UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM, ***et al.*****,** **Plaintiffs,** **v.** **ALEX M. AZAR II,** ***et al.*****,** **Defendants.**	**Civil Action No. 18-1900 (JEB)**

MEMORANDUM OPINION

Adrian McGonigal is 40 years old and lives with his brother in Pea Ridge, Arkansas. He used to have a job working in the shipping department of Southwest Poultry, a food-service company located nearby, although he received no medical insurance through his employer. Like many Americans, he has several serious medical conditions. Beginning in 2014, McGonigal was able to receive medical care — including regular doctor visits and numerous prescription drugs — through the state's expanded Medicaid program. In mid-2018, however, McGonigal learned that he would be subject to new work requirements, which he would have to report online, as a condition of receiving health benefits. These were imposed by the Arkansas Works Amendments (AWA), approved by the U.S. Secretary of Health and Human Services in March 2018. Despite his lack of access to, and difficulty working with, computers, he was able to report his employment in June 2018, but he did not know he needed to continue to do so each month. As a result, when he went to pick up his prescriptions in October, the pharmacist told him that he was no longer covered, and his medicines would cost him $800. In the absence of Medicaid, he could not afford the cost of the prescriptions and so did not pick them up. His

health conditions then flared up, causing him to miss several days of work, and Southwest Poultry fired him for his absences. He thus lost his Medicaid coverage and his job.

Anna Book is 38 years old and lives in Little Rock. She currently rents a room in an apartment but was homeless for most of the last eight years. In July 2018, she got a job as a dishwasher in a restaurant, for which she works about 24 hours each week. Before that, she was unemployed for two years. She nevertheless also had health care provided through Arkansas's Medicaid program, which a local pastor helped her sign up for in 2014. Book learned last August that, pursuant to AWA, she would have to report 80 hours each month of employment or other activities to keep that coverage. While she reported her compliance in August and September with the pastor's help —

suffered by Arkansans like Plaintiffs, the Court will vacate the Secretary's approval and remand for further proceedings.

I. BACKGROUND

As it did in Stewart I, the Court begins with an overview of the relevant history and provisions of the Medicaid Act. See 313 F. Supp 3d. at 243–44. It then turns to Arkansas's challenged plan before concluding with the procedural history of this case.

A.

known as Obamacare, "to increase the number of Americans covered by health insurance." Nat'l Fed. of Indep. Business v. Sebelius, 567 U.S. 519, 538 (2012). Under that statute, states can expand their Medicaid coverage to include additional low-income adults under 65 who would not otherwise qualify. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

Generally, a state must cover all qualified individuals or forfeit its federal Medicaid funding. Id. § 1396a(a)(10)(B). That was originally so for the ACA expansion population as well. See 42 U.S.C. § 1396c. In NFIB, however, the Supreme Court held that Congress could not, consistent with the Spending Clause of the Constitution, condition previously appropriated Medicaid funds on the state's agreeing to the expansion. See 567 U.S. at 584–85. The result was that states could choose not to cover the new population and lose no more than the funds that would have been appropriated for that group620 Td (,0 Tc T(a)3)4 c -0.00 ()(o m)-23t(, how)2 4 (e r)-67 U Ia
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care.

While the ultimate decision whether to grant § 1115 approval rests with the Secretary, his discretion is not boundless. Before HHS can act on a waiver application, the state "must provide at least a 30-day public notice[-]and[-]comment period" regarding the proposed program and hold at least two hearings at least 20 days before submitting the application. See 42 C.F.R. §§

administration's view that the ACA's expansion of Medicaid was "a clear departure from the core, historical mission of the program." See AR 85. They thus alerted states of the agency's "intent to use existing Section 1115 demonstration authority" to help revamp Medicaid. See AR 86. Together they promised to find "a solution that best uses taxpayer dollars to serve" those individuals they deemed "truly vulnerable." Id. Heeding HHS's call, Governor Asa Hutchinson proposed three substantial amendments to Arkansas Works under Section 1115. See AR 2057.

took effect for persons age 30 to 49 on June 1, 2018, and for persons age 20 to 29 on January 1, 2019. See ECF No. 26-3 (Arkansas Works Eligibility and Enrollment Monitoring Plan) at 7–8. As to retroactive coverage, the Secretary approved a reduction from the three months required by the Act to one month; the more drastic proposal of eliminating such coverage entirely was abandoned, as was the Governor's request to reduce eligibility down to 100% of the FPL. See AR 12, 22.

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the Secretary approved that project on the ground that it was likely to "improv[e] health outcomes" and "increas[e] individual engagement in health care decisions." Stewart I, 313 F. Supp. 3d at 258 (quoting AR 7).

Before the project took effect, several Medicaid recipients challenged the Secretary's approval in this Court. They argued, among other things, that the agency had failed to adequately explain why Kentucky HEALTH promoted the objectives of Medicaid and that approval of the project exceeded HHS's statutory authority. The Court concluded that the plaintiffs were right in one central and dispositive respect: "[T]he Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." Id. at 243. It therefore vacated the Secretary's approval and remanded the matter to the agency for further consideration. Id. at 273.

HHS has since reopened the comment period and subsequently reapproved Kentucky's project, offering additional explanation for why the project advances the objectives of the Medicaid Act. The parties have now come back to the Court and filed cross-motions for summary judgment in that case. The Court issues a separate Opinion today resolving those motions, which it will refer to as Stewart II.

C. Procedural History

Several Arkansas residents filed this lawsuit in August 2018. They assert that the Secretary's approval of the Arkansas Works Amendments was arbitrary and capricious, in excess of his statutory authority, and in violation of the Take Care Clause of the Constitution. Because it was designated as related to Stewart I, see ECF No. 2, the case was directed to this Court. While Defendants objected to the related-case designation, see ECF No. 17, the Court determined that the cases' common legal and factual issues militated in favor of its retaining the

matter. See Minute Order of Sept. 12, 2018. The State of Arkansas has since intervened as a Defendant, and numerous amici have also joined the fray. Dueling Cross-Motions for Summary Judgment are now ripe.

II. LEGAL STANDARD

The parties have cross-moved for summary judgment on the administrative record. The summary-judgment standard set forth in Federal Rule of Civil Procedure 56(c), therefore, "does not apply because of the limited role of a court in reviewing the administrative record." Sierra Club v. Mainella, 459 F. Supp. 2d 76, 89 (D.D.C. 2006); see also Bloch v. Powell, 227 F. Supp. 2d 25, 30 (D.D.C. 2002), aff'd, 348 F.3d 1060 (D.C. Cir. 2003). "[T]he function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." Sierra Club, 459 F. Supp. 2d. at 90 (quotation marks and citation omitted). "Summary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [Administrative Procedure Act] standard of review." Loma Linda Univ. Med. Ctr. v. Sebelius, 684 F. Supp. 2d 42, 52 (D.D.C. 2010) (citation omitted).

The Administrative Procedure Act "sets forth the full extent of judicial authority to review executive agency action for procedural correctness." FCC v. Fox Television Stations, Inc., 556 U.S. 502, 513 (2009). It requires courts to "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2). Agency action is arbitrary and capricious if, for example, the agency "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency

expertise." Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).

In other words, an agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." Id. at 43 (quoting Burlington Truck Lines v. United States, 371 U.S. 156, 168 (1962)) (internal quotation marks omitted). Courts, accordingly, "do not defer to the agency's conclusory or unsupported suppositions," United Techs. Corp. v. Dep't of Def., 601 F.3d 557, 562 (D.C. Cir. 2010) (quoting McDonnell Douglas Corp. v. Dep't of the Air Force, 375 F.3d 1182, 1187 (D.C. Cir. 2004)), and "agency 'litigating positions' are not entitled to deference when they are merely [agency] counsel's '*post hoc* rationalizations' for agency action, advanced for the first time in the reviewing court." Martin v. Occupational Safety & Health Review Comm'n, 499 U.S. 144, 156 (1991) (citation omitted). Although a reviewing court "may not supply a reasoned basis for the agency's action that the agency itself has not given," a decision that is not fully explained may, nevertheless, be upheld "if the agency's path may reasonably be discerned." Bowman Transp., Inc. v. Arkansas

v. Cent. Bank of Islamic Repub. of Iran, 896 F.3d 501, 509 (D.C. Cir. 2018). To establish standing under Article III, Plaintiffs must show

Amendments writ large, the Court declines to decide whether certain Plaintiffs have standing to challenge this particular part of the project.

B. Merits

With that threshold issue easily dispatched, the Court turns to the merits. Plaintiffs' central position is identical to that of the challengers in Stewart I: the Arkansas Works Amendments "fundamentally alter the design and purpose of Medicaid." ECF No. 27 (MSJ) at 13. They thus

record evidence." Am. Wild Horse Pres. Campaign v. Perdue, 873 F.3d 914, 923 (D.C. Cir. 2017). At minimum, the Secretary cannot "entirely fail[] to consider an important aspect of the problem." Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983). Rather, he must "adequately analyze . . . the consequences" of his actions. See Am. Wild Horse, 873 F.3d at 932. In doing so, "[s]tating that a factor was considered . . . is not a substitute for considering bst

1. The Secretary's Consideration of Medicaid's Objectives

Before approving a demonstration or pilot project, the Secretary must identify the objectives of Medicaid and explain why the project is likely to promote them. As it did in Stewart I, the Court assumes that the Secretary's identification of those objectives is entitled to Chevron deference. That is, in reviewing his interpretation, the Court must first ask whether "Congress has directly spoken to the precise question at issue," and, if not, whether "the agency's answer is based on a permissible construction of the statute." Chevron U.S.A., Inc. v. Nat'l Res. Def. Council, Inc., 467 U.S. 837, 842–43 (1984). According such deference is not of much practical significance here, however, because the Secretary agrees with the Court's understanding of a "core objective" of the Medicaid Act. See ECF No. 52 (HHS Reply) at 5.

In Stewart I, the Court explained that "one of Medicaid's central objectives" is to "furnish medical assistance" to persons who cannot afford it. See 313 F. Supp. 3d at 243, 261, 266, 273. That conclusion followed ineluctably from § 1396-1 of the Act, which provides that Congress appropriated Medicaid funds "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance . . . [to] individuals[] whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Case law discussing the program's objectives confirms as much. See, e.g., Schweiker v. Hogan, 453 U.S. 569, 571 (1982) (explaining that Congress established Medicaid "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons"); W. Va. Univ. Hosps. Inc. v. Casey, 885 F.2d 11, 20 (3d Cir. 1989) ("[T]he primary purpose of

[M]edicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it.”).

Defendants, as mentioned, agree that providing health coverage to the needy is a purpose of the Act. See ECF No. 37 (HHS MSJ) at 12; Ark. MSJ at 13. In Arkansas’s words, “[T]hat Medicaid coverage is a Medicaid objective is readily apparent from the substantive provisions of the statute.” Ark. MSJ at 13. The Secretary, in fact, refers to the provision of medical care to eligible persons as “Medicaid’s core objective.” HHS Reply at 5 (emphasis added). HHS nevertheless did not consider whether AWA would advance or impede that objective.

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deficiency is instructive. To “adequately analyze” the issue of coverage, Am. Wild Horse

requirements create. The bottom line: the Secretary did no more than acknowledge — in a conclusory manner, no less — that commenters forecast a loss in Medicaid coverage. But "[s]tating that a factor was considered . . . is not a substitute for considering it." Getty, 805 F.2d at 1055. His decision thus falls short of the kind of "reasoned decisionmaking" the APA requires. See Michigan, 135 S. Ct. at 2706.

Defendants argue that the Secretary did not need to and perhaps was not even able to provide a numeric estimate of coverage loss. See

must "recit[e] and refut[e] every objection submitted in opposition to the proposed demonstration." HHS MSJ at 22. It just means that, at a minimum, the agency cannot "entirely fail[] to consider an important aspect of the problem," repeatedly raised in the comment period. See State Farm, 463 U.S. at 43.

Arkansas maintains that the Secretary did not need to consider any reduction in coverage because it unlike Kentucky did not predict that the project would even cause coverage loss. See Ark. MSJ at 24. But the state's failure in that respect does not alter HHS's inquiry. Under the Medicaid Act, the Secretary may approve only those demonstration projects that are "likely to assist in promoting the objectives of [Medicaid]," and the parties agree that the provision of health coverage is a "central" objective of the Act. See 42 U.S.C. § 1315(a); HHS MSJ at 12–13; Ark. MSJ at 13. Whether a state gives the Secretary excellent data or no data at all about coverage, his duty remains the same: to determine whether the proposed project will promote the objectives of the Act, including whether it advances or hinders the provision of health coverage to the needy. If it were otherwise, HHS could approve a project that would decimate Medicaid coverage without so much as addressingas

explicitly require the Secretary to respond to comments or articulate the basis for his decision. See HHS MSJ at 22 (discussing 42 C.F.R. § 431.416). The APA, however, requires more. Where an agency decision is judicially reviewable, as the Court has already held this one is, see Stewart I, 313 F. Supp. 3d at 254–56, the Government “must give a reason that a court can measure . . . against the ‘arbitrary or capricious’ standard of the APA.” Kreis v. Sec’y of Air Force, 866 F.2d 1508, 1514–15 (D.C. Cir. 1989); see also Coburn v. McHugh, 679 F.3d 924, 934 (D.C. Cir. 2012) (“At the very least, the Board must 9sosti‘2 ,a2 (s()u+)7.(4)1 n Che AuoW34o.4. CJ

lead "Medicaid-eligible persons [to] wait even longer to have their conditions treated to avoid incurring medical bills they cannot pay." AR 1279. And when they do eventually arrive for treatment, they will be covered for less time than they would have been before AWA took effect, by definition reducing their Medicaid coverage. See AR 1338 (National Health Law Program describing this risk). HHS's brief reference to the potential coverage-promoting effects of the changes to retroactive eligibility thus does not get it across the line.

2. Counterarguments

Defendants offer two separate reasons for the Court to overlook the Secretary's failure to consider coverage, neither of which is persuasive. They say first that the Arkansas Works Amendments promote several other important objectives of Medicaid, including the health of Medicaid-eligible persons. Second, Defendants maintain that any deficiency in the administrative record in this case is cured by the agency's subsequent approval of Kentucky's similar project on remand from the Court's decision in Stewart I.

a. *Other Objectives*

Defendants justify the proposed demonstration project on the ground that, regardless of its effect on Medicaid coverage,-3 (l)-15.1 (e)1.1 (s)-4.1 re coeiciarat ct6 (ci(t)]J   0 Tc 0 Tw [(obj)-12 (e)4 (c)4

Kentucky HEALTH promoted independence and self-sufficiency. Id. at 271–72.

population." 313 F. Supp. 3d at 269. HHS conceded as much in that case. Id. Neither party has offered any reason to retreat from that determination.

Defendants' attempts to find refuge in other purposes of the Act and the rule [illegible]

removing

HEALTH allowed to be implemented pending further proceedings. Id. While the journey is somewhat different in this case, the Court arrives at the same destination.

1. Seriousness of Deficiencies

The first factor does not favor the Government. For starters, in Stewart I, the Court concluded that the same legal error was a "major shortcoming" going "to the heart of the Secretary's decision." 313 FWciSvtt h e t h 0 . 0 0 4

expansion

state's data-collection efforts. See HHS MSJ at 29. If Arkansas — as the party responsible for collecting and analyzing data from the project — has concerns about data collection in the event of vacatur, it does not say as much. See Ark. MSJ at 38–40 (mentioning only disruptive effects on education and outreach); ECF No. 45 (Ark. Reply) (same). Indeed, one amicus points out that the Secretary approved this project without "a proposed evaluation design." See Amicus Brief of Deans, Chairs, and Scholars at 19–20.

The Court assumes, however, that vacatur would interrupt the state's efforts to collect data on the effects of the work requirements and changes to retroactive coverage. While such concerns are not insignificant, they are tempered in the context of this case. Experimental projects are intended to help states like Arkansas "test out new ideas" for providing medical coverage to the needy, thereby influencing the trajectory of the federal-state Medicaid partnership down the line. See *supra* S. Rep. No. 1589 at 1961. If, after further consideration or after prevailing on appeal, the Secretary and Arkansas wish to move ahead with work requirements, they will remain able to do so in the future. And if they are dissatisfied with the data gathered from the initial months of the project because of the interruption caused by vacatur, Defendants could extend the project for an additional period of time to collect more information. This is not to minimize the importance of data collection in the context of an experimental project; it is just to say that vacatur will have litti6.1 (ti/)4 (a)4 (us)-1Aftatd furi(ove)4 (a3 o)-8 (f)5 8 (t)tur,

requirements will be confusing to Medicaid recipients who have just recently been informed that they have to meet those requirements. Id. at 38–39. The Court grants that vacatur of work requirements that have already been implemented may send mixed messages. But any disruption in this respect is not sufficiently significant to avoid vacatur. For one thing, Defendants have

might entail. Instead, it just requires them to communicate to providers that they should not disenroll persons moving forward on account of the requirements. The bottom line: "This is not a case in which the 'egg has been scrambled,' and it is too late to reverse course." Allina Health, 746 F.3d at 1110–11 (quoting Sugar Cane Growers Co-op of Fla. v. Veneman, 289 F.3d 89, 97 (D.C. Cir. 2002)).

Finally, the Court emphasizes that the disruptions to Arkansas's administration of its Medicaid program must be balanced against the harms that Plaintiffs and persons like them will experience if the program remains in effect.

IV. CONCLUSION

For the foregoing reasons, the Court will grant Plaintiffs' Motion for Summary Judgment and deny Defendants' Cross-Motions. A separate Order consistent with this Opinion will issue this day, remanding the matter to HHS.

/s/ *James E. Boasberg*
JAMES E. BOASBERG
United States District Judge

Date: March 27, 2019

APPENDIX A

Arkansas Health Plan Component	Comments
Community-Engagement Requirement	AR 1269 (Arkansas Advocates for Children & Families) (noting that the requirement "will increase the rate of uninsured Arkansans" based on comparable effect in TANF program) AR 1277 (American Congress of Obstetricians and Gynecologists, *et al.*) ("The experience of the TANF program . . . demonstrates that imposing work requirements on Medicaid beneficiaries would . . . lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment."); AR 1285 (Families USA) ("The presence of the requirement itself will be a barrier to enrollment, causing some eligible working individuals to forego applying for coverage, and will make it more difficult for some statutorily eligible individuals to maintain coverage."); AR 1291 (AARP) (expressing concern that requirements would "present an unnecessary barrier to health coverage for a gseseA an

Retroactive Eligibility	AR 1292 (AARP) (warning lack of retroactive coverage would increase debt obligations on previous beneficiaries and would "increase the burden of uncompensated care on providers"); AR 1297 (Human ARC) ("Gaps of time without medical coverage for the low-income population that are eligible and applying for Medicaid will be significant."); AR 1307 (Arkansas Hospital Association) ("AHA is concerned that the waiver of retroactive eligibility will result in unanticipated and avoidable gaps in coverage and healthcare debt."); AR 1320 (Cancer Action Network) (stating waiver of retroactive eligibility "could place a substantial financial burden on enrollees and cause significant disruptions in care"); AR 1338 (National Health Law Program) ("The entirely predictable result will be . . . more individuals experiencing gaps in coverage when some providers refuse to treat them.").