JOSEPH H. HUNT
Assistant Attorney General
JEAN LIN
Special Counsel, Federal Programs Branch
CAROL FEDERIGHI
Senior Trial Counsel
United States Department of Justice
Civil Division, Federal Programs Branch
P.O. Box 883
Washington, DC 20044
Phone: (202) 514-1903
Email: carol.federighi@usdoj.gov

Attorneys for Federal Defendants

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, *et al.*, *Plaintiffs*, v. ALEX M. AZAR II, *et al.*, *Defendants*.	Case No. 3:19-cv-02552-VC DEFENDANTS' NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF; OPPOSITION TO PLAINTIFF STATES' AND INTERVENORS' MOTIONS FOR SUMMARY JUDGMENT; AND REPLY IN FURTHER SUPPORT OF MOTION TO DISMISS Date: February 12, 2020 Time: 10:00 a.m. Courtroom: 4, 17th Floor Judge: Hon. Vince Chhabria

NOTICE OF MOTION AND MOTION

PLEASE TAKE NOTICE that on February 12, 2020, at 10:00 a.m., or as soon thereafter as the matter may be heard, in Courtroom 4 of the above-entitled Court, located at 450 Golden Gate Avenue, San Francisco, California 94102, Defendants Alex M. Azar II, Secretary of Health and Human Services, and the U.S. Department of Health and Human Services ("HHS") (collectively, the "Defendants"), by and through undersigned counsel, will move for summary judgment, for the reasons more fully set forth in the accompanying Memorandum of Points and Authorities.

Dated: December 20, 2019

Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

JEAN LIN
Special Counsel, Federal Programs Branch

/s/ *Carol Federighi*
CAROL FEDERIGHI
Senior Trial Counsel
United States Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, NW, Washington, DC 20044
Phone: (202) 514-1903
Email: carol.federighi@usdoj.gov
Attorneys for Defendants

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INTRODUCTION

This case involves the proper interpretation of the anti-reassignment provision of the Medicaid statute, 42 U.S.C. § 1396a(a)(32). This subsection dictates that state Medicaid plans must "provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise," subject to certain exceptions not applicable here. *Id.* The United States Department of Health and Human Services ("HHS") has concluded that this language clearly prohibits states from making Medicaid payments to anyone other than the providers or the beneficiaries themselves, absent an express statutory exception. On this basis, HHS rescinded a regulatory provision that permitted states to redirect portions of a provider's Medicaid payments, on their behalf, to third parties for union dues and benefits customary for employees, such as health insurance and skills training. Six states have challenged the final rule setting forth HHS's interpretation and implementing this rescission, 84 Fed. Reg. 19,718 (2019) ("the 2019 Final Rule"). Two unions ("Unions") and a few individual providers ("Individuals") have also intervened to challenge the same.

Defendants have previously moved to dismiss pursuant to both Federal Rule of Civil Procedure 12(b)(1) and Rule 12(b)(6), on three bases. First, Defendants argued that both the state plaintiffs ("States") and Plaintiff-Intervenors ("Intervenors")—collectively "Plaintiffs"—have failed to establish the Article III standing necessary to invoke this Court's subject-matter jurisdiction. Plaintiffs' claimed injuries from the 2019 Final Rule are too speculative and insufficiently concrete, and in any event would not be fairly traceable to the challenged decision, but would be attributable to the independent actions of third parties. In addition, the States fail to assert a cognizable injury to their sovereign, quasi-sovereign, or proprietary interests, and the Unions are not within the zone-of-interests of the Medicaid statute and have failed to establish redressability.

Second, Defendants argued that, even if the Court had jurisdiction, Plaintiffs have failed to state a claim under the Administrative Procedure Act ("APA") because the statutory language is clear that payments to anyone other than providers of Medicaid-covered services or care or the beneficiaries themselves are prohibited absent an express statutory exception. Plaintiffs' interpretation that the states may divert Medicaid payments to third parties, for, *e.g*., insurance premiums or union dues, is foreclosed by this language. Defendants further showed that, even if the Court were inclined to look beyond the actual language of the statute, the specific context in which the language is used, the statute as a whole, and the statute's legislative history support HHS's interpretation. Moreover, HHS provided a reasoned explanation for rescinding the prior regulation—the prior regulation was in conflict with the express language of the statute.

Third, Defendants contended that Intervenors failed to state either an Equal Protection or a First Amendment claim because, for both claims, they made only blanket assertions of entitlement to relief without the required factual enhancement. In addition, Intervenors' Equal Protection claim fails because the 2019 Final Rule does not implicate a fundamental right or discriminate against a suspect class. Nor does it draw distinctions between classes of people, and even if it did, it survives rational basis review. The Rule also does not plausibly implicate Intervenors' First Amendment rights to free speech and free association.

Defendants respectfully submit that this Court should grant their motion to dismiss, which would resolve this entire case. Should the Court decline to do so, Defendants are entitled to summary judgment on Plaintiffs' and Intervenors' APA claims for largely the same reasons that they are entitled to dismissal under Rule 12(b)(6)—there are no material facts in dispute and Defendants are entitled to judgment as a matter of law because their interpretation of the statute is mandated by the clear language of the statute. This memorandum, taken together with Defendants' prior memorandum supporting their motion to dismiss ("Defs.' Dismiss Br.," ECF No. 84), explains why this Court should dismiss this case or at a minimum grant summary judgment to

Defendants and deny Plaintiffs' motions for summary judgment. Intervenors have not moved for summary judgment on their Equal Protection and First Amendment claims, and Defendants seek only dismissal of those claims.

ARGUMENT[1]

I. Plaintiffs Have Failed to Establish that They Have Article III Standing.

A. The States Have Not Established Their Standing

In their opening memorandum in support of their motion to dismiss, Defendants showed that the States had not established a sufficient injury to their sovereign interest in "the power to create and enforce [their] own statutes" to establish standing. Defs.' Dismiss Br. 6-7. In response, the States who still assert standing (California, Illinois, Oregon, and Washington) contend that the 2019 Final Rule interferes with their state laws "authorizing collective bargaining for Medicaid homecare providers that require state officials to make payroll deductions." States' Br. at 7-8. However, a close examination of those laws reveals no conflict between the Final Rule and the state laws as written, as nothing in those laws *requires* collective bargaining agreements to provide for withholding of dues or other fees. *See, e.g.,* Cal. Welf. & Inst. Code § 12301.6(i)(2) (providing that the "Controller shall make any deductions from the wages of in-home supportive services personnel … *that are agreed to* by that public authority in collective bargaining with the designated

[1] The Statutory and Regulatory Background are set out in Defendants' prior memorandum (pp. 3-6) and will not be repeated here. The States' brief provides the appropriate standard of review on a summary judgment motion. *See* States' Br. at 7 (ECF No. 85). The procedural distinction between a Rule 12(b)(6) motion and a summary judgment motion is that, on the latter motion, matters outside the Complaint can be considered. *See San Pedro Hotel Co., Inc. v. City of Los Angeles*, 159 F.3d 470, 477 (9th Cir. 1998). Plaintiffs have provided such material here; however, nothing outside the Complaint is relevant to the only issue before the Court—the proper interpretation of the statutory language. Defendants cite material outside the record for purposes of their standing arguments only. *See Safe Air for Everyone v. Meyer*, 373 F.3d 1035, 1039 (9th Cir. 2004).

representative of the in-home supportive services personnel … and transfer the deducted funds as directed in that agreement") (emphasis supplied).[2] Thus, the 2019 Final Rule would require, at most, changes *at the collective bargaining level,* but it does not directly conflict with any state *statute*. The cases cited by the States (States' Br. 7-8) are distinguishable in that they involve the state's sovereignty over *territory* within the State (*Kansas v. United States*, 249 F.3d 1213, 1227 (10th Cir. 2001)), found standing only at a "preliminary stage" (*Hawaii v. Trump*, 859 F.3d 741, 765 (9th Cir. 2017), *vacated on other grounds by Trump v. Hawaii*, 138 S. Ct. 377 (2017)), or involve non-state plaintiffs.

Thus, properly construed, these States' claimed injury is that the 2019 Final Rule interferes with their collective bargaining with unions by precluding the option to withhold dues or make other third-party payments in a collective bargaining agreement. That alleged injury does not implicate the States' "sovereign power" to "create and enforce a legal code," *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 601 (1982), because, as explained, it does not conflict with any state statutes. Rather, as the States subsequently acknowledge in their brief (p. 9), it at most implicates the States' proprietary interest as "employers." *See* McCormick Decl. ¶ 5 (ECF No. 85-6) (stating that Oregon considers itself a "joint employer" of home care workers). But the States participate in Medicaid voluntarily, *Arc of Cal. v. Douglas*, 757 F.3d 975, 979 (9th

[2] *See also* Or. Rev. Stat. § 292.055 (requiring withholding "[*u*]*pon receipt of the request* in writing of a state officer or employee so to do) (emphasis supplied); Wash. Rev. Code § 74.39A.270 (providing that "the wages, hours, and working conditions of individual providers are determined solely through collective bargaining as provided in this chapter"); 5 Ill. Comp. Stat. 365/4(3) (stating that "[a]n employee … *may authorize* the withholding of a portion of his salary, wages, or annuity for … for payment to any labor organization designated by the employee") (emphasis supplied); AR 009214 (letter from Illinois State Comptroller stating that the "deduction processes *are allowable* under longstanding state law … as well as a multitude of current and historical collective bargaining agreements") (emphasis supplied) (in Ex. D, pt. 4, to Wilson Decl., ECF No. 87-9); AR 013734 (letter from Governor of Oregon and others stating that "[d]ues deductions are … an obligation that is required by existing collective bargaining agreements") (in Ex. D, pt. 8, to Wilson Decl., ECF No. 87-13).

Cir. 2014), and also have voluntarily included in-home personal care services in their plans, *see* Am. Compl. ¶¶ 2, 25. The States' voluntary acceptance of the obligation to comply with provisions of the Medicaid Act in administering their home care Medicaid programs cannot be viewed as an injury to their "proprietary interests." *Cf. City & Cty. of San Francisco v. Whitaker*, 357 F. Supp. 3d 931, 946 (N.D. Cal. 2018) ("The City's efforts to comply with the ADA are not an exercise of its proprietary interest … , but rather a fulfillment of its obligations as a regulated entity."); *Sobky v. Smoley*, 855 F. Supp. 1123, 1127 (E.D. Cal. 1994) ("[O]nce a state elects to provide an optional service [such as in-home personal care services], that service becomes part of the state Medicaid plan and is subject to the requirements of federal law."); *Ill. Hosp. Ass'n v. Ill. Dep't of Pub. Aid,* 576 F. Supp. 360, 371 (N.D. Ill. 1983) ("Once a state has voluntarily elected to participate in the Medicaid program, ... [it cannot] characterize its duty to comply with the requirements of [the program] as constituting a hardship to its citizens.").

Nor do these States provide any evidence to rebut Defendants' showing that their allegations of injury to the home care industry from the 2019 Final Rule were too speculative and conclusory to establish a concrete injury-in-fact. Defs.' Dismiss Br. 9-11. Although they provide new declarations to support their allegations of harm (States' Br. 10), those declarants describe only "hypothetical future harm that is not certainly impending," *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 416 (2013),[3] or simply make conclusory assertions with no factual support, *see* Murphy Decl. ¶ 5 (ECF No. 85-13) (stating without support that "[t]here is no question" that the Final Rule would "damage" Washington's "ability to effectively deliver" home care); Dearman

[3] *See* Jacobs Decl. ¶ 44 (ECF No. 85-8) (the 2019 Final Rule "*could* result in lower worker wages, higher worker turnover, greater worker shortages, and lower quality of care for the vulnerable individuals who depend on homecare workers") (emphasis supplied); Kuriniec Decl. ¶ 24 (ECF No. 85-11) (the 2019 Final Rule "*may* increase turnover of" home care workers) (emphasis supplied); Swannuck Decl. ¶ 8 (ECF No. 85-14) ("*if* the implementation of the rule negatively affects the individual providers' benefits it will cause a major and costly disruption of our system") (emphasis supplied).

Decl. ¶ 12 (ECF No. 85-5) (speaking generally of "interference"). In addition to the general uncertainty of how a system with a large number of independent actors (providers, unions, state authorities) will react to the 2019 Rule, there are other reasons for the declarants' qualified statements as to possible injury—for example, in Washington, "[a] new system of contracting out [payroll processing] is in the works," Swannuck Decl. ¶ 8, and Illinois may take the position that the 2019 Final Rule does not require any changes because home care workers are considered public employees under Illinois law. Kuriniec Decl. ¶ 25. In sum, these States' "[a]llegations of *possible* future injury," dependent on a "speculative chain of possibilities," do not satisfy the requirement that threatened injury must be "*certainly impending*." *Clapper*, 568 U.S. at 409-10 (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990)).

For related reasons, Defendants' opening memorandum (pp. 11-12) in support of their motion to dismiss also explained that the States fail the causation prong of the standing inquiry because they have not established that their alleged injuries can be fairly traced to the 2019 Final Rule, rather than to the independent actions of third parties, such as the individual providers and the unions. In response, the States assert that it is sufficiently "predictable" that the 2019 Rule will "impede the administration of benefits, disrupt collective bargaining, and weaken the unions' ability to serve their members," and, consequently, that the Rule will negatively impact "the States' ability to provide needed Medicaid services to beneficiaries." States' Br. 10. But the States' declarants fail to show a "predictable" link of causation between the inability to withhold portions of a provider's Medicaid payment to pay union dues and other benefits, and harm to the Medicaid program. Rather, they establish only that, as a result of the loss of automatic benefits deductions, the 2019 Final Rule will "likely" hurt the unions, Jacobs Decl. 42, and possibly result in fewer providers with health insurance. *See* Dearman Decl. ¶¶ 9-10; Kuriniec Decl. ¶ 21. The declarations do not establish that the downstream effects of these events will be inevitable harm to the home-care industry in the states, however. *See, e.g.,* Dearman Decl. ¶ 12 (providing no

connection between the harms in paragraphs 10 and 11 and paragraph 12's conclusory statement that "[a]ll of these costs and burdens will interfere with the San Francisco Public Authority's ability to maintain a stable and qualified [home care] workforce").

Returning to the injury prong of the standing inquiry, the States also assert they will incur "a new, unnecessary financial and administrative burden" to comply with the 2019 Final Rule. States' Br. 9. Only two States (California and Washington) submit declarations to support their claims in this regard, and those declarations do not specify when the States will begin to have to incur these costs, the size of the costs, or even the specific steps they will be taking. Rather, they assert simply that the States "will need" at some unspecified date "to expend time and resources" on a potential set of activities, using substantially the same boilerplate language. *See* Thomson Decl. ¶¶ 22-24 (California) (ECF No. 85-3); Moss Decl. ¶¶ 13-14 (Washington) (ECF No. 85-12). But unspecified, sometime-in-the-future financial injury is too speculative to satisfy the requirement that threatened injury must be "*certainly impending*." *Clapper*, 568 U.S. at 409.

The States also cite the risk of harm from loss of Medicaid funds if they decline to follow the 2019 Final Rule. States' Br. 9. But that would be a self-inflicted harm which is insufficient to confer standing. *Clapper*, 568 U.S. at 416. Moreover, as Defendants previously pointed out, this risk is too attenuated at this stage to establish standing. *See Thomas v. Anchorage Equal Rights Comm'n*, 220 F.3d 1134, 1139 (9th Cir. 2000) (en banc) ("[N]either the mere existence of a proscriptive statute nor a generalized threat of prosecution satisfies the 'case or controversy' requirement."). At present, there has been no determination that any of the States are in violation of the 2019 Final Rule and thus no action by the federal government to withhold Medicaid funding from any of the States on this basis. This asserted injury does not therefore present a challenge that is presently ripe for review. For a challenge to agency action to be ripe, the challenged action must have been "formalized and its effects felt in a concrete way." *Abbott Labs v. Gardner*, 387 U.S. 136, 148-49 (1967). In general, to determine whether a challenge to an agency action is ripe,

a court must consider: "(1) whether delayed review would cause hardship to the plaintiffs; (2) whether judicial intervention would inappropriately interfere with further administrative action; and (3) whether the courts would benefit from further factual development of the issues presented." *Ohio Forestry Ass'n, Inc. v. Sierra Club*, 523 U.S. 726, 733 (1998). Here, the issues "would benefit from further factual development," specifically, regarding how the Final Rule would apply to the particular states in this case, each of which has a unique relationship with its individual homecare providers, *see* Am. Compl. ¶¶ 45, 55, 64, 84, and at least some of which may soon modify their programs. *See* Swannuck Decl. ¶ 8 (Washington). Accordingly, this asserted injury as well cannot support standing here.

The remaining two states, Connecticut and Massachusetts, do not contest their lack of standing or move for summary judgment, and hence should be dismissed. States' Br. 2. They indicate that they have been advised by HHS that their current programs are in compliance with the 2019 Final Rule. States' Br. at 3 n.1. Although they contest dismissal because "those assurance have yet to be confirmed in this litigation," *id.*, it is not Defendants' burden to provide evidence of the *absence* of injury, but rather Plaintiffs' burden to establish the *existence* of injury. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992). These two states have failed to do so and therefore should be dismissed on that basis as well.

B. The Intervenors Have Not Established Their Standing

Contrary to Intervenors' suggestion (Intervenors' Br. 9), the Court's grant of permissive intervention does not operate as a conclusive determination that they have standing in this action. *See Perry v. Schwarzenegger*, 630 F.3d 898, 906 (9th Cir. 2011) ("In general, an applicant for intervention need not establish Article III standing to intervene."). In fact, the Intervenors, which include Individual providers and two Unions, lack standing for the reasons set forth in Defendants' opening memorandum.

Defendants previously argued that the Individual Intervenors lacked standing based on the inconvenience of needing to pay their union dues and make other payments to third parties themselves. Defs.' Br. 12-13. In response, the Intervenors point to the declarations previously submitted by the Individual Intervenors. Intervenors' Br. 9 n.13. But those Individuals cite principally the "inconvenience" and "stress" of having to make payments themselves and reference only unspecified "time and cost."[4] Such claimed injuries are "too de minimis to satisfy the standing doctrine's core aim of improving judicial decision-making by ensuring that there is a specific controversy before the court and that there is an advocate with sufficient personal concern to effectively litigate the matter." *Smith v. Aitima Med. Equip., Inc.*, No. EDCV1600339-ABDTBX, 2016 WL 4618780, at *4 (C.D. Cal. July 29, 2016) (quoting *Caldwell v. Caldwell*, 545 F.3d 1126, 1134 (9th Cir. 2008), and holding that "episodic discharge of battery power on two short occasions" insufficient injury to confer standing); *see also Harris v. Blueray Techs.*

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[4] *See* Christian Decl. ¶ 9 (ECF No. 8-2) (citing only the "stress of making timely payments" and the unspecified "time and cost of making a recurring payment"); Solseng Decl. ¶ 7 (ECF No. 8-4) (stating that without automatic deductions he would "pay a price in time, money, and worry every month"); Forsythe Decl. ¶ 9 (stating that, because she has "a full plate between work and [her] personal life[, i]t would be an unnecessary inconvenience for [her] to write [her monthly payments] out and send [them] in the mail") & Supp. Forsythe Decl. ¶¶ 5-7 (ECF No. 87-32) (same and stating she "strongly prefer[s]" not to use the no-cost method of automatic bank deductions); Sandoval Decl. ¶¶ 13-15 (ECF No. 8-10) (speaking only generally of difficulties that "homecare providers" may experience); Bright Decl. ¶ 8 (ECF No. 8-11) (citing the "additional inconvenience of calculating my dues and traveling to the union office each month to pay my dues") & Bright Supp. Decl. ¶ 8 (ECF No. 87-31) (discussing stress and her busy schedule and stating only that she "would" incur additional costs if she "had [to]buy checks or money orders"); Grant Decl. ¶ 8 (ECF No. 8-12) (citing her "already-busy lifestyle").

Intervenors Syrpis and Wright are from Massachusetts and Connecticut, respectively, where it appears the payroll system will not require any changes. *See* ECF No. 8-5, 8-6; States' Br. 3 n.1. They should therefore be dismissed from the suit for the same reasons those states should be dismissed. Intervenor Howze, from Minnesota, appears to be paid through a Fiscal Management Services vendor (fiscal intermediary), Supp. Howze Decl. ¶ 2 (ECF 87-34), like the system in place in Massachusetts and Connecticut, and therefore also has not established that that the 2019 Final Rule will affect her in any way. *See* 84 Fed. Reg. at 19,719.

S'holders, Inc., 669 F. Supp. 2d 1225, 1228 (E.D. Wash. 2009) ("mere inconvenience is not an injury in fact"); *Kushner v. Ill. State Toll Highway Auth.*, 575 F. Supp. 2d 919, 923 (N.D. Ill. 2008) ("There is no legally protected interest in freedom from administrative inconvenience. This is an unfortunate reality of daily life."). The Individual Intervenors should therefore be dismissed, as well as the claims Unions seek to bring on behalf of their members, since the Unions have likewise not provided any evidence of injury as to any of their members as required to establish the organization's standing to act as representatives of those members. *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977) ("[A]n association has standing to bring suit on behalf of its members when," among other requirements, "its members would otherwise have standing to sue in their own right.").

With regard to the Unions' standing to sue on their own behalf, Defendants have argued that the Unions' assertion that dues payments would drop and the Unions would lose members as a result of the 2019 Final Rule was too speculative. Defs.' Dismiss Br. 12. The declarations the Unions have submitted do not remove the element of speculation from their claims. The declaratns only vaguely assert that the unions will lose "many" members simply because the members will have to pay their dues directly. *See* Supp. Unger Decl. ¶ 8 (ECF No. 87-29); *see also* Supp. Maldonado Decl. ¶ 7 (ECF No. 87-30). Finally, the Intervenors have no serious response to Defendants' argument that the Intervenors had failed to establish that a reversal of the 2019 Final Rule would redress their injuries, as the States could still be free afterwards to decline to resume the withholding system previously in place. Defs.' Dismiss Br. 13; *see, e.g.,* Broder Decl. ¶¶ 25, 35 (ECF No. 87-28) (describing Virginia as deciding to end payroll deductions between 2010 and 2014). It is no answer to say, as the Unions do, Intervenors' Br. 10-11, that the States would be constrained to resume the system by state laws and contracts, as those can be readily revised as well.

More significantly for the Unions, however, they are not themselves within the zone of interests protected by the Medicaid Act, as Defendants previously argued. Defs.' Dismiss Br. 13-14. In response, the Intervenors argue only that union *members*, who are the providers, are within the zone of interests, Intervenors' Br. 11, a point which Defendants do not dispute. However, nothing cited by the Intervenors establishes that the Unions *themselves* are within the zone of interests, and therefore, they should at a minimum be dismissed from this suit to the extent they seek to proceed on their own behalf.

In sum, the Unions lack standing to sue on their own behalf because they are outside the zone of interests of the Medicaid Act. The Unions lack standing to sue on behalf of their members because that claim is based "only on speculation that unidentified members would be injured by" the 2019 Final Rule. *Nat'l Council of La Raza v. Cegavske*, 800 F.3d 1032, 1041 (9th Cir. 2015). And the Individual Intervenors lack standing for the same reason, a failure to show an imminent, concrete, nonspeculative injury from the 2019 Final Rule.

II. HHS's Interpretation Is Mandated By the Plain Language, Structure, and Context of the Statute, and Further Supported by Its Legislative History.

A. The Plain Text of the Statute Supports the Agency's Interpretation.

As Defendants explained in their previous memorandum, HHS's interpretation of the anti-reassignment provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(32), should be upheld under step one of *Chevron* because "Congress has directly spoken to the precise question," *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984), of whether the Medicaid Act allows state plans to divert portions of a provider's payments to third parties. Subsection (a)(32) specifies that no Medicaid payments "for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise," with four statutory exceptions. 42 U.S.C. § 1396a(a)(32). The agency has interpreted this language to mean that Medicaid

payments may only be made to the "individual" receiving such care or "the person or institution providing such care or service[,]" and to no one else, absent an exception. "Congress could not have chosen stronger words" than "shall" or "broader words" than "any" to express its intent that all payments be made only to providers or beneficiaries. *United States v. Monsanto*, 491 U.S. 600, 607 (1989); *see also Small v. United States*, 544 U.S. 385, 388 (2005) ("[T]he word 'any' demands a broad interpretation[.]"). Because "the intent of Congress is clear," the Court's inquiry is at an end. *Chevron*, 467 U.S. at 842-43.

In contesting Defendants' interpretation, the States focus on the language in two parts of Section (a)(32)—"payment under the plan for any care or services provided to an individual" and "under an assignment or power of attorney or otherwise." States' Br. 11. As to the first phrase, the States argue that "[i]nsurance companies, unions, retirement trusts, and other third parties to which the States currently remit a portion of Medicaid homecare provider payments are not receiving 'payment under the [Medicaid] plan for any care or service provided to an individual' Medicaid beneficiary, nor do those entities claim any legal right to payment of a Medicaid claim." *Id.* But this argument focuses on what the payment looks like from the viewpoint *of the insurance company, union, or other third party.* From the viewpoint of the Medicaid program, the portion of the payment remitted to the insurance company, union, or other entity, is *part of the* payment for the service rendered to the beneficiary. And the same applies from the viewpoint of the provider—the payment made to the insurance company or union is part of the Medicaid payment due the provider for the service provided, that part of the payment being paid to the third party *on behalf of* the provider.

As Defendants pointed out in their prior memorandum, the common and ordinary meaning of "payment" is "money … delivered in satisfaction of an obligation." *Black's Law Dictionary* 475 (11th ed. 2019). The money that the States seek to withhold to pay to third parties is—from the viewpoint of the Medicaid program, the beneficiary, and the provider—part of the Medicaid

program's "payment … for any care or service provided to an individual," 42 U.S.C § 1396a(a)(32, as it is delivered by the Medicaid program to satisfy the obligation owed by Medicaid for the care or service provided. This amount *includes* the portion the States are withholding as a deduction, which is "[a]n amount subtracted" from the gross. *Black's Law Dictionary* 475 (11th ed. 2019). The States' contrary argument thus fails.

The States' net-wage example actually highlights the error of their reasoning—they argue that "just because an employee receives net rather than gross wages does not mean that they have not received full 'payment' from their employer for their work." States' Br. 12. But, as the tax laws make clear, the "full payment" for the work is the employee's *gross* wages, which are the net wages *plus legally required payroll deductions*, including withholding for income tax, social security, and Medicare taxes, as well as, for example, any garnishments. *See* 26 U.S.C. § 3401(a) ("'wages' means all remuneration"); *Old Colony Trust Co. v. Comm'r*, 279 U.S. 716, 729 (1929) ("The payment of the tax by the employers was in consideration of the services rendered by the employee" and therefore "constituted income to the employee."). Significantly, those payroll deductions are counted as income to the employee, even though they are paid, on behalf of the employee, to other entities. Similarly, here, the withholdings the States are making for union dues or insurance payments are part of the payment to the provider for services rendered, even though remitted on behalf of the provider to other entities. Indeed, the Intervenors concede as much, agreeing that the deductions at issue come "out of money already earned by the provider." Intervenors' Br. 8.

The States also disagree that the payments at issue are encompassed within the phrase "or otherwise," 42 U.S.C. § 1396a(a)(32), arguing that if "otherwise" *includes all* payments made *other* than "under an assignment or power of attorney" then it renders the phrase "under assignment or power of attorney" superfluous. But the States mischaracterize the government's interpretation of "or otherwise." "Otherwise" means "anything *else*" or "in a *different* way or manner." *City of Toledo v. Beazer Materials & Servs., Inc.*, 912 F. Supp. 1051, 1069 n.4 (N.D. Ohio 1995)

(emphasis supplied), *rev'd on other grounds*, 103 F.3d 128 (6th Cir. 1996); *In re Riefberg*, 58 N.Y. 2d 134, 141 (1983) ("The employment of the word 'otherwise' … is better taken literally to mean 'different from' …."); *see also Merriam-Webster's Collegiate Dictionary* 822 (10th ed. 2001) (defining "otherwise" as "anything else," "to the contrary" and "in a different way or manner"). Thus, "or otherwise" as used in the statute does *not* include payments "made under an assignment or power of attorney" but rather all *other* forms of payment. *See Gooch v. United States*, 297 U.S. 124, 128 (1936). There is thus no superfluous phrasing—the statute includes two specific examples, highlighting the abuses Congress was targeting, and then a catchall phrase to capture any other payments that did not go to the provider.

The States alternately cite the canons of *ejusdem generis* and *noscitur a sociis* to argue that, if "or otherwise" means something different from "under an assignment or power of attorney," it should mean only indirect payment mechanisms "similar but not identical" to those two examples. States' Br. 13. However, "[t]he rule of *ejusdem generis*, while firmly established, is only an instrumentality for ascertaining the correct meaning of words when there is uncertainty." *Harrison v. PPG Indus., Inc*., 446 U.S. 578, 588 (1980) (declining to apply the rule of *ejusdem generis* and holding that the phrase, "any other final action" "must be construed to mean exactly what it says, namely, any other final action"). There is no uncertainty in the words "or otherwise" here that would justify a resort to these interpretive canons. *See id.* (finding no uncertainty in the phrase "any other final action"). Indeed, the remainder of the statute indicates that the "or otherwise" language is not limited to concepts similar to "an assignment or power of attorney[.]" 42 U.S.C. § 1396a(a)(32). Specifically, the statutory exceptions involve transactions that are different from and broader than payments made "under an assignment or power of attorney," including transactions ranging from "require[ments] as a condition of . . . employment" to "agency agreement[s]" to "arrangement[s]" to "voluntary replacement program[s.]" *Id*. If the language in the main phrase of subsection (a)(32) was not intended to preclude such a broad range of

reimbursement methods to begin with, there would have been no need to specify these exceptions. *See Fla. Gulf Coast Bldg. & Constr. Trades Council v. NLRB*, 796 F.2d 1328, 1341 (11th Cir. 1986) ("[A]n exception exists only to exempt something which would otherwise be covered [by the act.]"), *aff'd sub nom. Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568 (1988). In the case cited to the contrary by the States (Br. at 13 n.4), the word "other" appeared in a longer statutory phrase with more content ("other legal process") that linked the phrase back to the examples given in the statute, supporting application of the rule of *ejusdem generis*. *See Wash. State Dep't of Social & Health Servs. v. Guardianship Estate of Keffeler,* 537 U.S. 371, 385 (2003). In contrast, there is no such additional content here in the phrase "or otherwise" to link that phrase back to the other examples and thereby to suggest that Congress intended "to embrace only objects similar in nature to those objects enumerated by the preceding specific words." *Id.* at 384 (citation omitted).

Indeed, the existence of the statutory exceptions argues against Plaintiffs' reading for another reason. In accordance with the maxim *expressio unius est exclusio alterius*, courts will not read in additional exceptions into a statute because they presume that Congress knew how to create such an exception when it so intended. *United States v. Johnson*, 529 U.S. 53, 58 (2000). Thus, had Congress intended the deductions at issue in this case to be exempt from the provision's scope, it "would have said so in explicit terms," *Helvering v. Stockholms Enskilda Bank*, 293 U.S. 84, 93 (1934), as it did in creating the four existing exceptions.

The States argue that cases in which the provision at issue has been interpreted have "allow[ed] more, rather than less, flexibility when it comes to Medicaid payments." States' Br. 14. However, none of those cases involved payments directly made by either the Medicaid or the Medicare program to entities who are indisputably nonproviders. In *DFS Secured Healthcare Receivables Trust v. Caregivers Great Lakes, Inc.*, 384 F.3d 338, 341 (7th Cir. 2004), the payments were made by Medicare to the provider, who then turned them over to the factoring agent, and in

Danvers Pathology Associates, Inc. v. Atkins, 757 F.2d 427, 430 (1st Cir. 1985), the issue was whether a hospital could be considered the "provider" of laboratory services provided by an independent but in-house laboratory. Thus, whatever flexibility those courts found after Medicare or Medicaid funds "first flow through the provider," *DFS Secured*, 384 F.3d 350, or in the definition of "provider" itself, has no relevance here.

Here, Congress used clear and unambiguous language indicating its intent to prevent all payments to third parties unless a statutory exception applies. That prohibition plainly encompasses the deductions at issue. Thus, as the statutory language is clear, there is no need to resort to legislative history, and it is irrelevant whether Congress specifically contemplated those deductions when enacting the statute.

B. The Legislative History Supports the Agency's Interpretation.

Courts may only turn to extrinsic evidence such as legislative history if the statute's language cannot "be construed in a consistent and workable fashion," *Valentine v. Mobil Oil Corp.*, 789 F.2d 1388, 1391 (9th Cir. 1986); *see also Hearn v. W. Conference of Teamsters Pension Tr. Fund*, 68 F.3d 301, 304 (9th Cir. 1995), and then should "never allow it to be used to 'muddy' the meaning of 'clear statutory language.'" *Food Mktg. Inst. v. Argus Leader Media*, 139 S .Ct. 2356, 2364 (2019) (citation omitted). "[L]egislative history—no matter how clear—can't override statutory text." *Hearn*, 68 F.3d at 304.

However, even if the language of the anti-reassignment provision were not clear and the Court were permitted to consult legislative history, the legislative history is consistent with the agency's interpretation. To be sure, as the States point out, Congress's immediate focus in adding and later amending section (a)(32) was the so-called factoring arrangements (factoring is the selling of receivables to collection agencies who then present them to the state for payment). Congress was concerned that, in many cases, these third-party collection agencies submitted "incorrect and inflated claims … creating administrative nightmares and overpayments." *DFS*

Secured, 384 F.3d at 350 (citing H.R. Rep. No. 92-231 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5090). But the language chosen by Congress belies such a narrow focus. In drafting the language of section (a)(32), Congress chose much broader language that prohibited payment "to *anyone other than* the patient, his physician or other person who provided the service[.]" 1972 U.S.CCA.N. at 5090 (emphases added). Then, in amending the provision in 1977 to add the phrase "under an assignment or power of attorney," to make it clear that the already broad prohibition did indeed prohibit such payments, Congress included the broad phrase "or otherwise" to underscore the original broad scope of the statute. This deliberate choice of language therefore indicates Congress's intent to sweep broadly and prohibit any payments to third parties except as specified in the statute.

Moreover, the legislative history demonstrates that Congress was concerned with the broader goal of reducing opportunities for fraud or other improper activities. *See Prof'l Factoring Serv. Ass'n v. Mathews*, 422 F. Supp 250, 255 (S.D.N.Y. 1976) (noting "Congressional concern about possible frauds or overbillings"); *see*, *e.g.*, H.R. Rep. No. 95-393, at 44, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3047 ("[T]here exist, to a disturbing degree, fraudulent and abusive practices associated with the provision of health services financed by the medicare and medicaid programs. The disclosures to date have focused on a *broad range* of improper activities[.]") (emphasis added); *Fraudulent Payments in the Medicaid Program: Hearing Before the Subcomm. on Federal Spending Practices, Efficiency, & Open Gov't of the S. Comm. on Gov't Operations*, 94th Cong. 1 (1976) (statement of Sen. Lawton Chiles) ("Congressional committees in both Houses of Congress have spent a lot of time investigating abuses and fraud in the medical programs but new revelations spring up daily."); 1972 U.S.C.C.A.N. at 5090 (noting that payments to outside "organizations or groups" have caused "incorrect and inflated claims for services" and "administrative problems" leading to "[s]ubstantial overpayments to many such organizations"); *id.* at 5173 (on the "[p]rohibition of assignments[,]" seeking to "assure that benefits go to the

named payee," not to others). Even the title of the 1977 amendments ("Medicaid-Medicare Anti-Fraud and Abuse Amendments") reinforces this fact.

In this regard, there is evidence that Congress viewed as problematic all payments made to third parties "with no accountability for the nature and costs of the services rendered." *Danvers*, 757 F.2d at 430. This is not to say that all factoring arrangements or deductions to third parties are fraudulent, *see*, *e.g.*, *Medicare-Medicaid Administrative & Reimbursement Reform: Hearings before the Subcomm. on Health of the S. Comm. on Finance*, 94th Cong. 457-60 (1976) (statement of the Professional Factoring Association) (defending factoring arrangements), but Congress could have reasonably been concerned that the further the payee is away from the actual care or service rendered, the more opportunity there is for fraud. Congress has long been aware of the potential "abuses" that accompany home care and has often focused on addressing abuses in the system. *Efficiency of the Medicare Program in Disbursing Funds to Home Health Care Agencies: Hearing Before the Subcomm. on Federal Spending Practices, Efficiency, & Open Gov't of the S. Comm. on Gov't Operations*, 94th Cong. 1-2, 5 (1976) (as to home healthcare agencies, finding that "tremendous profits and tremendous rip-offs [that] can be made in this system" and "trying to determine now … how do we correct the abuses"). Congress could reasonably have concluded that a broad direct payment provision was a useful tool to cut down on opportunities for fraud. "[I]t is not absurd for Congress to want to prevent [fraud.]" *United States v. Chhun*, 744 F.3d 1110, 1116 (9th Cir. 2014).. In fact, this Court has recently accepted that there is "significant evidence in the legislative history of section 32 that the provision was designed … to prevent fraud against the government." *Aliser v. SEIU Cal.*, No. 19-cv-00426-VC, slip op. (N.D. Cal. Dec. 10, 2019).

Contrary to the States' contention (Br. 16-17), it is of no moment that the legislative history does not contain an express statement by Congress that it intended to target the practice at issue here. When "Congress has made a choice of language which fairly brings a given situation within

a statute, it is unimportant that the particular application may not have been contemplated by the legislators" at the time of the statute's enactment. *Barr v. United States*, 324 U.S. 83, 90 (1945); *see also Chhun*, 744 F.3d at 1116 ("As we have said before, the fact that a statute can be applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth.") (internal quotation marks and citation omitted). Indeed, Congress need not "explicitly delineate everything an agency cannot do." *Contreras-Bocanegra v. Holder*, 678 F.3d 811, 818 (10th Cir. 2012) (en banc) ("*Chevron* does not require Congress to explicitly delineate everything an agency cannot do before we may conclude that Congress has directly spoken to the issue. Such a rule would 'create an "ambiguity" in almost all statutes, necessitating deference to nearly all agency determinations.'" (quoting *Prestol Espinal v. Attorney Gen. of U.S.*, 653 F.3d 213, 220 (3d Cir. 2011)).

In sum, the legislative history, together with the choice of statutory language, makes Congress's overall objective unmistakably clear: to prevent opportunities for fraud or other improper activities by limiting who can directly receive Medicaid reimbursements. Because HHS's 2019 Final Rule is fully consistent with the statutory language, as well as this legislative history, the States' and Intervenors' claims should be dismissed for failure to state a claim or, in the alternative, summary judgment should be granted Defendants on these claims.

III. The Agency's Interpretation is Not Subject to Review as an Exercise of Discretion But, Even if It Were, the Interpretation is Reasonable and Should be Upheld.

A. If the Court Disagrees with HHS's Interpretation, It Should Remand the Case to the Agency

Should the Court nevertheless disagree with HHS's interpretation of the statute, the proper course of action is, as Intervenors themselves realize (Intervenors' Br. 12), to remand the case to the agency for further consideration. Where, as here, the agency believes that its interpretation was required by the statutory language, the agency has not exercised its discretion and the

interpretation cannot therefore be reviewed by the Court for reasonableness as an exercise of that discretion. "[I]t is black letter law that where an agency purports to act solely on the basis that a certain result is legally required, and that legal premise turns out to be incorrect, the action must be set aside, regardless of whether the action could have been justified as an exercise of discretion." *Regents of the Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, 908 F.3d 476, 505 (9th Cir. 2018). "As the D.C. Circuit flatly put it, 'An agency action, however permissible as an exercise of discretion, cannot be sustained where it is based not on the agency's own judgment but on an erroneous view of the law.' *Sea-Land Serv., Inc. v. Dep't of Transp.*, 137 F.3d 640, 646 (D.C. Cir. 1998) (internal quotation marks omitted) (quoting *Prill v. NLRB*, 755 F.2d 941, 947 (D.C. Cir. 1985))." *Id*. In the present case, it is clear from the 2019 Final Rule that HHS felt that it "lacked the authority" to create the exception it had created in 2014 and was now rescinding, and that it had no discretion in the matter. 84 Fed. Reg. at 19,720. Accordingly, if the government does not prevail on its interpretation of the statute, the Court must remand. In doing so, the Court should leave the 2019 Final Rule in place, since there is a reasonable chance that HHS "could adopt the same rule on remand" and there exist "disruptive consequences of an interim change that may itself be changed," with states and unions being forced to change course multiple times. *Pollinator Stewardship Council v. U.S. E.P.A*., 806 F.3d 520, 532 (9th Cir. 2015). And, should the Court enter any form of vacatur or injunctive relief, such relief should be limited to those parties with standing.

In the event the Court disagrees and determines it is proper at this stage to review the 2019 Final Rule as an exercise of discretion, the Court should find that the interpretation is reasonable and not arbitrary and capricious for the reasons set forth below.

B. If the Court Declines to Remand, HHS's Interpretation Is Not Arbitrary and Capricious.

1. HHS Considered all Important, Relevant Factors and Reasonably Explained its Change in Interpretation

Intervenors argue that, in developing the 2019 Final Rule, HHS failed to consider a number of important factors: "first, the employment relationship between homecare providers and states[;] second, the impact of the Rule on other authorized payroll deductions; third, the operation of fiscal management services ('FMS' or 'fiscal intermediaries'); and, fourth, the voluntariness of union dues deductions." Intervenors' Br. 15-16; *see also* States' Br. at 18 (also discussing states' relationships with providers). Those factors are in addition to stakeholders' reliance interests. Intervenors' Br. 13-14. However, Intervenors' claims that HHS did not consider these factors are belied by the text of the preamble to the 2019 Final Rule itself. HHS did specifically consider, and address, these issues to the extent they were raised by commenters. *See* 84 Fed. Reg. at 19,720 (addressing reliance interests); *id.* (addressing bona fide employment relationships); *id.* (addressing comment on tax deductions); *id.* at 19,719 (addressing situation of FMS and fiscal intermediaries); *id. at* 19,721 (addressing comment referencing "voluntary union dues"). HHS was not required to delve into the specific nature of relationships between individual states and their providers or the treatment of specific deductions. *See Shalala v. Guernsey Memorial Hosp*., 514 U.S. 87, 96 (1995) ("The APA does not require that all the specific applications of a rule evolve by further, more precise rules rather than by adjudication."). Indeed, HHS acknowledged that "[it] will take into consideration whether a regulation or further subregulatory guidance is needed to further clarify" certain issues raised by the commenters. *See* 84 Fed. Reg. at 19,720.

More generally, any further explanation by HHS to address contrary comments was not necessary here, where it reasonably concluded that it did not have any leeway to deviate from the statutory requirement as would be required by those comments. The agency is required to consider only those comments that could reasonably be considered relevant to its decision making. *See*

Altera Corp. & Subsidiaries v. Comm'r, 926 F.3d 1061, 1081 (9th Cir. 2019) ("If the comments ignored by the agency would not bear on the agency's 'consideration of the relevant factors,' we may not reverse the agency's decision."). Here, the factors raised by the Plaintiffs, including the reliance interests, are simply irrelevant to HHS's decision, which was based solely on the change in its statutory interpretation. And HHS sufficiently explained the basis for this change—that, upon revisiting the issue, it had concluded that the regulatory text added in 2014—allowing states to redirect Medicaid payments to third parties on behalf of providers for purposes of health and welfare benefit contributions, training costs, or other benefits customary for employees—"is neither explicitly nor implicitly authorized by the statute[.]" 84 Fed. Reg. at 19,718. "An agency may justify its policy choice by explaining why that policy 'is more consistent with statutory language' than alternative policies." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016) (quoting *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 175 (2007)); *see also Gonzales-Veliz v. Barr*, 938 F.3d 219, 235 (5th Cir. 2019) ("To the extent that the Attorney General overruled an erroneous BIA decision to be more faithful to the statutory text, there is no error."). That is what HHS did here, and for this reason the Final Rule is not arbitrary or capricious.

2. HHS Did Not Exceed its Authority

The States assert that HHS exceeded its authority by "interpreting the [anti-assignment] provision in [a] sweeping manner," which, in their view, improperly allows "HHS to dictate the terms of States' employment relationships with Medicaid providers, … to decide whether State should permit collective bargaining for Medicaid providers, hire an outside vendor or pay those providers directly, or forbid ordinary payroll deductions commonly enjoyed by employees." States' Br. 19. There are three errors with this argument. First, HHS clearly has authority to issue the 2019 Final Rule; it is charged with interpreting the provision that it administers, and rather than exercising any discretion, it merely determined that it was required to interpret the anti-assignment provision as set forth in that Rule. Second, the 2019 Final Rule is not as broad as the

States characterize it; the Rule merely forbids the States from using one particular payment method to pay union dues, insurance payments, or other deductions, but it does not otherwise control the relationships between the States and the providers or between providers and the unions or interfere with their collective bargaining relationships. Third, the States are wrong that HHS lacks the requisite authority to regulate the Medicaid program in the manner it does, and by extension, to regulate states and providers with regard to their participation in that program. In fact, the Secretary has quite broad authority in this area and, when exercising that authority, closely regulates the entities that participate in Medicaid. *See Schweiker v. Gray Panthers,* 453 U.S. 34, 43 (1981) ("Congress conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the [Social Security] Act [including] the provisions setting requirements for state Medicaid plans."); *cf. California v. U.S. Dep't of Health & Human Servs*., 941 F.3d 410, 425 (9th Cir. 2019) (addressing the more specific, "limited delegation" to Health Resources and Services Administration in the Women's Health Amendment). The States' claim that the Rule exceeds HHS's authority here must be dismissed.

IV. Intervenors' Equal Protection and First Amendment Claims Should Be Dismissed

Intervenors have failed to state a viable equal protection claim for the reasons set forth in Defendants' motion to dismiss. The 2019 Final Rule does not implicate a fundamental right or discriminate against a suspect class. Accordingly, to the extent it treats different groups differently (which Defendants dispute), it is subject to the highly deferential rational-basis review. In response, Intervenors allege that "the Final Rule is supported by no other legitimate rationale" (other than anti-union animus). Intervenors' Br. 18. This statement is not true. The 2019 Final Rule is supported at least two rational bases—first, HHS rationally concluded that it was statutorily obligated to rescind the 2014 Final Rule, and, second, the Rule is rationally related to the legitimate government interest in "ensur[ing] that Medicaid practitioners [are] paid fully and directly for their services as required by law." *Id.* at 19,724. Intervenors cannot state a "plausible" equal protection

claim by ignoring these "obvious alternative explanation[s]" for the 2019 Final Rule. *Ashcroft v. Iqbal*, 556 U.S. 662, 682 (2009). As between these "obvious alternative explanation[s] "and the purposeful, invidious discrimination [the States] ask[the Court] to infer, discrimination is not a plausible conclusion." *Id.*

Intervenors contend that the rule was motivated by an asserted "[c]onservative campaign for an anti-union rule," but they allege no connection between this "campaign" and the actions and intentions of the agency. *See* Intervenors' Compl. ¶¶ 13-134. The only "evidence" they allude to is the fact that the rule cites "conservative, anti-union sources such as the 'Fairness Center' and an opinion piece in the Washington Examiner." *Id. ¶* 125. But HHS cited those articles only for estimates regarding the amount of union dues at stake, not to support its statutory interpretation. Intervenors do not contest that the numbers relied upon by HHS were in error. 84 Fed. Reg. at 19,726 n.2. Therefore, they fail to state a plausible equal protection claim.

Intervenors also fail to meet the threshold requirements to state a plausible First Amendment claim. As Defendants previously argued, the 2019 Final Rule does not implicate Intervenors' First Amendment rights to speech or association because it does not target unions or union members specifically but merely prohibits one mechanism, withholding, by which individual providers are currently paying their union dues. The Final Rule does not restrict providers from paying their dues or other charges by any other means, and the Unions and their members may continue to exercise their freedom of speech as they see fit.

Intervenors disagree but acknowledge that the Supreme Court has already held that the First Amendment does not require states to make payroll deductions available to union members. Intervenors' Br. 20 n.31; *see Ysursa v. Pocatello Educ. Ass'n*, 555 U.S. 353, 359 (2009) ("[T]he State's decision [to limit public employer payroll deductions] is not an abridgment of the unions' speech; they are free to engage in such speech as they see fit."). As Supreme the Court put it, "[a] decision not to assist fundraising that may, as a practical matter, result in fewer contributions is

simply not the same as directly limiting expression." *Id.*; *see also Interpipe Contracting, Inc. v. Becerra*, 898 F.3d 879, 898 (9th Cir. 2018), *cert. denied*, 139 S. Ct. 2744 (2019). Intervenors attempt to distinguish the case on the ground that, in *Ysursa*, the state decided to limit payroll deductions while, in the present case, states are being *forced* to cease payroll deductions. Intervenors' Br. 20 n.31. But this distinction is irrelevant, and there is no appreciable difference between the two cases. Both in *Ysursa* and here, the statute or agency interpretation "does not suppress political speech but simply declines to promote it," it "applies to all organizations … regardless of viewpoint or message . . . [and] to all employers [or, here, all States and all Medicaid providers], and it does not single out any candidates or issues." *Id.* at 361 & 361 n.3. For these reasons, Intervenors' First Amendment claim should therefore also be dismissed.

CONCLUSION

For these reasons, the States' Amended Complaint and the Intervenors' Complaint-in-Intervention should be dismissed for lack of subject-matter jurisdiction and for failure to state a claim. In the alternative, Defendants are entitled to summary judgment and Plaintiffs' motion for summary judgment should be denied.

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Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

JEAN LIN
Special Counsel, Federal Programs Branch

/s/ Carol Federighi
CAROL FEDERIGHI
Senior Trial Counsel
United States Department of Justice
Civil Division, Federal Programs Branch
P.O. Box 883, Washington, DC 20044
Phone: (202) 514-1903
Email: carol.federighi@usdoj.gov
Attorneys for Defendants