

ROB BONTA
 Attorney General of California
 NELI PALMA
 Senior Assistant Attorney General
 KATHLEEN BOERGERS
 Supervising Deputy Attorney General
 MARIA F. BUXTON
 KATHERINE MILTON
 KEVIN G. REYES
 ANNA RICH
 Deputy Attorneys General
 State Bar No. 230195
 1515 Clay Street Suite 2000, P.O. Box 70550
 Oakland, CA 94612-0550
 Telephone: (510) 879-0296
 E-mail: Anna.Rich@doj.ca.gov
Attorneys for Plaintiff State of California

Additional Counsel Listed on Signature Page

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

**STATE OF CALIFORNIA; STATE OF
 ARIZONA; STATE OF COLORADO; STATE OF
 CONNECTICUT; STATE OF DELAWARE;
 STATE OF HAWAII; STATE OF ILLINOIS;
 STATE OF MAINE; STATE OF MARYLAND;
 COMMONWEALTH OF MASSACHUSETTS;
 STATE OF MICHIGAN; STATE OF
 MINNESOTA; STATE OF NEVADA; STATE OF
 NEW JERSEY; STATE OF NEW MEXICO;
 STATE OF NEW YORK; STATE OF OREGON;
 STATE OF RHODE ISLAND; STATE OF
 VERMONT; STATE OF WASHINGTON,**

Plaintiffs,

v.

**U.S. DEPARTMENT OF HEALTH AND HUMAN
 SERVICES; ROBERT F. KENNEDY JR.,** in his
 official capacity as Secretary of Health and Human
 Services; **U.S. DEPARTMENT OF HOMELAND
 SECURITY; KRISTI NOEM,** in her official
 capacity as Secretary of Homeland Security,

Defendants.

Case No. _____

**COMPLAINT FOR
 DECLARATORY AND
 INJUNCTIVE RELIEF**

Date:
 Time:
 Dept:
 Judge:
 Trial Date:
 Action Filed:

INTRODUCTION

1
2 1. In the seven decades since Congress enacted the Medicaid Act to provide medical
3 assistance to vulnerable populations, federal law, policy, and practice has been clear: personal and
4 private healthcare data collected about beneficiaries of the program is confidential, to be shared
5 only in certain narrow circumstances that benefit public health and the integrity of the Medicaid
6 program itself. This reticence makes sense. If members of our community cannot trust that the
7 government will keep their medical history and other personal data safe, they will think twice
8 about going to the doctor when needed.

9 2. In June, 2025, the federal government’s policy of keeping State Medicaid agencies’
10 healthcare records confidential abruptly changed, without notice, opportunity for public input, or
11 reasoned decision-making.

12 3. Upon information and belief, the U.S. Department of Health and Human Services
13 (HHS)’s Centers for Medicare & Medicaid Services (CMS) handed over a trove of individuals’
14 protected health data obtained from States, including California, Illinois, and Washington, to
15 other federal agencies, including the Department of Homeland Security (DHS). Millions of
16 individuals’ health information was transferred without their consent, and in violation of federal
17 law. In doing so, the Trump administration silently destroyed longstanding guardrails that
18 protected the public’s sensitive health data and restricted its use only for purposes that Congress
19 has authorized, violating federal laws including the requirements of the Administrative Procedure
20 Act (APA), 5 U.S.C. §§ 701 *et seq.* Meanwhile, the other Plaintiff States fear the
21 administration’s intent to improperly share their States’ sensitive data in the same way.

22 4. HHS claims it is giving this massive amount of personal data to the DHS “to ensure
23 that Medicaid benefits are reserved for individuals who are lawfully entitled to receive them,”
24 falsely implying the existence of widespread Medicaid beneficiary fraud. But Congress itself
25 extended coverage and federal funds for emergency Medicaid to all individuals residing in the
26 United States, even those who lack satisfactory immigration status. The States have and will
27 continue to verify individuals’ eligibility for federally funded Medicaid services using established
28 federal systems and cooperate with federal oversight activities to ensure that the federal

1 government pays only for those Medicaid services that are legally authorized. But never before
2 has this oversight required the type of unauthorized interagency data sharing that is at issue in this
3 case.

4 5. Moreover, the context in which CMS shared this data with ICE casts serious doubt on
5 the government's explanation for its actions. It has been widely reported that the Department of
6 Government Efficiency (DOGE) has been amassing federal benefit data, such as Social Security
7 recipient information, and individuals' tax information, to build a searchable database of
8 Americans' information for several purposes, including to assist ICE in immigration enforcement
9 actions.

10 6. DOGE has enlisted the help of technology company Palantir to help build this
11 searchable database that combines federal agencies' data on individuals. One former engineer at
12 the company has sounded the alarm in the press about Palantir's project, warning that
13 "[c]ombining all that data, even with the noblest of intentions, significantly increases the risk of
14 misuse."¹ Palantir's product, Foundry, has already been pushed to DHS and HHS, paving the
15 way for the administration to more easily merge information collected from these different
16 agencies.²

17 7. Plaintiffs bring this action to protect their State Medicaid programs, and to prevent
18 them from being used in service of an anti-immigrant crusade, or other purposes unrelated to
19 administration of those programs. Defendants' illegal actions carry serious consequences. States
20 will lose federal funds as fear and confusion stemming from the disclosures cause noncitizens and
21 their family members to disenroll, or refuse to enroll, in emergency Medicaid for which they are
22 otherwise eligible, leaving States and their safety net hospitals to foot the bill for federally
23 mandated emergency healthcare services. States will also ultimately bear the negative public
24 health costs associated with reduced utilization of healthcare for childbirth and other emergency
25

26
27 ¹ Sheera Frenkel and Aaron Krolif, *Trump Taps Palantir to Compile Data on Americans*, New
28 York Times (May 30, 2025), <https://www.nytimes.com/2025/05/30/technology/trump-palantir-data-americans.html>

² *Id.*

1 conditions. Meanwhile, the public will suffer irreparable damage due to increased morbidity and
2 mortality.

3 8. The Court should issue declaratory and injunctive relief to protect State data
4 containing this highly sensitive information, and to bar the federal government from reneging on
5 the terms of the longstanding State/federal Medicaid partnership.

6 JURISDICTION AND VENUE

7 9. The Court has jurisdiction pursuant to 28 U.S.C. §§ 1331, 1346, and 2201(a).

8 10. Venue is proper in this judicial district under 28 U.S.C. § 1391(e) because the
9 California Attorney General and the State of California have offices at 455 Golden Gate Avenue,
10 San Francisco, California and at 1515 Clay Street, Oakland, California, and therefore reside in
11 this district, and no real property is involved in this action. This is a civil action in which
12 Defendants are agencies of the United States or officers of such an agency.

13 11. Assignment to the San Francisco Division of this District is proper pursuant to Civil
14 Local Rule 3-2(c)-(d) and 3-5(b) because Plaintiffs maintain offices in the District.

15 PARTIES

16 *Plaintiffs*

17 12. Plaintiff the State of California, by and through Attorney General Rob Bonta, brings
18 this action. The Attorney General is the chief law officer of the State of California and head of
19 the California Department of Justice. He has the authority to file civil actions to protect
20 California's rights and interests and the resources of this State. Cal. Const., art. V, § 13; Cal.
21 Gov't Code §§ 12510-11, 12600-12; *see Pierce v. Superior Court*, 1 Cal. 2d 759, 761-62 (1934)
22 (The Attorney General "has the power to file any civil action or proceeding directly involving the
23 rights and interests of the state ... and the protection of public rights and interests.").

24 13. Plaintiff the State of Arizona is a sovereign state in the United States of America.
25 Arizona is represented by Attorney General Kris Mayes, who is the chief law enforcement officer
26 of Arizona.

14. Plaintiff the State of Colorado is a sovereign state of the United States of America. Colorado is represented by Attorney General Phil Weiser, who acts as the chief legal representative of the state and is authorized by Colo Rev. Stat. § 24-31-101 to pursue this action.

15. Plaintiff the State of Connecticut is a sovereign state of the United States of America. Connecticut is represented by and through its chief legal officer, Attorney General William Tong, who is authorized under General Statutes § 3-125 to pursue this action on behalf of the State of Connecticut.

16. Plaintiff State of Delaware is a sovereign state of the United States of America. This action is brought on behalf of the State of Delaware by Attorney General Kathleen Jennings, the “chief law officer of the State.” *Darling Apartment Co. v. Springer*, 22 A.2d 397, 403 (Del. 1941). Attorney General Jennings also brings this action on behalf of the State of Delaware pursuant to her statutory authority. Del. Code Ann. tit. 29, § 2504.

17. Plaintiff the State of Hawai‘i, represented by and through its Attorney General Anne Lopez, is a sovereign state of the United States of America. The Attorney General is Hawaii’s chief legal officer and chief law enforcement officer and is authorized by Hawaii Revised Statutes § 28-1 to pursue this action.

18. Plaintiff the State of Illinois is represented in this action by the Attorney General of Illinois, who is the chief legal officer of the State and is authorized to pursue this action on behalf of the State under Article V, Section 15 of the Illinois Constitution and 15 ILCS 205/4.

19. Plaintiff the State of Maine, represented by and through its Attorney General Aaron M. Frey, is a sovereign state of the United States of America. As the State’s chief law officer, the Attorney General is authorized to act on behalf of the State in this matter.

20. Plaintiff the State of Maryland is a sovereign state of the United States of America. Maryland is represented by Attorney General Anthony G. Brown who is the chief legal officer of Maryland.

21. Plaintiff the Commonwealth of Massachusetts is a sovereign state of the United States of America. Massachusetts is represented by Andrea Joy Campbell, the Attorney General of Massachusetts, who is the chief law officer of Massachusetts and authorized to pursue this action.

22. Plaintiff the State of Michigan is a sovereign state of the United States of America. Michigan is represented by Attorney General Dana Nessel, who is the chief law enforcement officer of Michigan.

23. Plaintiff the State of Minnesota is a sovereign state of the United States of America. Minnesota is represented by and through its chief legal officer, Minnesota Attorney General Keith Ellison, who has common law and statutory authority to sue on Minnesota's behalf.

24. Plaintiff the State of Nevada is a sovereign state in the United States of America. Nevada is represented by Attorney General Aaron D. Ford, who is the chief law enforcement officer of Nevada.

25. Plaintiff the State of New Jersey is a sovereign state in the United States of America. New Jersey is represented by Attorney General Matthew J. Platkin, who is the chief law enforcement officer of New Jersey.

26. Plaintiff State of New Mexico is a sovereign state in the United States of America. New Mexico is represented by Attorney General Raúl Torrez, who is the chief law enforcement officer of New Mexico authorized by N.M. Stat. Ann. § 8-5-2 to pursue this action.

27. Plaintiff the State of New York, represented by and through its Attorney General Letitia James, is a sovereign State of the United States of America. As the State's chief legal officer, the Attorney General is authorized to act on behalf of the State in this matter.

28. Plaintiff the State of Oregon is a sovereign state of the United States of America. Oregon is represented by Attorney General Dan Rayfield, who is the chief legal officer of Oregon.

29. Plaintiff State of Rhode Island is a sovereign state in the United States of America. Rhode Island is represented by Attorney General Peter F. Neronha, who is the chief law enforcement officer of Rhode Island.

30. Plaintiff the State of Vermont is a sovereign state of the United States of America. Vermont is represented by Attorney General Charity R. Clark, who is Vermont's chief legal officer and is authorized to pursue this action on behalf of the State. Vt. Stat. Ann. tit. 3, § 159.

31. Plaintiff State of Washington, represented by and through Attorney General Nicholas W. Brown, is a sovereign state of the United States of America. The Attorney General is Washington's chief law enforcement officer and is authorized under Wash. Rev. Code § 43.10.030 to pursue this action.

Defendants

32. Defendant Robert F. Kennedy, Jr., is the Secretary of the U.S. Department of Health and Human Services. He is sued in his official capacity.

33. Defendant U.S. Department of Health and Human Services is a department of the executive branch of the United States government. The Centers for Medicare & Medicaid Services (CMS) is an agency within HHS that is responsible for administering the Medicaid Act.

34. Defendant U.S. Department of Health and Human Services and Defendant Kennedy shall collectively be referred to as “HHS.”

35. Defendant Kristi Noem is the Secretary of the U.S. Department of Homeland Security. She is sued in her official capacity.

36. Defendant U.S. Department of Homeland Security is a department of the executive branch of the United States government, responsible for enforcement of the nation’s immigration laws, among other programs. Immigration and Customs Enforcement (ICE) is an agency within DHS that is responsible for interior enforcement of U.S. immigration laws.

37. Defendant U.S. Department of Homeland Security and Defendant Noem shall collectively be referred to as “DHS.”

LEGAL BACKGROUND

I. Overview of Federal Medicaid Act and Related Healthcare Laws

38. Created in 1965, Medicaid is an essential source of health insurance for lower-income individuals and particular underserved population groups, including children, pregnant women, individuals with disabilities, and seniors. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, §121, 79 Stat. 286, 343-352 (codified as amended at 42 U.S.C. §1396 et seq.).

39. States choose whether to participate in the Medicaid program. Each participating State develops and administers its own unique health plans; so long as States meet threshold

1 federal statutory criteria, they can tailor their plans' eligibility standards and coverage options to
2 residents' needs. States implement their Medicaid programs in accordance with comprehensive
3 written plans that must be reviewed and approved by the Secretary of HHS. *See generally* 42
4 U.S.C. § 1396a.

5 40. Medicaid is jointly funded by state and federal expenditures. The federal
6 government's share of funds available for services provided to States for Medicaid beneficiaries,
7 known as Federal Financial Participation (FFP), is calculated according to statutory formulae, the
8 Federal Medicaid Assistance Percentage (FMAP). The Children's Health Insurance Program
9 (CHIP) provides health coverage to children in families with incomes too high for regular
10 Medicaid but too low for private coverage; it is also jointly funded by state and federal
11 expenditures.

12 41. Eligibility for Medicaid depends in part on citizenship and immigration status.
13 Federal law divides individuals who are not United States citizens into "qualified" and "non-
14 qualified" categories for purposes of eligibility for federally funded Medicaid coverage not
15 limited to emergencies or childbirth (also known as "full-scope" Medicaid). 63 Fed. Reg. 41,658,
16 41,659 (Aug. 4, 1998) (explaining that non-qualified immigrants are excluded from non-
17 emergency, federally funded Medicaid, and other federal benefits). "Qualified immigrants"
18 currently include (1) lawful permanent residents (green card holders); (2) individuals granted
19 asylum; (3) refugees; (4) persons paroled into the United States under INA Section 212(d)(5) who
20 have been in the country for at least one year; (5) certain individuals subject to withholding of
21 removal (deportation); (6) noncitizens granted conditional entry prior to April 1, 1980; (7) certain
22 Cuban and Haitian entrants; and (8) individuals lawfully residing in the U.S. in accordance with a
23 Compact of Free Association (COFA). 8 U.S.C. § 1641(b). Certain victims of domestic violence
24 or human trafficking are also "qualified." 8 U.S.C. § 1641(c).

25 42. Not all qualified noncitizens are eligible for federally funded benefits like Medicaid,
26 however; some (such as lawful permanent residents) must wait five years before becoming
27 eligible. 8 U.S.C. § 1613. Others, like asylees and refugees, do not need to wait five years before
28 becoming eligible for full-scope, federally funded Medicaid.

43. Non-qualified immigrants include temporary visitors, asylum seekers whose applications are still pending, recipients of Deferred Action for Childhood Arrivals (DACA) status, holders of Temporary Protected Status (TPS), other lawfully present individuals not listed in 8 U.S.C. § 1641, as well as persons who are present in the United States without authorization from DHS. 8 U.S.C. § 1641(c).

44. Congress has ensured that a specific set of important and urgent healthcare services are available to all United States residents, including those in the “not qualified” category of noncitizens. These important and urgent services include emergency medical treatment and public health assistance for immunization and testing and treatment of communicable disease. 8 U.S.C. § 1611(b)(1)(A), (C). The federal Medicaid Act provides States with funding for emergency medical treatment for serious conditions, including emergency labor and delivery. 42 U.S.C. § 1396b(v)(3). A separate federal law, the federal Emergency Medical Treatment and Labor Act (EMTALA), requires hospitals to provide emergency medical treatment to everyone in need, regardless of insurance coverage or ability to pay and regardless of citizenship or immigration status. 42 U.S.C. § 1395dd.

45. Congress also gives States the choice to cover, with regular federal matching dollars, lawfully residing children and pregnant individuals under Medicaid and CHIP during their first five years in the United States. Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. No. 111-3, 123 Stat. 8. States also have an option to cover prenatal services regardless of immigration status under the “From-Conception-to-the-End-of-Pregnancy” option. *See* 42 C.F.R. § 457.10.

46. States also may use state funds to extend additional Medicaid-like benefits to a broader range of immigrants. *See, e.g.*, 8 U.S.C. § 1621(d).

II. Federal Laws Authorizing Data Sharing

a. Eligibility Verification

47. Personal data is routinely exchanged between the States and the federal government for purposes of verifying eligibility for Medicaid. States are required to affirmatively verify the

1 immigration status of all applicants for federally funded, full-scope Medicaid. 8 U.S.C. § 1642
2 (a-b); 42 C.F.R. § 435.910(a), (e)(2).

3 48. States must have an income and eligibility verification system for the exchange of
4 information regarding federally funded benefits that meets federal requirements. 42 U.S.C.
5 § 1320b-7(a). This system must include “adequate safeguards [...] so as to assure that [...] the
6 information exchanged by State agencies is made available only to the extent necessary to assist
7 in the valid administrative needs of the program receiving such information” and that “the
8 information is adequately protected against unauthorized disclosure for other purposes, as
9 provided in regulations established by the Secretary of Health and Human Services.” 42 U.S.C.
10 § 1320b-7(a)(5).

11 49. Applicants without Social Security Numbers who indicate an applicable status for
12 non-emergency, full-scope Medicaid will have that information verified with DHS, through an
13 automated system that “protects the individual’s privacy to the maximum degree possible.” *Id.*
14 § 1320b-7(d)(3)(B). States can comply by checking applicants’ eligibility via a centralized “Data
15 Services Hub” run by CMS that provides access to the Department of Homeland Security’s
16 Systematic Alien Verification for Entitlement (SAVE). Operated by DHS, SAVE is the federal
17 government’s central repository for biographic, citizenship, and immigration status information
18 on all individuals in the United States. SAVE data indicates whether an applicant is lawfully
19 present; whether the applicant is a qualified noncitizen, or a naturalized or acquired citizen; and
20 whether waiting periods or the Children’s Health Insurance Program Reauthorization Act
21 (CHIPRA) Section 214 exemptions for qualified noncitizens apply and have been met.

22 50. Federal law exempts noncitizens applying for or receiving Medicaid for treatment of
23 an emergency medical condition from providing Social Security Numbers and/or documenting
24 their immigration or citizenship status. 42 U.S.C. § 1320b-7(f).

25 51. If a State follows the required procedures for verification of citizenship or
26 immigration status, the federal government is not allowed to take “any compliance, disallowance,
27 penalty, or other regulatory action against a State” with respect to erroneous citizenship or
28 immigration status determinations. 42 U.S.C. § 1320b-7(e).

b. Transformed Medicaid Statistical Information System

52. In addition to eligibility verification, the States routinely share more detailed, protected health information with CMS. To obtain an enhanced FMAP, States must provide “detailed individual enrollee encounter data and other information that the Secretary may find necessary and including [...] data elements [...] that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine.” 42 U.S.C. § 1396b(r)(1)(F); 42 C.F.R. § 438.818.

53. Using its statutory authority, CMS mandates State participation in the Transformed Medicaid Statistical Information System (T-MSIS), CMS’s main Medicaid dataset. *See* 42 C.F.R. §§ 433.116, 438.242, 438.604, and 438.818. States must submit data to T-MSIS on at least a monthly basis. State-reported data held by CMS in T-MSIS includes Medicaid beneficiary eligibility and demographic information, including unique identifiers, addresses, sex, race and ethnicity, etc.; records of health claims and encounters, including beneficiaries’ diagnosis and treatment information; and Medicaid provider enrollment data, including identifiers and addresses. *See* CMS, T-MSIS Data Guide (Ver. 3.38.0), <https://www.medicaid.gov/tmsis/dataguide/v3/>.

54. The purpose of T-MSIS is to provide “improved program monitoring and oversight, technical assistance with states, policy implementation, and data-driven and high-quality Medicaid and CHIP programs that ensure better care, access to coverage, and improved health.” *See* CMS, Notice of a Modified System of Records, 84 Fed. Reg. 2,230-02 (Feb. 6, 2019).

c. Quality Reviews and Audits

55. The States also routinely provide CMS with Medicaid reports and data for federal oversight purposes. These include (but are by no means limited to) Quarterly Expenditure Reports & Data, an accounting statement of the state’s actual recorded expenditures and disposition of Federal funds; and Monthly Eligibility Determination, & Enrollment Reports & Data, which reflect the state’s enrollment activity for all populations receiving comprehensive Medicaid and CHIP benefits, as well as state program performance data. For example, every quarter, States file reports with CMS containing an estimate of their Medicaid benefit costs and

1 administrative expenses, and certifying the availability of state funds. The States further provide
 2 responses to “such other investigation as the Secretary may find necessary” to calculate proper
 3 payments to States. 42 U.S.C. § 1396b(d)(1).

4 **III. Federal Laws Limiting Data Sharing and Protecting Data Security**

5 **a. Social Security Act and Implementing Rules**

6 56. In recognition of the sensitive nature of personal data collected pursuant to the Social
 7 Security Act, Congress has authorized special guardrails that limit use of this collected data for
 8 purposes related to administration of Medicaid and other Social Security Act programs.

9 57. The Social Security Act provides, “[n]o disclosure ... of any file, record, report, or
 10 other paper, or any information [...] shall be made except as the head of the applicable agency
 11 may by regulations prescribe and except as otherwise provided by Federal law.” 42 U.S.C.
 12 § 1306 (a)(1) (emphasis added); *see also id.* § 1306(a)(2) (applying this privacy provision to both
 13 HHS and the Social Security Administration). This prohibition applies to all of the Medicaid data
 14 containing protected health information obtained by HHS in paragraphs 47-55 above.

15 58. HHS has not issued regulations authorizing the unfettered transfer of Medicaid data
 16 containing protected health information to DHS (or other law enforcement agencies), nor does
 17 federal law otherwise provide for this type of transfer from CMS to other federal agencies.

18 59. To the contrary, well-established HHS regulations prioritize confidentiality and
 19 limitations on disclosures of this type of data.

20 60. Most Medicaid data can only be made available “when this can be done consistently
 21 with obligations of confidentiality and administrative necessity.” 42 C.F.R. § 401.126(c).

22 61. Most Medicare information (and by extension Medicaid information, *see* 42 C.F.R.
 23 § 401.101(a)(1) (applying this subpart to “any other information subject to” the Social Security
 24 Act’s privacy mandate)) may only be released to “an officer or employee of an agency of the
 25 Federal or a State government lawfully charged with the administration of a program receiving
 26 grants-in-aid under title V and XIX [Medicaid] of the Social Security Act *for the purpose of*
 27 *administration of those titles[,]*” or the uniformed services civilian health program. 42 C.F.R.
 28 § 401.134(a) (emphasis added).

62. Disclosure for purposes of investigating program integrity concerns is permitted, but again, HHS regulations impose strict limits. Medicaid data may be shared with:

any officer or employee of an agency of the Federal or a State government lawfully charged with the duty of conducting an investigation or prosecution with respect to possible fraud or abuse against a program receiving grants-in-aid under Medicaid, but only for the purpose of conducting such an investigation or prosecution [...] provided that the agency has filed an agreement with CMS that the information will be released only to the agency's enforcement branch and that the agency will preserve the confidentiality of the information received and will not disclose that information for other than program purposes.

42 C.F.R. § 401.134(c).

63. State Medicaid plans similarly are required by federal statute to provide “safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with [...] the administration of the plan[.]” 42 U.S.C. § 1396a(7)(A)(i); *see also, e.g.*, 42 C.F.R. Chapter IV, Subchapter C, Part 431, Subpart F (“Safeguarding Information on Applicants and Beneficiaries”), including §§ 435.907(e)(1) (limiting state agency collection of information to only what is necessary to make eligibility determinations or administer state Medicaid plan), (e)(3) (limits on state collection of SSNs, including that non-applicant SSNs be voluntary and “used only to determine an applicant’s or beneficiary’s eligibility for Medicaid or other insurance affordability program or for a purpose directly connected to the administration of the State plan”).

64. State Medicaid agencies must enact their own state confidentiality protections to enforce the federal regulations for safeguarding information about beneficiaries and applicants. 42 C.F.R. § 431.303. States must also make assurances in their Medicaid plan that they submit for approval to CMS that such protections are in place.

65. HHS has communicated its confidentiality policy to Medicaid applicants and beneficiaries. For example, CMS’s template Medicaid application expressly states to prospective applicants, “We’ll keep all the information you provide private and secure as required by law. We’ll use personal information only to check if you’re eligible for health coverage.”³ States are

³ CMS Single Streamlined Application, OMB No. 0938-1191, expires: Sept. 30, 2027 (last visited Jun. 21, 2025), <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/single-streamlined-application.pdf>.

1 required to use this, or similar language, in their state-specific materials. 42 C.F.R. § 435.907(b).
 2 CMS has approved the States' application language.

3 66. In accord with these limits, DHS policy historically has not allowed use of Medicaid
 4 personal information for immigration enforcement purposes. An October 25, 2013 ICE policy
 5 memorandum states:

6 ICE does not use information about such individuals or members of their household that is
 7 obtained for purposes of determining eligibility for [Medicaid and other federally funded
 8 healthcare] coverage as the basis for pursuing a civil immigration enforcement action
 9 against such individuals or members of their household, whether that information is
 10 provided by a federal agency to the Department of Homeland Security for purposes of
 11 verifying immigration status information or whether the information is provided to ICE by
 12 another source.

13 This ICE policy has been publicly available on DHS's website for years.

14 **b. Privacy Act**

15 67. Congress enacted the Privacy Act of 1974 to "provide certain safeguards for an
 16 individual against an invasion of personal privacy," by requiring governmental agencies to
 17 maintain accurate records and providing individuals with more control over the gathering,
 18 dissemination, and accuracy of agency information about themselves. Pub. L. No. 93-579, § 2(b),
 19 88 Stat. 1896 (1974).

20 68. To accomplish this purpose, the Privacy Act sets forth conditions for disclosure of
 21 private information and precludes an agency from disclosing information in its files to any person
 22 or to another agency without the prior written consent of the individual to whom the information
 23 pertains. *See* 5 U.S.C. § 552a(b).

24 69. Among these instructions, the Privacy Act requires federal agencies to follow specific
 25 procedures before they "maintain, collect, use, or disseminate," any covered information. 5
 26 U.S.C. §§ 552a(a)(3), (e)–(f).

27 70. When an agency "establish[es] or revis[es]" a "system of records" containing
 28 retrievable information about individuals, it must "publish in the Federal Register . . . a notice of
 the existence and character of the system of records." 5 U.S.C. § 552a(e)(4), (a)(5) (defining
 "system of records").

1 71. This notice, commonly referred to as a System of Records Notice (“SORN”), must
2 identify, inter alia, the name and location of the system; the categories of individuals on whom
3 records are maintained in the system; the purpose for which information about an individual is
4 collected; the policies and practices of the agency regarding storage, retrievability, access
5 controls, retention, and disposal of records; and the procedures by which individuals can request
6 notification of and access to information pertaining to them. *Id.* § 552a(e)(4).

7 72. Each SORN provides the public with information regarding the relevant system of
8 records, which is a necessary precondition for an individual to exercise their right to “gain
9 access” to records that are “contained in the system.” 5 U.S.C. § 552a(d)(1).

10 73. At least 30 days before publishing a SORN, the agency must also publish notice in
11 the Federal Register “of any new use or intended use of the information in the system” and
12 provide an opportunity for interested parties to submit “written data, views, or arguments to the
13 agency.” *Id.* § 552a(e)(11).

14 74. Thus, before an agency can establish or revise a system of records, it must provide
15 notice and an opportunity for public comment at least 30 days in advance. The Privacy Act
16 establishes a similar notice and comment requirement for the establishment or revision of a data
17 match with other federal, state, or local government entities. 5 U.S.C. § 552a(e)(12).

18 75. The Privacy Act further provides that “[n]o agency shall disclose any record which is
19 contained in a system of records ... except pursuant to a written request by, or with the prior
20 written consent of, the individual to whom the record pertains.” 5 U.S.C. § 552a(b) (1982 ed.,
21 Supp. V).

22 76. The Privacy Act also lists exceptions to the bar on disclosure.

23 77. For example, an agency may disclose the records it maintains within the agency “to
24 another agency or to an instrumentality of any governmental jurisdiction within or under the
25 control of the United States for a civil or criminal law enforcement activity if the activity is
26 authorized by law, and if the head of the agency or instrumentality has made a written request to
27 the agency which maintains the record specifying the particular portion desired and the law
28 enforcement activity for which the record is sought.” *Id.* § 552a(b)(7).

78. Additionally, an agency may disclose a record “for a routine use,” defined as “the use of such record for a purpose which is compatible with the purpose for which it was collected.” *Id.* §§ 552a(a)(7), (b)(3). Any “routine use” must be detailed in the relevant System of Records Notice, published in the Federal Register.

c. Health Insurance Portability and Accountability Act (HIPAA)

79. The Health Insurance Portability and Accountability Act (HIPAA), is another key data privacy law that governs the use and disclosure of individuals’ protected health information. Pub. L. 104–191, 110 Stat. 1936; 45 C.F.R. pts. 160, 164.

80. Protected health information is, in part, information (including demographic information) that relates to the provision of health care to an individual, as well as the past, present, or future payment for health services provided to an individual. 45 C.F.R. § 160.103. Covered entities may not use or disclose protected health information unless expressly permitted or required, or at the individual’s consent. *Id.* at § 164.502.

81. Covered entities include health plans, health care clearinghouses, and health care providers. 45 C.F.R. § 160.103. CMS is a covered entity subject to HIPAA’s requirements with respect to Medicaid program administration because it pays for individuals’ health coverage through Medicaid.

82. HIPAA does contain exceptions for certain types of disclosures, such as compliance with an administrative request for which response is required by law (e.g., an administrative subpoena). 45 C.F.R. § 164.512(f). However, that exception is limited to requests that are sufficiently “specific and limited in scope.” *Id.* at § 164.512(f)(1)(ii)(C).

d. Federal Information Security Management Act (FISMA)

83. The Federal Information Security Management Act (“FISMA”) is a federal law enacted under Title III of the E-Government Act of 2002. Pub. L. 107-347, 116 Stat. 2933 (Dec. 17, 2002).

84. FISMA requires each federal agency to develop, document, and implement an agency-wide program to provide information security for the information and systems that support the operations and assets of the agency, including those provided or managed by another

1 agency, contractor, or other sources. As defined in FISMA, “[t]he term ‘Federal information
2 system’ means an information system used or operated by an executive agency, by a contractor of
3 an executive agency, or by another organization on behalf of an executive agency.” 40 U.S.C. §
4 11331(g)(1).

5 85. FISMA was later amended by the Federal Information Security Modernization Act of
6 2014, Pub. L. 113-283, 128 Stat. 3073 (Dec. 18, 2014). As the CMS website devoted to FISMA
7 explains, these 2014 reforms were “passed in response to the increasing amount of cyber attacks
8 on the federal government.” CMS, *Federal Information Security Modernization Act (FISMA)*,
9 <https://security.cms.gov/learn/federal-information-security-modernization-act-fisma> (last visited
10 June 25, 2025). The changes, among other things, strengthened the use of continuous monitoring
11 in systems and increased focus on the agencies for compliance and reporting that is more targeted
12 at the issues caused by security incidents. 44 U.S.C. § 3551.

13 86. In support of and reinforcing FISMA, OMB through Circular A-130, “Managing
14 Information as a Strategic Resource,” requires executive agencies within the federal government
15 to: plan for security; ensure that appropriate officials are assigned security responsibility;
16 periodically review the security controls in their systems; and authorize system processing prior
17 to operations and periodically thereafter, among other requirements. Off. of. Mgmt. & Budget,
18 Exec. Off. of the President, OMB Cir. No. A-130, *Managing Information as a Strategic Response*
19 (2016). This includes following standards set by the National Institute of Standards and
20 Technology (“NIST”). See CMS, *Federal Information Security Modernization Act (FISMA)*,
21 <https://security.cms.gov/learn/federal-information-security-modernization-act-fisma> (last visited
22 June 25, 2025) (“While FISMA sets the legal requirement for annual compliance, the National
23 Institute of Standards and Technology (NIST) is the government body responsible for developing
24 the standards and policies that agencies use to ensure their systems, applications, and networks
25 remain secure.”).

26 87. Accordingly, under FISMA, federal agencies need to provide “information security
27 protections commensurate with the risk and magnitude of the harm resulting from unauthorized
28 access, use, disclosure, disruption, modification, or destruction of (A) information collected or

maintained by or on behalf of an agency; [and] (B) information systems used or operated by an agency or a contractor of an agency or other organization on behalf of an agency.” 44 U.S.C. § 3553(a)(2). In addition, “federal agencies need to ‘*com[ply] with the information security standards*’ and guidelines, and mandatory required standards developed by NIST.” NIST, *NIST Risk Management Framework* (updated Sept. 24, 2024), <https://csrc.nist.gov/projects/risk-management/fisma-background> (emphasis in original).

88. The information security requirements established by NIST are binding on all federal agencies. *See* NIST Special Publication 800-53 Revision 5, *Security and Privacy Controls for Information Systems and Organizations*, at 2 (Sept. 2020) (“The use of these controls is mandatory for federal information systems.”).

89. NIST requires that federal agencies have, at a minimum, policies and procedures that address the following information security risks:

- a. Access control: Each agency must establish an internal control to “[d]efine and document the types of accounts allowed and specifically prohibited for use within the system;” “[r]equire approvals by” a designated official “for requests to create accounts;” and “[m]onitor the use of accounts.” *Id.* at 19. Each agency must ensure that “[u]sers requiring administrative privileges on system accounts receive additional scrutiny by organizational personnel responsible for approving such accounts and privileged access.” *Id.*
- b. Information exchange: Each agency must establish an internal control to “[a]pprove and manage the exchange of information between the system and other systems,” whether through memoranda of understanding or information exchange security agreements. *Id.* at 86-87. This includes any “organization-to-organization communications,” such as e-mails, and requires “[a]uthorizing officials [to] determine the risk associated with system information exchange and the controls needed for appropriate risk mitigation.” *Id.* at 87. Furthermore, each agency must have a process in place for responding to “information spillage,” or “instances where

information is placed on systems that are not authorized to process such information.” *Id.* at 159-60.

c. Insider threats: Each agency must “[i]mplement an incident handling capability for incidents involving insider threats,” and must provide for intra-organization coordination of insider threat response. *Id.* at 153-54.

d. Personnel sanctions: Each agency must “[e]mploy a formal sanctions process for individuals failing to comply with established information security and privacy policies and procedures.” *Id.* at 227.

90. CMS has implemented these requirements by establishing a set of “Acceptable Risk Safeguards” (ARS) that “provides the standard to CMS and its contractors as to the minimum acceptable level of required security and privacy controls.” CMS, *CMS Acceptable Risk Safeguards* (ver. 5.1, April 22, 2022), <https://security.cms.gov/policy-guidance/cms-acceptable-risk-safeguards-ars>. These safeguards (which can be downloaded as an Excel spreadsheet from that website) set forth detailed policies for handling CMS data, including policies governing information sharing and the processing of personally identifiable information (PII).

FACTUAL ALLEGATIONS

I. Background on State Medicaid Programs and Data Sharing

91. Plaintiffs’ Medicaid programs provide comprehensive healthcare benefits to tens of millions of participants. As of January, 2025, according to CMS records, 78.4 million people were enrolled in Medicaid and CHIP nationwide.

Arizona

92. The Arizona Health Care Cost Containment System (AHCCCS) is Arizona’s Medicaid agency that offers healthcare programs to serve qualifying Arizona residents. AHCCCS is Arizona’s largest insurer, covering more than 2 million individuals. AHCCCS uses federal, state, county, and other funds to provide healthcare coverage to the State’s Medicaid population.

1 93. Consistent with federal law, AHCCCS provides certain emergency healthcare
2 services to uninsured qualified and nonqualified immigrants through the Federal Emergency
3 Services Program.

4 94. AHCCCS uses the federal SAVE database to verify individuals' eligibility for
5 federally-funded Medicaid services.

6 95. AHCCCS also routinely responds to CMS requests related to Medicaid auditing and
7 oversight, including its supplemental review of reports required to determine the amount of FFP
8 to which the Arizona is entitled.

9 96. AHCCCS sends data to T-MSIS each month. This data contains personally
10 identifying and protected health information about all AHCCCS beneficiaries.

11 ***California***

12 97. The California Health and Human Services Agency (CHHS) is an agency within the
13 executive branch of the State of California. CHHS, through its sub-agency, California
14 Department of Health Care Services (DHCS), administers California's Medicaid program, known
15 as Medi-Cal.

16 98. California's Medi-Cal program provides healthcare coverage for one out of every
17 three Californians. In California, full-scope Medi-Cal gives beneficiaries access to primary and
18 preventative care, oral healthcare, hospitalization, prescription drugs, behavioral healthcare, and
19 other vital services.

20 99. California has elected to use state-only funds to provide a version of the Medi-Cal
21 program to all eligible state residents, regardless of immigration status. Cal. Welf. & Inst. Code
22 § 14007.8(a)(2)(A). California's Medi-Cal program provides healthcare coverage for more than
23 two million noncitizens.

24 100. DHCS has an agreement with CMS and DHS to use the federal SAVE database to
25 verify individuals' eligibility for federally funded Medicaid.

26 101. DHCS sends data to T-MSIS each month. This data contains protected health
27 information about all Medi-Cal enrollees.
28

102. DHCS also routinely responds to CMS requests for supplemental review of reports required to determine the amount of FFP to which the State is entitled, and other program audit and oversight functions.

103. On March 18, 2025, CMS sent a letter to DHCS stating that it would be reviewing claims for FFP to determine whether California “is using federal money to pay for or subsidize healthcare for individuals without a satisfactory immigration status.” The letter did not cite any new evidence or new concerns about improper use of federal dollars. Instead, the letter cited earlier audits initiated by California itself when it informed CMS that it had erroneously claimed FFP for non-emergency or non-pregnancy services to undocumented Medi-Cal enrollees, an error that has been corrected and led to the return of funds back to the federal government.

104. On March 31, 2025, CMS sent DHCS a follow up email requesting information the agency stated was necessary to confirm California was not applying federal funding unlawfully for individuals with unsatisfactory immigration statuses. CMS requested claim submission and enrollee data for the quarter ending on March 31, 2025, including individual enrollees’ Medicaid ID, immigration status, and the period they were eligible for emergency Medicaid, as well as descriptions of how DHCS operates Medi-Cal, including how emergency Medicaid services are paid for, how DHCS verifies immigration status, and how DHCS defines “emergency condition.” CMS required DHCS to respond by April 30, 2025. Nothing in the request indicated that CMS would share this information outside HHS.

105. DHCS responded to CMS’s information request on April 30, 2025, and provided a substantial amount of the requested information, including protected health information, assuming CMS planned to use this information for routine auditing consistent with that agency’s statutory authority to administer the Medicaid program.

Colorado

106. Colorado administers its state Medicaid program through the Colorado Department of Health Care Policy and Financing (HCPF). HCPF is Colorado’s single-state agency responsible for administering Health First Colorado, Colorado’s Medicaid Program. C.R.S. § 25.5-1-104(1).

1 HCPF's mission is to "improve health care equity, access and outcomes for the people we serve
2 while saving Coloradans money on health care and driving value for Colorado."

3 107. Health First Colorado is regulated by HHS and is jointly funded through both state
4 and federal dollars.

5 108. HCPF spends considerable resources to ensure that eligibility determinations for
6 Health First Colorado are correct. This ensures that only individuals who are eligible for
7 Medicaid are enrolled in Health First Colorado and that only those services provided to eligible
8 members are billed to the federal government.

9 109. HCPF sends eligibility data to CMS through the T-MSIS database. This data contains
10 sensitive, personally identifiable information about all Health First Colorado members.

11 110. HCPF routinely responds to CMS requests for data and information to substantiate
12 the amount of FFP HCPF requests from the federal government.

13 111. On June 6, 2025, HCPF received an email from CMS that included significant
14 requests for data related to the administration of Emergency Medicaid Services for certain
15 immigrant populations. CMS also requested data related to Colorado's state-only health care
16 program, Cover All Coloradans, which provides services for children and pregnant persons who
17 otherwise would be eligible for Health First Colorado but for immigration status.

18 112. CMS represented in the email that it "will be reviewing claims for FFP submitted by
19 the state to ensure that only claims for FFP that meet all applicable statutory requirements for
20 individuals without a satisfactory immigration status are included within the state's" claims
21 submission to the federal government.

22 113. The email does not cite any evidence or concerns about HCPF improper use of
23 federal dollars as related to "individuals without a satisfactory immigration status." Nor does the
24 email city any evidence or concerns regarding Colorado state-only health care program, Cover
25 All Coloradans.

26 114. The email asks HCPF to respond to the data requests by July 30, 2025. A meeting
27 between HCPF and CMS is scheduled for July 2, 2025 to discuss the data requests.
28

Connecticut

115. Connecticut's HUSKY Health is the State's program that provides comprehensive health coverage to all qualifying Connecticut residents, and it includes Connecticut's Medicaid and CHIP programs. Connecticut's Department of Social Services (DSS) is Connecticut's single state Medicaid agency and functions as one of the largest providers of health coverage in Connecticut. It is a leader in ensuring Connecticut residents have access to high-quality, affordable healthcare, and it is committed to whole-person care, integrating physical and behavioral health services for better results and healthier communities in Connecticut. DSS provides healthcare for over 1 million state residents annually through HUSKY. Connecticut implemented the CHIP option to cover the cost of prenatal care in 2022.

116. Connecticut has also elected to use state-only funds to provide a version of the HUSKY program to all eligible state residents up to the age of 19, regardless of immigration status. Connecticut has also elected to use state-only funds for postpartum services for women who do not qualify for Medicaid or CHIP based on their immigration status.

117. Connecticut DSS routinely shares protected health information concerning Connecticut residents and their use of Medicaid healthcare services with CMS. DSS sends data to T-MSIS on a regular basis, and also routinely responds to CMS requests for additional information concerning Medicaid claims and the use of federal dollars.

Delaware

118. The Division of Medicaid and Medical Assistance (DMMA) is an agency within the executive branch of the State of Delaware. DMMA administers the Medicaid and CHIP programs in Delaware, which provide health coverage to over 300,000 Delawareans.

119. Delaware routinely shares protected health information concerning Delaware residents and their use of Medicaid healthcare services with CMS. DMMA sends data to T-MSIS on a regular basis, and also responds to occasional CMS requests for additional information concerning Medicaid claims and the use of federal dollars.

Hawai'i

120. Hawaii's Medicaid program, Med-QUEST, is administered by the State of State of Hawai'i Department of Human Services. Med-QUEST provides health coverage to 400,000 low-income Hawai'i residents. In addition, Hawai'i administers federally funded emergency Medicaid benefits that provide emergency care and services to individuals regardless of their immigration status.

121. Med-QUEST routinely shares protected health information concerning Hawai'i residents and their use of Medicaid healthcare services with CMS. Med-QUEST sends data to T-MSIS on a regular basis, and also responds to occasional CMS requests for additional information concerning Medicaid claims and the use of federal dollars.

Illinois

122. The Illinois Department of Healthcare and Family Services (IDHFS) administers Medicaid, CHIP, and other affordable health care programs in the state of Illinois. These programs provide critical healthcare coverage to nearly 3.5 million individuals and families across Illinois, making IDHFS the largest source of medical insurance in the state.

123. Illinois has also significantly invested in outreach and enrollment for affordable health programs within the state.

124. Illinois has additionally elected to use state-only funds to expand healthcare coverage for certain noncitizens. For example, the Health Benefits for Immigrant Seniors program provides health benefits for Illinois residents 65 years and older regardless of their immigration status. 305 ILCS 5/12-4.35. Illinois also funds and administers the All Kids program, which provides comprehensive, affordable, health insurance for all Illinois children, regardless of immigration status.

125. Applications for Illinois benefits, including affordable health programs, in the state of Illinois are handled through a single web-based application portal called ABE, the Application for Benefits Eligibility. Applications may also be completed in person at certain locations, by mail, or initiated by telephone with Illinois caseworkers.

126. ABE can be used by anyone seeking Illinois Medicaid coverage, including new groups covered as a result of national health care reform under the Affordable Care Act.

127. Illinois uses an Integrated Eligibility System (IES) to determine eligibility for benefits programs including affordable healthcare benefits. This program interfaces with state and federal data sources to verify certain financial and nonfinancial information to assist in determining eligibility for various benefits programs.

128. Illinois verifies USCIS status of noncitizens applying for federally-supported medical benefits through the federal SAVE database.

129. Illinois sends extract data to T-MSIS on a monthly basis as required and full data on an annual basis.

130. Illinois also responds to CMS requests for information and data when CMS reviews Illinois' claims for reimbursement of expenditures, and when CMS performs other program audit and oversight functions. Given CMS's role in jointly administering the Medicaid program with Illinois, IDHFS complies with all routine requests for information.

Maine

131. Maine's Medicaid program is operated by the Maine Department of Health and Human Services (Me. DHHS). Maine's Medicaid program, known as MaineCare, provides healthcare coverage for approximately 400,000 residents in Maine. This includes 38,000 people with disabilities and 5,000 children with special health care needs.

132. In certain circumstances and consistent with federal law, non-qualified noncitizens who live in Maine are eligible for Medicaid coverage. For example, as with all Maine residents—regardless of immigration status—non-qualified noncitizens are eligible for Emergency Services Only Medicaid, which covers emergency medical services.

133. Consistent with federal law, non-qualified pregnant women are eligible for federal CHIP coverage for medical care during pregnancy and for twelve months after delivery.

134. Maine has elected to use state-only funds to provide a version of MaineCare to all eligible state residents under the age of 21 who are not qualified to receive federal match due to their immigration status. 22 M.R.S. § 3174-FFF.

135. MaineCare participants' personal data is available to CMS through T-MSIS.

136. Me. DHHS has an agreement with CMS and DHS to use the federal SAVE database to verify individuals' eligibility for federally funded MaineCare.

137. Me. DHHS also routinely responds to CMS requests for supplemental review of reports required to determine the amount of FFP to which the State is entitled, and other program audit and oversight functions.

Maryland

138. Maryland's Medicaid program (also known as the "Maryland Medical Assistance Program") is operated by the Maryland Department of Health (MDH). The Medicaid program provides healthcare coverage for approximately 1.5 million Maryland residents.

139. Consistent with federal law, Maryland affords emergency Medicaid coverage for immigrants who are otherwise eligible for Medicaid. Coverage extends from when the individual enters the hospital until the individual's emergency medical condition is stabilized. Under the state's Healthy Babies Equity Act of 2024, Maryland Medicaid provides comprehensive medical care and other health care services to noncitizen pregnant individuals who would be eligible for Medicaid but for their immigration status. Those individuals have full Medicaid benefits up to 4 months postpartum. *See* Md. Code. Ann. Health-Gen. §15-103(a)(2)(xviii).

140. MDH maintains the personal data of Medicaid enrollees through the Medicaid Management Information System ("MMIS"), while the Maryland Health Benefit Exchange ("MHBE") maintains the integrated eligibility system and statewide eligibility information database of Medicaid enrollees through the Health Benefit Exchange ("HBX"). Maryland Medicaid enrollees' personal data is available to CMS through the T-MSIS.

Massachusetts

141. Massachusetts administers Medicaid and CHIP through the MassHealth program, which is administered by the Massachusetts Executive Office of Health and Human Services ("EOHHS").

142. EOHHS's MassHealth and CHIP programs provide healthcare coverage for over 1,600,000 Massachusetts residents.

1 143. EOHHS maintains personal data of MassHealth enrollees, including eligibility
2 information. Massachusetts MassHealth enrollees' personal data is available to CMS through the
3 T-MSIS system used by CMS to collect and standardize Medicaid and CHIP data across states.

4 144. EOHHS additionally at times provides CMS with data in response to Medicaid
5 supplemental reviews and audits for federal oversight purposes.

6 ***Michigan***

7 145. Michigan's Medicaid program is operated by the Michigan Department of Health and
8 Human Services (MDHHS). Michigan Medicaid provides healthcare coverage for approximately
9 2.6 million residents in Michigan.

10 146. In certain circumstances and consistent with federal law, undocumented noncitizens
11 who live in Michigan are eligible for Medicaid coverage. For example, Michigan residents—
12 regardless of immigration status—are eligible for Emergency Services Only Medicaid, which
13 covers emergency medical services. And undocumented pregnant women are eligible for
14 Medicaid and CHIP coverage for limited maternity-related care during pregnancy and for two
15 months after delivery.

16 147. MDHHS maintains personal data of Medicaid enrollees through Bridges, MDHHS'
17 integrated eligibility system, and the MDHHS Data Warehouse, a statewide database with
18 information pertinent to the programs administered by MDHHS, including eligibility information.
19 Michigan Medicaid enrollees' personal data is available to CMS through T-MSIS.

20 ***Minnesota***

21 148. Minnesota's Medicaid program, Medical Assistance, provides low-income
22 individuals with comprehensive healthcare coverage and access to affordable, integrated, high-
23 quality healthcare at no or low cost. The Minnesota Department of Human Services (MDHS),
24 through its Health Care Administration, is the single state agency responsible for administering
25 Minnesota's Medicaid program, which is known as Medical Assistance. Today, Medical
26 Assistance provides health coverage for over one million Minnesotans, or approximately one in
27 every five state residents. MDHS administers federally funded emergency Medicaid benefits that
28 provide emergency care and services to individuals regardless of their immigration status.

1 149. MDHS works to ensure that eligibility determinations are made correctly, including
2 by ensuring that only individuals who are eligible for federally funded Medicaid are billed to the
3 federal government.

4 150. MDHS has an agreement with CMS and DHS to use the federal SAVE database to
5 verify individuals' citizenship or immigration status to determine eligibility for federally funded
6 Medicaid.

7 151. MDHS routinely shares protected health information concerning Minnesotans and
8 their use of Medicaid healthcare services with CMS. MDHS sends data to T-MSIS each month.
9 This data contains sensitive, personally identifiable information about all MDHS enrollees.
10 MDHS also routinely responds to CMS requests for additional information, including audits,
11 concerning Medicaid claims and the use of federal dollars.

12 152. On June 6, 2025, CMS sent an email to MDHS stating that it was requesting
13 information to confirm Minnesota was not applying federal funding unlawfully for individuals
14 with unsatisfactory immigration statuses. The email did not cite any specific evidence or
15 concerns about improper use of federal dollars. The email requested that MDHS respond with
16 sensitive, personally identifiable information about all MDHS enrollees by July 30, 2025.

17 153. MDHS also administers MinnesotaCare, which provides comprehensive healthcare
18 coverage for uninsured Minnesota residents who are not eligible for Medical Assistance and have
19 income at or below 200% of the Federal Poverty Guidelines. Minnesota has elected to use state-
20 only funds to provide a version of MinnesotaCare coverage to all eligible state residents up to the
21 age of 18, regardless of their immigration status.

22 *Nevada*

23 154. Nevada's Division of Health Care Financing and Policy (DHCFP) works in
24 partnership with CMS to assist in providing quality medical care for eligible individuals and
25 families with low incomes and limited resources. The Medicaid program in Nevada is authorized
26 to operate under DHHS and DHCFP per Nevada Revised Statutes (NRS) Chapter 422.

27 155. Nevada's Medicaid program provides health care coverage for many people including
28 low-income families with children whose family income is at or below 133% percent of poverty,

1 Supplemental Security Income (SSI) recipients, certain Medicare beneficiaries, and recipients of
2 adoption assistance, foster care and some children aging out of foster care. The DHCFP also
3 operates five Home or Community-Based Services waivers offered to certain persons throughout
4 the state. The Division of Welfare and Supportive Services (DWSS) determines eligibility for the
5 Medicaid program. Nevada Check Up provides health care benefits to uninsured children from
6 low-income families who are not eligible for Medicaid but whose family income is at or below
7 200% of the Federal Poverty Level.

8 156. The Medicaid Services Manual (MSM) along with the Medicaid Operations Manual
9 (MOM) is the codification of regulations adopted by Nevada Medicaid based on the authority of
10 NRS 422.2368, following the procedure at NRS 422.2369.

11 157. MSM Chapter 100.2 provides that “all individuals have the right to a confidential
12 relationship with DHCFP. All information maintained on Medicaid and CHIP applicants and
13 recipients (“recipients”) is confidential and must be safeguarded.” DHCFP, Medicaid Services
14 Manual, p 5. “Disclosures of identifiable information are limited to purposes directly related to
15 State Plan administration.” *Id.* at p 6. Further, “[e]xcept as otherwise provided in these rules, no
16 person shall obtain, disclose, use, authorize, permit, or acquiesce the use of any client information
17 that is directly or indirectly derived from the records, files, or communications of DHCFP, except
18 for purposes directly connected with the administration of the Plan or as otherwise provided by
19 federal and state law.” *Id.* at 7.

20 *New Jersey*

21 158. New Jersey’s Medicaid program is operated by the New Jersey Department of Human
22 Services (NJ DHS). NJ DHS provides healthcare coverage for approximately 1.9 million residents
23 in New Jersey.

24 159. NJ DHS maintains personal data of Medicaid enrollees, including eligibility
25 information. New Jersey Medicaid enrollees’ personal data is available to CMS through the T-
26 MSIS system.

27 160. NJ DHS additionally routinely provides CMS with data in response to Medicaid
28 supplemental reviews and audits for federal oversight purposes.

1 *New Mexico*

2 161. New Mexico's Medicaid program provides healthcare coverage for approximately
3 840,000 New Mexicans, over 40% of the state population. In New Mexico, full-scope Medicaid
4 gives beneficiaries access to primary and preventive care, dental health care, inpatient and
5 outpatient hospital treatment, prescription drugs, behavioral health care, home health care, and
6 other vital services.

7 162. In addition, New Mexico funds more limited scope healthcare programs that offer
8 more targeted services to specific populations. For example, New Mexico provides access to
9 family planning services, including contraceptives and reproductive health exams, under the
10 state's Family Planning Program; and helps low-income New Mexicans who qualify for Medicare
11 with out-of-pocket costs, such as premiums, deductibles, and co-insurance.

12 163. New Mexico also administers federally and state-funded emergency Medicaid
13 benefits that provide emergency care and services to individuals regardless of their immigration
14 status.

15 164. The New Mexico Medicaid program is administered by the New Mexico Health Care
16 Authority (HCA), a state agency.

17 165. New Mexico's HCA works diligently to ensure that Medicaid eligibility
18 determinations are made correctly and that claims billed to the federal government cover only
19 individuals and services eligible for federally funded Medicaid. The state agency has an
20 agreement with CMS and DHS to use the federal SAVE database to verify individuals' eligibility
21 for federally funded Medicaid.

22 166. New Mexico's HCA sends data to T-MSIS each month. This data contains sensitive,
23 personally identifiable information about all Medicaid enrollees.

24 167. New Mexico's HCA also routinely responds to CMS requests for supplemental
25 review of reports required to determine the amount of FFP to which the State is entitled, and other
26 program audit and oversight functions.

1 168. For instance, because New Mexico receives an enhanced FMAP, the state is required
2 by federal law to provide detailed enrollee data that is “necessary for program integrity, program
3 oversight, and administration.” 42 C.F.R. § 438.818.

4 ***New York***

5 169. New York’s Medicaid program provides health coverage to approximately 7 million
6 low-income New Yorkers. New York has elected to use state-only funds to provide Medicaid
7 health coverage to certain New Yorkers aged 65 and over and postpartum care for 12 months to
8 pregnant individuals, regardless of their immigration status. In addition, New York administers
9 federally funded emergency Medicaid benefits that provide emergency care and services to
10 individuals regardless of their immigration status as well as prenatal care up to labor and delivery
11 for pregnant individuals, regardless of their immigration status.

12 170. The New York State Department of Health (NYSDOH) works diligently to ensure
13 that Medicaid eligibility determinations are made correctly, and that claims billed to the federal
14 government cover only individuals and services eligible for federally funded Medicaid.

15 171. NYSDOH routinely shares protected health information concerning New Yorkers and
16 their use of Medicaid healthcare services with CMS. NYSDOH sends data to T-MSIS on a
17 regular basis, and also responds to occasional CMS requests for additional information
18 concerning Medicaid claims and the use of federal dollars.

19 ***Oregon***

20 172. The Oregon Health Authority (OHA) is the designated state agency responsible for
21 administering Oregon’s Medicaid program. ORS 413.032(1)(e). OHA’s mission is to “transform
22 the health care system in Oregon by: improving the lifelong health of people in Oregon;
23 increasing the quality, reliability, and availability of care for all people in Oregon; and lowering
24 or containing the cost of care so it’s affordable to everyone.”

25 173. OHA operates the Oregon Health Plan (OHP), Oregon’s Medicaid program regulated
26 by the U.S. Department of Health and Human Services. This program is jointly funded by both
27 state and federal dollars, though at different rates.

1 174. Oregon has also elected to use state-only funds to extend OHP coverage to all state
2 residents who meet income and other criteria regardless of their immigration status.

3 175. Oregon has significantly invested in outreach and enrollment for OHP. For example,
4 OHP certifies a network of community partners that includes approximately 300 organizations
5 and around 1,500 application assisters across Oregon. Among other things, community partners
6 provide culturally and linguistically responsive outreach and health coverage application
7 assistance.

8 176. OHA works to ensure that eligibility determinations are made correctly, including by
9 ensuring that only individuals who are eligible for federally funded Medicaid are billed to the
10 federal government.

11 177. OHA has an agreement with CMS and DHS to use the federal SAVE database to
12 verify individuals' eligibility for federally funded Medicaid.

13 178. OHA sends data to T-MSIS each month. This data contains sensitive, personally
14 identifiable information about all OHP enrollees.

15 179. OHA also routinely responds to CMS requests for supplemental review of reports
16 required to determine the amount of FFP to which the State is entitled as well as other program
17 audit and oversight functions.

18 180. On June 6, 2025, CMS sent an email to OHA stating that it would be "reviewing
19 claims for FFP submitted by the state to ensure that only claims for FFP that meet all applicable
20 statutory requirements for individuals without a satisfactory immigration status are included
21 within the state's Form CMS-64 submissions." The email did not cite any new evidence or new
22 concerns about improper use of federal dollars. The email requested that OHA respond with
23 certain specified data by July 30, 2025.

24 181. On June 26, 2025, OHA staff met with CMS staff to discuss the information CMS
25 requested and the purpose of its review. In that meeting, CMS staff confirmed that they intend to
26 combine any data OHA provides in response to the June 6, 2025 request with data OHA has
27 already submitted through T-MSIS. Combining these data sources will make it easier to
28 determine both the identity and immigration status of OHP members. When asked whether CMS

1 would transfer these data to DHS, CMS staff indicated they would confer with their leadership
2 and provide an answer in a subsequent communication. As of the date of this Complaint, CMS
3 has not provided a response.

4 ***Rhode Island***

5 182. Rhode Island's Medicaid program provides health coverage to more than 300,000
6 Rhode Islanders. Rhode Island has elected to use state-only funds to provide Medicaid coverage
7 to all children (individuals up to nineteen (19) years of age), regardless of their immigration
8 status. Rhode Island also extends Medicaid coverage to pregnant people who otherwise meet
9 requirements for Medicaid, regardless of their immigration status. In addition, Rhode Island
10 administers federally funded Medicaid benefits that provide coverage for individuals that require
11 treatment for an emergency health condition regardless of their immigration status.

12 183. The Rhode Island Executive Office of Health & Human Services (RI EOHHS) serves
13 as the Single State Agency for Medicaid. RI EOHHS has delegated authority to the Rhode Island
14 Department of Human Services (RI DHS) to determine Medicaid eligibility. RI EOHHS and RI
15 DHS work to ensure that Medicaid eligibility determinations are made correctly, and that claims
16 billed to the federal government cover only individuals and services eligible for federally funded
17 Medicaid.

18 184. RI DHS uses an integrated eligibility system known as RIBridges to determine
19 eligibility for various benefit programs, including Medicaid. RI EOHHS routinely shares
20 Medicaid data containing personally identifiable, protected health information with CMS. RI
21 EOHHS sends data to T-MSIS on a routine basis and routinely responds to CMS requests for
22 additional information concerning Medicaid claims and the use of federal funds.

23 ***Vermont***

24 185. Vermont's Medicaid program is operated by the Department of Vermont Health
25 Access (DVHA) within the Vermont Agency of Human Services. The mission of DVHA is "to
26 improve Vermonters' health and well-being by providing access to high-quality, cost-effective
27 health care."
28

186. In limited circumstances and consistent with federal law, undocumented noncitizens who live in Vermont are eligible for Medicaid coverage. For example, Vermont residents—regardless of immigration status—are eligible for Emergency Services Only Medicaid, which covers emergency medical services. Vermont also provides coverage to legal resident non-citizen children and teenagers under age 19 and pregnant women through the Dr. Dynasaur program.

187. Vermont regularly shares protected health information concerning Vermonters and their use of Medicaid healthcare services with CMS. DVHA sends data to T-MSIS and also routinely responds to CMS requests for additional information concerning Medicaid claims and the use of federal dollars.

188. Vermont shares this protected health information with the understanding that it is being safeguarded by CMS rules and procedures designed to protect data privacy and security, and that this data is only being used to administer Medicaid benefits and to further the healthcare goals and priorities of the Medicaid program.

Washington

189. In Washington State, the Health Care Authority (“Washington HCA”) administers the Medicaid program, the Children’s Health Insurance Program, and other healthcare programs under the umbrella term “Apple Health.” The Washington Legislature designated Washington HCA as the “single state agency” for purposes of the Medicaid program. *See* Wash. Rev. Code § 74.09.530(1)(a). HCA is responsible for assuring the federal Centers for Medicare and Medicaid Services (“CMS”) that the state will comply with federal Medicaid law.

190. There are more than 1.9 million Apple Health clients in Washington, including about 49,000 whose immigration status makes them ineligible for federal programs. Apple Health covers a range of healthcare services, including inpatient and outpatient hospital care, primary and preventative care, long-term services and supports, and behavioral health. Each year, Washington HCA receives nearly \$70 million from CMS for emergency medical services provided to clients who are “not qualified” noncitizens.

191. In 2023, the Washington Legislature directed Washington HCA to create a new program for certain individuals who are not eligible for Medicaid because of their immigration

1 status. *See* Engrossed Substitute Senate Bill (“ESSB”) 5187, § 211(83). The Legislature
2 appropriated about \$45.6 million of state funds to Washington HCA for the program for state
3 fiscal year (“SFY”) 2025. HCA named the program “Apple Health Expansion.” The Legislature
4 directed that the program provide services comparable to the “categorically needy” Medicaid
5 program. In 2024, the Legislature increased the budget for the program to about \$71 million for
6 SFY 2025. *See* ESSB 5950, § 211(82). In 2025, the Legislature appropriated about \$71.3 million
7 for the program for SFY 2026 and about \$70.9 million for SFY 2027. *See* ESSB 5167, § 211(52).

8 192. In creating Apple Health Expansion, Washington HCA adopted a managed care
9 delivery system, for the purpose of facilitating whole-person care to enrollees and for ease of
10 administration. Washington HCA entered into contracts with four managed care organizations
11 (“MCOs”), also called “health plans,” who are responsible for ensuring the provision of
12 healthcare services to Apple Health Expansion enrollees. Washington HCA also includes
13 emergency services funded by CMS in this managed care model, again to facilitate whole-person
14 care and for ease of administration.

15 193. The Apple Health Expansion program began offering services to enrollees as of July
16 1, 2024, through the MCO contracts. This was preceded by many months of meetings with
17 advocacy groups and other stakeholders, for the purpose of helping to define the parameters of
18 the program, encouraging outreach to potential enrollees, and creating rules under the
19 Washington Administrative Code.

20 194. Washington HCA, through a contractor known as Acentra, sends data to the federal
21 government’s T-MSIS system each month, using a secure portal. This data contains sensitive,
22 personally identifiable information about all Apple Health enrollees. Washington HCA’s most
23 recent submission of T-MSIS data occurred on or around May 27, 2025.

24 195. Washington HCA routinely responds to CMS requests for supplemental review of
25 reports required to determine the amount of FFP to which the State is entitled, and other program
26 audit and oversight functions.

27 196. On March 31, 2025, CMS sent Washington HCA an email requesting information the
28 agency stated was necessary to confirm Washington was not applying federal funding unlawfully

1 for individuals with unsatisfactory immigration statuses. This request was represented to
 2 Washington HCA as a routine audit in line with previous requests for information made to
 3 Washington HCA from CMS. Nothing in the request indicated that CMS would share this
 4 information outside HHS.

5 197. Washington HCA responded to CMS’s information request, as it would for other
 6 routine audits of Washington HCA. Nothing indicated that CMS planned to use this information
 7 for anything other than routine auditing consistent with the agency’s statutory authority to
 8 administer the Medicaid program.

9 198. Washington HCA learned through media reporting on June 13, 2025, that CMS had
 10 apparently, and improperly, transferred confidential data regarding its Apple Health clients to the
 11 Department of Homeland Security (“DHS”). On June 24, 2025, Washington HCA sent a letter to
 12 CMS seeking information on this reported data transfer. As of the date of this filing, Washington
 13 HCA has not received a response.

14 ***All Plaintiff States***

15 199. In all of the sharing of protected health information described above, the States have
 16 relied upon CMS rules, procedures, and practices designed to protect data privacy and security,
 17 and the understanding that this data is only being used to administer Medicaid benefits and to
 18 further the healthcare goals and priorities of the Medicaid program.

19 200. This policy and practice has been communicated to the public as well. For example,
 20 in its online privacy policy statement, CMS promises Medicaid enrollees and their family
 21 members that the agency is “committed to keeping your personal information safe with the
 22 highest level of privacy protections possible,” including “only sharing information with people
 23 who need to know.” CMS further assures the public that it will “tell you before we collect any
 24 personal information we need to run our health care programs, and only use it for that purpose.”⁴

25
 26
 27
 28 ⁴ CMS Privacy Home Page (last checked June 26, 2025), <https://www.cms.gov/about-cms/information-systems/privacy>.

II. Federal Actions Undermining Privacy, Security, and Confidentiality of Medicaid Data

201. Through a series of federal executive actions, the federal government has—without formal acknowledgment—dramatically changed its policy and practice of keeping personal Medicaid data private and refraining from weaponizing healthcare data and systems for immigration and other federal policy purposes.

202. In early February, CMS confirmed reports in the Wall Street Journal that DOGE representatives were accessing CMS systems and technology.⁵

203. On February 19, 2025, President Trump signed an Executive Order titled “Ending Taxpayer Subsidization of Open Borders.” Exec. Order No. 14,218, 90 Fed. Reg. 10,581 (Feb. 19, 2025) (hereinafter the “Borders EO”). It purported to give DOGE new authority to “enhance eligibility verification systems” for public benefits.

204. On February 28, 2025, HHS announced it was abandoning a long-time memorandum, referred to as the “Richardson Waiver,” pursuant to which HHS had previously committed to (1) follow the notice-and-comment rulemaking procedures in the Administrative Procedure Act (APA) for most rules issued by HHS; and (2) invoke the APA’s good-cause exception to public rulemaking only “sparingly.” HHS, Policy on Adhering to the Text of the Administrative Procedure Act, 90 Fed. Reg. 11,029 (Mar. 3, 2025).

205. On March 20, 2025, President Trump signed an Executive Order titled “Stopping Waste, Fraud, and Abuse by Eliminating Information Silos,” which calls on agencies to “remov[e] unnecessary barriers,” including rescission or modification of existing agency guidance, to ensure “unfettered access to comprehensive data from all State programs” in

⁵ See Anna Wild Mathews & Liz Essley Whyte, *DOGE Aides Search Medicare Agency Payment Systems for Fraud*, (Feb. 5, 2025), <https://www.wsj.com/politics/elon-musk-doge-medicare-medicaid-fraud-e697b162>; CMS, *CMS Statement on Collaboration with DOGE*, <https://www.cms.gov/newsroom/press-releases/cms-statement-collaboration-doge> (Feb. 5, 2025); Riley Griffin & Madison Muller, *Musk’s DOGE Team Mines for Fraud at Medicare, Medicaid*, (Feb. 5, 2025), <https://www.bloomberg.com/news/articles/2025-02-05/musk-s-dogeteam-mines-for-fraud-at-medicare-and-medicaid-agency>; Alan Condon, *DOGE Sets Sights on Medicaid*, New York Times (Feb. 3, 2025) (noting that DOGE has been provided access to key payment and contracting systems at CMS).

1 furtherance of the Administration’s goals. Exec. Order No. 14243, 90 Fed. Reg. 13,681 (Mar. 20,
 2 2025) (hereinafter the “Information Silos EO”). The Executive Order does not—and cannot—
 3 excuse agencies from acting “consistent with law.” *Id.*

4 206. In a May 27, 2025, announcement to California and other states, CMS stated that it
 5 was reviewing state Medicaid enrollees to ensure that federal funds had not been used to pay for
 6 coverage of people with “unsatisfactory immigration status” (UIS). This letter was purportedly
 7 an implementation of the February 19 Borders EO. Nothing in the letter mentioned interagency
 8 data sharing.

9 207. Around this same time, multiple media outlets reported that DOGE had enlisted the
 10 technology company Palantir to build a massive repository of data pulled from multiple federal
 11 agencies, including the IRS, SSA, and HHS, among others, for the purpose of immigration
 12 enforcement.⁶ It has also been reported that DHS and HHS have already adopted a key Palantir
 13 product called Foundry, which would streamline the implementation of such a project.⁷

14 208. On June 13, 2025, the Plaintiffs learned that HHS has transferred *en masse* California,
 15 Illinois, and Washington’s Medicaid data files, containing personal health records representing
 16 millions of individuals, to DHS.⁸ According to a news report, senior HHS political appointees
 17 ordered that the data be shared immediately, over the objections of career staff who advised that
 18 such a transfer of information would violate federal law, and CMS officials were given just 54
 19 minutes to comply with the directive. This data was personally identifiable, not anonymized or
 20 hashed, and it included Medicaid beneficiaries’ immigration status and addresses, among other
 21 details.

22
 23 ⁶ See Priscilla Alvarez, et al., *DOGE is Building a Master Database for Immigration*
Enforcement, Sources Say, CNN (April 25, 2025),
 24 <https://www.cnn.com/2025/04/25/politics/doge-building-master-database-immigration>; Makena
 Kelly & Vittoria Elliott, *DOGE Is Building a Master Database to Surveil and Track Immigrants*
 25 (April 18, 2025), <https://www.wired.com/story/doge-collecting-immigrant-data-surveil-track/>
⁷ See Sheera Frenkel & Aaron Krolic, *Trump Taps Palantir to Compile Data on Americans*, New
 26 York Times (May 30, 2025), [https://www.nytimes.com/2025/05/30/technology/trump-palantir-](https://www.nytimes.com/2025/05/30/technology/trump-palantir-data-americans.html)
 data-americans.html

27 ⁸ See Kimberly Kindy & Amanda Seitz, *Trump Administration Gives Personal Data of Immigrant*
Medicaid Enrollees to Deportation Officials, AP News (June 14, 2025),
 28 [https://apnews.com/article/medicaid-deportation-immigrants-trump-](https://apnews.com/article/medicaid-deportation-immigrants-trump-4e0f979e4290a4d10a067da0acca8e22?utm_source=copy&utm_medium=share)
 4e0f979e4290a4d10a067da0acca8e22?utm_source=copy&utm_medium=share.

1 209. CMS recently sent to some Plaintiff States additional requests for data concerning the
2 use of federal and state funds to provide Medicaid services to immigrant communities. In light of
3 recent news reports, these Plaintiff states are concerned that HHS is preparing to transfer a similar
4 collection of those states' Medicaid data files to DHS for the purpose of mass surveillance and
5 immigration enforcement.

6 210. HHS provided no warning or notice to California, Illinois, or Washington, or to the
7 Medicaid beneficiaries whose data was transferred. HHS has not identified the legal authority
8 under which it transferred this personal Medicaid data.

9 211. To date, HHS has not responded to inquiries from state Medicaid agencies requesting
10 confirmation of the data transfer and details about its scope or purpose.

11 212. An HHS spokesperson acknowledged to the Associated Press that the mass data
12 transfer had indeed occurred. HHS claimed that "HHS acted entirely within its legal authority—
13 and in full compliance with applicable laws," but without identifying any such authority. HHS
14 stated that the purpose of the data transfer was "to ensure that Medicaid benefits are reserved for
15 individuals who are lawfully entitled to receive them."

16 213. A DHS spokesperson also confirmed receipt of the mass personal Medicaid data
17 transfer from HHS. In its statement to the Associated Press, DHS claimed that "Joe Biden
18 flooded our country with tens of millions of illegal aliens," and that therefore "CMS and DHS are
19 exploring an initiative to ensure that illegal aliens are not receiving Medicaid benefits that are
20 meant for law-abiding Americans."

21 214. The DHS spokesperson's narrative that the number of persons residing unlawfully in
22 the United States increased by "tens of millions" during the Biden administration is not supported
23 by any evidence, nor is there evidence to support the implication that unauthorized residents are
24 engaged in some sort of theft of Medicaid benefits for which they are ineligible.

25 215. Despite Defendants' program integrity justifications, transfer of large amounts of
26 personal Medicaid information to DHS is unnecessary for administration of the Medicaid
27 program. HHS's disclosure of Medicaid personal data to DHS was far broader than would be
28 needed for the identification and prevention of waste, fraud, and abuse, and inconsistent with best

1 practices for such activities. HHS has never before enlisted DHS's participation in "oversight" of
2 the Medicaid program in such a manner.

3 216. To the extent that the federal government claims that DOGE needs vast quantities of
4 personal Medicaid data to upgrade technology or improve detection of waste, fraud, and abuse,
5 that justification is also not credible. Program integrity investigations typically start with access
6 to high-level, anonymized data based on the least amount of data the analyst or auditor would
7 need to know, and only if suspicious entries appear do auditors gain access to a limited amount of
8 more granular, non-anonymized data. This is consistent with FISMA's requirement as
9 promulgated by NIST that agencies "[e]mploy the principle of least privilege, allowing only
10 authorized accesses for users ... that are necessary to accomplish assigned organizational tasks."
11 NIST Special Publication 800-53 Revision 5 at 36.

12 217. Instead, upon information and belief, the federal government has adopted a new
13 policy that purports to allow for wholesale re-disclosure and use of State residents' personal
14 Medicaid data to pursue aims that are unrelated to Medicaid program administration, including
15 immigration enforcement. Put a different way, circumstantial evidence strongly suggests that the
16 federal government intends to punish individuals who receive emergency medical care for
17 themselves or their children using Medicaid, *as those individuals are legally permitted to do*, by
18 using the data collected from their hospital visit to locate and deport them.

19 218. Upon information and belief, the federal government has additional plans for this
20 data. DHS, with the assistance of DOGE and external entities, such as ICE contractor Palantir,
21 are combining federal, state, and local databases of information into a single interoperable
22 database for the purpose of "mass deportations" and other large-scale immigration enforcement
23 and mass surveillance purposes.⁹ This effort reportedly includes databases of personal
24 information that have never before been used for immigration enforcement or other purposes
25 unrelated to the agencies' primary missions. In addition to CMS, impacted federal agencies
26 reportedly include the Internal Revenue Service, the Supplemental Nutrition Assistance Program,

27 ⁹ See Muzaffar Chishti & Colleen Putzel-Kavanaugh, *Seeking to Ramp Up Deportations, the*
28 *Trump Administration Quietly Expands a Vast Web of Data*, Migration Policy Institute (May 29,
2025), <https://www.migrationpolicy.org/article/trump-ice-data-surveillance>.

1 the Social Security Administration, the U.S. Department of Housing and Urban Development, the
 2 U.S. Department of Veterans Affairs, the U.S. Education Department, and the U.S. Postal
 3 Service.¹⁰

4 219. Upon information and belief, DOGE engineers responsible for implementing these
 5 plans are handling sensitive HHS data, including data provided by Plaintiff States, “in a manner
 6 that disregards important cybersecurity and privacy considerations, potentially in violation of the
 7 law.”¹¹ For example, a letter sent by the ranking member of the House Oversight and
 8 Government Reform Committee to the Social Security Administration (SSA) included
 9 whistleblower allegations that “DOGE engineers have tried to create specialized computers for
 10 themselves that simultaneously give full access to networks and databases across different
 11 agencies. Such a system would pose unprecedented operational security risks and undermine the
 12 zero-trust cybersecurity architecture that prevents a breach at one agency from spreading across
 13 the government. Information obtained by the Committee also indicates that individuals
 14 associated with DOGE have assembled backpacks full of laptops, each with access to different
 15 agency systems, that DOGE staff is using to combine databases that are currently maintained
 16 separately by multiple federal agencies.” If true, these allegations represent a shocking misuse of
 17 data provided by the Plaintiff States that illegally puts the security and integrity of that data at
 18 risk. Plaintiff States’ concerns about the security of their data are well-founded given other
 19 whistleblower testimony reporting that DOGE’s databases are being targeted for infiltration by
 20 foreign hackers.¹²

21
 22 ¹⁰ *Id.*

23 ¹¹ Letter from Ranking Member Gerald E. Connolly, House Committee on Oversight and
 24 Government Reform, to SSA Assistant Inspector General for Audit Michelle L. Anderson (Apr.
 25 17, 2025), <https://oversightdemocrats.house.gov/sites/evo-subsites/democrats-oversight.house.gov/files/evo-media-document/2025-04-17.gec-to-ssa-oig-master-data.pdf>; *see also* Natalie Alms, *DOGE is Building a “Master Database” of Sensitive Information, Top Oversight Democrat Says*, NextGov/FCW (Apr. 18, 2025), <https://www.nextgov.com/digital-government/2025/04/doge-building-master-database-sensitive-information-top-oversight-democrat-says/404693/>.

27 ¹² *See* Letter from Whistleblower Aid Chief Legal Counsel Andrew P. Bakaj to Senate Select
 28 Committee on Intelligence Chairman Tom Cotton (Apr. 14, 2025), [2025_0414_Berulis-Disclosure-with-Exhibits.s.pdf](https://www.nextgov.com/digital-government/2025/04/doge-building-master-database-sensitive-information-top-oversight-democrat-says/404693/).

1 220. Defendants initiated the personal Medicaid data transfer “just as the Trump
2 administration was ramping up its immigration enforcement efforts in Southern California.”
3 Order Granting TRO, ECF No. 64, *Newsom v. Trump*, No. 25-cv-04870 (N.D. Cal., June 12,
4 2025).

5 221. Defendants have not published a new SORN or other notice in the Federal Register
6 relating to this change in practice, depriving Plaintiffs, and members of the public of information
7 such as planned routine uses of this system of records, and the opportunity for comment.

8 222. Defendants have not withdrawn or revised any of their statements and policies to the
9 States and members of the public advising that Medicaid data containing personal and protected
10 information shall only be used for purposes of administration of the Medicaid program.

11 223. Upon information and belief, Defendants’ rushed transfer of this data from HHS to
12 DHS over the objections of career staff, who reportedly questioned whether the transfer violated
13 federal law and ethics, raises concerns that Defendants failed to comply with FISMA’s
14 requirements concerning controls and limitations on access to and transfer of secure information,
15 as well as CMS policies and procedures promulgated to comply with FISMA and protect the
16 privacy, security and integrity of sensitive government data.

17 224. Even if Defendants had published a SORN describing immigration enforcement and
18 mass surveillance as intended uses for the collected Medicaid data, the Privacy Act would
19 nonetheless prohibit them from using the data for such purposes, because immigration
20 enforcement and mass surveillance are not compatible with the purpose for which the data was
21 collected—to administer the Medicaid program.

22 225. Upon information and belief, in making their decision to change longstanding policy
23 and transfer mass quantities of personal Medicaid data from HHS to DHS, Defendants have failed
24 to consider or grapple with the clear negative ramifications (described in paragraphs 226-254
25 below) of allowing DHS unfettered access to sensitive health records.

26
27
28

III. Defendants' Actions Will Cause Harm

a. Defendants Actions Will Interfere with State Medicaid Programs

226. In the absence of the requested relief, Defendants' actions will cause serious, irreparable harm to Plaintiff States and their Medicaid programs.

227. Defendants' actions imminently and irreparably threaten Plaintiffs' sovereign interests by interfering with State authority to administer the Medicaid program, and reducing the State's ability to access federal support for that program as Congress has authorized.

228. As California's state legislature has explained, "[a] relationship of trust between California's immigrant community and state and local agencies is central to the public safety of the people of California," and this "trust is threatened when state and local agencies are entangled with federal immigration enforcement, with the result that immigrant community members fear [...] seeking basic health services [...] to the detriment of public safety and the well-being of all Californians." Cal. Gov't. Code § 7284.2(c).

229. In administering their Medicaid and other healthcare programs, the States have relied on the federal government's assurances that it will follow the law and protect confidentiality. This includes the States' provision of federally funded Medicaid for health emergencies and childbirth to millions of patients who would otherwise not be Medicaid eligible. Defendants' actions undermine those reliance interests and interfere with the terms and conditions under which the States have agreed to operate their Medicaid programs.

230. Patients, in turn, have also relied on the government's representations of confidentiality. Individuals provide the most sensitive data to the States through the Medicaid program, because they trust that neither the State nor the federal government will use that protected health information for any purpose other than the administration of the program, as required by federal law. *See* 42 U.S.C. § 1306(a); 42 C.F.R. § 401.101(b).

231. If CMS is permitted to transfer participants' Medicaid data to DHS for general immigration enforcement purposes, that trust will likely be irreparably damaged, especially for the families (including U.S. citizens) of undocumented immigrants, who risk deportation as a result of lawfully seeking Medicaid coverage for emergency medical treatment.

232. As a result, Defendants’ mass transfer of sensitive Medicaid data will cause a predictable chilling effect on individuals’ willingness to enroll in Medicaid programs for which they are legally eligible. This chilling effect will be most acute among marginalized groups, such as: immigrants, transgender individuals, people with mental illness, and those seeking of reproductive and gender affirming care.

233. Already, advocates who advise noncitizens are recommending that individuals and families balance the value of seeking healthcare against the possible risks that their information may be shared with ICE for immigration enforcement purposes.

234. Many residents of the States are likely to avoid enrolling in healthcare programs for which they are eligible as a result of CMS’s data sharing with DHS, fearing their data will be used to initiate immigration enforcement actions against them or their family members. This includes both undocumented immigrants, who are legally entitled to Medicaid coverage for emergency medical services including childbirth, and legal residents, who reasonably fear that DHS will initiate immigration enforcement actions against them, given this administration’s track record of haphazard and error-prone immigration enforcement.¹³

235. As a result of CMS sharing personal information with DHS, uninsured immigrants will be more likely to avoid going to the emergency room or calling an ambulance to seek life-saving treatment—for themselves or for their children—for fear that doing so will make them a target for deportation.

236. Indeed, the public reporting of data sharing between CMS and DHS has already caused widespread confusion and fear that Medicaid data will be used to locate and target immigrants for deportation.

237. This fear is well-founded. DHS has rescinded a longstanding directive that had prohibited ICE from conducting immigration enforcement operations at “sensitive locations” such as hospitals and clinics. The administration has been outspoken about its goal of aggressive

¹³ See, e.g., Kyle Cheney, *Trump Administration Acknowledges Another Error in a High Profile Deportation*, Politico (May 16, 2025), <https://www.politico.com/news/2025/05/16/trump-administration-another-error-high-profile-deportation-00355377>.

immigration enforcement, promising “millions and millions of deportations.”¹⁴ Between January and April of this year, ICE has deported over 142,000 U.S. residents, at least 25% of whom had no convictions or pending criminal charges.¹⁵ Despite this aggressive enforcement campaign, news outlets have reported that the administration is still unhappy with the pace of deportation numbers, and ICE is under pressure from the President to arrest 1,200-3,000 people per day.¹⁶

238. Exacerbating the fear of deportation among immigrants is the fact that, under this administration, “deportation” no longer necessarily means being sent back to one’s home country. For example, DHS has “deported” nearly 300 U.S. residents to a Centre for Terrorism Confinement (CECOT) prison in El Salvador,¹⁷ including at least one individual who was mistakenly “deported,” despite being legally present in the United States.¹⁸ This has prompted the United Nations High Commissioner to call for changes in U.S. policy to avoid serious human rights concerns, including the risk of “torture or other irreparable harm” that may be suffered at CECOT.¹⁹ The administration has also announced that an undisclosed number of U.S. residents are now being detained at Guantanamo Bay due to immigration enforcement efforts.²⁰

239. Healthcare providers, including the California Medical Association, warn that the federal government’s failure to adhere to patient privacy protections and misuse of Medicaid data for immigration enforcement purposes will make people less likely to seek medically necessary healthcare.²¹

¹⁴ See, e.g., Rebecca Santana et al., *Trump Rolls Out His Blueprint on Border Security, But His Orders Will Face Challenges*, AP NEWS (Jan. 20, 2025), <https://apnews.com/article/trump-deportation-immigration-homan-asylum-inauguration-ac10480dc636b758ab3c435b974aeb19>.

¹⁵ Dep’t of Homeland Security Press Release, “100 Days of Making America Safe Again (April 29, 2025) <https://www.dhs.gov/news/2025/04/29/100-days-making-america-safe-again>.

¹⁶ See Welker, Kristen et al., Trump is ‘Angry’ that Deportation Numbers are not Higher, (Feb. 7, 2025), <https://www.nbcnews.com/politics/national-security/trump-angry-deportation-numbers-are-not-higher-rcna191273>.

¹⁷ See Dep’t of Homeland Security Press Release, *supra*, n. 15.

¹⁸ See *Id.*; Bustillo, Ximena, *Trump Administration Admits Maryland Man Sent to El Salvador Prison By Mistake*, NPR (April 1, 2025) <https://www.npr.org/2025/04/01/nx-s1-5347427/maryland-el-salvador-error>.

¹⁹ UN News, *US Deportations Raise Serious Human Rights Concerns*, (May 13, 2025) <https://news.un.org/en/story/2025/05/1163181#:~:text=13%20May%202025%20Human%20Rights,to%20El%20Salvador%20remain%20unclear>.

²⁰ See Dep’t of Homeland Security Press Release, *supra*, n. 15.

²¹ See Kristen Hwang, *Gov. Newsom Lambasts Trump for Giving Immigrants’ Health Data to Deportation Officials*, CalMatters (June 13, 2025), <https://calmatters.org/health/2025/06/newsom-trump-immigrant-data-deportation-medicaid/>.

1
2 **b. Chilling Effects on Public Health Program Participation Will Cause Further Harm**

3 240. The chilling effects caused by Defendants' actions will, in turn, harm both State
4 finances, operation of State programs, and the public health.

5 241. Individuals who are eligible for federally funded Medicaid but choose not to apply
6 due to concerns about data security and privacy will reduce the amount of federal funding with
7 which the State can provide healthcare to its residents. This will cause direct financial harm to
8 the States, which otherwise receive 50 percent or more in federal matching funds for qualified
9 Medicaid expenditures, including emergency Medicaid.

10 242. Instead of securing federal funding for providing healthcare services to otherwise
11 Medicaid-eligible individuals, Plaintiffs will incur increased uncompensated costs for hospital
12 care in which a treatment or service is not paid for by an insurer or patient, yet is still mandated to
13 be provided by EMTALA.

14 243. This economic harm will be particularly acute for those hospitals and other healthcare
15 facilities that serve a disproportionate share of low-income individuals and noncitizens. Such
16 facilities already operate on thin margins. If public funding drops, and uncompensated care rises,
17 these hospitals will be less able to serve all patients in need.

18 244. In the absence of requested relief, State healthcare providers (including those
19 facilities owned and operated by the State and its political subdivisions) will also face increased
20 administrative costs and burdens, as they will need to devote considerable time and resources to
21 educating frontline and clinical staff regarding new patient privacy risks and rebuilding trust and
22 overcoming objections resulting from confusion and fear.

23 245. To the extent Defendants' actions chill noncitizens and individuals in mixed-status
24 families from accessing publicly funded health insurance options for which they are eligible, this
25 will result in their being more likely to defer primary or preventive healthcare. Deferred care
26 leads to more complex medical conditions in the future that are more expensive to treat.

1 246. This chilling effect will have dire health consequences. Not seeking emergency
2 medical care when it is needed is likely to cause serious health consequences, and even death, not
3 only for undocumented immigrants but also for their children, regardless of immigration status.

4 247. For example, those chilled from accessing federally funded emergency Medicaid for
5 prenatal care will be more likely to experience adverse health effects during pregnancy and
6 childbirth. Decreased access to prenatal care will lead to increased rates of premature births, low
7 birth weight infants, and congenital defects, all of which produce considerable harm to Plaintiffs,
8 in addition to worse health outcomes for the child and parent. The average medical cost to
9 Plaintiffs in the first year of life of a premature or low birth weight baby is up to 10 times higher
10 than the cost of a full-term baby.

11 248. Overall, Defendants' actions will push more people into the ranks of the uninsured,
12 straining the budgets of state, local, and private health systems and programs.

13 249. As the primary funder for all their low-income residents' healthcare services,
14 Plaintiffs' publicly funded healthcare programs will ultimately bear the cost of both financial
15 pressure on safety net providers and the increased public health harms.

16 250. In addition, to the extent Defendants' actions make noncitizens and other individuals
17 more reluctant to enroll in federally-funded health care programs, Plaintiffs will incur greater
18 costs and burdens to conduct statutorily-required outreach efforts to enroll families and children
19 in those federally-funded programs. *See, e.g.*, 42 U.S.C. § 1397bb.

20 251. Defendants' actions will also make noncitizens and other individuals more reluctant
21 to enroll in fully state-funded public health insurance programs, undermining the efficacy of those
22 programs.

23 252. Moreover, the States also have a quasi-sovereign interest in protecting the safety and
24 well-being of their residents. This interest is particularly strong when it comes to emergency
25 Medicaid, which includes childbirth.

26 253. Defendants' actions will undermine the progress the States have made as a result of
27 Medicaid expansion, which has helped in reducing rates of individuals without health insurance
28

1 to historic lows. For example, in California, 96 percent of children now have private or public
2 health insurance.

3 254. While Plaintiffs do not seek to assert the States' residents' own interests in this
4 litigation, those interests are considerable. All residents have a right to access emergency medical
5 care. Those who already received federally funded emergency Medicaid face irreparable harm to
6 their privacy interests if Medicaid information and other PII is improperly accessed or
7 disseminated. Going forward, individuals and families will be forced to choose between those
8 privacy interests and accessing emergency healthcare services for which they are eligible under
9 both federal and state law.

10 CLAIMS

11 FIRST CAUSE OF ACTION

12 Violation of the APA – Arbitrary and Capricious

13 255. Plaintiffs reallege and incorporate by reference the foregoing allegations as fully set
14 forth herein.

15 256. The Administrative Procedure Act directs courts to hold unlawful and set aside
16 agency actions that are found to be arbitrary, capricious, an abuse of discretion, or otherwise not
17 in accordance with law. 5 U.S.C. § 706(2)(A).

18 257. HHS's decision to transfer Medicaid data containing protected health information to
19 other federal agencies, and DOGE and DHS's collection of that data, are "final agency action[s]
20 for which there is no other adequate remedy in a court," within the meaning of the APA. 5
21 U.S.C. § 704.

22 258. An agency action is arbitrary and capricious if the agency has "relied on factors
23 which Congress has not intended it to consider, entirely failed to consider an important aspect of
24 the problem, offered an explanation for its decision that runs counter to the evidence before the
25 agency, or is so implausible that it could not be ascribed to a difference in view or the product of
26 agency expertise." *Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*,
27 463 U.S. 29, 43 (1983).
28

259. Defendants failed to engage in reasoned decision-making as required by the APA. Among other deficiencies, Defendants failed to consider the important privacy and public health consequences of their unprecedented transfer and use of state Medicaid data. Defendants have failed to consider the impact their actions will have on their ability to fulfill the Medicaid Act's purpose of providing medical assistance to those in need.

260. Defendants additionally ignored substantial reliance interests in the federal government's well-established rules and policies regarding the privacy, security, and confidentiality of personal Medicaid healthcare data.

261. Although Defendants may change their policies within statutory limits, the agency must "provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016). Defendants have not even provided notice of their change in policy, much less the necessary "satisfactory explanation" for their about-face on Medicaid confidentiality rules. *See State Farm*, 463 U.S. at 43.

262. Defendants' actions are arbitrary and capricious in violation of § 706(2)(A) of the APA.

SECOND CAUSE OF ACTION Violation of the APA, Contrary to Law

263. Plaintiffs reallege and incorporate by reference the foregoing allegations as fully set forth herein.

264. HHS's transfer of Medicaid data containing personal health information to other federal agencies, and DOGE and DHS's collection of that data, are "final agency action[s] for which there is no other adequate remedy in a court," within the meaning of the APA. *See* 5 U.S.C. § 704.

265. These final agency actions are unlawful, and should be set aside by the court, because they are not in accordance with law, *id.* § 706(2)(A); were taken "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right," *id.* § 706(2)(C); and fail to observe "procedure required by law," *id.* § 706(2)(D).

1 266. As set forth in paragraphs 56-66, *supra*, the Social Security Act provides, “[n]o
2 *disclosure* ... of any file, record, report, or other paper, or any information [...] shall be made
3 except as the head of the applicable agency may by regulations prescribe and except as otherwise
4 provided by Federal law.” 42 U.S.C. § 1306 (a)(1) (emphasis added); *see also* 42 U.S.C.
5 § 1306(a)(2) (applying this privacy provision to both HHS and the Social Security
6 Administration).

7 267. Far from authorizing this transfer of data, federal regulations caution that Medicaid
8 records should only be disclosed for “purposes directly connected with the administration” of the
9 State’s Medicaid plan. 42 C.F.R. § 431.300(a).

10 268. Immigration enforcement, population surveillance, or other similar federal policy
11 objectives are not permissible grounds for disclosure of Medicaid data.

12 269. Defendants’ actions contravene the Social Security Act and are therefore not in
13 accordance with law in violation of the APA.

14 270. Defendants’ actions also trespass federal statutes enacted to protect the privacy,
15 integrity, and security of data held by the government.

16 271. As set forth in paragraphs 67-78, *supra*, the Privacy Act sets strict procedural
17 requirements before an agency can create or revise a system of records and collect individuals’
18 data. 5 U.S.C. § 552a(e).

19 272. By collecting and transferring personal Medicaid data, without publishing a notice
20 required by 5 U.S.C. § 552a(e), Defendants failed to comply with the Privacy Act’s informational
21 and procedural requirements.

22 273. Additionally, Section 552a(b) of the Privacy Act further prohibits disclosure of
23 records from systems of records absent certain conditions.

24 274. Disclosure from HHS systems of records to DOGE or DHS employees would not
25 meet any of the conditions enumerated in 5 U.S.C. § 552a(b), and is therefore inconsistent with
26 the Privacy Act.

27 275. Specifically, disclosure of personal Medicaid data to agencies outside HHS for the
28 purpose of immigration enforcement is not “a purpose which is compatible with the purpose for

1 which [the data] was collected.” *Id.* § 552a(a)(7). Therefore, even if CMS and DHS have
2 published a SORN describing immigration enforcement as a “routine use,” the agencies would
3 nevertheless be in violation of the Privacy Act. *Id.* § 552a(b)(3); 5 U.S.C. § 552a(a)(7).

4 276. Defendants’ actions contravene the Privacy Act and are therefore not in accordance
5 with law in violation of the APA.

6 277. As set forth in paragraphs 79-82, *supra*, HIPAA limits the use and disclosure of
7 individuals’ protected health information, including information transferred from CMS, which is
8 covered entity under HIPAA, to DHS.

9 278. Upon information and belief, none of the impacted individuals consented to the
10 transfer of their Medicaid data, and CMS is neither expressly permitted nor required to transfer
11 records to DHS.

12 279. To the extent DHS provided a written request for the data, that request was not
13 sufficiently specific and limited in scope to qualify for HIPAA’s law enforcement exception.

14 280. Defendants’ actions contravene HIPAA and are therefore not in accordance with law
15 in violation of the APA.

16 281. As set forth in paragraphs 83-90, *supra*, to comply with FISMA, CMS has developed,
17 documented, and implemented an agency-wide program to provide information security for the
18 information and systems that support the operations and assets of the agency, including those
19 provided or managed by another agency, contractor, or other sources. CMS was required to do so to
20 comply with standards implementing FISMA set out by NIST.

21 282. Upon information and belief, by transferring Plaintiff States’ Medicaid data files to
22 DHS in a rushed manner and over the objections of career staff, Defendants likely failed to
23 comply with CMS’s own policies for complying with FISMA, and for sharing and protecting
24 sensitive data in a manner that ensures the security and integrity of that data.

25 283. Defendants’ actions violate privacy and data security law and are therefore in
26 violation of the APA because they are not in accordance with law, 5 U.S.C. § 706(2)(A), in
27 excess of statutory authority, limitations, and right, 5 U.S.C. § 706(2)(C) and without observance
28 of procedure required by law, 5 U.S.C. § 706(2)(D).

THIRD CAUSE OF ACTION
Violation of the APA – Rulemaking Without Proper Procedure
(Against HHS)

284. Plaintiffs reallege and incorporate by reference the foregoing allegations as fully set forth herein.

285. Under the APA, an agency must provide the public with notice of a proposed rule, 5 U.S.C. § 553(b), and give “interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments.” *Id.* § 553(c). Agencies cannot evade the APA’s requirements merely by declining to publish a rule for comment.

286. Upon information and belief, as alleged in the First and Second Causes of Action above, HHS has abandoned or substantially amended well-established confidentiality requirements that limit transfer of data via policy and regulation, which may be released only under identified and limited circumstances.

287. HHS did so without the opportunity for notice and comment, without amending any otherwise applicable Medicaid rules and agreements with the States, and without any prior notice to the public whatsoever.

288. HHS’s rescission of the Richardson Waiver does not excuse HHS from compliance with the APA as applied to this kind of substantive change in policy.

289. Defendants’ actions are not in accordance with law because they violate the APA’s procedural requirements.

FOURTH CAUSE OF ACTION
Spending Clause: Lack of Clear Notice
U.S. Const. art. I, § 8, cl. 1

290. Plaintiffs reallege and incorporate by reference the foregoing allegations as fully set forth herein.

291. As explained in the prior Causes of Action above, to the extent that Defendants intend to create a novel expansion of the scope of allowable sharing of Medicaid data, their conduct is unlawful. Their conduct is also unconstitutional because Plaintiff States did not have clear notice that this was a condition of federal Medicaid funding.

292. Article I of the U.S. Constitution specifically grants Congress the power “to pay the Debts and provide for the common Defense and general Welfare of the United States.” U.S. Const., art. I, § 8, cl. 1.

293. Incident to the spending power, “Congress may attach conditions on the receipt of federal funds.” *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). However, any conditions must be imposed “unambiguously” to enable “States to exercise their choice knowingly, cognizant of the consequences of their participation.” *Id.* at 207 (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)).

294. There is no statute that clearly states that Medicaid funds provided by Defendants are conditioned on consent for unfettered transfer of that Medicaid data to agencies other than HHS for purposes of immigration enforcement, or any other purposes unrelated to the Medicaid program.

295. Therefore, conditioning federal Medicaid funding on unfettered access to state and residents’ personal healthcare data would violate this limitation on the spending power, because, inter alia, Plaintiffs did not have “clear notice” of such a condition. *See Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

296. Moreover, conditions on federal grants must be related to the national program for which the grant monies are provided. *Dole* at 207 (citing *Massachusetts v. United States*, 435 U.S. 444, 461 (1978)). Defendants’ efforts to mine sensitive and protected beneficiary data for purposes like immigration enforcement is not related to Medicaid’s programmatic goals of “provid[ing] health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities” and “provid[ing] an important foundation for maintaining the health of our nation.” Medicaid, <https://www.medicaid.gov/medicaid> and <https://www.medicaid.gov/about-us> (last visited Jun. 25, 2015). Nor is there any connection between this type of sharing of beneficiary data and the sound administration of the Medicaid program. Conditioning Medicaid funds on States’ sharing of sensitive beneficiary data is therefore inconsistent with the Spending Clause.

297. Additionally, to the extent that Defendants are attempting to create a new Medicaid data sharing condition on federal Medicaid funding, such a condition is unlawful because it was issued after Plaintiffs accepted federal funds, and Defendants cannot “surpris[e] participating States with post acceptance or ‘retroactive’ conditions.” *Pennhurst*, 451 U.S. at 25.

298. Pursuant to 28 U.S.C. § 2201(a), Plaintiffs are entitled to a declaration that their receipt of federal Medicaid funds is not conditioned on consent to unfettered waiver of Medicaid beneficiaries’ privacy and confidentiality rights.

299. Plaintiffs are also entitled to a preliminary and permanent injunction barring Defendants from suspending funds or otherwise taking enforcement action against Plaintiffs on the basis of such a purported consent to waiver.

FIFTH CAUSE OF ACTION Ultra Vires

300. Plaintiffs reallege and incorporate by reference the foregoing allegations as fully set forth herein.

301. No administrative agency can take any action that exceeds their statutory authority.

302. Defendants have acted ultra vires in disclosing the States’ Medicaid data files, including records containing millions of individuals’ personal health information, to DHS. Such disclosure is prohibited by statute and not within any exception permitting disclosure.

303. Defendants have acted ultra vires in using the States’ Medicaid data files for immigration enforcement and other purposes other than those expressly provided by statute.

304. Defendants have acted in excess of their legal authority contrary to specific prohibitions present in law and regulations governing the treatment and protection of the States’ Medicaid data files obtained and maintained by the federal government.

305. For these reasons, Plaintiffs are also entitled to a declaration that Defendants’ actions are unlawful, and the Court should preliminarily and permanently enjoin Defendants from the unlawful disclosure and use of this data except as provided by law and as necessary for the administration of the Medicaid program.

PRAYER FOR RELIEF

Wherefore, Plaintiffs respectfully request that the Court enter a judgment against Defendants and award the following relief:

1. A declaration that HHS's transfer of Medicaid data containing personally identifiable, protected health information to DHS was unauthorized and contrary to the laws of the United States;
2. A declaration that any actions implementing the Information Silos EO are contrary to the laws of the United States to the extent they are applied to interagency transfers of Medicaid data containing personally identifiable, protected health information;
3. Preliminarily and permanently enjoin HHS from further transferring Medicaid data containing personally identifiable, protected health information to DOGE, DHS, or any other federal agency, except as allowed under federal law;
4. Preliminarily and permanently enjoin DOGE, DHS, or any other federal agency from using Medicaid data containing personally identifiable, protected health information for purposes of immigration enforcement, population surveillance, or other similar purposes;
5. Ordering the impoundment, disgorgement, and destruction of all copies of any Medicaid data containing personally identifiable, protected health information that has already been unlawfully disclosed to DHS and DOGE;
6. Award the Plaintiffs costs and reasonable attorneys' fees; and
7. Grant such additional relief as the Court deems proper and the interests of justice may require.

1 Dated: July 1, 2025

Respectfully submitted,

2 KRISTIN K. MAYES
3 Attorney General for the State of Arizona

ROB BONTA
Attorney General for the State of California
NELI PALMA
Senior Assistant Attorney General
KATHLEEN BOERGERS
Supervising Deputy Attorney General
MARIA F. BUXTON
KATHERINE MILTON
KEVIN G. REYES

4 /s/ Alexa G. Salas
5 ALEXA G. SALAS*
Assistant Attorney General
6 2005 North Central Avenue
Phoenix, Arizona 85004
7 (602) 542-3333
Alexa.Salas@azag.gov
8 ACL@azag.gov
9 *Attorneys for the State of Arizona*
*Pro hac vice forthcoming

/s/ Anna Rich
ANNA RICH
Deputy Attorneys General
Attorneys for Plaintiff State of California

11 PHILIP J. WEISER
12 Attorney General for the State of Colorado

WILLIAM TONG
Attorney General of Connecticut

13 /s/ Ryan Lorch
14 RYAN LORCH
Senior Assistant Attorney General
15 SAM WOLTER
Assistant Attorney General
16 1300 Broadway, #10
Denver, CO 80203
17 (720) 508-6000
Ryan.lorch@coag.gov
samuel.wolter@coag.gov
18 *Attorneys for Plaintiff State of Colorado*

/s/ Janelle Medeiros
JANELLE MEDEIROS*
Special Counsel for Civil Rights
165 Capitol Ave
Hartford, CT 06106
(860) 808-5450
Janelle.Medeiros@ct.gov
*Pro hac vice forthcoming
Attorneys for Plaintiff State of Connecticut

19 KWAME RAOUL
20 Attorney General for the State of Illinois

KATHLEEN JENNINGS
Attorney General for the State of Delaware

21 /s/ Harpreet Khera
22 HARPREET KHERA*
Bureau Chief, Special Litigation
23 SHERIEF GABER*
Assistant Attorney General
Office of the Illinois Attorney General
24 115 S. LaSalle St.
Chicago, IL 60603
25 (773) 590-7127
sherief.gaber@ilag.gov
26 harpreet.khera@ilag.gov
27 *Attorneys for Plaintiff State of Illinois*

/s/ Vanessa L. Kassab
IAN R. LISTON
Director of Impact Litigation
JENNIFER KATE AARONSON
VANESSA L. KASSAB
Deputy Attorney General
Delaware Department of Justice
820 N. French Street
Wilmington, DE 19801
(302) 683-8899
vanessa.kassab@delaware.gov
Attorneys for Plaintiff State of Delaware

1 AARON M. FREY
Attorney General for the State of Maine

ANNE E. LOPEZ
Attorney General for the State of Hawai'i

3 /s/ Brendan Kreckel
BRENDAN KRECKEL
4 Assistant Attorney General
Office of the Attorney General
5 6 State House Station
Augusta, ME 04333-0006
6 Tel.: 207-626-8800
brendan.d.kreckel@maine.gov
7 Attorneys for Plaintiff State of Maine

/s/ Kaliko'onālani D. Fernandes
DAVID D. DAY
Special Assistant to the Attorney General
KALI'KO'ONĀLANI D. FERNANDES
Solicitor General
425 Queen Street
Honolulu, HI 96813
(808) 586-1360
david.d.day@hawaii.gov
kaliko.d.fernandes@hawaii.gov
Attorneys for Plaintiff State of Hawai'i

9 ANTHONY G. BROWN
Attorney General for the State of Maryland

KEITH ELLISON
Attorney General for the State of Minnesota

11 /s/ Michael Drenzer
MICHAEL DREZNER*
12 Senior Assistant Attorney General
Office of the Attorney General
13 200 Saint Paul Place, 20th Floor
Baltimore, Maryland 21202
14 410-576-6959
Mdrezner@oag.state.md.us
15 Attorneys for Plaintiff State of Maryland

/s/ Katherine J. Bies
KATHERINE J. BIES (CA Bar No. 316749)
Special Counsel, Rule of Law
445 Minnesota Street, Suite 600
St. Paul, Minnesota, 55101
(651) 300-0917
Katherine.Bies@ag.state.mn.us
Attorneys for Plaintiff State of Minnesota

16 ANDREA JOY CAMPBELL
17 Attorney General for the State of Massachusetts

AARON D. FORD
Attorney General for the State of Nevada

18 /s/ Katherine Dirks
KATHERINE DIRKS
19 Chief State Trial Counsel
Office of the Massachusetts Attorney General
20 1 Ashburton Place Boston, MA 02108
21 (617) 963-2277
katherine.dirks@mass.gov
22 Attorneys for Plaintiff Commonwealth of
Massachusetts

/s/ Heidi Parry Stern
HEIDI PARRY STERN (Bar. No. 8873)
Solicitor General
Office of the Nevada Attorney General
555 E. Washington Ave., Ste. 3900
Las Vegas, NV 89101
HStern@ag.nv.gov
Attorneys for Plaintiff State of Nevada

24 DANA NESSEL
Attorney General for the State of Michigan

MATTHEW J. PLATKIN
Attorney General for the State of New
Jersey

26 /s/ Neil Giovanatti
NEIL GIOVANATTI*
27 BRYAN BEACH*
Assistant Attorneys General
28 Michigan Department of Attorney General

/s/ Elizabeth R. Walsh
ELIZABETH R. WALSH*
ESTEFANIA PUGLIESE-SAVILLE*
Deputy Attorneys General
Office of the Attorney General

1 525 W. Ottawa
 2 Lansing, MI 48909
 3 (517) 335-7603
 4 GiovanattiN@michigan.gov
 BeachB@michigan.gov
Attorneys for Plaintiff State of Michigan

25 Market Street
 Trenton, NJ 08625
 (609) 696-5289
 elizabeth.walsh@law.njoag.gov
Attorneys for Plaintiff State of New Jersey

5 LETITIA JAMES
 6 Attorney General for the State of New York

RAUL TORREZ
 Attorney General of New Mexico

7 /s/ Mark Ladov
 8 MARK LADOV*
 9 Special Counsel
 10 RABIA MUQADDAM*
 11 Special Counsel for Federal Initiatives
 12 ZOE LEVINE*
 13 Special Counsel for Immigrant Justice
 NATASHA KORGAONKAR*
 Special Counsel
 28 Liberty St. New York, NY 10005
 (212) 416-8240
 mark.ladov@ag.ny.gov
Attorneys for Plaintiff State of New York

/s/ Amy Senier
 AMY SENIER
 Senior Litigation Counsel
 New Mexico Department of Justice
 P.O. Drawer 1508
 Santa Fe, NM 87504-1508
 (505) 490-4060
 asenier@nm DOJ.gov
Attorneys for Plaintiff State of New Mexico

14 PETER F. NERONHA
 15 Attorney General for the State of Rhode Island

CHARITY R. CLARK
 Attorney General for the State of Vermont

16 /s/ Lee Staley
 17 LEE B. STALEY*
 18 Chief, Health Care Unit
 19 150 South Main Street
 Providence, RI 02903
 20 Phone: (401) 274-4400
 Fax: (401) 222-2995
 lstaley@riag.ri.gov
Attorneys for Plaintiff State of Rhode Island

/s/ Ryan P. Kane
 RYAN P. KANE
 Deputy Solicitor General
 109 State Street
 Montpelier, VT 05609
 (802)828-3171
 Ryan.kane@vermont.gov
Attorneys for Plaintiff State of Vermont

22 DAN RAYFIELD
 23 Attorney General State of Oregon

NICHOLAS W. BROWN
 Attorney General of Washington

24 /s/ BRIAN SIMMONDS MARSHALL
 25 BRIAN SIMMONDS MARSHALL
 26 Senior Assistant Attorney General
 Oregon Department of Justice
 100 SW Market Street
 Portland, OR 97201
 27 Tel (971) 673-1880
 Fax (971) 673-5000
 28 Brian.S.Marshall@doj.oregon.gov

/s/ Zane Muller
 ZANE MULLER, WSBA 63777
 WILLIAM MCGINTY, WSBA #41868
 Assistant Attorneys General
 800 Fifth Avenue, Suite 2000
 Seattle, WA 98104-3188
 206-464-7744
Attorneys for Plaintiff State of Washington

1 *Attorneys for Plaintiff State of Oregon*

2

3

4

5

OK2025900292

6

CA v. HHS Medicaid Data Complaint Final 3 pm

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28