IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SAMUEL PHILBRICK, *et al.*, Plaintiffs, v. **ALEX M. AZAR II, *et al.*,** Defendants.	Civil Action No. 1:19-cv-00773 (JEB)

MEMORANDUM IN SUPPORT OF FEDERAL DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

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INTRODUCTION

This Court has recognized that the Secretary of Health & Human Services (the "Secretary") "is afforded significant deference in his approval of pilot projects," also known as demonstration projects, under Section 1115 of the Social Security Act. *Stewart v. Azar (Stewart I)*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018). As this Court knows, the Secretary is authorized to approve such demonstration projects where, "in the judgment of the Secretary," they are "likely to assist in promoting the objectives" of the Medicaid program. 42 U.S.C. § 1315(a).

This case involves one such demonstration project proposed by the state of New Hampshire and approved by the Secretary. Known as Granite Advantage, the project allows New Hampshire to implement two key changes to its statewide health care coverage for the Medicaid expansion population that States can opt to cover: (1) a community-engagement requirement and (2) a waiver of the requirement to provide retroactive eligibility upon beneficiary enrollment.

In his letter approving Granite Advantage, the Secretary explained why, in his judgment, the demonstration is likely to assist in promoting the objectives of Medicaid. Specifically, he described how the project's components will help further Medicaid's objective of furnishing medical assistance, by stretching limited Medicaid resources and maximizing available coverage for New Hampshire's citizens.

The Supreme Court and the D.C. Circuit have long recognized that "'considerable latitude' [] characterizes optional participation in a jointly financed benefit program" like Medicaid, *Pharm. Research & Mfrs. Of Am. ("PhRMA") v. Walsh*, 538 U.S. 644, 666 (2003), and that measures designed to stretch state resources further the objectives of Medicaid and similar programs. *See id.*; *see also N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405 (1973); *PhRMA v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004). States may "attempt to promote self-reliance and civic responsibility" in order "to assure that limited state welfare funds be spent on behalf of those genuinely incapacitated and most in need, and

to cope with the fiscal hardships enveloping many state and local governments." *Walsh*, 538 U.S. at 666–67 (quoting *Dublino,* 413 U.S. at 413).

In accordance with these decisions, Granite Advantage tests measures designed to help adults transition from Medicaid to greater financial independence and other forms of health coverage, including the subsidized coverage available through health exchanges. The community-engagement requirement is designed to enhance the financial independence of Medicaid recipients by requiring able-bodied adults to work, look for work, or engage in other activities that enhance their employability, such as job-skills training, education, and community service—and, thus, free up resources to provide medical assistance to others. The waiver of retroactive eligibility is designed to encourage eligible individuals to enroll in Medicaid while they are healthy, which in turn encourages them to become more engaged in their health care decisions and to rely more on preventive care, which both improves the health of beneficiaries and further conserves resources for other beneficiaries. Indeed, in 2012, HHS encouraged States to pursue initiatives that "encourage personal responsibility" and promote "healthier behaviors." Centers for Medicare & Medicaid Services ("CMS"), *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 15 (2012), attached hereto as Ex. A.

Plaintiffs object that Granite Advantage's community-engagement component is novel. But the central purpose of Section 1115 waiver authority is to foster innovation by allowing States to try new ideas, which may provide a template for new approaches at the federal level. For example, the work requirements in the Temporary Assistance for Needy Families ("TANF") program were informed by earlier demonstration projects such as the one upheld in *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973).

Plaintiffs also predict that Granite Advantage is doomed to fail. But evaluating such predictions is why Section 1115 demonstration projects exist—*to test* innovations that the Secretary

finds are likely to assist in promoting the objectives of the program. Even demonstration projects that do not yield the anticipated results serve Section 1115's purpose by providing valuable data and experience to help shape future innovations. Moreover, Congress entrusted *the Secretary* with making the predictive judgments about which experiments are worthwhile, and here the Secretary made the considered determination that Granite Advantage is likely to advance Medicaid's objectives. Plaintiffs' contrary conjecture is not a valid basis to overturn that judgment.

And while plaintiffs emphasize that some individuals might lose coverage for a period of time because some will not comply with Granite Advantage's community-engagement requirement, the same is true of any condition of eligibility—including the work requirements that preceded TANF. For example, an individual may have her Medicaid eligibility terminated for failing to report information requested by the State that could impact Medicaid eligibility, such as changes in income or residency status. 42 C.F.R. § 435.916. Medicaid eligibility is not a foregone conclusion, and requiring beneficiaries to provide information demonstrating that they comply with, and continue to meet, conditions of eligibility through a demonstration project is consistent with requirements established elsewhere in the Medicaid statute.

The arguments plaintiffs advance are especially weak because the individuals subject to Granite Advantage are entirely members of the new adult population. Thus, New Hampshire has the right to terminate that coverage *entirely*. That option flows from the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 575 (2012) ("*NFIB*"). Accordingly, in 2012, when many States were deciding whether to participate in the new adult expansion, HHS specifically assured them that States "have flexibility to start *or stop* the expansion." Ex. A at 11 (emphasis added). Plaintiffs' observation that the ACA describes this population "as a mandatory coverage group," Pls.' Mem. in Supp. of Mot. for Partial Summ. J., at 4, ECF No. 19-1 ("Pls.' Mem."), is simply irrelevant after *NFIB*'s contrary holding and the resulting 2012 CMS Guidance that encouraged States like New

Hampshire to expand coverage by assuring them they were free to later rescind that expansion. Here, tens of thousands of adults are receiving coverage only because New Hampshire made a discretionary decision to expand coverage to the new adult population in the first place. And now, New Hampshire has made clear that absent approval of Granite Advantage, "the state plans to end its current coverage of the new adult group." Admin. R. ("AR") 6. In considering the potential effect of Granite Advantage on Medicaid coverage for the new adult population, the Secretary properly took into account New Hampshire's prerogative to eliminate this optional coverage entirely.

In addition, Granite Advantage is independently justified because the Secretary found that it is likely to improve the health of the Medicaid recipients receiving coverage under the demonstration. Plaintiffs argue it cannot be a freestanding objective of Medicaid to improve the health of the people that program covers, but the Secretary emphatically disagrees. For the people who will receive coverage under New Hampshire's demonstration, an important purpose of medical coverage is to maintain or improve their health—not just to provide emergency, *ad hoc* treatment of individual ailments after their health has already deteriorated. After all, as the Secretary's approval letter explains, "there is little intrinsic value in paying for [medical] services if those services are not advancing the health and wellness of the individual receiving them." AR 1. Plaintiffs' argument also rests on the false premise that measures designed to improve the health of the persons covered under Granite Advantage have no bearing on the fiscal sustainability of New Hampshire's Medicaid program. Quite the contrary. Policies that help these Medicaid recipients become healthier lower the cost of their care for the simple reason that healthy and productive people are less expensive to insure. Such policies thus may enhance the fiscal sustainability of New Hampshire's overall Medicaid program and help preserve and expand the health-care safety net for those who need it the most.

Plaintiffs' remaining claims lack merit. Their challenge to the letter that HHS sent to state Medicaid directors is not justiciable and is meritless in any event. And plaintiffs' extravagant claim that

the Secretary's approval of Granite Advantage violates the President's responsibility to take care that the laws be faithfully executed is unsupported. The Court should dismiss the complaint or, alternatively, grant summary judgment to the federal defendants and deny plaintiffs' motion for partial summary judgment.[1]

BACKGROUND

Because this Court is already familiar with the central issues in this case, we focus the background discussion on the points most pertinent to the dispute.

I. STATUTORY BACKGROUND

The Medicaid program authorizes federal funding to States to assist certain individuals in obtaining medical care. 42 U.S.C. § 1396a(a)(10). To participate in the Medicaid program, a State must submit a plan for medical assistance (a "State plan") for approval by the Secretary. *Id.* § 1396a(b). A State plan defines the categories of individuals eligible for benefits and the specific kinds of medical services the State covers. *Id.* § 1396a(10), (17).

Under the traditional Medicaid program, States were required to cover only certain categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled. *See NFIB*, 567 U.S. at 575. There was no mandatory coverage for most able-bodied, childless adults, and the States typically did not offer any. *Id.*

As enacted, the ACA would have required States to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line (the "new adult group" or the "expansion population") or else leave the program entirely. *Id.* at 576.

[1] The federal defendants recognize that in *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019), and *Stewart v. Azar (Stewart II)*, 366 F. Supp. 3d 125 (D.D.C. 2019), this Court rejected reasoning similar to that advanced by the Secretary in his approval letter here, and vacated demonstration projects that similarly contained community-engagement requirements and waivers of retroactive eligibility. The federal defendants respectfully disagree with those decisions and have appealed them.

But the Supreme Court ruled in *NFIB* that Congress could not condition a State's preexisting Medicaid funding on its compliance with the ACA's adult eligibility expansion requirement. The effect of that ruling was to separate the decision whether to provide coverage to the new adult population from the rest of a State's Medicaid program—to functionally make the expansion optional. Accordingly, in 2012, when many States were deciding whether to expand their Medicaid programs, HHS encouraged States to expand Medicaid by assuring them that they "have flexibility to start or stop the expansion." Ex. A at 11; *see also id.* at 12 ("A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage."); Letter of Aug. 31, 2012 from CMS Administrator Cindy Mann to Arkansas Governor Mike Beebe, attached hereto as Ex. B (same).

Congress has separately given the Secretary the authority to approve "any experimental, pilot, or demonstration project" proposed by a State that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid statute. 42 U.S.C. § 1315(a). For such projects, the Secretary may waive "compliance with any of the requirements of section … 1396a" in the Medicaid statute, and may approve waivers "to the extent and for the period he finds necessary to enable such State or States to carry out [the demonstration] project," *Id.* § 1315(a)(1). The Secretary may treat a State's expenditures for an approved demonstration project that otherwise would not qualify for federal matching funds, *see id.* § 1396b, as expenditures under the State plan that are eligible for federal financial assistance to the "extent and for the period prescribed by the Secretary." *See id.* § 1315(a)(2)(A). Congress enacted Section 1115 to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 1961 (1962) (Conf. Rep.).

II. FACTUAL BACKGROUND

A. New Hampshire's Relevant Legislation

In 2014, New Hampshire's legislature passed, and the Governor signed, a bill to establish the New Hampshire Health Protection Program ("NHHPP"), which sought to expand Medicaid coverage in New Hampshire to adults with incomes up to 133% of the federal poverty level ("FPL"). AR 4380. While New Hampshire amended its state plan to expand its Medicaid program to cover the expansion population, HHS approved the NHHPP as a demonstration project, and, upon request, reauthorized the project to continue coverage of the expansion population until December 2018. *See* AR 4381. The NHHPP covered the expansion population through premium payments for individuals with access to employer-sponsored health insurance, as well as premium assistance for others. AR 4381. As of June 2018, NHHPP provided health care coverage to approximately 53,000 New Hampshire residents. AR 4384.

In 2017, the Governor of New Hampshire signed a bill that required the State to seek a waiver or state plan amendment from HHS to establish certain work and community-engagement requirements as conditions of eligibility for the NHHPP. AR 4381. The legislation, as amended, directed that any such waiver or state plan amendment must be in place by June 30, 2018. AR 4381. Thereafter, upon soliciting statewide public comment, New Hampshire submitted an application to HHS to amend the NHHPP demonstration project to include work and community-engagement requirements as a general condition of eligibility for the program. AR 4381. HHS approved the amendment in May 2018. AR 4381. The approval was effective through the end of 2018, though the community-engagement component was not scheduled to go into effect until 2019. *See* AR 101.

In June 2018, the Governor signed another bill directing the Medicaid expansion population to be transitioned from the premium-assistance program to managed care and modifying the previously enacted work and community-engagement requirements. AR 4381–82. In July 2018, the

State submitted another application to HHS to extend its demonstration project, now entitled "New Hampshire Granite Advantage Program 1115 Demonstration" ("Granite Advantage"), for an additional five years with the changes discussed above. AR 4377. The application, in addition to proposing the changes required by the June 2018 State bill and certain other changes not relevant here, requested that the state's previously approved waiver of New Hampshire's retroactive coverage requirement be authorized for implementation without being contingent on meeting any additional requirements.[2] *See* AR 4385–86.

B. The Secretary's September 2018 Approval of Granite Advantage

Upon consideration of New Hampshire's proposal and the comments received during the federal comment period, the Secretary on November 30, 2018 approved an extension of the Granite Advantage demonstration for a five-year period beginning January 1, 2019,[3] *see* AR 1. The Secretary concluded that Granite Advantage "is likely to assist in promoting the objectives of the Medicaid program," AR 4, including the objective of furnishing medical assistance to New Hampshire's citizens, *see* AR 6–7, which this Court identified as an important Medicaid objective. *See Stewart I*, 313 F. Supp. 3d at 265–66; *Stewart II*, 366 F. Supp. 3d at 139. Specifically, the Secretary found that Granite Advantage "will enable the state to continue coverage of the new adult group in the manner contemplated under state law," because if HHS did not approve the project, "the state plans to end its current coverage of the new adult group." AR 6. According to New Hampshire, "under its interpretation of state law, it would be required to terminate coverage for its expansion population should CMS not approve this demonstration extension." AR 6726. Further, the project was, in the

[2] New Hampshire separately applied, and HHS approved, an amendment to New Hampshire's state plan to enroll the State's new adult group into managed care. AR 3.

[3] New Hampshire announced that the community-engagement requirements must be complied with beginning June 1, 2019. *See* N.H. Dep't of Health and Human Servs., *N.H. Granite Advantage Health Care Program*, https://www.dhhs.nh.gov/medicaid/granite/ (last June 4, 2019).

Secretary's judgment, likely to "keep health care costs at more sustainable levels" by promoting improved health and wellness. The work and community-engagement requirement, in particular, was designed to "reduce dependency on public assistance" by assisting current members of the Medicaid expansion population in achieving financial independence, thereby "allowing New Hampshire to stretch its limited Medicaid resources" and enhance the long-term fiscal sustainability of New Hampshire's Medicaid program. AR 6. The components of Granite Advantage at issue here are described below.

1. Community Engagement

As approved by the Secretary, Granite Advantage includes a work and community-engagement requirement as a condition of eligibility for members of New Hampshire's Medicaid expansion population. Generally, members of the expansion population will have to complete and report 100 hours of participation in work and community engagement activities each month. Such activities can include (1) employment, both subsidized and unsubsidized; (2) job-skills training and education; (3) caregiving, (4) community service, (5) participation in substance use disorder treatment, and (6) participation in and compliance with Supplemental Nutrition Assistance Program ("SNAP") and Temporary Assistance for Needy Families ("TANF") employment requirements. AR 5; *see also* AR 25. Various groups, however, are exempt from this requirement, including (1) beneficiaries who are considered medically frail; (2) beneficiaries who experience, or who reside with an immediate family member who experiences, a hospitalization or serious illness; (3) caregivers of a dependent child (one caregiver per two-parent household); (4) beneficiaries who have, or residing with an immediate family member who has, a disability as defined by the Americans with Disabilities Act, Section 504, or Section 1557, who are unable to comply with the requirements due to disability-related reasons; (5) beneficiaries who are pregnant or up to 60 days post-partum; (6) participants in a state-certified drug

court program, and (7) beneficiaries who are exempt from SNAP and/or TANF employment requirements. AR 5; *see also* AR 24.

If a beneficiary fails to comply with the community-engagement requirement in a given month, she will receive a notice of non-compliance the next month and her eligibility for Medicaid will be suspended for the following month, unless she (1) demonstrates good cause for not meeting or reporting her qualifying activities, (2) demonstrates that she qualifies for an exemption, or (3) makes up the deficient hours the following month.[4] AR 26–28. Further, a beneficiary can re-activate her Medicaid eligibility even absent taking one of the steps above if she has been suspended from Medicaid eligibility and then (1) completes at least 100 hours of community engagement activities within a single month, (2) is determined to be exempt from the community-engagement requirement, (3) demonstrates good cause for the earlier noncompliance; or (4) becomes eligible for Medicaid under a different eligibility category. AR 8, 28. New Hampshire must "[p]rovide full appeal rights, as required under 42 CFR. Part 431 subpart E, prior to suspension and/or disenrollment and observe all requirements for due process for beneficiaries whose eligibility will be suspended or terminated for failing to meet the community engagement requirements." AR 32. These requirements include providing notice in advance of suspension, termination or reduction of an individual's Medicaid eligibility or services. *Id.*; *see also* 42 C.F.R. §§ 431.200–431.250.

2. Waiver of Retroactive Coverage

The approval also provides a waiver of the Medicaid requirement that States provide retroactive Medicaid eligibility to beneficiaries for any month prior to the month that a new-adult-group beneficiary applies for Medicaid coverage. AR 3; *see also* AR 23. However, the waiver of retroactive coverage does not apply if an individual eligible for adult group today would have been

[4] After May 2020, beneficiaries cannot cure consecutive months of non-compliance in this manner. AR 28.

eligible for Medicaid as a member of one of certain traditional Medicaid populations (e.g., pregnant women, parents and caretaker relatives, or the aged, blind, or disabled) had she applied during the prior 90 days. *See* AR 23–24.

C. This Action

Plaintiffs are four members of the adult expansion population who receive Medicaid coverage via New Hampshire's demonstration project. They filed this suit in March, seeking to challenge the Granite Advantage project under the Administrative Procedure Act ("APA") and the Take Care Clause of the U.S. Constitution. Count One seeks to challenge a letter that CMS sent to state Medicaid directors in January 2018. Class Action Compl. for Decl. and Inj. Relief ("Compl."), ECF No. 1, ¶¶ 188–96. Count Two challenges the Secretary's approval of Granite Advantage as a whole. *Id.* ¶¶ 197–201. Count Three asserts a claim under the Take Care Clause of the U.S. Constitution, Art. II, § 3, cl. 5. *Id.* ¶¶ 202–19. In relevant part, the complaint asks this Court to (1) certify this case as a class action, (2) declare that the January 2018 letter to state Medicaid directors is unlawful, (3) declare that the Secretary's approval of Granite Advantage is unlawful, and (4) enjoin the federal defendants from implementing the practices purportedly authorized by the January 2018 letter and the approval of Granite Advantage. Compl., Prayer for Relief 1–5. Plaintiffs have moved for partial summary judgment on Counts One and Two. ECF No. 19-1. However, they have not moved for class certification. This cross-motion addresses all counts of the Complaint.

ARGUMENT

I. THE SECRETARY DID NOT ACT ARBITRARILY OR EXCEED HIS AUTHORITY BY APPROVING GRANITE ADVANTAGE.

A. Legal Standards

Because "Congress expressly conferred on the Secretary authority to review and approve" demonstration projects, and intended the "Secretary's determinations" under the Medicaid statute to have "the force of law," his "interpretations of the Medicaid Act are [] entitled to *Chevron* deference."

Thompson, 362 F.3d at 822 (addressing the approval of state plan amendments). In addition, by authorizing the Secretary to approve a project that "in the judgment of the Secretary" is "likely to assist in promoting the objectives" of the program, and to waive requirements to the extent and for the period "he finds necessary to enable such State or States to carry out such project," Congress used the type of language that commits these determinations to the Secretary's discretion as a matter of law. 42 U.S.C. § 1315(a); *see, e.g.*, *Drake v. FAA*, 291 F.3d 59, 72 (D.C. Cir. 2002). This Court has determined that the Secretary's judgments under Section 1115 are judicially reviewable. *Stewart I*, 313 F. Supp. 3d. at 256–57; *Stewart II*, 366 F. Supp. 3d at 137. But at a minimum, the Secretary's discretionary determinations are entitled to the utmost deference because they entail the exercise of policy and scientific expertise to make predictions about a project's likely research utility in furthering broad Medicaid goals. *See, e.g.*, *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 821 (D.C. Cir. 1983) ("[P]redictive judgments about areas that are within the agency's field of discretion and expertise" are entitled to "particularly deferential" treatment.).

B. The Secretary Reasonably Determined That The Community-Engagement Requirements And Waiver Of Retroactive Eligibility Promote The Objectives Of The Medicaid Program.

Granite Advantage's work and community-engagement provisions generally require able-bodied members of the adult expansion population to spend 100 hours per month working, looking for work, or engaging in activities that enhance their employability, such as job-skills training, education, and community service. There are many exemptions designed to ensure that this requirement is not imposed on those who could not comply, such as the medically frail. The waiver of retroactive eligibility encourages those eligible for Medicaid in the population included in the demonstration not to wait to seek coverage until after they are already sick, which improves beneficiary health and engagement in their healthcare.

New Hampshire's application explained that these components were designed, in part, to

"sustain and improve its Medicaid expansion for low-income adults," AR 4378, and that the demonstration project is meant to positively impact "beneficiary health, while better integrating cost control and personal responsibility into the State's Medicaid program," AR 4378. The Secretary determined that Granite Advantage is likely to encourage beneficiaries to attain greater levels of financial independence and prepare them for the commercial health insurance market, including the federally subsidized insurance that is available through the Exchanges, *see* AR 6–7, thereby "preserving the health care safety net for those New Hampshire residents who need it most, AR 6.

The Supreme Court has long recognized that, in a cooperative federalism program like Medicaid, measures designed to stretch limited state resources further the program's objectives. *See N.Y. State Dep't of Social Servs. v. Dublino*, 413 U.S. 405 (1973) (mem.) (analyzing state work requirements on recipients of Aid to Families with Dependent Children (AFDC) benefits); *PhRMA v. Walsh*, 538 U.S. 644, 665–66 (2003) (plurality) (concluding that a Medicaid-related interest was served when a State provided some borderline Medicaid populations with access to prescription drugs without resorting to Medicaid benefits, thereby reducing Medicaid expenses); *see also Aguayo v. Richardson*, 473 F.2d 1090, 1103–04 (2d Cir. 1973) (upholding a Section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility because "Congress must have realized that extension of assistance to cases where parents, relatives or the child himself was capable of earning money would diminish the funds available for cases where they were not" and rejecting the argument "that the objective of federal participation in the AFDC program . . . is to assist the states 'to furnish financial assistance and rehabilitation and other services' . . . not to force their parents or relatives, or themselves, to work").

The Supreme Court and the D.C. Circuit applied the same reasoning in the context of Medicaid in *PhRMA v. Walsh*, 538 U.S. 644 (2003), and *PhRMA v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004) (concluding that the Secretary's interpretation of a Medicaid provision was permissible when

the Secretary decided that a State Medicaid initiative served the best interests of Medicaid recipients by being designed to "prevent[] borderline populations in Non–Medicaid programs from being displaced into a state's Medicaid program," because "more resources will be available for existing Medicaid beneficiaries," in accordance with *PhRMA v. Walsh*). Those decisions recognized that there is fluidity in Medicaid eligibility, and that it is a legitimate objective of Medicaid to conserve state resources via measures that reduce the likelihood that borderline populations will become Medicaid-eligible. *Thompson*, 362 F.3d at 383.

The logic of *Dublino*, *Aguayo*, *Walsh*, and *Thompson* extends to measures, like community-engagement requirements, that facilitate the transition of Medicaid recipients out of Medicaid eligibility and potentially into employer or other coverage. When such transitions occur, the consequence is that "more resources will be available for existing Medicaid beneficiaries," which "further[s] the goals and objectives of the Medicaid program." *Id.* at 825. Indeed, this Court has itself concluded that the Secretary may "take into account fiscal sustainability in determining under § 1115 whether a demonstration project promotes the objectives of the Act," *Stewart II*, 366 F. Supp. 3d at 149, since at least one of the purposes of Medicaid is to, "as far as practicable under the conditions in such State," furnish medical assistance to certain low-income populations. 42 U.S.C. § 1396-1. New Hampshire's community-engagement requirements are, in the Secretary's judgment, likely to advance that objective and thus fall comfortably within the principle of these decisions.[5]

[5] Plaintiffs note that the Secretary previously rejected a proposal by New Hampshire to institute a work requirement as a condition of eligibility. Pls.' Mem. 27–28. But there is nothing unusual about an agency exercising its discretion to change its interpretation of an ambiguous statute, and doing so "is not a basis for declining to analyze the agency's interpretation under the *Chevron* framework." *Nat'l Cable & Telecom. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005). Indeed, "change is not invalidating, since the whole point of *Chevron* is to leave the discretion provided by the ambiguities of a statute with the implementing agency." *Smiley v. Citibank (S. Dakota), N.A.*, 517 U.S. 735, 742 (1996).

Plaintiffs argue that thousands of members of the New Hampshire adult expansion population could lose coverage as a result of their failure to comply with the community-engagement requirement. *See* Pls.' Mem. 1. But it is the nature of any condition of eligibility, including those conditions that courts have upheld, that persons who fail to meet the condition may become ineligible for benefits; that fact alone does not render the condition inconsistent with the Medicaid statute. *See Walsh*, 538 U.S. at 667 ("The mere fact that the New York program imposed a nonfederal obstacle to continued eligibility for benefits did not provide a sufficient basis for pre-emption . . . . Similarly, in this case, the mere fact that prior authorization may impose a modest impediment to access to prescription drugs provided at government expense does not provide a sufficient basis for pre-emption."). Plaintiffs might insist that the eligibility condition here may prove to be less workable or more onerous than those previous similar conditions, but it is the very purpose of the demonstration project to test that empirical proposition. *See infra* Section I.C. The mere fact that a demonstration project places an additional condition on eligibility does not render it impermissible.

Further, by plaintiffs' own account, tens of thousands of adults—including the plaintiffs themselves—are receiving health care coverage in New Hampshire only because the State voluntarily chose to provide coverage for the new adult population. *See* Pls.' Mem. 6. The potential impact that New Hampshire's demonstration project may have on coverage is properly viewed in the context of the State's discretion to terminate optional coverage *entirely*. *Cf. Spry v. Thompson*, 487 F.3d 1272, 1276 (9th Cir. 2007) ("People in the [demonstration-only] expansion population [at issue in *Spry*] are not made worse off by inclusion in a demonstration project less favorable to them than to the categorically and medically needy because, without the demonstration project, they would not be eligible for Medicaid at all."). Indeed, New Hampshire indicated to HHS that if the Secretary did not approve its demonstration-project application, it would terminate Medicaid coverage for the expansion

population. *See* AR 6 (concluding that if HHS "were to disapprove the Granite Advantage demonstration, we recognize that the state plans to end its current coverage of the new adult group").

Although Congress purported to make coverage of the adult expansion population mandatory, the Supreme Court held in *NFIB* that the Constitution required that coverage to be optional. Thus, in 2012, when many States were considering whether to participate in the adult eligibility expansion, CMS assured the States that they would have "flexibility to start *or stop* the expansion." 2012 CMS Guidance at 11 (emphasis added); *see also id.* at 12 ("A state may choose whether and when to expand, and, if a state covers the expansion group, it may later decide to drop the coverage."); Letter of Aug. 31, 2012 from CMS Administrator Cindy Mann to Arkansas Governor Mike Beebe (same). Certainly, there is less risk of a conflict between the Medicaid statute and an experiment designed to help able-bodied adults transition out of Medicaid when the experiment is limited—as Granite Advantage is—to adults that a State has no obligation to cover at all.

Granite Advantage is also independently justified because the Secretary found that it was likely to improve the health of Medicaid recipients. Plaintiffs argue that it is not a freestanding objective of Medicaid to improve the health of the people that program covers, Pls.' Mem. 15–16, and this Court has reached a similar conclusion. *See Stewart II*, 366 F. Supp. 3d at 144–45. But as the Secretary explained, "there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence." AR 1. Indeed, the architect of Medicaid and other Great Society programs emphasized that the "aim is not only to relieve the symptom of poverty, but to cure it and, above all, to prevent it." Pres. Lyndon B. Johnson, Annual Message to Congress on the State of the Union (Jan. 8, 1964). The purpose of the Medicaid program is to improve the health and wellness of recipients so they can live happier, more independent lives; health care services are of greatest value if they advance those basic public-health objectives. AR 1, 4. That is why, in 2012, HHS explicitly encouraged States to

develop initiatives "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes." 2012 CMS Guidance at 15.

Further, as the Secretary explained, healthier people who are more engaged in their communities tend to consume fewer medical services and are generally less costly to cover. AR 2. Measures that promote those objectives thus redound directly to Medicaid's benefit by conserving state resources, *id.*, at the same time that they improve quality of life for recipients.

C. The Secretary Adequately Considered Potential Effects On Coverage.

Plaintiffs contend that the Secretary has not sufficiently considered the effects of Granite Advantage on coverage. Pls.' Mem. 21–28. But it is beyond dispute that the Secretary discussed coverage effects in his approval letter. *See, e.g.*, AR 10–12 (section of the letter titled "Comments on Coverage Loss"). That discussion was comprehensive. As an initial matter, and as described above, the Secretary explained how Granite Advantage is likely to promote coverage by ensuring the fiscal sustainability of the Medicaid program. AR 6. And while the Secretary recognized "that some individuals may choose not to comply with the conditions of eligibility imposed by the demonstration, and therefore may lose coverage," AR 11; *see also Stewart II*, 366 F. Supp. 3d at 149; *Stewart I*, 313 F. Supp. 3d at 272, the "goal" of the project "is to incentivize compliance, not reduce coverage," AR 11. Indeed, "section 1115 of the [Medicaid] Act explicitly contemplates that demonstrations may 'result in an impact on eligibility.'" *Id.* (quoting 42 U.S.C. § 1315(d)(1)).

Moreover, the Secretary considered the possibility of beneficiary noncompliance against the backdrop of the apparent alternative: that absent approval of Granite Advantage "the state plans to end its current coverage of the new adult group." AR 6; *see also* AR 10 ("[T]he ACA adult expansion could be eliminated if the state is unable to implement the demonstration project."). In other words, the Secretary recognized that the possibility of some coverage losses due to noncompliance would

pale in comparison to the possibility of losing coverage for the more than 50,000 individuals covered by the ACA expansion in New Hampshire, as well as other non-mandatory populations or benefits. AR 10. In this way, the demonstration "is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration." AR 11.

Plaintiffs insist that it was necessary for the Secretary to produce a "bottom-line" estimate of the number of people who would lose coverage over the course of the demonstration. Pls.' Mem. 23 (quoting *Stewart I*, 313 F. Supp. 3d at 262). But this Court recognized in *Stewart II* that such an estimate would be "admittedly subject to some uncertainty." *Stewart II*, 366 F. Supp. 3d at 141; *see also id.* ("[E]ven 'in the best of circumstances,' the agency 'has no access to infallible data.'" (quoting *Cablevision Sys. Corp. v. FCC*, 597 F.3d 1306, 1314 (D.C. Cir. 2010)). Nor do plaintiffs cite to any other authority suggesting that such a precise estimate is a necessary precondition to a Section 1115 approval. This is unsurprising, given that the demonstration does not even lend itself to an estimate of how many people "would lose Medicaid." Pls.' Mem. 23 (quoting *Stewart I*, 313 F. Supp. 3d at 262). A beneficiary may choose not to comply and thus lose coverage for a few months, but then complete 100 hours of community engagement activities in a given month and regain coverage once again. An estimate of the number of people who will lose coverage (the assumption being permanently) is therefore an inaccurate view of the effects of the demonstration on coverage.

In any event, because a demonstration project is an experiment, it is neither necessary nor practical for the Secretary to determine ex ante the exact number of individuals who may gain or lose coverage as a result of a project's features. Demonstration projects are designed to test innovations, and the actual impact on enrollment is not known in advance. That is particularly true here, where the State is testing whether individuals subject to a new incentive structure will comply with new incentives—something that is inherently difficult to predict. Such "predictive calculations are a murky science in the best of circumstances," *Cablevision*, 597 F.3d at 1314, and the Secretary is not required

to quantify the expected outcome of an experiment in advance. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009) ("It is one thing to set aside agency action under the [APA] because of failure to adduce empirical data that can readily be obtained. It is something else to insist upon obtaining the unobtainable." (internal citation omitted)).

Indeed, the Secretary correctly—and at least reasonably—recognized that under Section 1115 "[i]t is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes" at all. AR 12. "[T]he purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making." *Id.* Even when a demonstration project does not succeed in achieving the desired results, the information it yields provides policymakers real-world data on the efficacy of such policies. *Id.* That in itself promotes the objectives of the Medicaid statute, because Section 1115 "experiments are supposed to demonstrate the failings or success of such programs." *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 187 (3d Cir. 1996); *see also Aguayo*, 473 F.2d at 1103 (explaining that the Administrator may set "lower threshold for persuasion" when evaluating experimental project of limited duration); *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 498 (N.D. Cal. 1972) (holding that project was "designed to collect data which may well be of significance both in the administration of the present Medicaid program and in the process of proposing legislative modifications to it," and thus met "the requirements imposed by § 1115").

More fundamentally, although plaintiffs cite comments predicting significant coverage loss, Pls.' Mem. 21, any such losses likely would be dwarfed by the more than 50,000 newly eligible adults who stand to lose coverage if New Hampshire elects to terminate its non-mandatory ACA expansion. *See* AR 10. This observation underscores why it was reasonable for the Secretary to approve Granite Advantage without a precise estimate of coverage losses. Aside from the inherent difficulty in predicting such a figure, there is no evidence that losses would amount to the size of the State's new adult group.

Although the Secretary was not obligated to produce an estimate of the number of people who would lose coverage under the demonstration, he nonetheless considered the prospect that some individuals might lose coverage, even if just temporarily. And he balanced that prospect of coverage loss against the potential benefits of the demonstration to health, independence, and fiscal sustainability. *See* AR 11 ("[A]ny loss of coverage as the result of noncompliance must be weighed against the benefits New Hampshire hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.").

What is more, both the Secretary and New Hampshire sought to minimize effects on coverage by making compliance "achievable." AR 5. And rather than "limit[ing] his review to only 'vulnerable individuals,'" as plaintiffs assert, Pls.' Mem. 24 (quoting *Stewart I*, 313 F. Supp. 3d at 263–64), the Secretary considered the demonstration's impact on all beneficiaries subject to its requirements, and concluded that the demonstration as a whole seeks to make compliance with these requirements achievable for all beneficiaries subject to them.

The demonstration does this through a combination of exemptions and other provisions that are designed to accommodate a wide range of circumstances that beneficiaries subject to the demonstration's policies might face. For example, the demonstration exempts certain categories of individuals—such as the medically frail, the disabled, certain parents and caretakers, and pregnant women—who may face barriers to compliance with the program's requirements. *See* AR 5, 24. Indeed, plaintiff Joshua VLK would be exempt from the community-engagement requirement because he is currently attending court-ordered drug counseling and is exempt from SNAP work requirements. *See* Decl. of Joshua VLK ¶¶ 11, 12, ECF No. 19-5. Likewise, plaintiff Karin VLK may similarly be exempt because she may qualify as medically frail. *See* Decl. of Karin VLK ¶¶ 10, 16, 23, ECF No. 19-4 (stating that she suffers "a neurological degeneration of the discs in [her] spine" as well as "Attention Deficit

Hyperactivity Disorder and Obsessive Compulsive Disorder," and that "[b]ecause of her medical problems, [she] will not be able to work, volunteer, or complete other activities").

With respect to those individuals who are not exempt, the demonstration is designed to make compliance readily attainable. AR 5. For instance, the community-engagement requirement may be satisfied not just by working, but through community service, job skills training, or a number of other activities. Indeed, the two of the four plaintiffs who do not appear as if they may qualify for an exemption state that they are working or engaging in other activities such that they may either already meet the 100-hour monthly requirement or be able to meet it by engaging in a few additional hours of qualifying activities. *See* Decl. of Samuel Philbrick ¶ 4, ECF No. 19-2 (currently working as a cashier at a sporting goods store and working at least 16-24 hours per week); Decl. of Ian Ludders ¶ 4, ECF No. 19-3 (supporting himself through seasonal work and, when he is not working, helping his older neighbors with manual tasks that they have difficulty doing). Additionally, in order to ensure that beneficiaries are aware of the project's requirements, the State is obligated to engage in outreach and education, as well as to provide beneficiaries with sufficient notice of the project's requirements and their own status under it. AR 13; *see, e.g.*, Philbrick Decl. ¶ 11 (stating that he received a letter from the New Hampshire Department of Health and Human Services informing him of his status with respect to the community-engagement requirement).

Further, should an individual choose not to comply with the project's requirements, there are guardrails in place to limit any impact on coverage, including opportunities to avoid adverse actions stemming from noncompliance by demonstrating that there was good cause for the noncompliance, AR 8; full appeal rights prior to any loss of eligibility, AR 5; and the opportunity to regain coverage by coming back into compliance with the program's requirements, AR 8, 28. And if unexpected coverage losses do occur in significant numbers, CMS has reserved the right "to withdraw waivers" or to "require the state to submit a corrective action plan," AR 10.

In light of these design features and the Secretary's explanations, the Secretary adequately considered potential effects on coverage. The Secretary clearly grappled with the potential for beneficiaries to lose coverage, balanced that possibility against the expected benefits of the demonstration, and explained why the project is ultimately expected to promote coverage—easily demonstrating a "rational connection between the facts found and the choice made" and satisfying arbitrary and capricious review. *Kisser v. Cisneros*, 14 F.3d 615, 619 (D.C. Cir. 1994). The federal defendants recognize, of course, that the Secretary's analysis of coverage here is similar to the reasoning this Court rejected in *Stewart II*. *See* 366 F. Supp. 3d at 140–43. To the extent the Court's opinion in *Stewart II* forecloses the argument that the Secretary adequately considered coverage here, the federal defendants respectfully disagree and are seeking appellate review of *Stewart II*.

D. The Community-Engagement Requirement Does Not "Comprehensively Transform Medicaid."

Plaintiffs assert that the Secretary lacks authority to "comprehensively transform Medicaid" through a community-engagement requirement. Pls.' Mem. 34. But that assertion confuses a demonstration project with a statutory amendment. The decision whether to amend the Medicaid statute to include a community-engagement requirement is, of course, for Congress to make, just as the decision to include a work requirement in the TANF legislation was a matter for Congress. But the decision to allow States to *test* community-engagement requirements as part of a Section 1115 project is well within the Secretary's authority. The very purpose of Section 1115 is to ensure that federal requirements do not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." Conf. Rep. at 1961. And unlike a statutory amendment, which is typically permanent, a demonstration project is for a limited term—here only 5 years. AR 1. There is nothing unlawful about the Secretary exercising his waiver authority to temporarily approve a new component to gather data useful to policymakers.

This approach is the ordinary course. HHS has long recognized that demonstration projects of this kind can "influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other States." Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules, 77 Fed. Reg. 11,678, 11,680 (Feb. 27, 2012). Indeed, many States tested innovative welfare-reform initiatives through demonstration projects under AFDC, leading Congress to incorporate these policies into the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the legislation that replaced AFDC with the TANF program. Likewise, demonstration projects that allowed States to implement managed care and benchmark plans informed Congress's addition of Section 1932 of the Social Security Act in the Balanced Budget Act of 1997. *See* Pub. L. 105-33, 111 Stat. 251 (permitting States to implement managed care and benchmark plans through the State plan amendment process without having to seek waivers of Medicaid rules). And after demonstration projects tested the efficacy of family-planning services, the ACA incorporated these into an optional eligibility group that States can include in their plans, *see* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXI).

Plaintiffs are correct that Congress has not adopted a community-engagement requirement in the Medicaid statute, Pls.' Mem. 36–38, but that is just the point: the Secretary is temporarily testing a requirement not contained in the statute to inform future policymaking efforts. Nor does it matter that "during the 50-plus years of Medicaid," CMS has not previously approved a community-engagement requirement as a condition of Medicaid eligibility. Pls.' Mem. 28 (quoting *Stewart I*, 313 F. Supp. 3d at 245). The purpose of Section 1115 is to allow for this sort of experiment, and every experiment has a first time. Moreover, as a result of the ACA's adult eligibility expansion that began in 2014, many able-bodied adults are now covered by Medicaid—a stark departure from the 50-plus

years of Medicaid in which eligibility was confined to vulnerable populations such as children and persons with disabilities.

E. Plaintiffs' Challenge To The Waiver Of Retroactive Eligibility Is Non-Justiciable And Meritless.

Although plaintiffs purport to challenge the waiver of retroactive eligibility, none has established standing to do so. *See Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734 (2008) ("Standing is not dispensed in gross."). Each plaintiff is currently covered by Medicaid, and any fears of future disenrollment (and re-enrollment subject to the waiver) are speculative. Indeed, none of the plaintiffs even states in his or her declaration that if disenrolled, he or she would attempt to re-enroll in Medicaid. *See generally* Philbrick Decl., Ludders Decl., Karen VLK Decl., Joshua VLK Decl. Plaintiffs have the burden of establishing an Article III injury caused by the waiver of retroactive eligibility, and that "requirement will not be satisfied simply because a chain of events can be hypothesized in which the action challenged eventually leads to actual injury." *Northwest Airlines, Inc. v. FAA*, 795 F.2d 195, 201 (D.C. Cir. 1986); *see also In re Sci. Applications Int'l Corp. (SAIC) Backup Tape Data Theft Litig.*, 45 F. Supp. 3d 14, 24 (D.D.C. 2014).[6]

At any rate, plaintiffs' contentions regarding the waiver of retroactive eligibility are meritless. They assert the Secretary has not sufficiently explained how the waiver promotes coverage. Pls.' Mem 38. But the Secretary has done just that: he explained that this feature of the demonstration (which

[6] The federal defendants recognize this Court has previously found standing for challenges to demonstrations in their entirety where a plaintiff has demonstrated an injury-in-fact from just one of the demonstration's components. *See, e.g.*, *Stewart I*, 313 F. Supp. 3d at 251. The federal defendants respectfully disagree with this Court's application of Article III, and maintain that plaintiffs must establish standing for each project component they wish to challenge. *See, e.g., Lewis v. Casey*, 518 U.S. 343, 358 (1996) (plaintiff lacked standing to challenge, and court lacked power to enjoin, practices that "ha[d] not been found to have harmed any plaintiff in this lawsuit").

has been approved across administrations[7]) is designed to test whether beneficiaries will be encouraged "to obtain and maintain health coverage, even when healthy," and whether there will be a reduction in "gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick." AR 5, 12. Studies bear out that such churn occurs.[8] And the Secretary recognized that gaps in coverage matter because when people who can enroll in Medicaid when they are healthy "wait until they are sick" to do so they are less likely to "obtain preventive health services during periods when they are not enrolled." AR 5. By encouraging eligible individuals to enroll in Medicaid while they are healthy, the waiver seeks to enable New Hampshire to better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health care. AR 13. This promotes coverage because it helps "in making New Hampshire's Medicaid program fiscally sustainable over time, better ensuring continued coverage of individuals and services"—such as the new adult group and vision and dental services—"for which coverage is optional under Medicaid." *Id.*

Plaintiffs dismiss this explanation as "conclusory," relying on this Court's opinions in *Stewart I* and *Stewart II*. *See* Pls.' Mem. 27 (quoting *Stewart I*, 313 F. Supp. 3d at 265, and citing *Stewart II*, 366 F. Supp. 3d at 143). The federal defendants respectfully disagree that the Secretary's reasoning is conclusory. Waiving retroactive coverage by necessity eliminates some coverage, but, as described above, the Secretary has fully explained how he expects the waiver to promote coverage overall.

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[7] *See* Indiana HIP 2.0 (2015) (Ex. C); Delaware Diamond State Health Plan (2012) (Ex. D); Montana HELP (2016) (Ex. E); Oklahoma SoonerCare (2010) (Ex. F); Healthy Michigan (2013) (Ex. G); Arkansas Safety Net Benefit Program (2011) (Ex. H); New Hampshire Health Protection Program Premium Assistance (2015) (Ex. I); Tennessee TennCare II (2012) (Ex. J); Oregon Health Plan (2002) (Ex. K).

[8] *See, e.g.*, *Profile of the Medicaid Expansion Population* (Jan. 2018), at 3 https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mzmw/~edisp/pw_g330411.pdf ("Across plans and states, the expansion population experienced high disenrollment rates, indicating that, as in other Medicaid eligibility groups, there is substantial churn in this population.").

Plaintiffs may believe that lost retroactive coverage will outweigh coverage gains from earlier sign-ups, a more healthy population, and a more sustainable Medicaid program. But such weighing of costs and benefits is a decision for the Secretary, not Plaintiffs, and approving a test to gather more information on the question is well within the Secretary's discretion and expertise. *See Sec. Indus. & Fin. Markets Ass'n v. CFTC*, 67 F. Supp. 3d 373, 430 (D.D.C. 2014) (the weighing of costs and benefits "epitomize[s] the types of decisions that are most appropriately entrusted to the expertise of an agency").

F. Granite Advantage Is Likely To Promote Health And Financial Independence.

Finally, plaintiffs cite comments in the record which they claim show that Granite Advantage will not actually promote health and financial independence. Pls.' Mem. 29–32. As an initial matter, plaintiffs' argument displays a fundamental misunderstanding about the nature of a demonstration project—which is, again, a temporary experiment rather than a permanent revamp of Medicaid, and which does not require definitive results before the experiment has even begun. Plaintiffs' position also presumes an impossibly high standard for approval, whereby the Secretary's conclusions on matters within his technical expertise are unreasonable unless every contrary comment has been described and refuted. But that is not the law. As this Court recognized in *Stewart I*, "the Secretary was not required to address each comment in writing." 313 F. Supp. 3d at 263. Moreover, "it is not [this Court's] job to referee battles among experts; [it] is only to evaluate the rationality of [the agency's] decision." *Mississippi v. EPA*, 744 F.3d 1334, 1348 (D.C. Cir. 2013) (per curiam). Indeed, only if objections to the project show such results "as to negate any appreciable possibility of success would the Secretary's approval be arbitrary and capricious." *Aguayo*, 473 F.2d at 1107; *see also C.K.*, 92 F.3d at 185 ("[W]e … decline to find . . . a rule that in all cases an administrative record is deficient and must be supplemented where it does not contain a specific recitation and refutation of objections submitted in opposition to a proposed section 1315(a) waiver.").

Here, the Secretary's conclusion that Granite Advantage would likely promote health and independence was plainly rational in light of studies in the record showing a correlation between work and/or community engagement and improved health outcomes, AR 3786, 3799, 4006, 4013, 4020, 4033, 4071. Plaintiffs may not agree with the Secretary's conclusions, but nothing required the Secretary to give dispositive weight to their views.[9]

II. ANY RELIEF SHOULD BE LIMITED TO THE FOUR PLAINTIFFS AND TO PROJECT COMPONENTS THAT BOTH HAVE INJURED PLAINTIFFS AND ARE FOUND DEFICIENT.

Plaintiffs ask this Court to enjoin the implementation of Granite Advantage full stop. Compl., Prayer for Relief ¶ 4. Even assuming that some relief should be granted, there is no basis for relief in such sweeping form. On the contrary, any relief should be tailored to the four individuals before the Court. As the Supreme Court recently reaffirmed, a court's "constitutionally prescribed role is to vindicate the individual rights of the people appearing before it," and "[a] plaintiff's remedy must be tailored to redress the plaintiff's particular injury." *Gill v. Whitford*, 138 S. Ct. 1916, 1933, 1934 (2018). While the complaint here was styled as a class action, Plaintiffs did not move for class certification. Any relief accordingly must "be limited to the inadequacy that produced the injury in fact" with respect to the plaintiffs. *See Lewis*, 518 U.S. at 357.

It makes no difference that plaintiffs pled claims under the APA, as the APA preserves all ordinary principles of equity. *See* 5 U.S.C. § 702(1) ("Nothing herein affects . . . the power or duty of the court to . . . deny relief on any other appropriate legal or equitable ground[.]"); *see also id.* § 703. Nor does the APA's text permit, let alone require, relief beyond what is necessary to redress a plaintiff's own cognizable injuries. *Cf. Trump v. Hawaii*, 138 S. Ct. 2392, 2425 (2018) (Thomas, J., concurring)

[9] The federal defendants recognize that this Court concluded in *Stewart II* that the Secretary was required to "estimate the number of people who will gain employment and move onto commercial coverage or otherwise attain financial independence." 366 F. Supp. 3d at 147. The federal defendants respectfully disagree that such an estimate is required under the APA or even feasible.

("No statute expressly grants district courts the power to issue universal injunctions."). The text of 5 U.S.C. § 706(2) merely requires that the Secretary's approval, if found deficient, be "set aside"—not that it be set aside *on its face* rather than *as applied to the plaintiffs*. Absent a statutory provision specifically authorizing review of the entire program, the application of the program to the plaintiffs would be the only proper ripe subject of review, *see Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 891 (1990), and thus the outer limit of any relief. *See L.A. Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 664-65 (9th Cir. 2011) (vacating district court's grant of nationwide injunction in APA case); *Va. Soc'y for Human Life, Inc. v. FEC*, 263 F.3d 379, 383 (4th Cir. 2001) (same), *abrogated on other grounds by Fed. Election Comm'n v. Wisconsin Right To Life, Inc.*, 551 U.S. 449 (2007).[10]

Moreover, the APA's equitable remedies are discretionary. *See Abbott Labs. v. Gardner*, 387 U.S. 136, 148 (1967) ("injunctive and declaratory judgment remedies are discretionary"). There is no equitable reason to disrupt the statewide implementation of Granite Advantage and thus jeopardize the expansion coverage for tens of thousands of individuals who are not before this Court. Nor is there reason to believe that other members of the new adult group share plaintiffs' desire to take the risk that New Hampshire will terminate the expansion if the demonstration project does not go forward. Even if the four plaintiffs are prepared to put their own coverage at risk, their views should not be imposed on New Hampshire's expansion population at large.

In addition to limiting any relief to the specific plaintiffs in this action, the Court should also limit any relief to the particular component(s) of Granite Advantage that it finds have caused the plaintiffs' injury in fact and as to which they have raised a valid legal objection. *See Lewis*, 518 U.S. at 357-358 (plaintiff lacked standing to challenge, and court lacked power to enjoin, practices that "ha[d]

[10] The historical backdrop to the APA's enactment bolsters this reading. The absence of nationwide injunctions before Congress's enactment of the APA in 1946 (and for over fifteen years thereafter), *see Hawaii*, 138 S. Ct. at 2426 (Thomas, J., concurring), suggests that the APA was not originally understood to authorize courts to issue such broad relief.

not been found to have harmed any plaintiff in this lawsuit"). The Supreme Court has emphasized that courts "have no business answering" questions about the validity of provisions that concern only "the rights and obligations of parties not before the Court," *Printz v. United States*, 521 U.S. 898, 935 (1997); *see also Murphy v. NCAA*, 138 S. Ct. 1461, 1485-87 (2018) (Thomas, J., concurring), and project components that injure only non-parties are not within the proper scope of the Court's remedial discretion. So, for example, if this Court identifies some deficiency with Granite Advantage's community-engagement requirement, it should issue no relief reaching the waiver of retroactive coverage unless it also identifies a deficiency with respect to that component and a plaintiff with standing to challenge it.

To be sure, *the Secretary* considers a demonstration project as a whole in determining which (if any) parts to approve and in turn which statutory requirements to waive under 42 U.S.C. § 1315(a). But that has no bearing on the constitutional and equitable limits on the authority of *a court* to grant relief beyond what is necessary to redress the plaintiffs' injuries, and provides no basis for the Court to issue relief regarding components not shown to injure any plaintiff. Congress vested the Secretary with discretion to determine whether demonstrations should proceed, and accordingly, in the event a particular component of Granite Advantage is found to be deficient, the determination whether to proceed with the remaining component would lie with the Secretary, in consultation with New Hampshire. Thus, if a project component that causes a plaintiff injury is ruled invalid, the appropriate course would be to so declare and then remand to the agency so that the Secretary may determine how to proceed. In such event, the remand should be without vacatur. *See, e.g., Defs. of Wildlife v. Jackson*, 791 F. Supp. 2d 96, 118–19 (D.D.C. 2011) (mem.).[11]

[11] The federal defendants recognize that in *Stewart I* and *Stewart II*, this Court vacated Kentucky HEALTH in its entirety and, in *Gresham*, the Court likewise vacated the amendments to Arkansas Works in their entirety. The federal defendants respectfully disagree with the remedies issued by this Court in those cases.

III. PLAINTIFFS' CHALLENGE TO CMS'S LETTER TO STATE MEDICAID DIRECTORS IS NON-JUSTICIABLE AND MERITLESS.

Plaintiffs also purport to challenge a January 11, 2018, letter that CMS sent to state Medicaid directors, but that letter was not final agency action subject to judicial review. The letter did not mark the "consummation of the agency's decisionmaking process" nor did it determine "rights or obligations." *Bennett v. Spear*, 520 U.S. 154, 156 (1997) (citation omitted).

Instead, the letter simply provided guidance for state Medicaid directors and indicated that CMS was prepared to assist States in their efforts to encourage work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability. AR 57. The letter explained that CMS would "support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects." *Id.* The letter indicated that demonstration projects are intended to give States "more freedom to test and evaluate approaches to improving quality, accessibility, and health outcomes in the most cost-effective manner." AR 59. The letter provided "a number of issues for states to consider" in developing such demonstration projects, such as the project's alignment with other state welfare programs, the population that would be subject to any community-engagement requirements, and considerations of budget neutrality, monitoring, and evaluation. AR 58–65. And it provided guidance to assist the States in developing successful demonstration projects. *See, e.g.*, AR 61–62.

Guidance of this sort is commonplace for CMS, and it neither commits CMS to a course of action nor requires state Medicaid directors to act. For example, in 2012 guidance, CMS explained that it was "interested in working with states to promote better health and health care at lower costs and [had] been supporting, under a demonstration established by the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors." 2012 CMS Guidance at 15. CMS "invite[d]

states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes," and noted that "states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100%" of the FPL. *Id.*

Such CMS guidance does not constitute final agency action. "No legal consequences flow from the agency's conduct …, for there has been no order compelling [the regulated party] to do anything." *Reliable Automatic Sprinkler Co. v. Consumer Prod. Safety Comm'n*, 324 F.3d 726, 732 (D.C. Cir. 2003). The "long-standing practice in circumstances like this is to require the complaining party to challenge the specific implementation of the broader agency policy." *Fund for Animals, Inc. v. U.S. Bureau of Land Mgmt.*, 460 F.3d 13, 22 (D.C. Cir. 2006). Here, of course, plaintiffs have done exactly that by challenging the requirements of Granite Advantage.

There is thus no reason or authority to adjudicate a freestanding challenge to the letter. CMS itself characterizes the letter as nonbinding guidance. *See* AR 57. Moreover, CMS did not cite the letter as the legal authority for its November 30, 2018 approval of Granite Advantage; indeed, the Secretary's approval did not cite the SMD letter at all. AR 1–14. The Secretary's approval of the New Hampshire demonstration project is supported "just as if the [letter] had never been issued," because the agency considered the specifics of the project and supporting record in deciding to approve the project. *Nat'l Min. Ass'n v. McCarthy*, 758 F.3d 243, 253 (D.C. Cir. 2014).

In any event, plaintiffs' challenge to the letter has no merit. For largely the same reasons that the letter is not final agency action, it is also not a legislative rule subject to the APA's notice-and-comment requirement. "General statements of policy" are exempt from notice-and-comment unless another statute provides otherwise, 5 U.S.C. § 553(b)(3)(A), and no statute does so here. The letter "compels action by neither the recipient nor the agency" and thus cannot be a legislative rule. *Holistic Candlers & Consumers Ass'n v. FDA*, 664 F.3d 940, 944 (D.C. Cir. 2012). By contrast, a State's

submission of a proposed demonstration project *is* subject to specified public notice procedures, further demonstrating why the earlier letter is not subject to such procedures. *See* 42 C.F.R. §§ 431.408(a)(1), (3). Plaintiffs' contention that the Secretary lacks authority to approve demonstration projects with community-engagement requirements, or that he has failed adequately to explain the reasons for doing so, is meritless for reasons discussed above.

IV. THE CLAIM UNDER THE "TAKE CARE CLAUSE" SHOULD BE DISMISSED.

Plaintiffs offer no argument in support of their allegation that the Secretary's approval violates the President's responsibility to "take Care that the Laws be faithfully executed." U.S. Const. art. II, § 3. This is not a suit against the President; it is an APA action against an agency and its officials. Plaintiffs do not meaningfully explain how the Secretary's approval of Granite Advantage could be regarded as a violation of the President's duty to take care that the laws be faithfully executed. *See* Compl. ¶¶ 202–19. Moreover, even assuming *arguendo* that the Clause applies directly to the Secretary, separate from its application to the President, the Supreme Court has held that "the duty" the Clause imposes "in the exercise of the [President's] power to see that the laws are faithfully executed" is not judicially enforceable. *Mississippi v. Johnson*, 71 U.S. (4 Wall.) 475, 499 (1866). Nor do plaintiffs have a cause of action to raise that constitutional claim, because neither the APA nor the Take Care Clause itself furnishes a right to sue the President. *See Franklin v. Massachusetts*, 505 U.S. 788, 796 (1992); *cf. Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1383-1384 (2015). Count Three, accordingly, should be dismissed.

CONCLUSION

For the foregoing reasons, the Court should dismiss plaintiffs' complaint or, in the alternative, grant summary judgment to the federal defendants and deny plaintiffs' motion.

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