UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

MEMORANDUM OPINION

This Court again takes up a challenge to the federal approval of Kentucky HEALTH, an experimental project proposed by the Commonwealth of Kentucky intended to "comprehensively transform" its Medicaid program. The Secretary of Health and Human Services has authority to approve such experimental proposals — or "demonstration projects" — as long as they promote the objectives of the Medicaid Act. Kentucky HEALTH, which the Secretary initially approved on January 12, 2018, would condition Medicaid eligibility for a large portion of its beneficiaries on work or community-engagement requirements and impose several additional obligations intended to make Medicaid more like commercial insurance.

Plaintiffs, Kentucky residents currently enrolled in the Commonwealth's Medicaid program, believed HHS's approval unlawful. In a ruling last summer, this Court agreed. Finding that the "Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens" and thus promote a central objective of the Medicaid Act, the Court concluded that this "signal omission render[ed] his determination arbitrary and capricious." Stewart v. Azar, 313 F. Supp. 3d 237, 243 (D.D.C. 2018). In

particular, it found that the Secretary had not grappled with Kentucky's estimate that a substantial number of people were likely to lose coverage under Kentucky HEALTH. Id. at 260. The Court, consequently, vacated the approval and remanded to HHS for further review.

The bell now rings for round two. Following the Court's remand and an additional notice-and-comment period, the Secretary reapproved the program last November, this time relying on somewhat different reasoning. Plaintiffs now challenge the reapproval, contending principally that the Secretary has not remedied the defects that rendered his prior action unlawful. Specifically, they maintain that he has still not adequately considered Kentucky HEALTH's likelihood to cause significant coverage loss. The Secretary, by contrast, believes that this time around he has cured any critical omission. Defendants now rely primarily on a new argument to that effect — namely that, although Kentucky HEALTH may cause nearly 100,000 people to lose coverage, that number will be dwarfed by the approximately 450,000 people who would suffer that fate if Kentucky ends its coverage entirely of those who have joined the Medicaid rolls via the Affordable Care Act, as it has threatened to do if this project is not approved.

The Supreme Court, in holding that Congress could not require states to adopt that Medicaid expansion by conditioning all their Medicaid funding on a decision to do so, explained that the states could not be compelled to engage in a program they had not bargained for with "a gun to the head." Nat'l Fed. of Indep. Business v. Sebelius, 567 U.S. 519, 581 (2012). Kentucky, it seems, has now picked up that gun by threatening to de-expand Medicaid. Defendants urge the Court to adopt the proposition that the Secretary need not grapple with the coverage-loss implications of a state's proposed project as long as it is accompanied by a threat that the state will de-expand — or, indeed, discontinue all of Medicaid. By definition, so this

program also includes features similar to health-insurance plans on the commercial market, including "an incentive and savings account called *My Rewards*." Id. at 247 (citations omitted).

2. Stewart I

Two weeks after the Secretary's approval of Kentucky HEALTH, fifteen Kentuckians headed to Court, filing a nine-count suit seeking declaratory and injunctive relief on behalf of themselves and a "statewide proposed class . . . of all residents of Kentucky who are enrolled in the Kentucky Medicaid program on or after January 12, 2018." ECF No. 1 (Complaint), ¶ 33. The Court granted Kentucky's Motion to Intervene, see Minute Order of March 30, 2018, and the parties subsequently filed competing Motions for Summary Judgment. See ECF Nos. 33, 50, 51. Because Kentucky HEALTH was slated to take effect on July 1, 2018, the Court operated on an expedited schedule and

result of the demonstration project, they “cannot excuse the Secretary’s failure” to consider coverage. Id. at 271. The Court reasoned similarly regarding self-sufficiency after expressing “doubts whether such an objective is proper.” Id. at 271. It consequently “den[ied] Defendants’ Motions for Summary Judgment,” “grant[ed] Plaintiffs’ Motion for Summary Judgment . . .[,] vacate[d] the Secretary’s approval of Kentucky HEALTH, and remand[ed] to the agency.” Id. at 274.

3. Action on Remand

Following the decision in Stewart I, the Secretary returned to the drawing board and re-opened the public-comment period for Kentucky HEALTH. See AR 25,499. On November 20, 2018, he reapproved K

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coverage" if the state makes good on its threat to terminate its participation in the ACA expansion in the absence of the demonstration project. See AR 6730–32.

The question here, of course, is whether this second effort gets the Secretary over the

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

that is not fully explained may, nevertheless, be upheld "if the agency's path may reasonably be discerned." Bowman Transp., Inc. v. Arkansas–Best Freight System, Inc., 419 U.S. 281, 285–86 (1974) (citation omitted).

III. ANALYSIS

Plaintiffs' challenge, fortunately, does not require the Court to start from square one; indeed, this round of litigation resembles in many respects the one concluded in Stewart I. Plaintiffs again essentially contend that the Secretary has sought to "rewrite the Medicaid Act in a way that is contrary to the pw08 0 Tt .4.55 0 Tda w c-2 (r)-dAutpos-4 (s)11, laiBorth-2 (i)-2 (s1. 0.004 Tc 0.0

Before moving to the substance of the dispute, the Court will address two jurisdictional objections — one concerning standing and one on justiciability.

A. Jurisdiction

Having addressed these issues in depth previously, see Stewart I, 313 F. Supp. 3d at 250–57, no more than a limited treatment is required here.

The Court takes standing first. Article III restricts the jurisdiction of federal courts to

There is no further analysis, however, much less a proffered reason that the Court should revisit its prior thorough treatment of this issue. As a result, it has little trouble concluding once again that the approval is judicially reviewable.

B. Merits

Having cleared the ground, the Court can now move to Plaintiffs' main beef: the Secretary's reapproval of Kentucky HEALTH is, they contend, arbitrary and capricious primarily because he did not adequately consider whether his § 1115 waiver promotes the objectives of the Medicaid Act. The Court agrees.

The Secretary can only approve demonstration projects that are "likely to assist in promoting the objectives" of the Medicaid Act. See 42 U.S.C. § 1315(a). He must, consequently, first identify those objectives. Courts reviewing an agency's statutory interpretation employ the two-step Chevron framework. That is, they 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). The Court need not reach Plaintiffs' contention that this case is an exceptional one in which Chevron should not apply at all. See ECF No. 119 (Plaintiffs' Reply) at 2–4. That is because, even according the Secretary appropriate deference, his action cannot stand.

As the Court concluded in Stewart I, a central objective of the Act is "furnish[ing] medical assistance" to needy populations. See 313 F. Supp. 3d at 243. Rather than adequately addressing Kentucky HEALTH's potential to cause loss of medical coverage, the Secretary continues to press his contention that the program promotes his alternative proposed objectives of beneficiary health, financial independence, and the fiscal sustainability of Medicaid. The

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

Indeed, the Secretary agrees — as he did in the last round of litigation, see Stewart I, 313 F. Supp. 3d at 260 — that § 1396-1 is "include[d]" in the "purposes of Medicaid" and "makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations." AR 6719 (citing 42 U.S.C. § 1396-1). At oral argument, the federal government again agreed that it is an objective of Medicaid, including for the expansion population. See Oral Argument Transcript at 6; see also Tr. at 10 (acknowledging that "the central objective of Medicaid under the Court's analysis in Stewart I

The Court concludes, therefore, as it did previously, that § 1396-1 provides a central

his consideration of the program's effects on medical assistance inadequate. His examination of the other three aims, two of which the Court finds are not stand-alone objectives of the statute in the first instance, cannot make up for that failure. This is especially true where the Secretary made no attempt to weigh any of those three aims against the coverage-loss consequences of the program. Although the Court takes up fiscal sustainability last, the reader should be aware that this is the principal new position Defendants press in this round of litigation and the one requiring the most analysis.

a. *Furnishing Medical Assistance*

In Stewart I, the Court found that the Secretary had "ignored" the Act's objective to furnish medical assistance. See 313 F. Supp. 3d at 261. As the Court explained then, "There are two basic elements to that problem" — namely, "whether the project would cause recipients to lose coverage" and "whether the project would help promote coverage." Id. at 262. Although he has no longer entirely "ignored" this objective of the Act, his reapproval was nevertheless legally inadequate because he "failed to 'adequately analyze' coverage." Id. (quoting Am. Wild Horse, 873 F.3d at 932). To explain why, the Court separately examines his more recent consideration of coverage loss and of coverage promotion.

i. Coverage Loss

In the original approval, the Secretary "never provided a bottom-line estimate of how many people would lose Medicaid with Kentucky HEALTH in place," an "oversight" that was especially "glaring" since, "[i]n its application, Kentucky estimated that the project would cause" a substantial number of people to leave its Medicaid rolls — the equivalent of 95,000 people losing coverage for a year. Id. As the Court noted before, "*Amici* maintain that such number is conservative and peg the real figure as between 175,000 and 297,500" people losing coverage in

the first year of the program. Id. (citing ECF No. 44 (Amicus Brief of Deans, Chairs, and Scholars) at 18). Whatever the precise calculation, the number is undoubtedly substantial. While the Secretary has now nominally acknowledged that estimate, none of his responses evinces the kind of "reasoned decisionmaking" that arbitrary-and-capricious review requires. See Michigan v. EPA, 135 S. Ct. 2699, 2706 (2015).

The most significant point that the Secretary now makes about coverage is one he couches as a fiscal-sustainability consideration — namely, that because Kentucky is facing budget woes and has as a result threatened to terminate the entire Medicaid expansion if this demonstration project is not approved, any coverage loss from the project should be viewed against the Commonwealth's unbridled prerogative to scrap the entire population. See AR 6726, 6731; HHS MSJ at 3–4, 22. The Court will, accordingly, address this point in its discussion of fiscal sustainability. See Section B.2.d, *infra*. For now, it will note only that the argument is inconsistent with and relies on an unreasonable reading of the Secretary's § 1115 authority. It cannot, as a result, satisfy his obligation to analyze coverage loss.

Defendants next make two arguments questioning the extent of his obligation to consider coverage losses. The Secretary first contends that § 1115 contemplates that demonstrations may result in an impact on eligibility, meaning coverage loss does not necessarily render a project unlawful. See AR 6726, 6729–30

sufficiently significant — even at the low end of the estimated range — that it cannot be waved off by the rejoinder that <u>some</u> amount of coverage loss is legally permissible.

Second, the

commenters detailed the widespread predicted nature of coverage loss and its devastating effects, see AR 13175, 15482, 19489, including the destructive effects of coverage gaps. See AR 12918, 12967, 15486, 19388–89, 19985–86; see also ECF No. 99 (Amicus Brief of American Academy of Pediatrics) at 10–15, 19–20. In other words, understanding of the loss estimate was baked into their analysis of the magnitude of coverage loss, and the Secretary is not relieved of his obligation to consider the significance of the number — whether it represents primarily permanent losses of coverage or a high incidence of gaps.

He makes no effort, moreover, to cite evidence or otherwise provide a reasoned basis for the assertion that some number of people will transition to commercial coverage and, if so, how many he might expect. Once again, "[w]hile the agency spoke generally of 'creating incentives for individuals to obtain and maintain coverage through private, employer-sponsored insurance,' it cited no research or evidence that this would happen, nor did it make concrete estimates of how many beneficiaries might make that transition." Stewart I, 313 F. Supp. 3d at 264. In addition, he made no effort to explain how — given that Kentucky HEALTH contains community-engagement rather than work requirements — beneficiaries could reasonably expect to get commercial insurance from "

also several guardrails — including a good-cause exemption to certain penalties, an opportunity for re-enrollment after coming back into compliance with program requirements, screening beneficiaries for other eligibility possibilities before the lockout, full appeal rights prior to eligibility loss, and maintaining a system for "reasonable modification[]" of the requirements for persons with disabilities, "among other assurances." AR 6729; see

medical-frailty exemption — that predated the Secretary's original approval but postdated its 95,000 estimate. These additions, the Commonwealth contends, would have reduced its estimate. See Tr. at 23–25. Because the reapproval letter evinces consideration of neither of those things, the Court cannot consider them either, see SEC v. Chenery Corp., 318 U.S. 80, 87 (1943), nor can they be imagined to mitigate the coverage-loss estimate.

ii. Coverage Promotion

The Secretary devotes little space, conversely, to describing how Kentucky HEALTH would promote coverage. He does elaborate that the "*My Rewards Account* incentives for healthy behaviors are intended to increase uptake of preventive services," and the "waiver of retroactive eligibility" is designed to "encourage preventive care." AR 6724. He also explains that the program will allow Kentucky to "evaluate whether the *My Rewards* and *Deductible* accounts, as well as redetermination and reporting requirements, will strengthen beneficiary engagement in their personal health and provide an incentive structure to support responsible consumer decision-making about maintaining health and accessing care and services," particularly given that a "prior evaluation of one demonstration project with beneficiary engagement components has shown some promise that these strategies can have a positive impact on beneficiary behavior." Id.

As the Court noted before, the invocation of the incentive created by the waiver of retroactive eligibility is a "'conclusory' reference" to coverage promotion that "cannot suffice, 'especially when viewed in light of' an obvious counterargument." Stewart I, 313 F. Supp. 3d at 265 (quoting Getty v. Fed. Sav. and Loans Ins. Corp., 805 F.2d 1050, 1057 (D.C. Cir. 1986)). In fact, "restricting retroactive eligibility will, by definition, reduce coverage." Id. Whether or not the program generally will lead to an uptick in preventive care, the Secretary makes no effort to

quantify that uptick or to weigh it against coverage losses for those whom Kentucky HEALTH may deprive of all access to care, preventive and otherwise. Likewise, even if beneficiaries become more engaged with their care, the Secretary must balance that with the possibility that there will be widespread lack of access to care. In light of the failure to weigh any coverage promotion in the face of the likelihood of substantial coverage loss, the Secretary did not "adequately analyze the . . . consequences" of the reapproval. See Am. Wild Horse, 873 F.3d at 932.

b. Health

Moving off of coverage, the reapproval relies in part on the Secretary's conclusion that Kentucky HEALTH will promote the health and wellness of its beneficiaries. Indeed, the Government contends that " s

outside “the bounds of reasonableness.” Abbott Labs v. Young, 920 F.2d 984, 988 (D.C. Cir. 1990). “‘The reasonableness of an agency’s construction depends,’ in part, ‘on the construction’s fit with the statutory language, as well as its conformity to statutory purposes.’” Goldstein v. SEC, 451 F.3d 873, 881 (D.C. Cir. 2006) (quoting Abbott Labs, 920 F.2d at 988).

Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes.") (internal quotation marks omitted).

No more persuasive is Kentucky's argument that the ACA altered the objectives of the Act to include health as a stand-

conditions could promote ‘health’ or ‘well-being’ . . .[,] both are far afield of the basic purpose of Medicaid: ‘reimburs[ing] certain costs of medical treatment for needy persons.’”

c. Financial Independence

The Secretary also posits that the project will "test[] measures designed to help adults transition from Medicaid to greater financial independence and other forms of health coverage," including by preparing them for the commercial health market. See HHS MSJ at 2; AR 6724–25. As the Court found before, financial self-sufficiency is not an independent objective of the Act and, as such, cannot undergird the Secretary's finding under § 1115 that the project promotes the Act's goals. This is so even where the Court accords Chevron deference to his interpretation of financial independence as an "objective" contemplated in § 1115. For the reasons that follow, it is an unreasonable reading of the relevant provision because it is incompatible with the surrounding statutory language and aims. See Goldstein, 451 F.3d at 881.

The Secretary does not specify the statutory basis from which he derives financial independence as a purpose. Rather, he explains that "there is little intrinsic value in paying for services if those services are not" improving beneficiaries' health "or otherwise helping . . . individual[s] attain independence." AR 6719. As before, the Secretary is not free to generalize or otherwise extrapolate the ultimate value of the program Congress designed. Rather, he must employ the means Congress prescribed to tackle the problem it identified. See Waterkeeper Alliance ,

17. The Court finds this position unconvincing because even able-bodied adults may require rehabilitation or other services to "retain" that capacity, even if they need not "attain" it. See 42 U.S.C. § 1396-1. (And, of course, it is worth noting here that 20% of the beneficiaries to which Kentucky HEALTH would apply are members of the traditional Medicaid population. See Stewart I, 313 F. Supp. 3d at 268.)

Kentucky contends finally that its "interpretation of 'independence' is bolstered by 42 U.S.C. § 1396u-1(b)(3)(A), which permits termination of Medicaid benefits to those individuals who have had Temporary Assistance for Needy Families benefits terminated 'because of refusing to work,'" and the Second Circuit's decision in Aguayo v. Richardson, 473 F.2d 1090 (2d Cir. 1973), in which it believes that the court approved a similar waiver application for a different entitlement program on the basis that it would promote beneficiaries' self-sufficiency. See Kentucky MSJ at 18–19. Neither the statutory provision nor the Second Circuit's decision, however, sheds light on the objectives of Medicaid. Section 1396u-1(b) is a specific statutory provision allowing states to coordinate eligibility for people who are covered by both Medicaid and TANF. TANF has job preparation as one of its objectives and includes work requirements. See 42 U.S.C. § 601; 42 U.S.C. § 607. That Congress allows for states to coordinate their administration of these two different programs does not transform the purposes of Medicaid.

Aguayo is no more instructive. In that case, the Second Circuit upheld a waiver allowing for work requirements in the Aid to Families with Dependent Children statute. The

Commonwealth's "argument for uniform usage" and "ignore[] the cardinal rule that statutory language must be read in context since a phrase gathers meaning from the words around it." Gen. Dynamics Land Sys., Inc. v. Cline, 540 U.S. 581, 596 (2004). That is so because the AFDC statute also contained purposes such as keeping children in their own homes, in addition to achieving "maximum self-support." See Aguayo, 473 F.3d at 1104. The Medicaid Act lacks those additional objectives. The AFDC statute, moreover, already included some work requirements when the court upheld it in Aguayo, including some from the inception of the program "quite similar to those" at issue in the waiver. Id.; see also H.R. Rep. No. 74-615 at 3 (

but would not come with health coverage. See Stewart I, 313 F. Supp. 3d at 264; see also AR 12823–24, 12858, 12973–75, 14044–45, 16716–18 (explaining beneficiaries unlikely to get coverage on labor market). Even if some number of beneficiaries were to gain independence, the Secretary does not weigh the benefits of their self-sufficiency against the consequences of coverage loss, which would harm and undermine the financial self-sufficiency of others. See AR 12916–17, 13547, 16723–24, 17464–65, 19985–87, 26311. These deficiencies render his determination arbitrary and capricious.

d. Fiscal Sustainability

Long diverted into myriad other byways, the Court now arrives at the broad avenue that constitutes Defendants' key position. Fiscal sustainability is, in fact, the primary rationale on which the Secretary relied in approving this demonstration. In his view, "Demonstration projects that seek to improve beneficiary health and financial independence" improve well-being and "at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs." AR 6720. The Secretary explained that "Kentucky expects that the reforms included in the demonstration will enable the Commonwealth to continue to offer Medicaid to the ACA expansion population," since Kentucky "has repeatedly stated that if it is unable to move forward with its Kentucky HEALTH demonstration project, it will discontinue coverage for the ACA expansion population." AR 6726. "[E]ven assuming" that the program would result in the estimated eligibility losses, he posits that the number of people who lose coverage under Kentucky HEALTH "is likely dwarfed by the 454,000 newly eligible adults who stand to lose coverage if Kentucky elects to terminate the non-mandatory ACA expansion." AR 6732. And because "the demonstration provides coverage to individuals that the state is not required to cover[,] [a]ny potential loss of coverage that may result from a demonstration is properly

considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage" altogether for the expansion population. See AR 6731.

In this explanation, the Secretary does not make entirely clear whether he interprets fiscal sustainability to be an independent objective of the Act, or whether making the program more fiscally sustainable is essentially a point about coverage promotion — that is, whether saving money by covering fewer people is ultimately coverage promoting because any number of people Kentucky still covers under the demonstration would be greater than the number of people covered if it terminated the ACA expansion. Based on federal Defendants' representations during oral argument, it seems that the Government primarily presses the latter iteration. See Tr. at 8, 53. The Court, nevertheless, will address each in turn, finding that either way the argument is sliced, it cannot support the Secretary's reapproval here.

i.

an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better 'enabling each [s]tate, as far as practicable under the conditions in such [s]tate,' to furnish medical assistance." AR 6719 (citing 42 U.S.C. § 1396-1). Federal Defendants, at oral argument, offered that portion of the letter in support of this contention. See Tr. at 50–51.

As discussed previously, the Court finds at Chevron step one that the word "objectives" as it appears in § 1115 is ambiguous. It therefore proceeds to Chevron's second step and asks whether the Secretary's interpretation is reasonable. The statutory text on which Defendants rely provides that the Act aims to "enabl[e] each State, as far as practicable under the conditions in such state, to furnish" first, medical assistance and second, rehabit en-2 (ons)-1u-2 (ng(c)74 (c)4 u - (l)-2t0u7 (s)

that rationale, he must so find. Otherwise, as here, he has not marshaled substantial evidence for that position and, indeed, has ignored contrary evidence in the record. See Fred Meyer Stores, Inc. v. NLRB, 865 F.3d 630, 638 (D.C. Cir. 2017) (finding agency acted arbitrarily and

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of Medicaid." Tr. at 11–12. This case, they believe, is parallel because it seeks to lift people out of Medicaid to make the program smaller and therefore more fiscally viable. Id. at 12. Thompson, in turn, relies significantly on Walsh. See 362 F.3d at 821. Neither, however, aids Defendants here. In fact, their analysis demonstrates why this approval was legally defective.

Walsh is a fractured opinion upholding the vacatur of a preliminary injunction preventing the implementation of a Medicaid-covered outpatient drug program that the state of Maine sought to implement. See 538 U.S. 644. In the part of the opinion on which the Government relies, three Justices affirmed that the program served "two Medicaid-related interests" in benefiting the "medically needy" and in "enabling some borderline aged and infirm persons better access to prescription drugs earlier," thereby "reduc[ing]" Medicaid expenses. Id. at 663 (plurality opinion). "A third rather obvious Medicaid purpose [would]" also "be fostered" because "[a]voiding unnecessary costs in the administration of a State's Medicaid program obviously serves the interests of both the Federal Government and the States that pay the cost of providing prescription drugs to Medicaid patients." Id. at 663–64 (plurality opinion).

"The analyses in Walsh enlighten[ed]" that of the D.C. Circuit in Thompson, which concerned a similar program. See 362 F.3d at 821. There, the court considered a challenge to the Secretary's approval of "a low-cost state prescription drug coverage program . . . for beneficiaries of Medicaid and two non-Medicaid state health programs." Id. at 819. The D.C. Circuit held that the approval did not violate "the general statutory mandate that Medicaid services be provided in a manner consistent with the best interests of recipients." Id. (citing 42 U.S.C. § 1396a(a)(19)). The court upheld the Secretary's determination that "the best interests requirement . . . allow[s] a state to establish a Medicaid prior authorization program in order to secure rebates on drugs for non-Medicaid populations" if a state demonstrates that the program

will further "the goals and objectives of the Medicaid program." Id. at 824–25. In that case, the prior authorization program furthered Medicaid's objectives because it allowed the state to make prescription drugs accessible to borderline Medicaid populations who were, in turn, less likely to become Medicaid eligible. The rebate program thereby preserved Medicaid resources. Id. at 825. In Defendants' view, Thompson demonstrates that it is permissible to "impose a burden on Medicaid recipients to keep other people off of Medicaid." Tr. at 11–12.

Those cases do not establish that the Secretary acted reasonably here. If anything, they illuminate how the project in this case — and the reasoning given to support it — departs from previous ones. Most importantly, the programs in those cases involved only incidental burdens on Medicaid recipients. Specifically, the drug-rebate programs at issue in Walsh and Thompson made certain drugs, but not others, more difficult to obtain and in so doing provided reduced-cost medication to all individuals in the state. Neither program entirely stripped coverage or a mandatory benefit from Medicaid recipients. Language in those opinions addressed this very concern. As Walsh noted, "[P]roviding benefits to needy persons and . . . curtailing the State's Medicaid costs . . . would not provide a sufficient basis for upholding the program if it severely curtailed Medicaid recipients' access to prescription drugs." 538 U.S. at 664–65 (emphasis added). Thompson reasoned similarly, pointing out "the absence of any demonstrable significant impediment to Medicaid services from [the challenged] prior authorization requirement." 362 F.3d at 826 (citing Walsh, 538 U.S. at 664, 688).

Those disclaimers make eminently clear that a project that enhances financial sustainability may not advance the objectives of Medicaid if it significantly impedes or curtails Medicaid services or coverage. Important to both the D.C. Circuit and the Supreme Court was the fact that neither program threatened the entirety of beneficiaries' Medicaid coverage — or

even an aspect of their coverage, like that for prescription drugs — in the name of cost savings. Rather, both of those cases explicitly sanctioned an incidental burden on Medicaid recipients. They do not suggest that Medicaid recipients can be significantly burdened — that is, for example, their eligibility significantly restricted or benefits significantly cut — in the name of saving money. That there are limits on the extent to which fiscal sustainability can justify cuts like those outlined in these cases makes sense. Most cuts to Medicaid services would reduce the cost of Medicaid and thus advance the sustainability of the program to some extent. But it would be nonsensical to conclude that any cut therefore always promotes the Act's objectives.

Perhaps the most important takeaway from these cases is what the Court has been saying all along: the Secretaricanic(i)-6 ao.to wM They dt

only that Congress was “not free . . . to penalize States that choose not to participate in [the expansion] by taking away their existing Medicaid funding.” Id. That is, the Court held that, as with traditional Medicaid, Congress may impose requirements on the states for the use of expansion funds. Nothing in that analysis allows for “additional discretion” in how the states comply with Medicaid requirements for the expansion population as compared to the traditional one.

Defendants did not give one. See Tr. at 9–11, 13–14. Could a state decide it did not wish to cover pregnant women? The blind? All but 100 people currently on its Medicaid rolls? The Secretary offers no reason that his position would not allow for any of those results.

Not only does Defendants' position entail radical results, but it is also inconsistent with the text of § 1115. The statute requires the Secretary to evaluate whether the project will promote the objectives of the Act. See 42 U.S.C. § 1315; see also Tr. at 35, 38–39. Against what baseline is he supposed to evaluate the project? The structure of the waiver provision assumes the implementation of the Act. It confirms that the relevant baseline is whether the waiver will still promote the objectives of the Act as compared to compliance with the statute's requirements, not as compared with a hypothetical future universe where there is no Act. This is so because the overarching provision authorizing these waivers stipulates that, if the Secretary makes a judgment that a demonstration promotes the objectives of the Act, he may then waive compliance with certain of its provisions "to the extent and for the period necessary" to carry out the project. See 42 U.S.C. § 1315(a), (a)(1). That is, the provision contemplates a limited waiver. It would make little sense to have such waiver authority and limitations where the relevant consideration was not full compliance with the Act's requirements but instead no engagement whatsoever in the program.

The Court, furthermore, need not exclude the possibility that fiscal considerations are ever permissible in any context to reject the staggering breadth of the argument that Defendants present here. To summarize, their central contention is that, where a state threatens to discontinue Medicaid coverage entirely, any waiver approval would promote coverage. The argument does not depend on dealing with the expansion population; it is equally applicable to traditional Medicaid. It does not depend on a state's being in a fiscally precarious position

because it does not take into account the reason the state wants to discontinue participating in the Medicaid program. It is not subject to any kind of limiting principle. The Secretary's interpretation constitutes "an impermissible construction of the statute . . . because [it] is utterly unreasonable in" its "breadth" — "nothing in this record . . . indicate[s] that Congress empowered the agency to effect" such a sweeping authority. See Aid Ass'n for Lutherans v. U.S. Postal Serv., 321 F.3d 1166, 1178 (D.C. Cir. 2003). Its interpretation is therefore "arbitrary [and] capricious in substance." See Agape Church, 738 F.3d at 410. That provision of the Act does not turn the comprehensive Medicaid program that Congress designed into a buffet for states. Defendants' remarkable interpretation of Section 1115 thus cannot stand.

In finding the Secretary's position unreasonable, the Court does not suggest that the agency may never consider the fiscal sustainability of the Medicaid program. He very well might properly assess whether a more efficient way of administering a state's Medicaid program would save resources or whether, as in Thompson, a state might save money by continuing to deliver mandatory care to mandatory populations while restricting precisely which kinds of tests or medications are available, for example. Those considerations are not incompatible with the prime objective of the Act being the furnishing of medical assistance. But that is not the exercise the Secretary engaged in here.

3. Relief

Where a court concludes that an agency's action is unlawful, "the practice . . . is ordinarily to vacate the rule." Ill. Pub. Telecomms. Ass'n v. FCC, 123 F.3d 693, 693 (D.C. Cir. 1997). Defendants, however, protest that any relief should be limited to Plaintiffs here, rather than all Kentuckians who would lose coverage. See HHS MSJ at 41

Cir. 1993) (citation omitted). As before, “[n]either factor favors the Government.” Stewart I, 313 F. Supp. 3d at 273.

Failure to consider an important aspect of the problem is a “major shortcoming[]” generally warranting vacatur. Human Soc’y, 865 F.3d at 614–15; see also SecurityPoint Holdings, Inc. v. TSA, 867 F.3d 180, 185 (D.C. Cir. 2017); Wedgewood Village Pharmacy v. DEA, 509 F.3d 541, 552–53 (D.C. Cir. 2007). Stewart I offered clear guidance that Section 1115 mandated that coverage considerations be a central part of the analysis. Rather than follow that direction, the Secretary doubled down on his consideration of other aims of the Medicaid Act. Given a second failure to adequately consider one of Medicaid’s central objectives, the Court has some question about HHS’s ability to cure the defects in the approval. Vacatur would not, moreover, be especially disruptive. Unlike in Arkansas, Kentucky HEALTH has yet to take effect. Far from there being “no apparent way to restore the status quo ante,” Sugar Cane Growers Co-op of Fla. v. Veneman, 289 F.3d 89, 97 (D.C. Cir. 2002), there has yet been no departure. The Court therefore still “belie(n t)-2 (he)b7761 0a[(S)or of be10(t)-2 (or)3 (e)4 (t)-2 (he)4 (s)-1 (t)-

seek. “While those [other] questions may resurface on remand, they will not trouble the Court now.” Id.