyond Medicaid. The fact that expanded Medicaid is tied solely to income casts substantial doubt on that argument. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

The Plaintiffs do acknowledge that some form of independence is an objective of Medicaid based upon the language of 42 U.S.C. § 1396-1. In their view, to the extent independence is an objective of Medicaid, that independence refers only to *functional* independence, not to *financial* independence. (Pls. Br. at 20.) This argument, as Kentucky has explained, takes a definition of independence that makes some sense for the traditional Medicaid populations that are listed in Section 1396-1 and imposes it onto a population for whom that definition is nonsensical. Instead of grappling with this point, the Plaintiffs claim that Kentucky is advancing "the 'two program' argument the Court already rejected." (Pls. Br. at 17.) Kentucky, however, is merely arguing that the Secretary rationally determined that independence means different things to different people. The Medicaid expansion brought into Medicaid a population that is different in kind from the traditional Medicaid populations. This is not just the Secretary's or Kentucky's position, but the Supreme Court's. It held in *NFIB* that:

> The Medicaid expansion, however, accomplishes *a shift in kind, not merely degree*. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. See 42 U.S.C. § 1396a(a)(10). . . . Under the Affordable Care Act, Medicaid is *transformed* into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level.

NFIB, 567 U.S. at 583 (emphasis added). In light of the Medicaid expansion's "shift in kind" that "transformed" Medicaid, it was rational for the Secretary to take account of the different characteristics of the population covered by Kentucky HEALTH (most of whom are in the new adult population) in defining "independence."

The Plaintiffs next understate the differences between the traditional Medicaid populations and the population covered by Kentucky HEALTH. The Plaintiffs claim that there is a "substantial overlap between all Medicaid-eligible population groups." (Pls. Br. at 18.) That argument not only ignores the above quotation from *NFIB*, but also overlooks Kentucky HEALTH's careful structure,

which excludes all but the most able-bodied from most of its challenged requirements. Kentucky HEALTH, for example, excludes the "medically frail" from its community-engagement program as well as many other requirements. (AR at 6757, 6760, 6762, 6766, 6774.) Kentucky HEALTH also excludes the primary caregiver of a dependent child from the community-engagement requirement. (AR at 6774.) In short, Kentucky HEALTH goes out of its way to include only those most able to comply with its community-engagement requirement. To say, as the Plaintiffs do, that there is "substantial overlap" between the traditional Medicaid populations and the population covered by Kentucky HEALTH is to ignore the careful carve-outs in Kentucky HEALTH.

The Plaintiffs also attempt to marginalize 42 U.S.C. § 1396u-1's role in defining the objectives of the Medicaid Act. The Plaintiffs, however, cannot escape the simple fact that if financial independence is not an objective of the Medicaid Act, then Section 1396u-1, which is part of the Medicaid Act, contradicts the Act's objectives by allowing Medicaid to be terminated for "refusing to work" in non-compliance with TANF's work requirements. *See* 42 U.S.C. § 1396u-1(b)(3)(A). The Court's job, though, is to read the Medicaid Act so that all of it, not just some of it, makes sense. *See, e.g.*, *W. Fuels-Utah, Inc. v. Lujan*, 895 F.2d 780, 785 n.6 (D.C. Cir. 1990) (holding that a statutory provision is "a part of the 'statute as a whole' that we must interpret"). The Plaintiffs argue otherwise by claiming that Section 1396u-1 does not relate to the objectives of Medicaid because it is "an example of Congress's careful balancing of competing policy interests." (Pls. Br. at 19.) But all statutes in some way or another constitute a "careful balancing of competing policy interests." The Plaintiffs also try to distinguish Section 1396u-1 by analogizing it to 42 U.S.C. § 1396f, which grants religious protections to those receiving medical assistance through Medicaid. Statutes like these, according to the Plaintiffs, simply do not define the "core objectives of the statute." In essence, the Plaintiffs claim that these provisions of the

Medicaid Act have a second-class status in discerning Medicaid's objectives. But Section 1396f clearly relates to the objectives of Medicaid by clarifying that the objective of providing medical assistance does not extend to providing medical assistance over a recipient's religious objections.

III. The Secretary amply considered the effect of Kentucky HEALTH on coverage.

The Plaintiffs claim that the Secretary's revised approval does not "show a reasonable evaluation of the coverage loss" that Kentucky HEALTH allegedly will cause. (Pls. Br. at 25.) The Plaintiffs' brief on this point is riddled with contradictions. They argue that "criticisms of the 95,000 figure are unfounded," but then concede the Secretary's conclusion that Kentucky's initial budget projections "do not show that '95,000 individuals will completely lose coverage and not regain it.'" (*Id.* (citing AR at 6731).) The Plaintiffs then fault the Secretary for not providing a "bottom-line estimate" of how many enrollees will lose coverage (*id.* at 27), but elsewhere acknowledge that they "do not claim that the Secretary must perfectly predict the exact outcomes of a Section 1115 proposal" (*id.* at 23).

The Plaintiffs relegate to a brief footnote their discussion of the fact that Section 1115 itself envisions that a waiver can cause individuals to lose coverage. (Pls. Br. at 25 n.4.) This is a critical fact. As Kentucky and the Federal Defendants have explained, Section 1115(d)(1) provides that a demonstration project can "result in an impact on eligibility." *See* 42 U.S.C. § 1315(d)(1). Section 1115(d)(1) does not foresee that a waiver "may" alter eligibility, but instead that a waiver "would" change Medicaid eligibility. Rather than admit that Section 1115(d)(1) specifically contemplates what they think is wrong with Kentucky HEALTH, the Plaintiffs try to draw a distinction between a demonstration project that affects eligibility versus one that causes coverage loss. This is a distinction without a difference. If a demonstration project alters eligibility requirements, as Section 1115(d)(1) anticipates, coverage loss naturally will follow for those who are no longer

eligible. Also, Section 1115(d)(1) mentions that a demonstration project can affect "enrollment" or "benefits" as well, which further undermines the Plaintiffs' position.

Continuing the Plaintiffs' theme of putting points that favor Kentucky HEALTH in footnotes, the Plaintiffs summarily dismiss the many "guardrails" and "on-ramps" in Kentucky HEALTH that the Secretary concluded will temper any coverage loss. (Pls. Br. at 26 n.5.) According to the Plaintiffs, these enrollee-protection measures were "'baked in' to the concerns commenters raised about coverage loss," with the implication being that these provisions are insufficient to mitigate the commenters' concerns. In reapproving Kentucky HEALTH, the Secretary noted that the Plaintiffs' "baked in" argument does not hold water as to all of Kentucky HEALTH's many guardrails. (AR at 6731 ("[T]he [95,000] projection[was] made prior to the inclusion of changes made to the demonstration at approval, including additional beneficiary guardrails expected to help beneficiaries maintain enrollment.").) In any event, it was rational for the Secretary to conclude that the commenters' concerns about coverage loss (to the extent the Secretary had to address the comments) were overstated because of Kentucky HEALTH's then-existing guardrails and on ramps. (*See* AR at 6729.) Section 1115 gives the Secretary, not the Plaintiffs, the judgment to determine whether the guardrails and on ramps in Kentucky HEALTH are sufficient to mitigate coverage-loss concerns or whether further guardrails and on ramps are needed. The Secretary rationally considered this issue in detail.

The Plaintiffs' continued emphasis on the Secretary's purported need to provide a "bottom-line estimate of coverage loss" is problematic. (Pls. Br. at 27 (citing *Stewart*, 313 F. Supp. 3d at 262).) Neither Section 1115 nor the APA imposes a magic-words requirement before a Section 1115 project can be approved, which is essentially what the Plaintiffs want with a "bottom-line estimate of coverage loss." The Court's previous statement about the failure of the Secretary to

provide a "bottom-line estimate of coverage loss" was made on the record as it then existed (*i.e.*, before the Secretary had responded in depth to the concerns raised about the 95,000 figure). Also, the notion of requiring a "bottom-line estimate" before a five-year project even begins is in substantial tension with the notion of Section 1115 being a way to test out novel policy approaches. As another district court correctly put it, "[t]he requirements of § 1115 do not require certainty much less prescience, on the Secretary's part as to the results." *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 497 (N.D. Cal. 1972).

The Plaintiffs also criticize the Secretary's discussion of the role that the waiver of retroactive coverage plays with respect to the 95,000 figure. (Pls. Br. at 25.) The Secretary, they assert, is claiming that any temporary coverage loss associated with the waiver of retroactive coverage is irrelevant. As the Secretary explained, however, the 95,000 figure is an inaccurate projection of coverage loss that is based solely on the number of covered member months—a figure that is driven, in part, by the waiver of retroactive coverage. (AR at 6730-31.) The Secretary's point is not that any temporary coverage loss associated with the waiver of retroactive coverage is irrelevant, but that the 95,000 figure does not "reflect[] that 95,000 individuals will completely lose coverage and not regain it." (AR at 6731) In other words, the waiver of retroactive coverage only means that a participant will not have coverage for the three months prior, not that the participant cannot get coverage going forward. Indeed, a person for whom the waiver of retroactive coverage is relevant necessarily already has Medicaid or is currently eligible for it. *See* 42 U.S.C. § 1396a(a)(34).

IV. The Secretary did not otherwise err or act irrationally in approving Kentucky HEALTH.

The Plaintiffs take aim at the "experimental" nature of Kentucky HEALTH by noting that at least some of Kentucky HEALTH's individual components have been approved in other Section

1115 waivers. (Pls. Br. at 22-23.) This argument, which is based in large part on individual waiver components approved by the prior administration, undermines the Plaintiffs' theme that Kentucky HEALTH is an attempt by the current administration to "explode" expanded Medicaid. More problematically, by focusing on the individual components of Kentucky HEALTH, the Plaintiffs fall into the trap of arguing that Section 1115 waivers are judged piece by piece, rather than as a whole, as the statute directs. *See* 42 U.S.C. § 1315(a). The Court has already rejected this reading of Section 1115, *see Stewart*, 313 F. Supp. 3d at 257 ("To the extent Plaintiffs mean to argue that none of those features is independently likely to further the Act's objectives, such focus would be misplaced."), and there is no reason for the Court to reconsider that conclusion. No state has tested Kentucky HEALTH's unique combination of components. And obviously, no state has tried Kentucky HEALTH's holistic program on a population like Kentucky's. (*See* AR 5432 (listing some of the health issues facing Kentuckians).)

The Plaintiffs continue to use the preliminary data from Arkansas Works to attack Kentucky HEALTH. (Pls. Br. at 29.) As has been explained in the *Gresham* case, these initial numbers are not even sufficient to invalidate Arkansas Works. *See, e.g.*, *Gresham v. Azar*, 1:18-cv-1900, ECF No. 52, at 12-14 (D.D.C.). It follows that this early Arkansas data is not sufficient to invalidate Kentucky HEALTH, either.[4] The Plaintiffs also try to play "gotcha" with Arkansas Works's preliminary numbers. Kentucky, they observe, argues that several months of preliminary data from Arkansas does not discredit Kentucky HEALTH, but also argues that data from other

[4] At least some of the purported concerns with Arkansas Works relate to how enrollees report their community engagement—whether online or through some other method, which Arkansas has addressed. *See Gresham v. Azar*, 1:18-cv-1900, ECF No. 51 (D.D.C.). Kentucky's model for reporting community engagement is an all-of-the-above approach. *See* Kentucky HEALTH Community Engagement Summary, *available at* https://kentuckyhealth.ky.gov/Parts/Pages/Community-Engagement.aspx (last visited Mar. 1, 2019).

demonstration projects supports the Secretary's approval of Kentucky HEALTH. (Pls. Br. at 29.) There is nothing inconsistent about these positions. In his judgment, the Secretary can appropriately determine that some preliminary data justifies further testing while also concluding that different preliminary data does not suffice to invalidate a hypothesis in the early stages of testing in a different state under different conditions. That is what the Secretary's judgment is all about.

The Plaintiffs double down on their argument that two recent failed bills in Congress somehow provide insight into whether Kentucky HEALTH's community-engagement program likely will assist in promoting Medicaid's objectives. (Pls. Br. at 39-40.) The Plaintiffs do not mention the binding Supreme Court precedent cited by the Commonwealth in explaining why failed legislative proposals matter not. (Ky. Op. Br. at 42.) In fact, if anything, the fact that Congress has repeatedly considered whether to include "work requirements" in the Medicaid program underscores why a Section 1115 waiver is justified for Kentucky HEALTH's community-engagement program. As the Plaintiffs' correctly acknowledge, "Congress has used the results of past [Section 1115] projects to inform its Medicaid policy decisions." (Pls. Br. at 22.) The results of Kentucky HEALTH's community-engagement program will inform Congress on a topic that it has repeatedly considered in past years.

The Plaintiffs also take issue with the Commonwealth's discussion of how Section 1115 waivers were an impetus for Congress to incorporate work requirements into SNAP and TANF as part of welfare reform in 1996. (Pls. Br. at 39.) The Plaintiffs do not actually dispute that the results from Section 1115 waivers that tested work requirements played a role in this landmark reform, but claim that SNAP and AFDC already had "work requirements" before the 1996 reform bill. That is a mischaracterization. For SNAP, the Plaintiffs cite an act that essentially encouraged

participants to look for work and terminated benefits if they refused to accept work at or above a certain wage. *See* An Act to Amend the Food Stamp Act of 1964, Pub. Law No. 91-671, § 4, 84 Stat. 2048, 2050 (1971). For AFDC, the Plaintiffs cite an act that, generally speaking, gave a state the discretion to change its state plan to make expenditures as payments for work performed "for the State agency or any other public agency under a program." *See* An Act to Extend & Improve the Public Assistance & Child Welfare Programs of the Social Security Act, and for Other Purposes, Pub. Law No. 87-543, § 105, 76 Stat. 172, 186 (1962). Although these preexisting statutes touched on the topic of work (as does the Medicaid Act in 42 U.S.C. § 1396u-1), they nonetheless differ in meaningful respects from the work requirements currently in SNAP and TANF. *See* 42 U.S.C. § 607(c); 7 U.S.C. § 2015(d), (o).

Turning to premiums, the Plaintiffs' brief presupposes that premiums never can further the objectives of the Medicaid Act. But the Plaintiffs ignore that, even without a waiver, the Medicaid Act authorizes the imposition of premiums on certain enrollees. *See, e.g.*, 42 U.S.C. § 1396*o*(c)(1). This places the Plaintiffs in an untenable position of opposing as inconsistent with the objectives of the Medicaid Act something that the Act specifically authorizes in some circumstances. It is reasonable to conclude that Section 1115 can be used to test preexisting requirements on differently situated participants to determine whether those preexisting requirements should be expanded. More importantly, the Plaintiffs' brief does nothing to meaningfully dispute the Secretary's reliance on the health care utilization data associated with Indiana's program, which conveys that paying modest premiums incentivizes better health care utilization (better use of primary and preventive care, for example). (AR at 6734-35.) The most that the Plaintiffs can say against that data is that the Secretary "incorrectly imputed causation into studies showing correlation." (Pls. Br. at 36.) Even if the Indiana data only shows correlation at this time, that is

reason enough to further study whether modest premiums, like Kentucky's, lead to better health care utilization.

The Plaintiffs also nitpick Kentucky's discussion of the Indiana data regarding the effect of premiums on coverage. (Pls. Br. at 30-31.) They dispute Kentucky's interpretation that only five percent of Indiana's enrollees lost coverage due to non-payment of premiums, claiming that the actual number is seven percent. Although it is true that an additional two percent of participants were disenrolled in Indiana, they were *not* subject to the six-month lockout period, unlike the five percent on which Kentucky relied. (AR at 13465.) In any event, the Indiana data elsewhere reports that only "four percent of individuals who did not make a payment" out of the total universe of participants who "did not make a PAC at some point in time during their enrollment" were disenrolled. (AR at 13463.) The Plaintiffs further claim that the 55 percent of Indiana enrollees who failed to pay premiums "faced consequences for failure to pay." (Pls. Br. at 31.) The vagueness of the Plaintiffs' reference to "consequences" is intentional. As Kentucky has explained, the overwhelming majority (88 percent) of the Indiana enrollees who did not make a premium payment were not required to pay premiums to maintain coverage. (Ky. Op. Br. at 29.) As best as Kentucky can tell, the unspecified "consequences" that the Plaintiffs reference is that these participants merely were enrolled in a more basic health plan. (*See* AR at 13463.) The Plaintiffs' "consequences" argument, then, is analogous to criticizing Kentucky HEALTH because some enrollees with incomes of less than 100 percent FPL do not make premium payments, even though they are not required to do so to maintain coverage. (AR at 6755, 6771.)

As for the redetermination requirements, the Plaintiffs dismiss as irrelevant the fact that only 37 percent of Kentucky Medicaid enrollees who needed to submit additional paperwork to complete Medicaid redetermination actually do so. (Pls. Br. at 33 (discussing AR 6727).) But that

statistic acutely demonstrates why a temporary demonstration project is needed to see if Kentucky HEALTH can incentivize more enrollees to complete the redetermination process—something that has benefits beyond mere program compliance. The Plaintiffs do not dispute that the Medicaid program already requires a redetermination of Medicaid eligibility each year. *See* 42 C.F.R. § 435.916. The Plaintiffs' position, then, is that it is foreign to Medicaid's objectives to attempt to increase compliance with a preexisting requirement of the Medicaid program by attaching a stiffer penalty for non-compliance. By definition, an attempt to improve program compliance is in keeping with the objectives of that program. Surely that is a rational approach to addressing the 37 percent statistic that the Secretary identified, as well as to strengthening beneficiary engagement, giving beneficiaries knowledge about how commercial coverage operates, and improving the fiscal sustainability of Kentucky's Medicaid program. (AR at 6724-25, 6736.) To the extent that Kentucky HEALTH's redetermination requirements cause individuals to lose coverage for six months, the corresponding requirement that Kentucky complete *ex parte* redeterminations for at least 75 percent of enrollees minimizes the number of enrollees who will lose coverage for six months. (AR at 6757-58.)

The Plaintiffs' argument opposing the waiver of retroactive coverage reduces to their assertion that the Secretary has only offered a "conclusory" justification for this aspect of the demonstration. (Pls. Br. at 34 (citing *Stewart*, 313 F. Supp. 3d at 265).) In the Plaintiffs' paradigm, the Secretary must know the unknowable—a notion that is facially inconsistent with Section 1115's allowance of an "experimental . . . project." *See* 42 U.S.C. § 1315(a). That is not the applicable standard, as Kentucky has explained. (Ky. Op. Br. at 3-5.) At most, the Secretary simply must have a rational basis for his conclusion that the waiver of retroactive coverage, when viewed in conjunction with Kentucky HEALTH's other components, "is likely to assist in promoting" the

objectives of Medicaid. *See* 42 U.S.C. § 1315(a). Note Section 1115's language: The project as a whole need not "promote" the objectives of Medicaid, in the Secretary's judgment. It must only "assist in promoting," and it must only be "likely" that it will do that, in the Secretary's judgment. *See id.* Judged by this standard, the waiver of retroactive coverage easily surpasses this bar, when viewed in conjunction with Kentucky HEALTH's other components. Because it has been fully briefed, the Commonwealth will not belabor this point other than to note that promoting continuity of care, rather than churning on and off Medicaid, is essential for the effectiveness of Kentucky's Medicaid program. In a state where, in the year following expansion, less than 10 percent of new adults enrollees actually received an annual wellness or physical exam, surely the Secretary can test time-limited policies that, in his judgment, are "likely to assist" in fixing this root problem. (*See* AR at 6724, 6736.) To hold otherwise is to tie the Secretary's hands in using Section 1115 to respond in innovative ways to structural problems with how Kentucky's Medicaid recipients approach their health.

CONCLUSION

The Court should grant the Commonwealth's motion for summary judgment and deny the Plaintiffs' motion. For the reasons explained in the Federal Defendants' briefs, the Court also should grant judgment to Kentucky on Counts 1 and 9 of the Plaintiffs' Amended Complaint.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on March 1, 2019, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to counsel of record.

/s/ Matthew F. Kuhn
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