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

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA; STATE OF CONNECTICUT; STATE OF OREGON AND GOVERNOR KATE BROWN; COMMONWEALTH OF MASSACHUSETTS; AND STATE OF WASHINGTON;

Plaintiffs,

and

SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 503; UNITED DOMESTIC WORKERS, AFSCME LOCAL 3930; SHERLEEN BRIGHT; CAMILLE CHRISTIAN; LESLEY FORSYTHE; VIRGINIA GRANT; DEBRA HOWZE; REBECCA SANDOVAL; ED SOLSENG; ELENI SYRPIS; AND KAY WRIGHT;

Plaintiff-Intervenors.

v.

ALEX M. AZAR II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No.: 3:19-cv-02552-WHA

COMPLAINT-IN-INTERVENTION BY SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 503, UNITED DOMESTIC WORKERS AFSCME LOCAL 3930, SHERLEEN BRIGHT, CAMILLE CHRISTIAN, LESLEY FORSYTHE, VIRGINIA GRANT, DEBRA HOWZE, REBECCA SANDOVAL, ED SOLSENG, ELENI SYRPIS, AND KAY WRIGHT

INTRODUCTION

1. Section 1902(a)(32) of the Medicaid Aid, 42 U.S.C. §1396a(a)(32)—the Act's "anti-reassignment" provision—prohibits Medicaid providers from selling their entitlement to payments for Medicaid services to third-party collection agencies. Prior to the enactment of this prohibition, collection agencies that purchased such receivables had historically submitted false and inflated claims for payment to the federal government. Section 1902(a)(32) was adopted in 1972 to prevent such abuses of the Medicaid system.

2. Over the first four decades of its existence, §1902(a)(32) had been construed to apply only to practices that, like selling receivables, implicate such concerns about fraud and abuse. Thus, until the May 6, 2019 regulatory action that is the subject of this lawsuit, routine, authorized deductions from the paychecks of individual Medicaid providers, including paycheck deductions for matters "such as health insurance, skills training and other benefits customary for employees," 42 C.F.R. §447.10(g)(4), had never been deemed to be barred by §1902(a)(32).

3. This complaint challenges the final regulatory action by Defendant Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS") withdrawing 42 C.F.R. §447.10(g)(4). This challenge is based on CMS's erroneous construction of Medicaid's anti-reassignment provision as prohibiting individual providers of homecare services who receive payments through Medicaid ("homecare providers"), and who have voluntarily elected to become union members, from authorizing their states to deduct union dues and transmit those dues to their unions.[1]

4. In the final agency action challenged in this complaint, CMS withdrew a regulation expressly permitting deductions for matters "such as health insurance, skills training and other benefits customary for employees," based on its entirely new and unprecedented construction of the anti-reassignment provision as prohibiting all such deductions, including deductions for union dues.

5. CMS's erroneous construction of the anti-reassignment provision threatens not only

[1] The Complaint uses the term "homecare providers" to refer to individual providers paid directly through Medicaid, while using the term "homecare workers" to refer more broadly to all individuals who perform homecare work, including those employed by private agencies.

union dues deductions, but also other common employment deductions such as health insurance contributions, none of which Congress ever intended to prohibit. Under CMS's erroneous interpretation, Plaintiff-Intervenors face substantial and immediate harms, including both the loss of an efficient and reliable means for processing voluntary union dues and health insurance contributions and an inability to negotiate new or expanded contractual benefits, in areas such as health insurance or retirement savings, that depend upon payroll deductions.

6. Because CMS's regulatory action fails to comply with the Administrative Procedure Act, 5 U.S.C. §551, *et seq.* (the "APA"), it must be set aside. The regulatory action is arbitrary, capricious, and contrary to law because it is premised on a legally incorrect misreading of the governing statute as prohibiting routine employment-related payroll deductions. The regulatory action is also arbitrary and capricious because it is based on anti-union animus, rather than any legitimate purpose, because CMS failed to consider the reliance interests engendered by decades of practice permissible under the governing statute, and because CMS did not engage in reasoned decisionmaking.

7. CMS's regulatory action is also unconstitutional because it targets a politically disfavored group without a legitimate purpose, in violation of the Equal Protection Clause of the Fifth Amendment, and because it is designed to suppress Plaintiff-Intervenors', and their members', First Amendment rights to speech and association.

JURISDICTION

8. This Court has subject matter jurisdiction under 28 U.S.C. §1331 because this action arises under the Constitution and laws of the United States, and under 5 U.S.C. §§702 and 704 because Plaintiff-Intervenors have suffered legal wrong and are adversely affected by a final agency action for which there is no other adequate judicial review.

VENUE AND INTRADISTRICT ASSIGNMENT

9. Venue is proper in this Court under 28 U.S.C. §1391(e) because the venue here was properly laid in the original complaint that initiated this action.

10. Viewing the complaint-in-intervention independently from the original complaint, venue would nevertheless lie because Plaintiff-Intervenor Camille Christian resides in this judicial

district.

11. For the same reasons, intradistrict assignment to the San Francisco and Oakland divisions is proper.

PARTIES

12. Plaintiff-Intervenor Service Employees International Union Local 503 ("SEIU Local 503") is the labor union that represents Oregon's long-term care providers. It represents over 30,000 Medicaid-funded homecare providers in Oregon. Homecare providers represented by SEIU Local 503 who choose to become members of the union routinely contribute dues via payroll deductions, and many have done so for several years.

13. Plaintiff-Intervenor United Domestic Workers, AFSCME Local 3930 ("UDWA") is the labor union that represents 112,000 Medicaid-funded homecare providers in 21 counties across the State of California. Homecare providers represented by UDWA who choose to become members of the union routinely contribute dues via payroll deductions, and many have done so for several years.

14. Plaintiff-Intervenor Camille Christian is a homecare provider in California. Ms. Christian has chosen to be a member of SEIU Local 2015 because she believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Christian pays her union dues, health insurance monthly contributions, and dental insurance through payroll deductions. It would impose a significant burden upon Ms. Christian to pay her union dues, health insurance contributions, and dental insurance regularly if they were not deducted from her paycheck.

15. Plaintiff-Intervenor Lesley Forsythe is a homecare provider in California. Ms. Forsythe has chosen to be a member of UDWA because she believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Forsythe pays her union dues, monthly health insurance contributions, and dental insurance through payroll deductions. It would impose a significant burden upon Ms. Forsythe to pay her union dues, health insurance contributions, and dental insurance regularly if they were not deducted from her paycheck.

16. Plaintiff-Intervenor Virginia Grant is a homecare provider in Illinois. Ms. Grant has chosen to be a member of SEIU Healthcare Illinois Indiana Missouri and Kansas ("HCII") because

she believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Grant pays her union dues through payroll deductions, and it would impose a significant burden upon her to pay her union dues regularly if they were not deducted from her paycheck.

17. Plaintiff-Intervenor Debra Howze is a homecare provider in Minnesota. Ms. Howze has chosen to be a member of SEIU Healthcare Minnesota because she believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Howze pays her union dues through payroll deductions. She does not have a bank account or a credit card, and it would impose a significant burden upon her to pay her union dues regularly if they were not deducted from her paycheck.

18. Plaintiff-Intervenor Rebecca Sandoval is a homecare provider in Oregon. Ms. Sandoval has chosen to be a member of SEIU Local 503 because she believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Sandoval pays her union dues through payroll deductions, and it would impose a significant burden upon her to pay her union dues regularly if they were not deducted from her paycheck.

19. Plaintiff-Intervenor Ed Solseng is a homecare provider in Washington State. Mr. Solseng has chosen to be a member of SEIU 775 because he believes the union has successfully advocated on his behalf for better wages and working conditions. Mr. Solseng pays his union dues and his health care premium through payroll deductions. It would impose a significant burden upon Mr. Solseng to pay his union dues and health care premiums regularly if they were not deducted from his paycheck.

20. Plaintiff-Intervenor Kay Wright is a homecare provider in Connecticut. Ms. Wright has chosen to be a member of SEIU, Healthcare 1199 New England ("1199NE") because she believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Wright pays her union dues through payroll deductions, and it would impose a significant burden upon her to pay her union dues regularly if they were not deducted from her paycheck.

21. Plaintiff-Intervenor Eleni Syrpis is a homecare provider in Massachusetts. She has chosen to be a member of SEIU Local 1199 United Healthcare Workers East ("UHE") because she

believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Syrpis pays her union dues through payroll deductions, and it would pose a significant burden upon her to pay her union dues regularly if they were not deducted from her paycheck.

22. Plaintiff-Intervenor Sherleen Bright is a homecare provider in Virginia. She has chosen to become a member of SEIU Local 512 because she believes the union has successfully advocated on her behalf for better wages and working conditions. Ms. Bright pays her union dues through payroll deductions and it would impose a significant burden upon her to pay her union dues regularly if they were not deducted from her paycheck.

23. Defendant U.S. Department of Health and Human Services ("HHS") is an agency of the United States government.

24. Defendant Alex M. Azar II is the Secretary of the U.S. Department of Health and Human Services. Secretary Azar is sued in his official capacity.

FACTUAL AND LEGAL BACKGROUND

A. Homecare Programs Under the Medicaid Act

25. Medicaid is a cooperative federal-state program that provides medical care to needy individuals. To qualify for federal funds, states must submit to CMS a state Medicaid plan that details the nature and scope of the state's Medicaid program.

26. For many decades, states have provided homecare services to elderly and disabled individuals as part of their Medicaid programs.

27. Homecare services enable elderly and disabled recipients to remain safely in their homes and community while receiving in-home care and assistance, rather than face dangers to their health and physical wellbeing by living alone or being placed in an institutional setting like a nursing home. These services thus allow elderly and disabled individuals to live in more integrated settings, which enhances their autonomy and saves resources, rather than face the isolation and segregation of institutional care that would otherwise be far more expensive.

28. Providers of homecare services perform tasks such as hands-on care services, including bowel and bladder assistance, feeding, bathing, oral hygiene and grooming, dressing, assistance with prosthetic devices, menstrual care, and skin care. They also perform household work

such as housecleaning services, meal preparation and clean-up, laundry, and shopping. In some cases, they provide protective supervision for recipients requiring 24-hour care, medication management, or paramedical services, such as the insertion of medical devices into the body or health procedures requiring puncturing the skin.

29. Many states provide Medicaid homecare services through private agencies that employ homecare workers. Some states also use the so-called consumer-directed model (sometimes called the independent provider model), whereby homecare providers are employed by the Medicaid beneficiary, who may hire, fire, and supervise their own individual homecare provider, but the providers are also employees of the state, county or other entity for certain other purposes, such as collective bargaining and payment of wages. In the consumer-directed model, the state finances homecare services through Medicaid and sets wages and benefits for providers and authorizes hours of service and types of services that may be provided to participating consumers.

30. The agency action at issue in this litigation applies only to homecare workers who provide consumer-directed Medicaid services such as the plaintiffs here. Those Medicaid-funded homecare workers that work through private agencies will not be affected by the agency action and will keep the rights CMS seeks to deprive from Plaintiff-Intervenors.

B. Collective Bargaining and Its Impact on Homecare Providers and Consumers

31. Historically, homecare workers, who are predominantly women and often women of color, were excluded from the protections of many federal laws establishing minimum labor standards, including the Fair Labor Standards Act and the National Labor Relations Act.

32. Efforts by homecare workers to organize into unions to improve their terms and conditions of employment date back to the 1950s. In its modern form, the efforts by Medicaid-funded homecare workers to form and join unions began in the mid-1980s with campaigns in Illinois and Los Angeles. Without a legal framework providing for union recognition, freedom of association, and a duty to bargain terms of employment, these early efforts achieved limited success.

33. The first opportunity for homecare workers to receive official recognition of their union and engage in collective bargaining came in California in the early-1990s. At that time, the California state legislature authorized and funded the establishment of county-level "public

authorities"—semi-public entities that could manage their widely dispersed consumer-employed homecare provider workforces and negotiate with a union designated by those homecare providers as their representative. After several counties adopted this public-authority approach—with union recognition and improvements in labor standards following shortly thereafter—the state legislature in 1999 mandated that all counties adopt a comparable approach for their homecare provider workforces by 2003.

34. In the 2000s, homecare providers in other California counties and other states continued efforts to organize into unions to advocate for higher wages and improved working conditions. Oregon voters approved a ballot initiative to create a statewide version of California's county-based public authorities in 2000, and Washington voters followed suit the next year. In 2003, the Illinois legislature recognized its homecare providers as employees of the state for the purposes of bargaining over the various terms and conditions of their employment set by the state, and the Massachusetts legislature did the same in 2006. As discussed in greater detail below, the well-established bargaining relationships in each of these five states have led to significant improvements in labor standards through higher wages, the establishment of basic benefits such as health insurance and paid time off, and increased access to training and other career development opportunities.

35. These gains have been particularly important for homecare providers because homecare work has historically been poorly paid and excluded from other labor protections, such as federal and state minimum wages and overtime protections, notwithstanding the importance of the work, which enables consumers to safely remain in their homes with dignity instead of being institutionalized. The gains achieved because of these organizing efforts have helped reduce turnover of homecare workers, attract more people to the homecare profession, and increase the training and experience levels of those performing this work.

36. Building on these successful examples, five additional states—Maryland, Missouri, Connecticut, Vermont, and Minnesota—have since adopted similar approaches to developing their homecare provider workforces and providing a means for homecare providers to negotiate for improved terms and conditions through forms of collective bargaining. Unions have won representation and bargained contracts in each of these states. Unions also represent homecare

providers in Pennsylvania and Virginia, but providers there do not have the right to collectively bargain.

37. Currently, approximately 700,000 homecare providers in ten (10) states are represented by unions.

38. Under the consumer-directed or independent provider model, Medicaid recipients retain the ability to hire and fire homecare providers and to direct their daily tasks. Unions representing Medicaid-funded homecare providers bargain with the appropriate state or local agencies over critical aspects of employment, like wages, health care benefits, training, and background check requirements, over which the public officials have authority. The state issues paychecks to the homecare providers, makes applicable tax deductions, and withholds employment taxes and other deductions from the providers' paychecks.

39. Through collective bargaining, homecare providers have seen dramatic wage increases. For example, homecare providers in California who were earning just $3.72 per hour when they first began union organizing can, in some counties, earn more than $13 per hour today. All but a few counties in California pay at least $11 per hour. In Connecticut, the union has negotiated a $15 per hour wage, and some homecare providers are eligible for up to $22.35 per hour, depending on the types of services they provide. In Illinois, homecare providers who earned just $7 per hour when their union was recognized in 2003 now earn $13 per hour. Homecare providers in Massachusetts earn $15 per hour, and are eligible for a time-and-a-half premium for working certain holidays. Similarly, in Minnesota, which has a $12 per hour pay floor, homecare providers have negotiated the right to holiday premium pay. In Oregon, homecare providers currently earn $14.65 per hour. As of January 2019, homecare providers in Washington earn an hourly wage of at least $15, with more experienced and trained workers earning over $18.

40. In addition to these wage increases, homecare providers have negotiated paid time off in Connecticut, Massachusetts, Minnesota, Oregon, and Washington.

41. Tens of thousands of homecare providers have also negotiated healthcare benefits through their unions. Thus, two states, Illinois and Washington, as well as a number of counties in California, now provide some form of state-funded health insurance for homecare providers. In

Oregon, SEIU Local 503 has established two healthcare trusts that provide financial assistance with healthcare premiums, medical out-of-pocket expenses, and dental and vision benefit expenses. As is the case with most employees, homecare providers' contributions to health insurance premiums are typically paid through a payroll deduction. In California workers in over 25 counties—including four counties where workers are represented by UDWA—make regular monthly contributions through payroll deductions to maintain their healthcare benefits.

42. In addition, SEIU Local 503 has recently negotiated with the State of Oregon a retirement savings plan that would allow homecare providers to make contributions to the plan via a payroll deduction. When implemented, this program would allow providers to achieve retirement security via a mechanism—using payroll deductions to contribute to retirement savings—that is standard throughout the private and public sectors.

43. Union membership also provides homecare providers with other significant benefits. For example, Local 503, UDWA, SEIU Local 2015, SEIU Healthcare Minnesota, UHE, and HCII all offer life insurance to their members. HCII also offers its members accidental death and dismemberment insurance; a voluntary dental, vision and pharmaceutical benefit; and access to educational assistance programs. UDWA offers its members life insurance as well, plus accidental death and dismemberment insurance, dental insurance, low-cost group hearing and vision benefits plans, and no-cost enrollment and degrees at an online community college. Homecare unions also offer their members mortgage and tax preparation assistance, legal services for certain issues such as workers compensation, pet insurance, and discounts on things like auto and homeowner insurance, cell phones, and gym memberships. Some of these benefits, such as HCII's and SEIU Local 2015's life insurance programs, and UDWA's dental insurance plan, require provider contributions. As with dues and healthcare, contributions for these additional benefits are usually made through payroll deduction.

44. Not only has union representation improved the wages and working conditions of homecare providers, it has increased the quality of care provided to recipients. For example, many homecare providers are now able to attend no-cost or paid training through their union. In Oregon and a number of counties in California, homecare providers are provided with supplies such as

gloves, masks, and antibacterial soap, to help protect their health and the health of those for whom they care.

45. Additionally, better wages and working conditions have significantly decreased homecare provider turnover, thus creating a more stable workforce with greater experience, which is better able to anticipate and meet the needs of those for whom they care. This has also reduced the number of elderly or disabled homecare recipients who are unable to find qualified providers. Overall, union representation has improved the quality and availability of providers and the quality of the care they provide.

46. Through collective bargaining, homecare providers have also established government-operated provider registries. These registries make it easier for homecare recipients to locate qualified providers in their area. The registries also help homecare recipients efficiently search for homecare providers that match their needs, such as a language preference or particular skills. Such measures help people receive the best possible care and avoid the risk of going without care or going into a nursing home.

47. Further, union-represented homecare providers are able to play a critical role in improving long-term care by participating in an organized and broadly representative way in stakeholder groups. For example, the homecare providers who organized in HCII have a seat on Illinois' Older Adult Services Advisory Committee, a group that, among other things, advises the state legislature on ways to improve home-based services in order to help older adults remain safely in their homes. A representative of Local 1199NE has served on Connecticut's Long-Term Care Advisory Council, which was established by statute to provide recommendations to the state's Long-Term Care Planning Committee. And a representative of the homecare providers organized in UHE has served on Massachusetts's One Care Implementation Council, a group created by the state's Executive Office of Health and Human Services to integrate care, including long-term care, for individuals who are eligible for both Medicare and Medicaid.

48. Homecare providers who voluntarily choose to become union members and to support and enable the union's work become union members by signing authorization cards. On those cards, the members "authorize[s] [their] employer to deduct from [their] earnings and to pay over to [the

union] an amount equal to the regular monthly dues . . . ." States are bound through collective bargaining agreements and/or state law to honor such dues deduction requests and transmit dues to members' unions. This practice has been in place for years and CMS, which has long been aware of the practice, has never previously taken the position that it is unlawful or inconsistent with the Medicaid Act. In California, the state law governing homecare provider collective bargaining has specifically authorized such deductions since 2002.

49. Although no homecare provider is required to become a union member or to pay dues, under state law homecare unions have a legal obligation to fairly represent all the workers within their respective bargaining units.

C. The Medicaid Act's Anti-Reassignment Provision

50. 42 U.S.C. §1396a sets forth numerous requirements for states' Medicaid plans. Section 1396a(a)(32), the anti-reassignment statute, provides generally that "no payment . . . for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise . . . ." 42 U.S.C. §1396a(a)(32).

51. Congress initially enacted the anti-reassignment statute in 1972. The statute was amended into substantially its current form in 1977.

52. Section 1396a(a)(32) was enacted to address problems associated with "factoring" in the Medicaid system, a practice whereby providers sold Medicaid receivables at a discount to third parties, who in turn submitted the claims to the government in their own names. *See* H.R. Rep. 92-231 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5090. According to a 1971 House Report, "[s]uch reassignments have been a source of incorrect and inflated claims for service and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments." H.R. Rep. 92-231, *reprinted in* 1972 U.S.C.C.A.N. 4989, 5090; *see also id.* ("Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in medicare, one involving over a million dollars.").

53. The anti-reassignment statute sets forth several exceptions. For example, Medicaid

providers may assign payments to a governmental agency and may appoint an agent for billing purposes, provided that the agent is not paid based on the amount of Medicaid payments recovered.

54. In 1978 CMS issued a regulation, set forth at 42 C.F.R. §447.10, implementing the anti-reassignment statute. The regulation describes both the scope of the statute's prohibition on reassignments, and a series of practices that are not prohibited by the statute. As to individual Medicaid providers, those practices include paying their employer, their facilities, or a foundation, plan, or similar organization operating an organized health care delivery system.

55. Although some of these practices are expressly referenced within the statutory text, *see, e.g.*, 42 C.F.R. §447.10(g)(1) (permitting payments to providers' employers), others are not, *see, e.g.*, 42 C.F.R §447.10(g)(3) (permitting payments to an "organized health care delivery system").

56. In 2014, CMS confirmed the scope of the anti-reassignment regulation to reflect longstanding and accepted practices. CMS explained in a notice of final rulemaking that the purpose of 42 U.S.C. §1396a(a)(32) "was to prohibit factoring arrangements, and not to preclude a Medicaid program that is functioning as the practitioner's primary source of revenue from fulfilling the basic responsibilities that are associated with that role." 79 Fed. Reg. 2948-01, 2949 (Jan. 16, 2014); *see also* 77 Fed. Reg. 26364 (May 3, 2012) (including same reasoning in notice of proposed rulemaking). As CMS acknowledged, the statute must not be applied in a manner that "would contravene the fundamental purpose of th[e] provision," and its prohibition therefore did not apply where a Medicaid program withholds practitioner funds to pay for standard costs and benefits of employment, rather than as part of a factoring-type arrangement. 79 Fed. Reg. 2949 (Jan. 16, 2014); 77 Fed. Reg. 26364 (May 3, 2012); *see also* 77 Fed. Reg. 26381-82 (May 3, 2012) (noting that prohibition's purpose "was to curb perceived abuses that stemmed from 'factoring' of accounts receivable by physicians and individual practitioners" and that the "direct payment principle" should not be applied to payments that do not create the potential for such abuses).

57. CMS thus added 42 C.F.R. §447.10(g)(4) (the "2014 Regulation"), which states that, for those providers for whom "the Medicaid program is the primary source of service revenue," the anti-reassignment statute does not prohibit routine employment-related deductions for matters "such as health insurance, skills training and other benefits customary for employees." The 2014

Regulation does not expressly address union dues deductions.

D. The Challenged Regulatory Action

1. Conservative campaign for an anti-union rule

58. After the November 2016 Presidential Election and change in administration in January 2017, anti-union organizations and individuals began spreading the false narrative that homecare provider unions were "skimming" Medicaid money intended for homecare services (that is, taking money designated for homecare services and sending it to unions) and urging HHS to take action to end this misleadingly described "diversion" of Medicaid funding. This pressure was part of a broader campaign to undermine the stability of labor unions in general.

59. For example, in November 2017, former U.S. Secretary of Labor nominee Andrew Puzder published an opinion decrying "states [for] diverting millions of … Medicaid dollars from home health-care to labor unions" and urging HHS to take action to prohibit deductions for union dues. The conservative, anti-union State Policy Network began disseminating the false attack that unions were "skimming" money away from the Medicaid system throughout their online fora and their network of state affiliates like the Washington-based Freedom Foundation, placing hundreds of articles in both mainstream media and affiliated websites.

60. On January 18, 2018, the Governor of Illinois, Bruce Rauner, urged CMS to reevaluate the longstanding practice of dues deductions for union-represented homecare providers. Governor Rauner's General Counsel and the Director of Illinois' Department of Healthcare and Family Services wrote to Acting HHS Secretary Eric Hargan (the "January 18 letter"), claiming that the practice of deducting voluntary dues on behalf of union member homecare providers "appears to conflict with 42 U.S.C. §1396a(a)(32) of the Medicaid Act."

61. Illinois' January 18 letter also challenged the 2014 Regulation. The letter asserted that, "regardless of whether union dues . . . fall under [the 2014 Regulation], we are concerned that the 2014 regulation itself may exceed HHS's statutory authority under the Medicaid Act by adding a new exception that Congress did not authorize."

62. Meanwhile, in January 2018 Fox News reported that "House Republicans want to pull the plug" on voluntary dues deductions for homecare providers. Joseph Weber, "House GOP takes

aim at union 'dues skimming' from family caregivers, Medicaid," Fox News Network LLC (Jan. 17, 2018), https://www.foxnews.com/politics/house-gop-takes-aim-at-union-dues-skimming-from-family-caregivers-medicaid. The Chairwoman of the House Republican Conference stated that she intended to introduce legislation to prohibit the practice. *Id.* No such legislation was ever introduced or adopted.

2. Notice of Proposed Rulemaking

63. Instead, on July 12, 2018, CMS issued a notice of proposed rulemaking (the "NPRM"). The NPRM proposed to rescind the 2014 Regulation in its entirety, which it stated would "remove the regulatory text that allows" deductions from homecare providers' paychecks for customary employee benefits. Although the 2014 Regulation made no mention of union dues, the NPRM discussed the deduction of union dues almost exclusively.

64. The NPRM characterized the 2014 Regulation as "grant[ing] permissions that Congress has foreclosed," noted that CMS does not have authority "to create new exceptions" to a statutory prohibition, and expressed "concern[]" that the 2014 Regulation was "overbroad, and insufficiently linked to the exceptions expressly permitted by the statute."

65. Although CMS justified its proposed regulatory action on the ground that the 2014 Regulation was "insufficiently linked to the exceptions expressly permitted by the statute," it did not address other provisions of the same regulation that are not expressly permitted by the anti-reassignment provision. *See, e.g.*, 42 C.F.R §447.10(g)(3) (permitting payments to an "organized health care delivery system").

66. Despite taking the position that it could not "quantify the[] direct financial impacts" of the rule change, the NPRM suggested that money that had been voluntarily contributed by homecare providers as dues could be saved by states because states might have "increased reimbursement levels to reassign portions of a provider's reimbursement to a third party." And it speculated that "states may elect to decrease payment levels" based on the rescission of the 2014 Regulation.

3. Comment Period

67. CMS provided a truncated 30-day comment period for the NPRM, as opposed to the 60-day period that is customary for non-emergency regulations. Nevertheless, the agency received

over 15,000 comments, the majority of which opposed the proposed rule and the truncated comment period through which it was being implemented. Commentators speaking out against the rule included over 100 members of Congress, officials from California, Connecticut, Illinois, Massachusetts, Minnesota, Oregon, and Washington, industry groups such as Kaiser Permanente, and scores of organizations representing the elderly and disabled.

68. For example, UHE submitted comments informing CMS that "[v]oluntary dues deductions were implemented in Massachusetts in January, 2009, long before the 2014 regulation that the [NPRM] would repeal," undermining CMS's characterization of the 2014 Regulation as creating a new regulatory exception to the anti-reassignment provision. UHE also informed CMS that prohibiting payroll deductions would impose hardship on its members, "many of whom lack credit cards or bank accounts." UHE warned CMS that its proposed action, which applied only to homecare providers under the consumer-directed model, and not to homecare workers who work for private agencies, would show favoritism and encourage states to move towards the private agency model and away from the consumer-directed model.

69. UDWA submitted comments arguing that CMS's proposed regulatory action would infringe on its members' First Amendment rights to associate with and speak through the union. UDWA also provided information and data to CMS regarding the costs and burdens that its proposed action would impose on its members.

70. AFSCME, which is UDWA's parent union and represents homecare providers in four states, submitted comments explaining that CMS's proposed action was inconsistent with the legislative history of the anti-reassignment provision. AFSCME also informed CMS that dues deductions from the paychecks of homecare providers "preceded the 2014 rule by decades" and that the 2014 Regulation therefore did not create a new exception allowing such dues. AFSCME explained to CMS why dues payments are not "reassignments" within the meaning of the statute or the regulation.

71. SEIU Local 503 submitted comments informing CMS how the proposed action would harm Local 503's members and Local 503's efforts on their behalf. The comments explained that many Local 503 members would experience significant difficulties in paying their dues and for other

benefits without payroll deductions.

72. SEIU Local 2015 submitted comments informing CMS that dues deductions from the paychecks of its bargaining unit members long preceded the 2014 Rulemaking, and that such deductions are not "assignments" within the meaning of the anti-reassignment provision or the regulation. SEIU Local 2015's comment also provided CMS information about the burdens and costs that its members would incur if payroll dues deductions were prohibited.

73. Many other unions and individual union members—including individual Plaintiff-Intervenors Camille Christian, Rebecca Sandoval, Ed Solseng, Eleni Syrpis, Kay Wright, Debra Howze, and Virginia Grant, and labor organizations SEIU HCII, SEIU Minnesota, SEIU 775, the Service Employees International Union, UHE, and 1199NE—submitted comments raising similar issues and arguments, and providing additional data and information about the likely negative impact that its proposed action would have on homecare providers by imposing significant new costs and burdens on providers who wish to make their union dues payments and/or other benefits payments without the benefit of payroll deduction. Rebecca Sandoval attached her paystubs to her comment.

4. Issuance of Final Rule

74. On May 6, 2019, CMS issued its final regulation (the "Final Rule"), repealing the 2014 Regulation (42 C.F.R. §447.10(g)(4)). 84 Fed. Reg. 19,718 (May 6, 2019).

75. Because the 2014 Regulation merely confirmed existing practices relating to payroll administration as not in conflict with the Medicaid Act's anti-reassignment provision, its repeal does not have the effect of prohibiting these practices. Contrary to CMS's characterization, the 2014 Regulation did not establish any new exemption from the Medicaid Act's anti-reassignment provision, but merely confirmed that the anti-reassignment provision did not prohibit existing state practices. While its repeal would not itself have the effect of prohibiting payroll deductions for union dues and other benefits, the rationale for CMS's final regulatory action makes clear that CMS intends to enforce its erroneous reading of the Medicaid Act and to require states to cease authorization of payroll deductions for union dues and other workplace benefits.

76. In the Final Rule, CMS reiterated its mistaken characterization of the 2014 Regulation as having created a new exception to §1902(a)(32), rather than as having codified a longstanding

interpretation of the anti-reassignment provision as not applying to situations where the state makes payments to third parties on behalf of individual homecare providers "for benefits such as health insurance, skills training, and other benefits customary for employees." 42 C.F.R. §447.10(g)(4).

77. In the Final Rule, CMS justified its position by relying solely on the text of §1902(a)(32) and concluding that Congress had spoken directly to the issue, precluding CMS itself from exercising any discretion with respect to the matter and eliminating any ambiguity in the statutory text CMS might be required to interpret. Specifically, CMS contended that that Congress chose to list specific exceptions in §1902(a)(32) to the exclusion of all others. 84 Fed. Reg. at 19,719. However, in response to comments that pointed out that CMS was not withdrawing other regulatory exceptions listed in 42 C.F.R. §447.10 that were not among §1902(a)(32)'s listed exceptions—as would be required by CMS's statutory interpretation—CMS stated merely that those other regulatory provisions were "outside the scope of this rulemaking." *Id.* at 19,720. CMS therefore failed to acknowledge that it had recognized more than four decades ago that §1902(a)(32) does not apply to payment practices that do not implicate concerns about fraud or abuse, even if those practices are not listed in the specific statutory exemptions. It also failed to acknowledge the basic principles of statutory interpretation that conflict with its new interpretation of the anti-reassignment provision. *See infra* ¶98-107.

78. In the Final Rule, CMS failed to respond to the arguments raised in the comments it received that the 2014 Regulation could not have created a new exception authorizing payroll deductions for union dues or other benefits because, in many states, these deductions long pre-dated 2014.

79. CMS's rationale in the Final Rule is also self-contradictory and contrary to well-known facts. For example, to justify its withdrawal, CMS states "Section 447.10(g)(4) pertained to payment diversion, not to voluntary wage deductions made under a bona fide employment arrangement. Specifically, it pertained to the class of practitioners for which the Medicaid program is the primary source of service revenues, such as home health workers, who are *not* employees of the state. As non-employees, such practitioners do not receive salaries or wages from the state. Instead, they are the recipients of Medicaid payment for services they furnish. Certain assignments or other

transfers of such payments are permitted under section 1902(a)(32) of the Act; however, the diversion to other third parties not otherwise identified in the statute is not." 84 Fed. Reg. at 19,721 (emphasis in original). Additionally, CMS stated that it does "not interpret section 1902(a)(32) of the Act as prohibiting employee payroll deductions that are made by a bona fide employer," including "voluntary deductions for things like health and life insurance, contributions to charitable causes, retirement plan contributions, and union dues." *Id.* at 19,720.

80. This discussion of "bona fide employment" and the Final Rule's repeated assertions homecare providers "are not employees of the state" and "do not receive salaries or wages from the state" demonstrates a misunderstanding of how the consumer-directed model operates. *See* 84 Fed. Reg. at 19,721. The Final Rule makes clear that CMS intends that the effect of its withdrawal of §447.10(g)(4) will be to prohibit union dues deductions from all homecare providers who provide services through the consumer-directed model. *Id.* at 19,723; *see also id.* at 19,725-26 ("[O]ne likely impact of this rulemaking is that states will stop redirecting a portion of homecare workers' payments to unions for membership dues"). But in states that have adopted the consumer-directed model and have recognized homecare providers' rights to organize and be represented by a union for collective bargaining (including Oregon, where Local 503 represents homecare providers, and in California, where UDWA represents homecare providers), homecare providers are jointly employed by the state (or its subdivisions, or other local entities or agencies), as well as by the Medicaid beneficiary for whom they provide services.

81. Specifically, states (or, in some cases, their fiscal intermediaries, state subdivisions like counties, or other authorized entities) perform the joint-employer functions of establishing wages and benefits, authorizing hours of service and types of services that can be provided, collective bargaining, issuing paychecks, deducting employment taxes, and complying with the tax withholding and reporting obligations that apply to employers, while individual Medicaid beneficiaries perform the joint employer functions of hiring, firing, and supervising services rendered.

82. These are commonly known facts that were in the record before CMS when it issued the Final Rule. Nonetheless, the Final Rule reflects CMS's fundamental misunderstanding of the relationship between states, Medicaid beneficiaries, and homecare providers, at times even suggesting

that such providers are "not employees" at all. 84 Fed. Reg. at 18,724.

83. Besides resting on erroneous facts, the Final Rule's discussion of "bona fide employment" is also arbitrary and capricious in that it misconstrues the anti-reassignment provision and makes contradictory statements about the continued availability of such deductions. The Final Rule rests its "bona fide employment" dividing line on a statutory provision that authorizes assignments to employers under certain circumstances, but that provision applies only to assignments that the employer *mandates* as a condition of employment. *See, e.g.*, 84 Fed. Reg. at 19,721; 42 U.S.C. §1396a(a)(32). The Final Rule offers no explanation for why CMS now construes that exception to extend to *voluntary* assignments to employers. Moreover, given the actual joint-employer role of Plaintiff-States, the Final Rule suggests contradictory positions: that deductions from the wages of "bona fide employees" would remain permissible and that deductions from the wages of homecare providers would be prohibited.

84. The Final Rule is also arbitrary and capricious in that it appears to rest on CMS's misunderstanding of the voluntary nature of payroll deductions for union dues, benefit contributions, and other similar purposes. The Final Rule announces that its withdrawal of the 2014 Regulation "puts Medicaid providers back in control of their reimbursements," 84 Fed. Reg. at 19,720, but the Final Rule's effect is to deprive homecare providers of their ability to voluntarily authorize payroll deductions in order to maintain union benefits, health insurance, and other important benefits.

85. CMS's misunderstanding of the way that fiscal management services operate also renders the rule arbitrary and capricious because it is based on erroneous facts. The Final Rule distinguishes between "certain assignments or other transfers . . . permitted under section 1902(a)(32)" and "diversion to other third parties," and states that it "will not impact a state's ability to perform Financial Management Services (FMS) or secure FMS through a vendor arrangement," in that "the arrangements under FMS are not affected by the provisions of the final rule because this model involves the FMS vendor receiving monies from the state to administer the participant-directed budget and make payment to providers on behalf of the beneficiary." 84 Fed. Reg. at 19,719. However, regardless of how FMS receives payment for its provision of administrative services, the Final Rule does not explain how the mere pass-through of Medicaid payments for services from a

state to an FMS vendor to a homecare provider renders the deductions of union dues and other benefit payments a lawful assignment.

86. The Final Rule, both in its substantive justification and in its regulatory impact analysis, also fails to meaningfully address the substantial costs and burdens imposed on individual homecare providers, whom CMS admits will be forced to find alternative means for paying for their union dues and other employment benefits as a result of its action.

87. As with the NPRM, CMS concedes in the Final Rule that it failed to gather relevant data on the economic impacts of its regulatory action. In the NPRM, CMS admitted it lacked any data and asked the public to submit data to assist its economic analysis. However, CMS provided only a truncated 30-day comment period, and rejected requests to extend the comment period. Despite the truncated period, many unions and their members submitted information and data to inform CMS about the true cost of its proposal. In the Final Rule, CMS rejected this data out of hand, saying that the comments "were not supported by any substantive analysis." 84 Fed. Reg. at 19,724. Where the Final Rule does cite to data, it relies on right-wing news sources. *Id.* at 19,726 n.2.

88. In the Final Rule, CMS stated it was not preparing an analysis under the Regulatory Flexibility Act ("RFA") because it "ha[d] determined, and the Secretary certifies, that this final rule will not have a significant economic impact on a substantial number of entities." 84 Fed. Reg. at 19,726. CMS's determination is unsupported by data or analysis, as the agency conceded it lacked any reliable data on the economic impact of the Final Rule. Further, it contradicts OMB's determination that the Final Rule is economically significant and a major rule. OMB, *OIRA Conclusion of EO 12866 Regulatory Review*, https://www.reginfo.gov/public/do/eoDetails?rrid=128936 (last visited May 6, 2019).

89. Following issuance of the NPRM, numerous commenters notified CMS that they had long relied on CMS's decades-old interpretation of the anti-reassignment provision as not prohibiting payments to third parties for the benefit of providers that did not implicate the concerns about fraud and abuse that motivated Congress to enact the anti-reassignment provision. CMS did not address these reliance interests in its Final Rule, because it failed to acknowledge that longstanding position and failed to recognize that the 2014 Regulation simplified codified that understanding.

90. Even with respect to the reliance interests engendered by the 2014 Regulation, CMS's analysis was inadequate. CMS merely asserts, without any justification, that those interests "are not serious – and in any event, even if they are for the sake of argument, deemed to be serious – we believe that we have justified moving forward with our proposal notwithstanding those reliance interests." 84 Fed. Reg. at 19,720-21. The Final Rule reveals no serious consideration of the reliance interests of homecare providers, unions, and Plaintiff-States, based upon many years of payroll deduction practices.

5. Resultant Harm

91. If CMS is allowed to implement its erroneous construction of the anti-reassignment provision by adopting the Final Rule, Plaintiff-Intervenors will suffer substantial and immediate harm. Although the anti-reassignment statute, properly interpreted, does not prohibit customary deductions for employment costs and benefits such as union dues or health insurance premiums, the Final Rule purports to adopt, as CMS's final and conclusive interpretation, the new position that such deductions are prohibited by the statute.

92. Under this new interpretation of the statute, every state that processes homecare providers' requests to make payroll deductions from homecare providers' paychecks, even if voluntarily authorized, would be out of compliance with the requirements of the Medicaid Act. States that currently process voluntary dues deductions would be forced to terminate those deductions, and homecare providers' unions would face a risk of monetary liability (or at least the threat of litigation) for dues voluntarily paid by their members through payroll deductions transacted by the state. To avoid the substantial risks posed by CMS's new interpretation of the anti-reassignment provision, states, homecare provider unions, and homecare providers will be required to pursue alternative, far less effective, and higher cost mechanisms through which providers can pay voluntary union dues.

93. The elimination of dues deductions would impose substantial burdens on homecare providers who have voluntarily chosen to contribute to their unions by requiring them to mail monthly membership dues via check or otherwise. This would be particularly burdensome for the

many homecare providers who do not have bank accounts or credit cards and who work out of the homes of their care-recipient clients, rather than in a central location. SEIU members have first-hand experience with these difficulties in Virginia, where the state has in the past ceased dues deductions. Following the most recent termination of deductions, SEIU Virginia 512 was forced to commit substantial resources (which would otherwise have been committed to training homecare workers and advocating for improvements to the homecare system) to developing an alternate payment system, reaching out to members to sign them up, processing payments, and addressing payment problems. Even with this new system in place, only approximately 41% of former members were able to sign up for the new dues payment system. Because they could not pay their dues, the remaining 59% lost access to the local union's Member Services team, which helps members whose paychecks are missing or late; to the local union's CPR training; and to member discounts on numerous products. Under any alternative system, there is a substantial risk that providers will miss dues payments, putting the substantial benefits they gain from union membership at risk.

94. The Final Rule's interpretation of the anti-reassignment provision will have severe consequences for homecare providers beyond dues deductions. As discussed, many critical employment benefits, such as health insurance, are funded in part through payroll deductions. Under the Final Rule's interpretation of the anti-reassignment provision, such deductions will not be permissible. To continue paying for such benefits, providers will have to identify alternative mechanisms, which, even if available, will be far less reliable, add unnecessary costs, and greatly increase the risk that providers will miss one or more payments and therefore lose their benefits.

95. The Final Rule will also severely impair the ability of homecare provider unions to negotiate new or increased benefits for homecare providers. Many customary employment benefits that include an employee-paid portion, such as health insurance, retirement savings, or life insurance, are paid through payroll deduction, which ensures that the employee-paid portion of the benefits' cost is paid in a timely and reliable fashion. If payroll deduction cannot be used to pay that cost, benefits providers will either refuse to offer the benefits, significantly increase the cost of the benefits to account for the loss of a reliable means of ensuring provider payments, or cut off providers who fall delinquent in their payments, significantly compromising the utility of the benefits to the workforce.

96. Additionally, eliminating dues deductions will directly harm the unions that homecare providers have chosen to represent them in bargaining, including Local 503 and UDWA. Homecare providers have for years relied on payroll deductions to finance their unions' representational activities. By imposing an obstacle to voluntary dues payments, the Final Rule will impair members' ability to voluntarily support their unions through payment of member dues, severely eroding the unions' ability to advocate effectively for their members. Unions will have to divert significant resources to assist members in making their voluntary dues payments through alternative methods. Based on the experience in Virginia, it is also clear that homecare provider unions will see a substantial decrease in dues revenue following implementation of the Final Rule.

97. Homecare workers who provide Medicaid services but are employed by private agencies rather than by individual consumers face no risk of such injuries. Because Medicaid funds go to the agencies that employ them, and then to the homecare workers in their paychecks, the interpretation of the anti-reassignment provision set forth in the Final Rule will not present any impediments to continued deductions of union dues or deductions for other employee benefits from their paychecks.

FIRST CLAIM FOR RELIEF
(Violation of 5 U.S.C. §706(2)(A) because based on erroneous statutory interpretation)

98. Plaintiff-Intervenors incorporate by reference all preceding paragraphs as if fully set forth herein.

99. Defendants are subject to the requirements of the APA. *See* 5 U.S.C. §703. The Final Rule is final agency action subject to judicial review because it marks the "consummation of the . . . decisionmaking process" and is one "from which legal consequences will flow." *Bennett v. Spear*, 520 U.S. 154, 178 (1997) (internal quotation marks omitted).

100. The Final Rule is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law because it is based on an erroneous interpretation of the governing statute, 42 U.S.C. §1396a(a)(32).

101. The anti-reassignment statute was drafted to address factoring arrangements under

which Medicaid providers sold their right to Medicaid receivables at a discount. The anti-reassignment statute's terms do not proscribe routine employment deductions such as health care premiums and union dues deductions, and the statute was never intended to (and has never been construed to) apply to such deductions.

102. Section 1902(a)(32) prohibits "payment under the [state's Medicaid] plan to anyone other than such individual [recipient of care or service] or the person or institution providing such care or service, under an assignment or power of attorney or otherwise." Deductions to pay voluntary union membership dues do not involve payments "under an assignment or power of attorney," because union members do not assign their right to receive Medicaid payments to their union or grant their union any power of attorney.

103. Nor can the residual "or otherwise" language of the provision reasonably be construed to cover such deductions. Instead, that language must be interpreted to refer only to mechanisms similar to an "assignment" or "power of attorney" that permit third parties to act in the provider's shoes in seeking Medicaid payments, and thus present a similar potential for abuse. Under the established interpretive canons of *noscitur a sociis* and *ejusdem generis*, where general words (such as "or otherwise") follow specific words (such as "assignment or power of attorney") in a statutory enumeration, the general words must be construed to embrace only objects similar in nature to those enumerated by the preceding specific words. Deductions to pay voluntary union membership dues are nothing like payments premised upon an assignment or power of attorney, and in no way present the concerns raised by such assignments. They thus do not fall within the scope of §1902(a)(32)'s prohibition.

104. The Final Rule's interpretation of the statute to prohibit any payment to anyone other than a recipient or provider of services also violates the statutory construction principle that statutes should not be construed in a manner that renders words or phrases in the statutory language meaningless or insignificant. That is because the construction would make meaningless the phrase "under an assignment or power of attorney or otherwise"—the prohibition's scope would be exactly the same if that language were omitted.

105. Further, CMS's interpretation—that all payments to anyone other than the direct

provider are prohibited under the anti-reassignment statute—is inconsistent with its own prior interpretation of the Act. For example, 42 C.F.R. §447.10(g)(3) permits Medicaid payments to organized healthcare delivery systems, even though such payments are not expressly exempted from the anti-reassignment statute. The Final Rule is also inconsistent with the so-called "double lockbox" arrangement, where payments are deposited into a provider's account but are immediately transferred to a third party pursuant to the provider's standing instructions. This mechanism has been used for years to process Medicaid payments, with CMS's blessing, but is entirely inconsistent with its new interpretation of the anti-reassignment statute. Further, as described above, CMS explained in 2012 and 2014 that the anti-reassignment statute should not be interpreted to apply to practices that do not implicate the core concerns motivating its enactment.

106. These inconsistencies were raised in public comments during the rulemaking period.

107. The Final Rule is based on CMS's erroneous construction of the anti-reassignment statute as prohibiting deductions for routine employment costs and benefits. For that reason, it is arbitrary, capricious, and contrary to law, and the Final Rule must be invalidated.

SECOND CLAIM FOR RELIEF
(Violation of 5 U.S.C. §706(2)(A) because based on erroneous facts and arbitrary reasoning)

108. Plaintiff-Intervenors incorporate by reference all preceding paragraphs as if fully set forth herein.

109. The requirement that agency action not be arbitrary and capricious includes a requirement that the agency explain its result and respond to relevant and significant public comments.

110. The requirement that agency action not be arbitrary and capricious means that the agency must articulate a reasoned basis for its decision, and its action cannot be founded upon unsupported assertions or unstated inferences.

111. Here, however, the Final Rule is based on a fundamental misunderstanding of the employment relationship of homecare providers, the operation of fiscal management services, and the voluntariness of union dues deductions.

112. The Final Rule is also internally contradictory regarding the nature of the payroll deductions that are prohibited.

113. The Final Rule purports to rest on the view that the anti-reassignment statutory provision permits no additional exceptions or deviations from the statutorily delineated exceptions, but completely dismisses comments that pointed out an additional regulatory exception besides the 2014 Regulation.

114. The Final Rule failed to respond or address the numerous comments submitted that prohibiting payroll deductions for union dues and other benefits would result in significant costs and burdens to individual homecare providers. The Final Rule suggests alternatives for payment, such as bank account deductions, that the comments explained were not feasible. *See* 84 Fed. Reg. at 19,723. The Final Rule states that prohibiting payroll deductions "in no way prevents health care workers from purchasing health insurance, enrolling in trainings, or paying dues to a union." *Id.* at 19,722. But this statement is directly contradicted by comments in the record from individual homecare providers explaining why prohibiting payroll deductions would do exactly that.

115. The Final Rule also fails to respond to several other comments that raised serious flaws in CMS's reasoning and provided important data bearing on its decision.

THIRD CLAIM FOR RELIEF
(Violation of 5 U.S.C. §706(2)(A) based on failure to consider reliance interests)

116. Plaintiff-Intervenors incorporate by reference all preceding paragraphs as if fully set forth herein.

117. The Final Rule is arbitrary and capricious because Defendants failed to consider the substantial reliance interests engendered by the 2014 Regulation and decades of prior practice by CMS and states throughout the country pursuant to their longstanding interpretation of the anti-reassignment provision as not applying to payroll deductions for dues and other standard employee benefits, and the substantial reliance interests engendered by CMS's non-interference with states' past agreements to deduct union dues from providers' paychecks. Defendants incorrectly tie these reliance interests solely to the 2014 Regulation, despite being informed that these arrangements predated 2014.

118. Dues deductions for homecare providers have enabled the emergence of stable collective bargaining relationships that have improved the quality of the provider workforce and reduced provider turnover. Eliminating union members' ability to pay their voluntary dues through payroll deduction will both burden the providers and their unions, who must establish alternative and less reliable payment mechanisms, and threaten the stability of the collective bargaining system, which will be underfunded to the extent that some providers are unable to make alternative payment arrangements (because, for example, they cannot afford to pay the fees required to maintain a checking account that would enable electronic payment of dues) or others who will simply be unwilling to manually transmit dues to their union because of the additional inconvenience. In promulgating the Final Rule, CMS entirely ignored these reliance interests, even though they were raised in the public comments CMS received.

119. In promulgating the Final Rule, Defendants also ignored homecare providers' long-standing reliance on routine employment deductions for critical benefits such as health insurance. Requiring homecare providers to mail checks or otherwise submit healthcare insurance premiums on a periodic basis imposes a substantial burden on their ability to access healthcare. A homecare provider that inadvertently misses a payment could lose coverage, potentially resulting in large doctors' bills. Defendants failed to give any consideration or weight to these issues, although they were also raised in comments on the NPRM.

120. Instead, the Final Rule dismisses such reliance interests as "not serious" and fails to demonstrate that CMS gave any consideration to them. 84 Fed. Reg. at 19,720.

121. For these reasons as well, the Final Rule must be invalidated.

FOURTH CLAIM FOR RELIEF
(Violation of 5 U.S.C. §706(2)(A) based on improper considerations)

122. Plaintiff-Intervenors incorporate by reference all preceding paragraphs as if fully set forth herein.

123. Defendants' rulemaking is arbitrary and capricious, an abuse of discretion, and not in accordance with law because, among other things, Defendants' decision was based on improper considerations. Specifically, Defendants' rulemaking was motivated primarily by anti-union animus,

rather than any legitimate purpose.

124. As described above, the rulemaking was prompted by lobbying in op-eds and statements by lawmakers that specifically targeted payroll deductions for union dues.

125. The NPRM and the Final Rule focused almost exclusively on union dues deductions—indeed, it is the sole quantitative impact that the agency has suggested will result from the regulatory change. *See* 83 Fed. Reg. at 32254-55 (July 12, 2018); 84 Fed. Reg. at 19,725-26. And the NPRM's analysis was premised in part on the baseless assumption that union dues increase the amount of Medicaid payments. *See* 83 Fed. Reg. at 32254. Moreover, the NPRM and the Final Rule expressly relied upon conservative, anti-union sources such as the "Fairness Center" and an opinion piece in the Washington Examiner. *See* 83 Fed. Reg. at 32254 n.1; 84 Fed. Reg. at 19,726 n.2.

126. In the Final Rule, CMS dismissed out of hand data and information that the public comments provided it as not being based on substantive analysis (despite having allowed only a truncated 30-day comment period), yet relied again on these biased and unreliable sources focused entirely on union dues deductions.

127. In the Final Rule, CMS failed to undertake any economic analysis required under RFA, despite conceding that it lacked reliable data on the economic impacts of the action.

128. Defendants have rescinded a regulation, 42 C.F.R. §447.10(g)(4), that makes no mention of union dues deductions, yet the focus of its analysis of the Final Rule's impact is on such deductions. There is no basis in the text of the regulation or in any other relevant consideration for distinguishing union dues deductions from payroll deductions for other purposes. The only explanation for CMS's action is that it was motivated by a desire to harm unions.

129. For these additional reasons, the Final Rule must be invalidated.

FIFTH CLAIM FOR RELIEF
(Violation of Equal Protection; U.S. CONST. amend. V)

130. Plaintiff-Intervenors incorporate by reference all preceding paragraphs as if fully set forth herein.

131. The Final Rule violates the equal protection component of the 5th Amendment because it is not rationally related to a legitimate government interest. Rather, it was motivated by

animus toward unions and unionized workers.

132. Although the Final Rule ostensibly prohibits all deductions from Medicaid wages, its rationale, like the NPRM before it, makes clear that Defendants' overriding consideration in promulgating the rule was to harm unions representing Medicaid-funded homecare providers.

133. Because the Final Rule was motivated by a desire to harm a group that is particularly disfavored with the current federal administration and its supporters, it violates the equal protection component of the Fifth Amendment.

134. For this reason, the Final Rule must be struck down as unconstitutional.

SIXTH CLAIM FOR RELIEF
(Violation of the First Amendment; U.S. CONST. amend. I)

135. Plaintiffs incorporate by reference all preceding paragraphs as if fully set forth herein.

136. In prohibiting dues deduction, the Final Rule targets unions' and union members' ability to speak. CMS's new interpretation targets funds that unions and their members use to engage in speech and lobbying on matters of important public concern.

137. By interfering with providers' ability to support their unions, the Final Rule also deprives union members of the ability to associate with each other and their union.

138. CMS took these actions due to the expressive content of the speech and associational conduct of the unions and their members.

139. The Final Rule is intended to suppress speech by unions and their members, which is not a legitimate government purpose.

140. For this reason, the Final Rule must be struck down as unconstitutional.

RELIEF REQUESTED

WHEREFORE, Plaintiff-Intervenors pray that the Court:

1. Enter a preliminary injunction enjoining Defendants from implementing the Final Rule and requiring Defendants to leave 42 C.F.R. §447.10(g)(4) in place pending a decision on the merits;

2. Enter a declaratory judgment that the Final Rule is arbitrary and capricious and therefore invalid;

3. Enter a declaratory judgment that the Final Rule unconstitutionally targets a politically

disfavored group and therefore violates the Equal Protection Clause of the Fifth Amendment.

4. Enter a declaratory judgment that the Final Rule unconstitutionally targets Plaintiff-Intervenors' First Amendment-protected speech and associational activities and is therefore invalid;

5. Enter a permanent injunction prohibiting Defendants from implementing or otherwise giving effect to the Final Rule;

6. Award Plaintiff-Intervenors their costs and expenses, including reasonable attorneys' fees; and

7. Award such further and additional relief as is just and proper.

Dated: May 15, 2019

Respectfully submitted,

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