UNITED STATES DISTRICT COURT
DISTRICT OF THE DISTRICT OF COLUMBIA

MONTE A. ROSE, JR., *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 1:19-cv-02848-JEB
ALEX M. AZAR II, *et al.*,	)	
	)	
Defendants.	)	

MEMORANDUM OF INTERVENOR-DEFENDANT INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

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INTRODUCTION

For well over a decade Indiana has used the Healthy Indiana Plan (HIP) to deliver consumer-driven health coverage to Hoosiers in need. The Centers for Medicare & Medicaid Services (CMS) first approved HIP in December 2007, reapproved it multiple times over the next several years, and in January 2015 approved the State's plan to expand HIP to include individuals newly eligible for Medicaid under the Affordable Care Act. The program improved health outcomes and earned widespread approval from HIP members, so in 2017 the State applied to renew HIP for another three years in largely the same form. While CMS was considering this request, it separately suggested States might require Medicaid beneficiaries to seek or train for employment, and Indiana amended its renewal to add such requirements to HIP. In February 2018 CMS renewed HIP as amended, authorizing Indiana to continue to operate a program that now covers 400,000 Hoosiers.

Plaintiffs filed their challenge to the HIP approval on September 23, 2019—more than a year-and-a-half after the approval was issued, nearly five years after the State expanded HIP under the Affordable Care Act, and more than a decade after HIP first began. They principally challenge HIP's new community-engagement requirements under this Court's decisions invalidating work requirements in Kentucky and Arkansas—but demand that *all* of HIP fall as a consequence.

Several qualities distinguish the HIP waiver from the waivers this Court has previously addressed, but the most important is this: Vacating the HIP waiver would throw into chaos healthcare coverage for hundreds of thousands of HIP members—the vast majority of whom are not subject to the community-engagement requirements in the first place. And, because the State has already suspended the community-engagement requirements, that remedy would do nothing to help Plaintiffs. Invalidating HIP would be grossly inequitable. The Court should reject Plaintiffs' demand to do so.

STATEMENT OF FACTS

I. Statutory Background

Since its adoption in 1965, the Medicaid Act has offered federal funding to assist States in providing for the healthcare needs of especially needy individuals. *See* 42 U.S.C. § 1396a(a)(10). To receive funding, States must submit a Medicaid plan for approval by the Secretary of Health and Human Services, whose review is largely conducted by CMS; the state plan "must comply with federal criteria governing matters such as who receives care and what services are provided at what cost." *Nat'l Fed'n of Indep. Bus. (NFIB) v. Sebelius*, 567 U.S. 519, 541–42 (2012); *see generally* 42 U.S.C. § 1396a(a)–(b). "By 1982 every State had chosen to participate in Medicaid," *NFIB*, 567 U.S. at 542, and by 2010 "Medicaid spending account[ed] for over 20 percent of the average State's total budget," *id.* at 581, while federal Medicaid funds constituted "over 10 percent of most States' total revenue" *id.* at 542.

As originally enacted, the Medicaid Act provides funding for the most vulnerable categories of Americans: "pregnant women, children, needy families, the blind, the elderly, and the disabled." *Id.* at 575 (citing 42 U.S.C. § 1396a(a)(10)). The Affordable Care Act, however, expanded Medicaid's scope to "cover *all* individuals under the age of 65 with incomes below 133 percent of the federal poverty line." *Id* at 576 (citing 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)). The Affordable Care Act threatened States with the loss of *all* Medicaid funds if they failed to extend coverage to this expansion population, but in *NFIB* the Supreme Court held that the Constitution forbids the federal government from "withdraw[ing] existing Medicaid funds for failure to comply with the requirements set out in the expansion." *Id.* at 585. Accordingly, States may choose to provide coverage to both the original Medicaid population and the expansion population, or may "choose to reject the expansion" and provide coverage to just the original Medicaid population. *Id.* at 587.

Whichever choice a State makes, it will receive federal Medicaid funding so long as its state plan complies with the applicable statutory requirements. And federal law has long authorized the Secretary to waive many of these requirements: Under Section 1115 of the Social Security Act, the Secretary may approve any "experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid Act, and may waive any of the requirements in section 1396a "to the extent and for the period he finds necessary to enable such State or States to carry out such project." 42 U.S.C. 1315(a).

II. History of the Healthy Indiana Plan

1. HIP is a long-running Section 1115 demonstration project. It first took shape in 2007: After raising state funds through an increase in Indiana's cigarette tax, the Indiana legislature authorized the Indiana Family and Social Services Administration (FSSA) to seek approval from CMS for a health coverage program for uninsured Hoosiers who were not part of the original Medicaid population and were therefore at that time not otherwise eligible for Medicaid. *See* Ind. House Enrolled Act No. 1678 (2007).

CMS approved the Healthy Indiana Plan Section 1115 demonstration project in December 2007, for a five-year period beginning January 1, 2008, and ending December 31, 2012. *See generally* Center for Medicare & Medicaid Services, *Healthy Indiana Plan Special Terms and Conditions (Original STCs).* [1]

As further described in the terms and conditions of the demonstration approval, the waiver had two components: (1) "Hoosier Healthwise," which was Indiana's managed care program for low-income children and parents and caretaker relatives under Section 1931 of the Medicaid Act;

[1] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/files/IN_-_Healthy_Indiana_Plan_(HIP).pdf.

and (2) the Healthy Indiana Plan, which extended coverage to adults aged 17 to 64 with household income below 200% of the federal poverty level and who were not otherwise eligible for Medicaid. *See* U.S. Gov't Accountability Office, GAO-13-384, *Medicaid Demonstration Waivers* at 42 (2013), https://www.gao.gov/assets/660/655483.pdf ("Indiana received approval to operate two distinct health insurance programs."). As originally constituted, enrollment in HIP was capped so as not to exceed available state and federal funding. *See Original STCs* at 10.

From its inception, HIP was differentiated from Hoosier Healthwise and the rest of Indiana's Medicaid program. HIP was designed to empower its members to take greater personal ownership over their healthcare decisions and become more cost-conscious consumers of healthcare services. The cornerstone of that structure is a Personal Wellness and Responsibility (POWER) account, which operates similar to a health savings account. As further described in the Original HIP terms and conditions, the POWER accounts are primarily funded by the State, with additional contributions from participants according to a sliding scale based on income. *Original STCs* at 1–2, 19–23. Each participant is enrolled in a comprehensive coverage plan, with the first $1100 in services paid through the POWER account (not including $500 of preventive health services, which were not charged against the account). *Id.* at 1–2. At the end of the year, members would roll-over unspent balances—thereby decreasing future contributions—so long as they had obtained certain preventive services. *Id.* at 20.

In its initial iteration, HIP required all members to make a minimal monthly contribution to the POWER account, according to a sliding scale based on income. *Id.* at 20–21. HIP also eliminated retroactive coverage: Coverage instead began on the first day of the month after the initial HIP contribution. *Id.* Individuals who did not make a contribution within 60 days of the required due date were terminated from the program and could not re-apply for one year. *Id.* at 24–25. Other

unique features of HIP included an increased copayment for non-emergency use of the emergency room, *see id.*, at 18; a benefit package that did not include non-emergency transportation, *id.*, at 16–17; and an annual and lifetime cap on benefits, *id.* at 18. (Individuals who reached the cap were transferred into a state high-risk pool). These various features were implemented through waivers of Medicaid rules governing retroactive eligibility, prompt enrollment into Medicaid, non-emergency transportation, and imposition of premiums. *See* Expenditure Authority for Health Indiana Plan (Jan. 1, 2008 through December 31, 2012), Waivers # 1, 2, 3, 7, and 9).[2]

Early evaluations of the program indicated that the HIP design led to greater patient engagement with health providers, higher utilization of preventative care services, lower emergency department usage, and member satisfaction rates of more than 94 percent. *See* Healthy Indiana Plan 1115 Waiver Extension Application at 5 (submitted December 28, 2011).[3]

2. In March 2010, two years after HIP's implementation, Congress enacted the Affordable Care Act. The Affordable Care Act's expansion population had a substantial overlap with the HIP demonstration population, and Indiana officials immediately informed CMS that it hoped to "find a way to use the successful HIP plan as the vehicle for covering the newly eligible population in 2014," and that "Indiana is interested in continuation of the waiver, if HIP can be the coverage vehicle for all the newly eligible individuals" Letter from Anne Murphy to Cindy Mann, dated May 17, 2010.[4]

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[2] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-HIP/in-healthy-indiana-plan-expnditure-auth-01012008-12312012-amended-012010.pdf.

[3] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/HIP1115RenewalSubmission.pdf.

[4] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/CMS_HIP_letter_May_17_2010.pdf.

When CMS expressed concern that the required POWER account contributions were not consistent with Medicaid rules limiting premiums at certain income levels, Indiana Governor Mitch Daniels explained to Kathleen Sebelius, the Secretary of Health and Human Services, that the POWER account contributions are "central to the HIP structure, and eliminating the program's POWER account would effectively be the demise of this program." Letter from Governor Mitch Daniels to Secretary Kathleen Sebelius, dated January 14, 2011.[5] Governor Daniels pointed out that "over 98%" of HIP participants made their POWER account contributions on time, proving "that the Medicaid population is capable of making this very modest payment, which is critical to appropriate utilization and cost-containment." *Id.* He further noted that "HIP was implemented with bi-partisan support in the Indiana General Assembly and reflects the values of our state. Indiana prefers to promote this program that contains consumer-focused incentives for personal responsibility instead of a traditional Medicaid entitlement program." *Id.* And finally Governor Daniels observed that the Indiana General Assembly would soon "consider a bill that calls for the HIP plan to be the coverage vehicle for the newly-expanded population under ACA" and asked the Secretary to "review HIP's advantages carefully and allow this program not only to survive, but also serve all of Indiana's newly-eligible Medicaid population." *Id.*

In December 2011, one year before the original HIP waiver was set to expire, Governor Daniels submitted an application to extend it for another three years "on behalf of the 50,000 current HIP participants and the approximately 500,000 Hoosiers who will be newly eligible to receive Medicaid in 2014." Letter from Governor Daniels to Secretary Sebelius, dated December

[5] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/011411letter.pdf.

28, 2011.[6] He noted that "the Indiana Legislature passed a law (Indiana Code 12-15-44.2), on a bipartisan basis, that calls for HIP to be the coverage vehicle for the Medicaid expansion in 2014." He also pointed out that the evidence indicated that HIP had "proven to be far superior to a traditional Medicaid program." *Id.* HIP members liked HIP: "Over 99% of HIP participants that were surveyed would re-enroll in the program." *Id.* And HIP's modest requirements accomplished the program's objectives: "Eighty percent of HIP participants completed their preventive services required for their personal POWER account rollover. Members have lower non-emergency ER use versus the traditional Medicaid population, higher generic drug use than a comparable commercial population, and over 97% pay their required contributions on time." *Id.* Most importantly, Governor Daniels explained that "HIP gives dignity to its participants. It believes in their ability to make consumer driven choices and value based decisions when they seek health care." *Id.*

While Indiana's application was pending, the Supreme Court issued its decision in *NFIB* holding that the Affordable Care Act's Medicaid expansion was optional rather than mandatory. Several weeks after the Court issued the decision, FSSA inquired as to the status of its waiver extension request and informed CMS that, in light of *NFIB*, it had "not yet made a decision to expand our Medicaid program . . . however, if Indiana chooses to do so, the State is committed to using the HIP program to cover this new population." Letter from Michael Gargano to Cindy Mann, dated July 25, 2012.[7]

CMS responded by approving "a one-year extension of the Demonstration through December 31, 2013" in order to "allow Indiana to provide continued coverage under its Demonstration

[6] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/HIP1115RenewalSubmission.pdf.

[7] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/Healthy_Indiana_Plan_1115_Waiver_07_25_2012.pdf.

while allowing time for the state and CMS to continue our discussions as Indiana considers its options for 2014." Letter from Cindy Mann to Michael Gargano, dated July 31, 2012.[8]

In February 2013, Indiana again applied for a three-year extension of HIP. In the renewal request, Indiana Governor Michael Pence informed the federal government that "our administration will not pursue an expansion of traditional Medicaid as permitted under the Affordable Care Act" and that "[o]ur administration would predicate any expansion of Medicaid in Indiana on our ability to promote Hoosier innovation in the Healthy Indiana Plan to the expanded population." Letter from Governor Michael Pence to Secretary Sebelius, dated February 13, 2013.[9] While the parties discussed whether and how HIP could be modified to address CMS's concerns regarding HIP's suitability for the Medicaid expansion population, CMS again extended the demonstration for a one-year period. *See* Letter from Cindy Mann to Debra Minott, dated September 3, 2013.[10]

The Affordable Care Act's Medicaid expansion went into effect on January 1, 2014, providing 100% federal funding for the first three years of operation. Still in the midst of negotiations with CMS, Indiana chose not to participate, instead accepting a more limited federal match for a smaller population through the HIP waiver. *Id.*

On July 2, 2014, after months of discussion with CMS, Indiana filed yet another application for a Section 1115 waiver to modify and expand HIP to include the entire Medicaid expansion population. Indiana's application proposed modifications to address various concerns CMS had

[8] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/CMS_IN_Letter_7_31_12.pdf.

[9] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/Letter_HIP_Updated246.pdf.

[10] Publicly available on the CMS website at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/esrd/in-esrd-tenp-ext-09302013.pdf.

raised, and in his letter submitting the application on behalf of the State, Governor Pence noted that HIP "has an exceptional level of bipartisan support from a wide array of health care consumers, stakeholders, and legislators" and thanked CMS for "many months of productive, good faith discussions." Letter from Governor Pence to Secretary Sylvia Burwell, dated July 2, 2014.[11] He noted, however, that if CMS were to "require modifications to this waiver that would compromise [HIP's] consumer-driven approach, the State of Indiana would need to reassess the feasibility of expansion." *Id.* Several more months of extensive discussions and negotiations ensued, necessitating another brief extension of the existing HIP demonstration while the parties finalized the terms and conditions of "HIP 2.0," as the proposed program was then known.

CMS approved HIP 2.0 on January 30, 2015, for the period from February 1, 2015 through January 31, 2018. The cover letter to the special terms and conditions (STCs) noted that "[t]hrough this demonstration and associated state plan amendments, the state will provide coverage to adults in Indiana with incomes through 133 percent of the federal poverty level (FPL)." *See* Letter from Eliot Fishman to Joseph Moser, dated January 30, 2015.[12] The "Fact Sheet" released by CMS also noted that "[t]his demonstration extends coverage to adults in Indiana with incomes through 133 percent of the federal poverty level (FPL) beginning February 1, 2015." Healthy Indiana Plan 2.0 Section 1115 Medicaid Demonstration Fact Sheet (HIP 2.0 Fact Sheet), dated January 27, 2015.[13]

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[11] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-exp-app-07022014.pdf.

[12] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appvl-ltr-01302015.pdf.

[13] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-old-fs-01272015.pdf.

Shortly after it received the approval to operate HIP 2.0, Indiana submitted a state plan amendment adopting the Medicaid expansion, with a retroactive effective date of February 1, 2015, to coincide with the HIP approval date. *See* Public Notice, Indiana State Plan Amendment, dated February 11, 2015.[14] CMS approved the plan amendment on February 12, 2015.

HIP 2.0 kept many of the features of the original HIP demonstration, but also made several changes. Among other things, HIP 2.0 separated HIP from Hoosier Healthwise—which was now authorized under a separate authority—and eliminated the annual and lifetime caps on benefits. HIP 2.0 increased the POWER accounts to $2500, but modified the structure for member contributions by giving some members the option to choose between two benefit packages: HIP Basic (which requires co-payments for certain services but does not require POWER account contributions) and HIP Plus (which requires POWER account contributions, but requires no co-payments and provides additional benefits). Both plans include state contributions to members' POWER accounts and cover all essential health benefits mandated by the Affordable Care Act, and HIP Basic's cost-sharing provisions comply with the Medicaid Act. As the CMS Fact Sheet explains, the POWER accounts are "used to pay for some of beneficiaries' health care expenses covered under the demonstration. Through the use of such accounts the state intends to promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care." HIP 2.0 Fact Sheet at 1.

The Section 1115 waiver authorized Indiana to require POWER account contributions as a condition of eligibility for individuals with incomes above 100 percent of the FPL but not for individuals with lower incomes, who are automatically enrolled in HIP Basic if they do not make

[14] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/HIPSPAPublic-Notice(1).pdf.

POWER account contributions. *See id.* As with the original HIP program, individuals who enrolled in HIP and were required to make a POWER account contribution (*i.e.*, individuals with incomes above 100% of the FPL) but failed to do so were subject to disenrollment after a 60-day grace period. HIP 2.0, however, shortened the "lock out" time after disenrollment from 12 months to 6 months. In addition, unlike the original HIP, members who were determined to be medically frail or who met specific circumstances, would not be disenrolled but instead would move from HIP Plus to HIP Basic or state plan coverage. *Id.*

HIP 2.0 retained the original HIP's waiver of non-emergency transportation and the waiver of "retroactive eligibility" (*i.e.*, payment under for costs incurred prior to the date an individual applies for Medicaid coverage). As CMS explained in the HIP 2.0 Fact Sheet, "reflecting the unique design of HIP 2.0, coverage will be effective: 1) the first day in the month in which an individual makes a POWER account contribution; or, for those with incomes at or below 100 percent of the FPL who do not make a POWER account contribution, coverage will start 2) the first of the month in which the 60 days payment period expires." *Id*. CMS required the State to evaluate and report on the impact on access to care of both the waiver of non-emergency transportation and the waiver of retroactive eligibility, which the State did in November 2015[15] and February 2016,[16] respectively.

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[15] *See Prior Claims Payment Program Report* at 4 ("The Prior Claims Payment Program has had little use within the State, as indicated by just 10 percent (628 of 5,950) of eligible members having claims under the program. Through the combination of the individual mandate and the expansion of affordable healthcare coverage options through HIP and the Marketplace, more Hoosiers are enrolling (and staying enrolled) in health insurance plans."). Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-prior-claims-pymt-rpt-10272015.pdf.

[16] *See* LewinGroup, *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver* (2016), at 42 ("In sum, the member surveys show a small number of individuals

3. On January 31, 2017, the State submitted its application to renew HIP for another three years. *See* Healthy Indiana Plan Section 1115 Waiver Extension Application.[17] As Governor Holcomb noted in his cover letter to the application, HIP's "consumer skin-in-the-game approach has yielded better health outcomes and helped members be better informed and more active participants in their health outcomes." *Id.* He noted:

- Of the nearly 70 percent of members who have enrolled in HIP Plus, 92 percent of members below the poverty line and 94 percent of those above the federal poverty level make regular contributions to an account similar to a health savings account.
- HIP members making contributions to their accounts are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not.
- HIP provides a $2,500 deductible, which is funded by a combination of personal and state contributions. After their first year of enrollment, more than 62% of all HIP members successfully managed their POWER accounts, spending less than their $2,500 deductible.

missed appointments due to transportation related issues. However, both members with and without NEMT, whether provided by the State or a MCE [(managed care entity)], reported transportation issues leading to missed appointments. The rates were similar, particular for those with and without MCE-provided coverage, implying that simply providing NEMT benefits does not eliminate all transportation problems for HIP 2.0 members."). Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-eval-nonemerg-med-transport-02262016.pdf.

[17] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-02152017.pdf.

- Nearly half of all HIP members (48 percent) earned the rollover incentive, with an average amount of $113 eligible to offset future contribution requirements.

Id. As part of this waiver application, Indiana also sought to include expanded access to substance use disorder (SUD) services, including residential treatment services and addiction recovery management. *Id.*

While the application was pending, on March 14, 2017, the Secretary, together with the new CMS Administrator, sent a letter to the nation's governors announcing their intent to support "innovative approaches to increase employment and community engagement" in Medicaid through Section 1115 waivers. Letter from Secretary Thomas Price to Governors.[18] In response, on July 20, 2017, the State submitted an amendment to its application to include a community-engagement requirement known as "Gateway to Work" for certain HIP members. AR 3832–3924.

As the State noted in its amendment to its waiver application, the proposed Gateway to Work program was an extension of an existing voluntary program that the State first implemented in 2015. This voluntary program reflected the well-known connection between employment and health by integrating the State's various work-training and job-search programs with HIP: Any eligible HIP member who was unemployed or working less than 20 hours per week was referred to available employment, work-search, and job-training programs to assist the member in securing gainful employment. The State explained that because this initial voluntary program had very few participants, it sought to make participation in Gateway to Work a condition of eligibility for all able-bodied working-age HIP members who are unemployed or working less than 20 hours per week averaged over eight (8) months of the eligibility period. *Id.* at 3836. The State proposed a

[18] Publicly available on the CMS website at https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

number of targeted exemptions to these requirements, including exceptions for pregnant women, students, homeless individuals, recently incarcerated individuals, and the medically frail, as well as a wide range of activities that would qualify to meet the requirement. *Id.* at 3839.

The State proposed a careful and deliberate implementation, to begin during the first year of the waiver renewal period (2018) and phased in during the second year, with a grace period of six months. *Id.* at 3837. The community-engagement requirements would gradually increase from five hours per week up to a maximum of twenty hours per week. *Id.* at 3838–39. Following the six month grace period, HIP members who were unemployed or working fewer than 20 hours per week and not otherwise meeting an exemption would be required to participate in the Gateway to Work program and report community-engagement hours as a condition of eligibility. *Id.* Members would be assessed for compliance once per year, and would be required to meet the minimum number of community-engagement hours (or an applicable exemption) for eight out of twelve months. *Id.* Members who failed to complete the specified number of required hours would be suspended from HIP until they satisfied the requirement for one full month. *Id.* Members who were suspended and then became exempt—by becoming pregnant, for example—would be able to reenter HIP without completing the community-engagement requirement. *Id.* at 3839.

On February 1, 2018, CMS approved the State's waiver application, effective from February 1, 2018 through December 31, 2020. In addition to renewing HIP, the approval made some minor modifications related to calculations of POWER account contributions, included a newly enhanced SUD benefit, and authorized the Gateway to Work community-engagement requirements. Under the waiver, HIP continues to include the previously approved two-tier benefit system; the previously approved requirement for POWER account contributions to access HIP Plus

benefits; the previously approved six-month lockout for failure to make a POWER account contribution (which applies to those over 100% of the federal poverty level and not otherwise exempt); the previously approved waiver of non-emergency transportation; and the previously approved waiver of retroactive eligibility.[19] The community-engagement requirements included in the approval were largely in line with those proposed in the State's application. *Id.* at 0025–32.

The State began implementation of the Gateway to Work program in January 2019. *See HIP Quarterly Report January – March 2019* at 6.[20] Working through the managed care entities that help administer HIP, the State classified members into "reporting," "reporting, requirements met," and "exempt." *Id.* The number of required activity hours began at zero in the first two quarters of January 2019 to allow members time to learn about the program, find activities, and set up their FSSA Benefits Portal account. *See Learn about Gateway to Work*.[21] The number of required hours then gradually increased to 20 hours per month in the third quarter and 40 hours per month in the fourth quarter. *Id.* FSSA required the managed care entities to provide education, coordination, and employment-related training assistance to enrollees, including those who are at risk of falling short of the threshold requirements. *See Renewal Request for the Healthy Indiana Plan* at 24–25.[22] Members received regular communications regarding their reporting status, hours, and

[19] The waiver approval also authorized the State to impose a six-month lock-out penalty for individuals who failed to return the forms required as part the annual redetermination process, but the State has declined to implement this penalty. AR 0039.

[20] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-hip-qtrly-rpt-jan-mar-2019.pdf.

[21] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/2592.htm.

[22] Publicly available on Indiana's HIP website at https://www.in.gov/fssa/hip/files/HIP%20Extension.pdf.

available resources, and their health plans conducted direct outreach to members who have not yet met their reporting requirements. *Id.*

FSSA initially planned to begin enforcement of the Gateway to Work community-engagement requirements in December 2019. FSSA would determine whether members who were subject to the requirements met the engagement threshold in at least 8 of the previous 12 months, and if a member had not done so, eligibility would be suspended—to be lifted as soon as the member met reporting requirements for one month or qualified for an exemption. *Id.* at 25. On October 31, 2019, however, after Plaintiffs filed the present action, FSSA announced that it is voluntarily suspending enforcement of the community-engagement requirements; FSSA is therefore not currently suspending any HIP members for failure to comply with the requirements. *Id.* at 25.

III. Procedural History

On September 23, 2019, Plaintiffs filed a complaint against the Department of Health and Human Services, CMS, and the officials who administer these agencies (collectively, the Federal Defendants) challenging the Secretary's 2018 approval of HIP. ECF 1. The complaint challenges the following aspects of the program: (1) the work and community engagement component; (2) the premium requirements; (3) lockouts for failure to comply with the Medicaid redetermination procedures; (4) the waiver of the retroactive coverage requirement; and (5) the waiver of the non-emergency transportation benefit. *See id.* at ¶¶ 241–73. Plaintiffs also challenge HIP as a whole, as well as a letter the Secretary issued to state Medicaid directors in January 2018. *Id.* at ¶¶ 227–40; 274–91. On October 11, 2019, Indiana filed a motion to intervene in this action, which the Court granted. ECF 12.

On October 23, 2019, Plaintiffs moved for an expedited briefing schedule. ECF 16. On October 31, 2019, FSSA announced that its voluntary suspension of the Gateway to Work requirements, doing so in large part to minimize any risk to the continued operation of HIP as a whole. ECF 18-2. In light of that voluntary action, FSSA and the Federal Defendants jointly moved to stay this case pending the resolution of the appeals in *Stewart v. Azar*, No. 19-5096 (D.C. Cir.). and *Gresham v. Azar*, No. 19-5094 (D.C. Cir.). ECF 18; ECF 19.

On November 21, 2019 the parties appeared for a hearing on the pending motions. The Court invited FSSA and the Federal Defendants to file a memorandum explaining why "a) the approval of Indiana's work requirements is materially different and/or b) why even if it is not, other challenged components of HIP should not be struck down in the event the D.C. Circuit affirms this Court's rulings on the Kentucky and Arkansas approvals." Minute Order of November 21, 2019. On December 9, 2019, FSSA timely informed the Court of its intent to do so. ECF 27.

SUMMARY OF THE ARGUMENT

The approval of HIP's community-engagement requirements should be decided on its own merits because this approval is materially different than the approvals challenged in *Stewart* and *Gresham*. Unlike the approvals at issue in those cases, here the State designed the new community-engagement requirements to minimize coverage loss and consequently projected a considerably smaller estimate of the requirements' effect on coverage. In particular, the State provided for gradual implementation of the community-engagement requirement over time, included a range of qualifying activities, and put in place a number of exemptions from the requirement.

Regardless, even if there were a defect in the approval of the community-engagement requirements, it would not justify striking down all of HIP. The community-engagement requirements are severable from the rest of HIP, which has been approved and extended by CMS since 2007 and on which hundreds of thousands of Hoosiers rely. HIP is a comprehensive coverage

vehicle that has long included many other features that operate independently of the community-engagement requirements, and there is strong evidence that CMS would have approved the waiver without the community-engagement requirement as it had before; it is therefore proper to sever these requirements from the rest of HIP. Moreover, completely vacating the waiver is inappropriate here because doing so would invalidate HIP in its entirety. This would impose enormous disruption on HIP beneficiaries while—because of the State's voluntary suspension of the community-engagement requirements—providing no benefit to Plaintiffs.

ARGUMENT

I. The Approval of HIP's Community-Engagement Requirements Is Materially Different From the Approvals This Court Invalidated in *Stewart* and *Gresham*

A. Indiana's community-engagement program uniquely minimizes coverage loss

Consistent with HIP's overall mission of promoting health outcomes and personal responsibility, the objective of the Gateway to Work community-engagement requirements is to connect Medicaid recipients who are able to work with the resources and opportunities to do so. This initiative first began in 2015 when the State consolidated its work search and job training programs to form Gateway to Work and referred all Medicaid applicants working fewer than 20 hours a week to the program for voluntary participation. When the first 15 months of the program resulted in only 580 members accepting the referral (even though many HIP enrollees are unemployed or working less than 20 hours a week), the State concluded that under the voluntary initiative, "members are not properly incentivized to actively seek employment" and that "non-exempt able-bodied HIP participants, as well as the State in general, would benefit from conditioning HIP eligibility on the member: (1) working at least 20 hours per week; (2) being enrolled in full-time or part-time education, or (3) participating in the Gateway to Work initiative." AR 3839–40.

Because the State's goal was to increase employment among covered individuals, not to induce coverage loss, it created an approach specifically tailored to that goal by (1) phasing in the required hours over several months from five per week to 20 per week; (2) engaging HIP managed care entities to provide education, coordination, and employment-related training assistance to enrollees at risk of falling short of threshold requirements; (3) providing members regular communications regarding their reporting status, hours, and available resources, including communications directly from their health plans; (4) determining compliance only annually and only by reference to whether the member met the requirements 8 out of the preceding 12 months; and (5) permitting reinstatement where a suspended member shows compliance for just one month.

In addition, the State afforded numerous deliberate exemptions for students, pregnant women, individuals with temporary illness or incapacity, or other good causes. AR 0025–26. The State also identified a range of activities that would meet the engagement requirements, such as job skills training, job search activities, education, community or public service, and volunteer work. *Id.* at 0026–27.

For these reasons, Indiana's program is unique with respect to both its planning and its implementation. HIP, for example, assesses members' compliance with the requirements *annually*, requires compliance in only 8 out of 12 months, and reinstates members after just one month of compliance. Kentucky's and Arkansas's programs, on the other hand are much stricter. Kentucky's program assesses compliance *monthly* and suspends coverage approximately 30 days after a beneficiary fails to meet the monthly requirements. *See* Letter from Paul Mango to Carol H. Steckel, dated November 20, 2018, *Special Terms and Conditions* at ¶ 46.[23] Under Arkansas's program,

[23] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

"individuals who do not report sufficient qualifying hours for *any three months* in a plan year are *disenrolled from Medicaid for the remainder of that year* and not permitted to re-enroll until the following plan year." *Gresham v. Azar*, 363 F. Supp. 3d 165, 172 (D.D.C. 2019) (emphasis added).

Because HIP's community-engagement requirements are meaningfully distinct from the requirements at issue in *Stewart* and *Gresham*, there is no reason those cases require invalidating Indiana's community-engagement requirements. Because Indiana has used its actual experience with an unsuccessful voluntary program to design HIP's community-engagement requirements so as to maximize successes and minimize coverage loss, the Court should uphold CMS's approval of these requirements.

B. In light of the unique aspects of HIP's community-engagement requirements, Indiana's waiver application estimated a coverage loss considerably smaller than those at issue in *Stewart* and *Gresham*

Furthermore, in light of the community-engagement requirements' many features that work to maximize compliance and minimize coverage loss, Indiana's application projected that the requirements would have a considerably smaller effect on coverage than the requirements at issue in *Stewart* and *Gresham*. In particular, as set forth in attachments to the State's application, the State's actuary estimated that the Gateway to Work program would be mandatory for approximately 30% of current HIP members (roughly 130,000 of HIP's 400,000 members), only about 75% of whom would remain enrolled in HIP for a year and be subject to community-engagement assessment. AR 3865. The State's actuary estimated that about 25% of these remaining HIP members—somewhat less than 25,000 individuals, or about 6% of all HIP members—would experience coverage suspension for non-compliance until they satisfied the requirements for one full month or became exempt from the program. *Id.*

Notably, this proportion of affected individuals is considerably smaller than those at issue in *Stewart* and *Gresham*. *Stewart* involved a projected coverage loss each year of 95,000, *21%* of the projected 454,000 participants in Kentucky's waiver program, *see Stewart v. Azar (Stewart II)*, 366 F. Supp. 3d 125, 141 (D.D.C. 2019). *Gresham*, meanwhile, involved an actual coverage loss of 16,000 over just four months, and it is reasonable to presume that over the course of a year that number would rise threefold to approximately 48,000, or about *17%* of the roughly 278,000 participants in Arkansas's waiver program. *See Gresham*, 363 F. Supp. 3d at 171–72; Plaintiffs' Reply Mem. at 16, 29, *Gresham*, 363 F.3d at 172, ECF 42; Arkansas Works Reports June–November 2018 at 18, 27, 36, 45, *Gresham*, 363 F.3d at 172, ECF 42-1.

In sum, HIP's community-engagement requirements are meaningfully distinct from the requirements challenged in *Stewart* and *Gresham*—distinctions underscored by the State's waiver application itself. Accordingly, the approval of these requirements should be evaluated on its own terms and should be upheld because the requirements are "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a).

II. Even If the Approval of HIP's Community-Engagement Requirements Were Unlawful, HIP's Unique History and Structure Would Make Vacating the Entire Waiver Inappropriate Here

Even if the Court were to conclude that the Secretary's approval of the HIP community-engagement requirements is materially similar to the approvals it invalidated in *Stewart* and *Gresham*, any deficiency in the approval of this discrete, recently added component of HIP would come nowhere close to justifying invalidation of the entire program. The waivers invalidated in *Stewart* and *Gresham* pertained to newly approved programs that had been implemented, if at all, only recently; vacating the waivers challenged in these cases therefore produced negligible, if any, changes to the status quo as practically experienced by the Medicaid beneficiaries in Kentucky

and Arkansas. The Court therefore concluded that the harms beneficiaries would "suffer from leaving in place a legally deficient order" outweighed "the disruptions" caused by vacatur. *Gresham v. Azar*, 363 F. Supp. 3d 165, 185 (D.D.C 2019).

Here, however, the situation is precisely reversed. The State has suspended implementation of the community-engagement requirements for the duration of this litigation, so Plaintiffs face no prospect of harm arising from any deficiency related to the approval of these requirements. And the waiver Plaintiffs challenge authorizes the entirety of HIP—a program that has existed in some form for well over a decade and covers more than 400,000 beneficiaries, nearly one quarter of Indiana's entire Medicaid population. Wholly vacating the waiver would drastically disrupt the justified and longstanding expectations of the hundreds of thousands of Hoosiers who are satisfied with HIP and have come to rely on it for their healthcare needs. It would be patently inequitable to invalidate HIP and thereby impose severe uncertainty on *all* HIP members—much less to do so on the basis of a defect relating to a new HIP component that applies to a narrow subset of HIP members, was approved just two years ago, and has yet even to be fully implemented.

For these reasons, the Court should decline Plaintiffs' invitation to invalidate all of HIP. It should instead either sever the community-engagement requirements from the rest of the program or simply remand the matter back to CMS without vacating the approval. Severability is appropriate because CMS has approved HIP multiple times without the community-engagement requirements; there can therefore be little doubt that CMS would have approved FSSA's waiver application if it, as originally submitted, did not include the Gateway to Work program. And remand without vacatur is appropriate because the "disruptive consequences" of vacatur far outweigh any deficiency in the approval of the community-engagement requirements. *Chamber of Commerce v. S.E.C.*, 443 F.3d 890, 908 (D.C. Cir. 2006) (quoting *Allied-Signal, Inc. v. U.S.*

Nuclear Regulatory Comm'n, 988 F.2d 146, 150–51 (D.C. Cir. 1993)). Because the State has already voluntarily suspended implementation of the community-engagement requirements, severing the community-engagement requirements and remanding without vacatur would prevent any injury to Plaintiffs while still ensuring that the hundreds of thousands of HIP members can continue to receive the consumer-focused medical coverage on which they have come to depend.

A. The approval of the recently adopted community-engagement requirements should be severed from the approval of HIP's longstanding components

"Whether an administrative agency's order or regulation is severable, permitting a court to affirm it in part and reverse it in part, depends on the issuing agency's intent." *Davis Cty. Solid Waste Mgmt. v. E.P.A.*, 108 F.3d 1454, 1459 (D.C. Cir. 1997) (per curiam) (quoting *North Carolina v. F.E.R.C.*, 730 F.2d 790, 795–96 (D.C. Cir. 1984)). Severance is the default: Severing an unlawful portion of an agency decision from the otherwise-lawful remainder is only "improper if there is 'substantial doubt' that the agency would have adopted the severed portion on its own." *Id.* (quoting *North Carolina*, 730 F.2d at 796). And in answering the counterfactual question posed by the severability analysis, courts routinely rely on the agency's prior decisions: Where, as here, an agency has *previously* favored a policy that did not include the now-challenged provision, it stands to reason that, had it known the provision was unlawful, the agency would have favored the policy *this time* as well. In such a circumstance, the court will vacate the challenged provision while leaving the rest of the agency's decision intact.

This is, for example, the approach the D.C. Circuit took in *Republican National Committee v. Federal Election Commission*, 76 F.3d 400, 403 (D.C. Cir. 1996), where the Court considered a challenge to a Federal Election Commission regulation that required political committees to respond to a donor's failure to disclose certain personally identifying information by sending a follow-up that (1) requested the information; (2) stated that federal law obligates political committees

to report the information; and (3) refrained from including anything else other than a brief expression of gratitude. The Court held that the mandatory statement was unlawful, but because the "initial proposed regulation did not even include the requirement of a mandatory statement, [the Court had] little doubt that the regulation is severable." *Id.* at 410 (internal citations omitted). It therefore vacated *only* the mandatory statement and allowed the Commission to continue to enforce the regulation's other provisions, including the requirement to send a follow-up request. *Id.*

Similarly, in *Davis County Solid Waste Management*, the D.C. Circuit relied on the Environmental Protection Agency's prior regulations in severing emission standards the agency had promulgated for municipal waste combustors. The standards violated the Clean Air Act because they categorized combustors on the basis of the aggregate capacity of the plant at which a combustor was located instead of combustor's individual unit capacity. *Davis Cty. Solid Waste Mgmt.*, 108 F.3d at 1455. Yet the Court vacated the standards *only* as applied to combustors with a small unit capacity, allowing them to continue to apply to large units. *Id.* at 1460. It was irrelevant that the agency had not "separately issued standards for existing large units." *Id.* at 1459. Instead, what mattered was whether the agency "would have adopted the same standards for existing large units . . . had [it] not erroneously interpreted [the Clean Air Act] as allowing it to adopt an aggregate . . . capacity approach." *Id.* The Court concluded that it was "clear" that the agency would have done so, because the previous emissions standards had "consistently differentiated between . . . units based on size," and because the standards for large and small units "operate[d] entirely independently of one another." *Id.*

Indeed, this is precisely the approach this Court took in *Stewart*, which involved a challenge to CMS's approval of Kentucky's "KY HEALTH" Section 1115 demonstration project. *Stewart v. Azar (Stewart I)*, 313 F. Supp. 3d 237, 246 (D.D.C. 2018). Kentucky's proposal included

"two key programs," "as well as some others not challenged": "(1) Kentucky HEALTH—not to be confused with the umbrella KY HEALTH—a 'program' that applies only to 'adult beneficiaries who do not qualify for Medicaid on the basis of a disability'; and (2) Substance Use Disorder (SUD) Treatment, which would be available for all Medicaid beneficiaries." *Id.* While the Court held that the Secretary's approval of Kentucky Health was unlawful, it declined to invalidate the entire waiver because "CMS has repeatedly affirmed its commitment to approving stand-alone SUD programs and has regularly done so for other states." *Id.* at 273. "The Court therefore ha[d] no 'substantial doubt' that the Secretary would have approved the SUD project without Kentucky HEALTH," and it thus vacated the Secretary's approval of Kentucky Health while "leav[ing] that [SUD] program—along with the rest of KY HEALTH—intact." *Id.* at 273–74 (quoting *North Carolina*, 730 F.2d at 796); *see also Newton-Nations v. Betlach*, 660 F.3d 370, 382 (9th Cir. 2011) (concluding that the approval of Arizona's increased cost-sharing requirements violated Section 1115, but—instead of invalidating the demonstration project in its entirety—vacating only the increased cost-sharing requirements themselves).

Similarly, here there is no "substantial doubt" that CMS would have approved HIP without the community-engagement requirements. The community-engagement requirements plainly "operate entirely independently of" the other features of HIP. *Davis Cty. Solid Waste Mgmt.*, 108 F.3d at 1459. These other features existed for many years without the community-engagement requirements, and the State's initial HIP renewal application sought to renew these features without adding community-engagement requirements; the State added the request to implement community-engagement requirements only after CMS invited States to do so. AR 0081–90. Indeed, because the State has suspended implementation of the community-engagement requirements, to this day HIP continues to operate independently of them—notably, without objection from CMS.

Moreover, CMS's practice of approving such Section 1115 applications, both as to Indiana and other States, demonstrates that it would have approved this initial application. With respect to HIP itself, CMS initially approved the waiver for the demonstration project in December 2007 and extended the waiver twice before approving, in January 2015, Indiana's application to use HIP to cover the Medicaid expansion population. Throughout this sequence of applications and approvals, HIP did not include community-engagement requirements.

CMS has also approved Section 1115 demonstration projects in other States that share many of the central features of HIP. In December 2018, for example, CMS approved New Mexico's request for a Section 1115 waiver that, as with Indiana's waiver, allows the State to waive retroactive eligibility, to require beneficiaries in the expansion population to make monthly contributions, and to suspend coverage and impose a lockout penalty on those who fail to do so. *See* Letter from Seema Verma to Nancy Smith-Leslie at 5–6, dated December 14, 2018.[24] Similarly, in November 2019, CMS reapproved Iowa's Section 1115 demonstration project, which for several years has, like HIP, included a waiver of non-emergency transportation benefits, a waiver of retroactive eligibility, and mandatory monthly contributions. *See* Letter from Calder Lynch to Michael Randol at 3–6, dated November 15, 2019.[25]

CMS's history of approving Section 1115 demonstration projects that do not include community-engagement requirements is powerful evidence that "the agency would have adopted the same disposition" here if—as in Indiana's initial application—these requirements "were subtracted." *North Carolina*, 730 F.2d at 796. For this reason, the Court should sever the community-

[24] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf.

[25] Publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf.

engagement requirements from the rest of the approval and refuse to allow an alleged defect in this minor, newly added component of HIP to bring down the entire program.

B. In light of the State's voluntary suspension of the community-engagement requirements and the especially severe consequences of vacatur, the only appropriate remedy is remand without vacatur

Beyond severability, vacating the entire HIP approval is inappropriate for an additional, independently sufficient reason: Because the disruptions complete vacatur would inevitably cause would far outweigh any actual harm caused by a defect in the approval of the community-engagement requirements, the Court should simply remand the matter back to the agency without vacating the approval. "Under [D.C. C]ircuit precedent, the decision to remand or vacate hinges upon court's assessment of 'the seriousness of the . . . deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed.'" *Chamber of Commerce*, 443 F.3d at 908 (ellipsis in original; quoting *Allied-Signal*, 988 F.2d at 150–51). These factors are "balance[d]" against each other, and a "strong showing of one factor may obviate the need to find a similar showing of the other." *Am. Bankers Ass'n v. Nat'l Credit Union Admin.*, 934 F.3d 649, 674 (D.C. Cir. 2019).

Applying this framework here makes clear that remand without vacatur is the only proper remedy. Any deficiency in the explanation of the approval of the community-engagement requirements is—in the context of the approval of HIP as a whole—relatively minor and can be redressed on remand. Regardless, even if the agency's decision had "serious deficiencies," *Defenders of Wildlife v. Jackson*, 791 F. Supp. 2d 96, 118 (D.D.C. 2011), it should still not be vacated because there is a "high likelihood" that vacatur "would cause significant disruption," *id.* at 119. Vacating the entire HIP waiver would prove enormously disruptive to the many members who have "relied on it in good faith" for nearly five years. *A.L. Pharma, Inc. v. Shalala*, 62 F.3d 1484, 1492 (D.C.

Cir. 1995). Worse, these disruptive consequences are unnecessary: Because the community-engagement requirements are currently suspended, "nothing in the record suggests that significant harm would result from allowing the approval to remain in effect pending the agency's further explanation." *Id.* In such circumstances vacatur is clearly inappropriate.

1. First, if there were a defect in the explanation of the approval of the community-engagement requirements, such a defect would be relatively insignificant and would likely be adequately addressed on remand. The community-engagement requirements are a new part of HIP. The program's central features—the POWER accounts, the waiver of retroactive eligibility, and the waiver of non-emergency transportation benefits—have existed for many years and are far more fundamental to the overall operation of the program. While these other features are essential to making HIP work, the community-engagement requirements are not—as the current suspension of those requirements demonstrates. The Gateway to Work community-engagement requirements are a powerful tool to promote HIP members' health and build on longstanding efforts to connect members with job opportunities, skills training, and the State remains committed to the program. But in the context of HIP as a whole, a flaw in the approval of the community-engagement requirements is not a serious deficiency and does not justify vacating the entire waiver.

In addition, if the Court were to remand the matter back to the agency, "there is at least a serious possibility that the [agency] will be able to substantiate its decision.'" *Allied-Signal*, 988 F.2d at 151. This Court has recognized that the Medicaid Act authorizes the Secretary to issue a Section 1115 waiver even if the waiver will cause some individuals to lose coverage. *Stewart II*, 366 F. Supp. 3d at 140 ("The Secretary first contends that § 1115 contemplates that demonstrations may result in an impact on eligibility, meaning coverage loss does not necessarily render a project unlawful. That is certainly true: the Act expressly provides for a 'demonstration project . . . that

would result in an impact on eligibility.'") (ellipsis in original; quoting 42 U.S.C. § 1315(d)). Though in *Stewart* and *Gresham* the Court found flaws in the agency's explanation for its approval of work requirements, the Court acknowledged that these flaws "do[] not mean it will be impossible for the agency to justify its approval of a demonstration project like this one." *Gresham*, 363 F. Supp. 3d at 182. And here an adequate explanation is all the more likely, because—due to the community-engagement requirements' limited scope and the many steps FSSA has taken to facilitate compliance with the requirements—the estimated coverage loss is much lower: As explained above, the many targeted exemptions HIP provides from the community-engagement requirements led the State's actuary to project that over the course of a year only about 6% of HIP members (25,000 individuals) would face any suspension of coverage at all, a much smaller effect on coverage than the effects at issue in *Stewart* and *Gresham*. *See supra* at 20–21; AR 3865.

Accordingly, if the Court were to remand Indiana's waiver, the agency "may well be able to explain why" the community-engagement requirements further the Medicaid Act's purposes notwithstanding the relatively small coverage loss they might cause. *A.L. Pharma, Inc.*, 62 F.3d at 1492. For example, the agency could point out that, by encouraging members to participate in their communities and obtain employment, these requirements foster health coverage (via employer-provided health insurance) and health outcomes. *See* AR 0003–04.

2. Second, even if the agency's explanation for its approval of the community-engagement requirements did have "serious deficiencies," *Defenders of Wildlife*, 791 F. Supp. 2d at 118, the unnecessary and extremely disruptive consequences of invalidating HIP would still make vacatur inappropriate here. Because the State has voluntarily suspended enforcement of the community-engagement requirements, vacatur is not needed to remedy the deficiencies in the approval. That leaving the order in place would do no "affirmative harm" is alone sufficient reason to remand

without vacatur. *See Advocates for Highway and Auto Safety v. Federal Motor Carrier Safety Admin.*, 429 F.3d 1136, 1151 (D.C. Cir. 2005) (explaining that the order "while plainly inadequate, may do some good, if it does anything at all" (quoted in *Am. Bankers Ass'n*, 934 F.3d at 674)).

Furthermore, even while vacatur provides no assistance to Plaintiffs, it seriously harms both the State and myriad non-parties. Because the waiver at issue in this case authorizes the community-engagement requirements *and* renews HIP as a whole, vacating the waiver would entirely eliminate the approval authorizing HIP. Such a result would be an "invitation to chaos," and doubtlessly "would have significant disruptive consequences"—all for no practical purpose. *Defenders of Wildlife*, 791 F. Supp. 2d at 119 (internal quotation marks and citation omitted). "Thus, vacatur is not the required remedy . . . and it would not be appropriate here." *Id.* (internal quotation marks and citation omitted).

HIP provides consumer-focused health coverage to more than 400,000 Hoosiers, the vast majority of whom are satisfied with the program. AR 3927, 3941. "Even temporarily depriving these members of the" healthcare program they like and have become accustomed to "is inequitable." *Am. Bankers Ass'n*, 934 F.3d at 674. And it is all the more inequitable to burden needlessly these HIP members, who are not even represented in this litigation, at the behest of four individuals challenging community-engagement requirements that merely *apply* to—much less burden—less than 30% of the total HIP population. *See* AR 3865.

Even worse, vacating the waiver approval would not merely upset the expectations of HIP members; it would undermine the State's ability to provide health coverage to them at all. Because HIP uses different funding sources, provider networks, reimbursement rates, and capitation rates than other state Medicaid programs, FSSA could not easily or quickly transition from HIP to an alternative plan to provide coverage to the expansion population. In the short term, this very well

could leave HIP members with reduced coverage or no coverage at all. And it would force FSSA to make difficult decisions to account for the budget appropriations shortfall that inevitably would occur, which could impact the Medicaid population as a whole.

And even over the longer term, there is a substantial question as to how FSSA could provide coverage to the current HIP members if the waiver were vacated. If the waiver were vacated, the State would be barred under federal law from applying several of HIP's elements. Without the waiver, for example, the Medicaid Act would prohibit FSSA from enforcing (1) HIP's premium payment requirements, *see* 42 U.S.C. § 1396a(a)(8), (10), (14), (17), and (52); (2) the lockout periods, *see* 42 U.S.C. § 1396a(a)(10), (34), and (52); and (3) the elimination of retroactive coverage, *see* 42 U.S.C. § 1396a(a)(34). Indiana law, however, specifically contemplates including these elements in HIP. *See* Ind. Code §§ 12-15-44.5-3.5–5.7 (providing that HIP requires enrollees to have health care accounts, imposes a minimum $2,500 deductible amount, and penalties and lockouts for failure to pay). In addition, while Indiana law empowers FSSA to "negotiate and make changes to" HIP, it expressly provides that FSSA "may not negotiate or change the plan" to alter certain specified elements of HIP—including those that relate to the amount of state funding, premium amounts, and deductible amounts. *See* Ind. Code § 12-15-44.5-10(b)(1)–(8). If FSSA cannot comply with these state-law requirements, it is unclear what state legislative authority FSSA would have to provide coverage to the current HIP members.

3. Finally, remanding without vacatur here is consistent with this Court's approach in *Stewart* and *Gresham*. As this Court observed, in each of those cases, vacatur produced little or no disruption to the status quo. In *Stewart*, the Court emphasized that vacatur would not be "especially disruptive" because Court severed the unchallenged parts of the waiver and the part it did invalidate had "yet to take effect" at the time of the Court's order. *Stewart II*, 366 F. Supp. 3d at 156.

Similarly, in *Gresham* the practical effect of the Court's vacatur was merely to invalidate the recent *amendments* to the Section 1115 demonstration project, known as "Arkansas Works," that the State uses to cover its Medicaid expansion population. *Gresham v. Azar*, 363 F. Supp. 3d 165, 185 (D.D.C. 2019). Vacatur in *Gresham* did not threaten the Arkansas's entire demonstration project because the waiver at issue merely authorized a handful of changes to Arkansas Works and did not authorize the entire program itself. *Id.* at 171. The reason for this is largely a happenstance of timing: Because the waiver authorizing Arkansas's Medicaid expansion demonstration project—issued in December 2016—is not set to expire until December 31, 2021, Arkansas responded to CMS's March 2017 invitation to implement work requirements by asking to amend, not renew, its waiver.[26] Vacatur in *Gresham* invalidated a minor, newly added component of Arkansas's demonstration project, while vacatur here would invalidate Indiana's *entire* demonstration project. There is no reason for the Court to countenance such different results.

Indeed, in *Gresham* this Court recognized that vacatur would interfere with Arkansas's efforts to collect data and educate beneficiaries about the work requirements and would thereby disrupt the State's expectations and harm its interests. 363 F. Supp. 3d at 183. Balancing these disruptions "against the harms that Plaintiffs and persons like them will experience if the program remains in effect," the Court concluded that these disruptions, though "not insignificant," were not quite enough to "tip the scales against vacatur." *Id.* at 183–84. If *Gresham* was a close case, this

[26] The initial approval of Arkansas's demonstration project set the waiver to expire on December 31, 2016; on December 8, 2016, CMS approved Arkansas's first application to renew the waiver, extending it through December 31, 2021. The approvals of Arkansas's initial waiver request and its renewal request are publicly available on the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf; https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-amndmnt-appvl-12292017.pdf.

is an easy one. Because FSSA has already suspended the community-engagement requirements, remanding without vacatur here will—unlike in *Gresham*—not harm Plaintiffs in the slightest. And here the state interests threatened by vacatur are far more significant: Interrupting data-collection and public-awareness might have impeded Arkansas's efforts to improve its program, but vacating the waiver here would immediately eliminate the very *existence* of Indiana's program—a program that provides health coverage to nearly one quarter of the State's entire Medicaid population.

Neither *Stewart* nor *Gresham* presented the Court with the choice at issue here. Remanding without vacatur prevents severe harms to HIP members and imposes no harms on Plaintiffs; a more inequitable result can scarcely be imagined. Accordingly, if the Court concludes that the approval of HIP's community-engagement requirements is flawed, it should remand the matter for further consideration without vacating the entire approval.

CONCLUSION

Even if the D.C. Circuit affirms this Court's decisions in *Stewart* and *Azar*, this Court should deny refuse Plaintiffs' request to vacate the HIP waiver approval in its entirety.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 6, 2020, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which shall send notification of such filing to any CM/ECF participants.

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