UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ANDREA YOUNG, *et al.*,	)	
	)	
Plaintiffs,	)	
v.	)	
	)	
ALEX M. AZAR II, *et al.*,	)	Case No. 3:19-cv-03526
	)	
Defendants.	)	
	)	

MEMORANDUM OF INTERVENOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Toni L. Harris (P63111)
Attorney for Michigan Department of Health and Human Services
Assistant Attorney General
Michigan Department of Attorney General
Health, Education & Family Services Division
P.O. Box 30758
Lansing, MI 48909
(517) 335-7603
HarrisT19@michigan.gov

Philip J. Peisch, D.C. Bar No. 1005423
Brown & Peisch PLLC
1233 20th Street, NW, Suite 505
Washington, D.C. 20036
(202) 449-4261
ppeisch@brownandpeisch.com

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INTRODUCTION

The Michigan Department of Health and Human Services ("MDHHS") agrees that the approval of the community engagement component of the Healthy Michigan Plan Section 1115 Demonstration's ("HMP Demonstration") is unlawful under circuit precedent in light of the D.C. Circuit's decision in *Gresham v. Azar*, No. 19-5094, and it has sought an expedited decision from this Court to confirm that fact.

However, vacatur of the entire HMP Demonstration approval – including longstanding provisions that do not result in coverage loss for any beneficiaries – is unwarranted, unnecessary, and would have adverse consequences for the State of Michigan and Healthy Michigan Plan beneficiaries. Specifically, vacatur of the entire HMP Demonstration approval would mean that MDHHS loses its legal authority to cover the new adult population added by the Affordable Care Act ("ACA") through its managed care delivery system, which currently provides services to approximately 540,000 beneficiaries. This would force MDHHS to transition this population into Medicaid fee-for-service and/or seek new federal approval for the authority to continue to cover these individuals through managed care, which is a process that generally takes months. An abrupt transition to fee-for-service (even if temporary) would disrupt care for many Healthy Michigan Plan beneficiaries, risking significant health harms; would impose unnecessary costs on a budget-constrained state; and would be extraordinarily burdensome for MDHHS.

Instead of vacating the entire HMP Demonstration approval, this Court should sever the approval of the community engagement requirements from the approval of the other provisions of demonstration, vacate the approval of those community

engagement requirements only, and evaluate the approval of those other provisions independently (e.g., through briefing on a motion for summary judgment and/or motion to dismiss). Alternatively, if this Court finds the entire HMP Demonstration approval unlawful, it should vacate the approval of the community engagement requirements only and remand approval of the other provisions without vacatur to avoid the potential adverse impacts of immediately ending a program that provides critical benefits to hundreds of thousands of residents of Michigan.

STATEMENT OF FACTS

A. Federal Legal Background

As originally established in 1965, the Medicaid Act provided federal funding – "federal financial participation" or "FFP" – for States to deliver health care services to certain groups of low-income Americans: "pregnant women, children, needy families, the blind, the elderly, and the disabled." *Nat'l Fed'n of Indep. Bus. (NFIB) v. Sebelius*, 567 U.S. 519, 575 (2012) (citing 42 U.S.C. § 1396a(a)(10)).

The ACA 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 § 1396a(a)(10)(A)(i)(VIII)). As originally enacted, the ACA would have allowed the federal government to withhold all FFP from States if they failed to cover this new adult group, but 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 now "choose to reject the expansion" and provide coverage to just the original Medicaid population, without losing Medicaid funding for other populations. *Id.* at 587.

Regardless of whether a State chooses to participate in the ACA's Medicaid expansion, all States accepting Medicaid funding must comply with federal statutory and regulatory requirements, most of which are set out in Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (the "Medicaid statute") and 42 C.F.R. Parts 430-455.

However, federal law has long authorized the Secretary of the U.S. Department of Health and Human Services ("HHS") to waive many of these requirements under certain circumstances: Under Section 1115 of the Social Security Act, 42 U.S.C. § 1315, the Secretary may approve an "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 42 U.S.C. § 1396a "to the extent and for the period he finds necessary to enable such State or States to carry out such project." In addition, Section 1115 allows the Secretary to approve and authorize state expenditures in such a demonstration project "which would not otherwise be included as expenditures" under the federal Medicaid statute.

B. History of the Healthy Michigan Plan Demonstration

In January 2004, the Secretary – acting through HHS's Centers for Medicaid & Medicare Services ("CMS") – approved Michigan's "Adult Benefits Waiver" ("ABW") to provide a limited package of Medicaid benefits to uninsured low-income adults with incomes at or below 35 percent of the federal poverty level ("FPL") who would not

have otherwise been eligible for Medicaid at the time.[1] In December 2009, CMS approved the "'Michigan Medicaid Non-pregnant Childless Adults Waiver (Adult Benefits Waiver)' (11-W-00245/5), to allow the continuation of the ABW health coverage program" through September 30, 2014.[2]

In 2013, the Michigan Legislature authorized the State to expand Medicaid to cover the ACA's new adult group (subsuming the group of adults previously covered under the ABW Demonstration), but required MDHHS to seek a waiver to implement certain features that could not be implemented under the state plan. As required under state law, the State both amended the state plan to cover the new adult group and "amended and transformed" the ABW Demonstration to "test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group," with both the state plan amendment ("SPA") and the "transformed" demonstration becoming effective on April 1, 2014.[3] This Healthy

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[1] *See* HMP Section 1115 Demonstration, 11-W-00245/5, at 4 (app. eff. Jan. 1, 2019) (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf).

[2] *See id.*; *see also* Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration, 11-W-00245/5 (Jan. 1, 2010) (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-stc-01012010-09302014.pdf).

[3] *See* Healthy Michigan Section 1115 Demonstration, 11-W-00245/5, at 2 (app. eff. Dec. 30, 2013) (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-cms-amend-appvl-12302013.pdf); *see also* Michigan State Plan Amend. TN-14-0170 (app. eff. Apr. 1, 2014) (available at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-14-0170.pdf).

Michigan Plan Section 1115 Demonstration ("HMP Demonstration") waived several provisions of federal Medicaid law with respect to coverage of the new adult group:

1) Cost Sharing and MI Health Accounts. CMS authorized the State to establish "MI Health Accounts" for each beneficiary. Under this system, beneficiaries are notified of the cost sharing liability by the provider, but are not required to make payment at the time of service. Instead, the cost sharing liability is tracked in the beneficiary's MI Health Account, which sends quarterly bills to the beneficiary for payment. All beneficiary contributions, as well as their credits from healthy behaviors (described below in (2)), are tracked and reflected in their MI Health Accounts. The cost sharing charged through the MI Health Accounts are consistent with federal limits on cost sharing, except as specified in (3) below, and failure to pay cost sharing does *not* result in the beneficiary losing eligibility for benefits.

2) Incentives for healthy behaviors. CMS waived the "comparability requirement" in Section 1396a(a)(17), and authorized expenditures not otherwise permitted under the Medicaid statute, to allow the State to reduce beneficiaries' cost sharing liability in their MI Health Accounts based on their achievement of certain healthy behaviors, such as attending an initial appointment with a primary care provider, completing a Health Risk Assessment, or getting vaccinated.

3) Additional premiums for individuals above 100 percent of the FPL. CMS waived the cost sharing and premium requirements in Section 1396a(a)(14) – insofar as it incorporates 42 U.S.C. §§ 1316 and 1396o(a) – to allow the State to require individuals with incomes above 100 percent of the FPL to make contributions to their MI Health Accounts. Failure to pay the premiums did *not*, and does not, result in the loss of coverage or benefits.

4) Managed care delivery system. The demonstration provided MDHHS with the authority to use a managed care delivery system, with two different types of plans, to provide benefits: contracted "Medicaid Health Plans" ("MHPs") provide health care and pharmacy benefits; and behavioral health plans provide inpatient and outpatient mental health, substance use disorder, and developmental disability services. This includes allowing MDHHS to have only a single managed care entity operating in rural areas of the State. (Michigan's state plan did not, and does not, authorize this delivery system for individuals in the new adult group.)

In addition, CMS waived several provisions of federal law, including the following:

- To allow MDHHS to avoid giving beneficiaries a choice of plans in certain circumstances, CMS waived the "freedom of choice" requirement in Section 1396a(a)(23)(A) and the "proper and efficient administration" requirement in Section 1396a(a)(4).

- To allow MDHHS to mandate enrollment in managed care only in certain parts of the State, CMS waived the "statewideness" requirement in 42 U.S.C. § 1396a(a)(1).[4]

Utilizing a managed care delivery system for the HMP Demonstration allowed MDHHS to provide cost-effective, expansive coverage to the new adult group. For example, in addition to the services specified in the state plan, MDHHS's contracted MHPs provide care coordination and case management not available to all beneficiaries in Michigan's fee-for-service program, which includes assigning all members to a primary care provider to manage their overall health care. Second Decl. of Robert Gordon, ¶ 5 ("Second Gordon Decl.") (Exhibit 1). The MHPs also provide: access to providers not available through Michigan's fee-for-service program; support for behavior changes to address tobacco use, high blood pressure, obesity and immunization status; and interventions to address social determinants of health and reduce health disparities for their members. *Id.*

This first version of the HMP Demonstration operated for nearly five years, from April 1, 2014 through December 30, 2018. In December 2018, CMS approved a five-year extension of the demonstration, effective January 1, 2019 through

[4] Healthy Michigan Section 1115 Demonstration, 11-W-00245/5, Expenditure Authority, Waiver List; *see also* Michigan State Plan, Att. 3.1-C (app. eff. Apr. 1, 2014) (available at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-14-0001.pdf).

December 31, 2023. The extension generally retains the same features of the original HMP Demonstration. Most importantly, the HMP Demonstration continues to provide services through the original managed care delivery system and related waivers of federal managed care requirements. In addition, the HMP Demonstration continues to use MI Health Accounts for tracking and collecting cost sharing, and it continues to provide incentives for healthy behaviors.

The extension of the HMP Demonstration also added three new features to the program, which were required by a 2018 amendment to state law:

1) Community engagement requirements. CMS waived 42 U.S.C. § 1396a(a)(8) and § 1396a(a)(10) to permit the State to require that non-exempt HMP beneficiaries complete a community engagement activity as a condition of eligibility.

2) Mandatory premiums for individuals above 100 percent of the FPL. CMS waived 42 U.S.C. § 1396a(a)(14) – insofar as it incorporates 42 U.S.C. §§ 1316 and 1396o(a) – to allow the State to require beneficiaries with income above 100 percent of the FPL who have 48 months of cumulative HMP eligibility to pay premiums of five percent of their income, as a condition of continued eligibility. MDHHS plans to begin implementing this provision effective October 1, 2020.

3) Other mandatory requirements for individuals above 100 percent of the FPL. CMS waived 42 U.S.C. § 1396a(a)(8) and § 1396a(a)(10) to permit the State to require non-exempt beneficiaries with income above 100 percent of the FPL who have 48 months of cumulative HMP eligibility to complete a health risk assessment or a healthy behavior as a condition of continued eligibility. MDHHS plans to begin implementing this provision effective October 1, 2020.[5]

All three of these new features are conditions of continued eligibility; that is, for any beneficiary subject to these new requirements, failure to comply will result in the temporary loss of Medicaid coverage. This is in contrast to the provisions that were

[5] *See* HMP Section 1115 Demonstration, 11-W-00245/5, at 5 and Waiver List.

carried over from the original HMP Demonstration, none of which result in coverage loss for otherwise eligible beneficiaries.

C. Procedural History

On November 22, 2019, nearly a year after the Secretary approved the extension of the HMP Demonstration, which included new program features impacting Medicaid eligibility, Plaintiffs filed a complaint against HHS, CMS, and the officials who run those agencies (collectively, the Federal Defendants) challenging the December 2018 approval of the HMP Demonstration extension, including the new additions to the demonstration and amendments. ECF No. 1. Plaintiffs' Complaint challenges CMS' approval of the work and community engagement requirements; premium, cost sharing, and "similar charge" requirements; and the healthy behavior requirements. *See id.* at ¶¶ 208-61. In addition, Plaintiffs also challenge the approval of the HMP Demonstration as a whole. *Id.* at ¶¶ 208-221.

On February 19, 2020, MDHHS filed a motion to intervene in this action, ECF No 20, which this Court granted. On February 24, 2020, MDHHS filed an expedited motion for partial summary judgment on the issue of whether CMS's approval of the HMP Demonstration's community engagement requirements is lawful, in light of the D.C. Circuit's decision in *Gresham v. Azar*, No. 19-5094.

SUMMARY OF ARGUMENT

As MDHHS explained in its Expedited Motion for Partial Summary Judgment, MDHHS agrees that the federal approval of the HMP Demonstration's community engagement requirement is unlawful under circuit precedent.

However, the D.C. Circuit's decision in *Gresham* does not mean there are any defects in the federal approval of the other components of the HMP Demonstration, particularly those components of the HMP Demonstration extension which do not result in the loss of coverage for any beneficiaries and have been part of MDHHS's Medicaid program for over five years. There is strong evidence that CMS would have approved the demonstration extension without the community engagement requirements, and it is therefore proper to sever the community engagement requirements from the provisions of the HMP Demonstration that operate independently of the community engagement requirements and do not result in the loss of Medicaid coverage. Further, even if this Court concludes that the entire December 2018 extension approval was flawed, remand without vacating the entire approval is the appropriate remedy.

ARGUMENT

I. Outside of the Community Engagement Requirements, the HMP Demonstration is Materially Different than the Arkansas Demonstration Analyzed in *Gresham*.

In *Gresham v. Azar*, this Court, later affirmed by the D.C. Circuit, struck down the approval of Arkansas' community engagement requirements, explaining that the Secretary should have considered the extent to which they "would be likely to cause

recipients to *lose* coverage and whether it would cause others to *gain* coverage," but "did neither." 363 F. Supp. 3d 165, 177 (D.D.C. 2019) (emphasis in original).

Outside of the community engagement requirements, the demonstration approval in *Gresham* did not involve any of the same features as those approved in the HMP Demonstration, and thus the D.C. Circuit's analysis is not determinative of the legality of the Secretary's approval of those other provisions of the HMP Demonstration. For example, as explained above, the HMP Demonstration includes a number of features that have been in place since 2014, none of which impact beneficiaries' eligibility for coverage: cost sharing requirements and MI Health Accounts; incentives for healthy behaviors; and Michigan's unique managed care delivery system. None of these longstanding provisions of the HMP Demonstration are even analogous to the demonstration provisions at issue in *Gresham*.

The December 2018 extension of the HMP Demonstration did add new provisions, in addition to the community engagement requirements. Specifically, under the extension, certain individuals above 100 percent of the FPL are required to pay premiums and engage in healthy behaviors to retain their Medicaid eligibility. *See* HMP Section 1115 Demonstration, 11-W-00245/5, at 5, Waiver List. While both of these new provisions may result in the loss of coverage for certain individuals, neither are the same as the provisions at issue in *Gresham* and thus deserve a separate, independent analysis by this Court.

II. The Approval of the Community Engagement Requirements Should Be Severed from the Approval of HMP's Other Provisions.

"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. FERC*, 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); *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 42 U.S.C. § 1315, but vacating only the increased cost sharing requirements themselves, instead of invalidating the demonstration project in its entirety).

In this case, there is little doubt (let alone "substantial doubt") that CMS would have approved the provisions of the HMP Demonstration that were first approved in 2013 absent the community engagement requirements. In fact, CMS did approve these provisions without the community engagement requirements in December 2013 when it approved of the first iteration of the HMP Demonstration, which included the MI Health Accounts, the incentives for healthy behaviors, and the managed care delivery system, including the necessary waivers of federal managed care requirements, *without the community engagement requirements*. *See* Healthy Michigan Section 1115 Demonstration, 11-W-00245/5, Waiver List and Expenditure Authority.

The 2018 extension approval also included two other features – the mandatory premiums and the mandatory healthy behaviors for certain individuals over 100 percent of the FPL – that do not predate the extension approval, and thus were not approved independently by CMS in 2013. Unlike the longstanding provisions of the HMP Demonstrations, these provisions may result in the loss of coverage for some beneficiaries. Even if the court concludes that CMS's approval of these newer provisions is invalid and that they are not severable from the community engagement requirements, the Court should still sever the provisions that were approved independently in 2013 and have been part of the program for over five years, *i.e.*, the cost sharing requirements and MI Health Accounts; the incentives for healthy behaviors; and the managed care delivery system, including the necessary waivers of federal managed care requirements. These longstanding provisions of the HMP Demonstration – which have not and do not result in any coverage losses – were approved in 2013 without the mandatory premiums and mandatory healthy behavior exceptions, just as they were approved in 2013 without approval of the community engagement requirements.

Further evidence that CMS would have approved these original features of the HMP Demonstration in the absence of the newer, eligibility-impacting provisions is the fact that CMS has recently approved similar features of demonstrations in other States, under both the Obama Administration and the Trump Administration, *without* community engagement requirements and *without* mandatory premiums

and healthy behaviors that can impact beneficiaries' eligibility.[6] In fact, the Trump Administration has approved dozens of Section 1115 demonstrations without community engagement requirements or other features that may result in beneficiaries losing coverage.[7] And there is no evidence that CMS under the Trump Administration would have rejected the HMP Demonstration if it had not included community engagement requirements. This all demonstrates that "the agency would have adopted the same disposition" here if the community engagement requirements "were subtracted." *See North Carolina*, 730 F.2d at 796.

Severing the community engagement requirements from the other provisions of the HMP Demonstration is consistent with the approach this Court took in *Stewart v. Azar (Stewart I)*, 313 F. Supp. 3d 237, 246 (D.D.C. 2018). In that case, Kentucky's demonstration included "two key programs" that were part of the same demonstration approved by CMS: "(1) Kentucky HEALTH," which included community engagement requirements "applie[d] only to 'adult beneficiaries who do not qualify for Medicaid on the basis of a disability'"; and (2) the Substance Use Disorder ("SUD") Treatment program, which was available to all Medicaid beneficiaries. *Id.* While the Court held that the Secretary's approval of Kentucky

[6] *See, e.g.*, Iowa Wellness Plan Section 1115 Demonstration, 11-W-00289/5 (app. eff. Jan. 1, 2020) (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf) (incentives for healthy behaviors); Oregon Health Plan, 21-W-00013/10 and 11-W-00160/10 (app. eff. Jan. 12, 2017) (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf) (limits choice of managed care plan).

[7] *See* CMS, State Waiver List, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html (last visited Mar. 2, 2020).

HEALTH was unlawful, it declined to invalidate the SUD Treatment program part of the demonstration because "CMS has repeatedly affirmed its commitment to approving standalone 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 leaving the SUD Treatment program and the other provisions of the demonstration in place. *Id.* at 273-74 (quoting *North Carolina*, 730 F.2d at 796).

Similarly, in this case, there is no "substantial doubt" that CMS would have approved the HMP Demonstration without the community engagement requirements, as explained above. And the community engagement requirements plainly "operate entirely independently of" these other features of the HMP Demonstration. *See Davis Cty. Solid Waste Mgmt.*, 108 F.3d at 1459. Accordingly, this Court should sever the approval of the community engagement requirements from the approval of the other provisions of demonstration, vacate the approval of those community engagement requirements only, and evaluate the approval of those other provisions independently.

III. Vacating the Other Components of the HMP Demonstration Would Be Inappropriate and Harmful to Michigan's Medicaid Enrollees.

If this Court nevertheless concludes that the original parts of the demonstration cannot be severed from the community engagement requirement, and the entire December 2018 demonstration extension approval was flawed, vacating the entire HMP Demonstration approval is inappropriate for an additional,

independently sufficient reason: the disruption complete vacatur could cause far outweighs any defect in the approval of the demonstration. Accordingly, the Court should simply remand the matter back to the agency without vacating that approval.

Under D.C. Circuit precedent, the question of whether a court should deploy the remedy of vacatur "hinges" on balancing "'the seriousness of the deficiencies'" against "'the disruptive consequences'" of vacatur. *SEC v. Chamber of Commerce of U.S.*, 443 F.3d 890, 908 (D.C. Cir. 2006) (quoting *Allied-Signal v. U.S. NRC*, 988 F.2d 146, 150-51 (1993)). 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 of the HMP Demonstration approval (other than the community engagement requirements approval) is the only proper remedy if the Court concludes the entire extension approval is flawed. Any deficiency in the explanation of the approval of other HMP Demonstration components – in the context of the approval of HMP Demonstration as a whole – can be redressed on remand. And even if the agency's decision had "serious deficiencies," *Defenders of Wildlife v. Jackson*, 791 F. Supp. 2d 96, 118 (D.D.C. 2011), there is a "high likelihood" that vacatur "would cause significant disruption," *id.* at 119, for the State and the many beneficiaries who have "relied on it in good faith," *A.L. Pharma, Inc. v. Shalala*, 62 F.3d 1484, 1492 (D.C. Cir. 1995).

More specifically, vacatur of the entire HMP Demonstration approval would eliminate the legal authority for the managed care system through which MDHHS

covers 540,000 beneficiaries in the new adult group. *See* HMP Section 1115 Demonstration, 11-W-00245/5, at 5, 26-28; HMP Section 1115 Demonstration, 11-W-00245/5, Waiver List; Michigan State Plan, Att. 3.1-C. This would force the State to transition 540,000 individuals into Medicaid fee-for-service, and/or seek new federal approval for the authority to cover these individuals through managed care, which is a process that generally takes months. Second Gordon Decl., ¶ 8.

While Michigan would retain the legal authority to provide fee-for-service benefits to the new adult group through its state plan, immediately transitioning hundreds of thousands of beneficiaries from their current health plans to fee-for-service Medicaid would be extraordinarily disruptive for beneficiaries, who would need to navigate a new and different network of providers overnight. *See id.* ¶¶ 9-10. For example, a beneficiary who has long received treatment for her diabetes from a provider enrolled in her MHP's network may find that same provider is not enrolled in MDHHS's fee-for-service program, forcing her to find a new provider with whom she has no experience. This transition would risk significant health harms. *See id.* Similarly, a member with multiple chronic conditions who has worked with the same MHP case manager for months or years could see that relationship end. *Id.* The loss of such services on which individuals have relied could result in significant negative health effects. *See id.* Ending managed care coverage would also disrupt the State's non-emergency medical transportation system, as the MHPs are a significant provider of these services. *See id.* ¶ 7. In the absence of the MHPs, MDHHS would need to establish alternative arrangements for non-emergency medical

transportation, which is a critical service for Medicaid beneficiaries with no means of transportation to medically necessary health appointments. *See id.* While MDHHS would work to assist beneficiaries with the transition to fee-for-service, the reality is that many individuals would experience a break in treatment or otherwise have their care disrupted, especially when the State and the impacted beneficiaries do not have a significant lead time to plan for the transition. *See id.* ¶ 9-10.

Further, an abrupt, large-scale transition from managed care to fee-for-service would be extraordinarily costly and administratively burdensome for the State. *See id.* ¶ 9. To facilitate this transition, MDHHS would have to, among many other things: "provide written notice and ongoing customer service to 540,00 beneficiaries to explain the changes in their coverage; assist these beneficiaries in connecting to new providers; immediately begin processing provider claims for 540,000 beneficiaries through the State's fee-for-service claims processing system; and cease making capitation payments to the MHPs that formerly covered the population." *Id.* ¶ 9(e). While MDHHS has not estimated the cost, it would require, at the very least, dozens of full-time equivalents working for months on the transition. Given budget constraints, funding this transition "would likely mean less funding for other MDHHS responsibilities, such as improving maternal-infant health and providing economic assistance to low-income families." *Id.*

Finally, eliminating the managed care system would also deprive Michiganders of the services they are currently receiving from MHPs that are not available through the state's fee-for-service program, such as the MHPs' enhanced

care coordination and the MHPs' additional investments in community health workers. *See id.* ¶¶ 5, 9(c).

Outside of the managed care issues, vacatur of the entire HMP Demonstration approval would also end the legal authority for MDHHS to operate its system for charging cost sharing and incentivizing healthy behaviors through the MI Health Accounts. *See* HMP Section 1115 Demonstration, 11-W-00245/5, Waiver List. Instead, beneficiaries would be subject to the full cost sharing amounts specified in the state plan,[8] and would not be eligible for cost share reductions for engaging in healthy behaviors.

Remand without vacatur is appropriate in this case because, 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,'" and thus obviate the potential for a major disruption to Michigan's program. *Allied-Signal*, 988 F.2d at 151. CMS "may well be able to explain why" the provisions of the demonstration that do not result in any coverage losses further the Medicaid Act's purposes. *A.L. Pharma, Inc.*, 62 F.3d at 1492.

Remanding without vacatur here is also consistent with this Court's approach in *Stewart* and *Gresham*. In each of those cases, in contrast to the situation in Michigan, vacatur produced little or no disruption to the status quo. In *Stewart II*,

[8] *See* Michigan State Plan, G2a, G3 (eff. Jan. 1, 2014) (available at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-13-0016.pdf); Michigan State Plan, G2c (eff. Apr. 1, 2017) (available at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-16-0500.pdf).

vacatur was not "especially disruptive" because the 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 v. Azar (Stewart II)*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019). Similarly, in *Gresham* the practical effect of the Court's vacatur was merely to invalidate the recent amendments to the Section 1115 demonstration project, and it did not threaten the Arkansas' entire demonstration project because the approval at issue merely authorized a handful of changes to Arkansas Works and did not authorize the entire program itself. 363 F. Supp. 3d at 185.

In contrast, in this case, all provisions of the HMP Demonstration – including those approved in 2013 that do not result in any loss of coverage – are currently authorized through the same federal action: the December 2018 approval of the demonstration extension. While the longstanding provisions were also approved by CMS in the December 2013 approval, that approval is no longer operative; its provisions had to be, and were, re-approved in the December 2018 extension approval. If that extension approval is vacated, as Plaintiffs request, the entire HMP Demonstration falls and MDHHS loses the authority to operate key components of its program. Neither *Stewart* nor *Gresham* presented the Court with the choice at issue here. Remanding without vacatur prevents severe harms to Michigan residents receiving services through the HMP Demonstration. Accordingly, if the Court concludes that the approval of the entire HMP Demonstration extension was flawed, it should remand without vacating.

CONCLUSION

For the foregoing reasons, the D.C. Circuit's decision in *Gresham* does not mean there are any defects in the federal approval of the components of the HMP Demonstration other than the community engagement requirements, and therefore this Court should sever approval of the community engagement requirements from the approval of those other provisions of the HMP Demonstration and review the latter independently.

Respectfully submitted,

/s/ Toni L. Harris
Toni L. Harris (P63111)
Attorney for Michigan Department of Health and Human Services
Assistant Attorney General
Michigan Department of Attorney General
Health, Education & Family Services Division
P.O. Box 30758
Lansing, MI 48909
(517) 335-7603
HarrisT19@michigan.gov

/s/ Philip J. Peisch
Philip J. Peisch, D.C. Bar No. 1005423
Brown & Peisch PLLC
1233 20th Street, NW, Suite 505
Washington, D.C. 20036
(202) 449-4261
ppeisch@brownandpeisch.com

March 3, 2020

CERTIFICATE OF SERVICE

I hereby certify that on March 3, 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.

/s/ Toni L. Harris
Toni L. Harris (P63111)
Attorney for Michigan Department of Health and Human Services
Assistant Attorney General
Michigan Department of Attorney General
Health, Education & Family Services Division
P.O. Box 30758
Lansing, MI 48909
(517) 335-7603
HarrisT19@michigan.gov

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Andrea Young, et al.,	)	
	)	
Plaintiff,	)	No. 1:19-cv-03526-JEB
	)	
	)	
v.	)	
	)	
	)	
Alex M. Azar, et el.,	)	
	)	
Defendants.	)	

SECOND DECLARATION OF ROBERT GORDON

1. My name is Robert Gordon. I am the Director of the Michigan Department of Health and Human Services ("MDHHS" or "the Department").

2. The Healthy Michigan Plan ("HMP") is a demonstration project approved under Section 1115 of the Social Security Act. It was first approved on December 30, 2013. On December 21, 2018, the Centers for Medicare & Medicaid Services ("CMS") approved a five-year extension of HMP, for the period from January 1, 2019 to December 31, 2023.

3. The HMP Demonstration allows MDHHS to mandatorily enroll most beneficiaries in the new adult group added by the ACA into the State's Medicaid managed care system. According to MDHHS data, approximately 540,000 of the approximately 650,000 beneficiaries in this eligibility group are enrolled in Medicaid managed care.

4. Under Michigan's managed care delivery system, Medicaid Health Plans, or "MHPs," provide beneficiaries with all state plan Medicaid services, except for certain behavioral health services, which are provided through other managed care entities called prepaid inpatient health plans ("PIHPs").

5. In addition to covering state plan services, MHPs provide their members with a number of services not covered by the state plan. For example:

a. MHPs provide enhanced care coordination and case management. This includes assigning all members to a primary care provider to manage their overall health and completing joint care plans for members who are receiving behavioral health services administered by a behavioral health PIHP.

b. MHPs provide support for behavior changes to address alcohol use, substance use, tobacco use, obesity and immunization status. The MHPs identify these through the HMP Demonstration's Healthy Behaviors program.

c. MHPs use evidence-based interventions to address social determinants of health and reduce health disparities for their members, including home visits by community health workers and partnerships with community-based organizations to support food access, safe and stable housing and other critical non-medical needs.

6. MHPs provide members with a different network of providers, which is broader for certain services, such as certain dental and behavioral health.

7. MHPs arrange non-emergency medical transportation for their members, which allows beneficiaries to attend medically necessary health appointments if they do not have other means of transportation.

8. If the legal authority to enroll the new adult group into this managed care delivery system was eliminated, MDHHS would be forced to transition approximately 540,000 individuals into Medicaid fee-for-service, and/or seek new approval from CMS to cover these individuals through managed care. Obtaining approval from CMS to cover a population through managed

care – whether through an amendment to the state plan or through a waiver or demonstration approval, or a combination of both – is a process that usually takes months.

9. An abrupt end to the managed care delivery system for the new adult group would have serious, adverse consequences for the State of Michigan and Healthy Michigan Plan beneficiaries. For example:

a. MDHHS would need to immediately transition approximately 540,000 beneficiaries from their current MHPs to fee-for-service Medicaid.

b. Beneficiaries moving from an MHP to fee-for-service would need to navigate a new and different network of providers. Because Michigan's fee-for-service program does not have the same network of providers as the MHPs, many beneficiaries would need to change providers, disrupting current and often longstanding patient-provider relationships, and risking significant health harms.

c. Beneficiaries' relationships with the MHP's community health workers and case managers would end, leaving many beneficiaries (including beneficiaries with chronic conditions) to coordinate complex care from multiple providers either on their own or with a new case manager unfamiliar with the patient's history and circumstances, resulting in a degradation of medical care quality and uncertain health effects.

d. Michiganders in the new adult group would be deprived of the additional services provided by the MHPs that are not available through state plan fee-for-service coverage.

e. While MDHHS has not done any formal cost estimates, the transition of 540,000 people from managed care to fee-for-service would be extraordinarily burdensome, costly and administratively challenging for the State. For example, MDHHS would need to:

provide written notice and ongoing customer service to 540,00 beneficiaries to explain the changes in their coverage; assist these beneficiaries in connecting to new providers; immediately begin processing provider claims for 540,000 beneficiaries through the State's fee-for-service claims processing system; and cease making capitation payments to the MHPs that formerly covered the population. MDHHS would need to devote dozens (maybe more) of full-time equivalents (employees and/or contractors) for months to execute the transition, minimize care disruption, and ensure that providers are promptly paid for the services they deliver. Given the State's budget constraints, redirecting funding to this transition would likely mean less funding for other MDHHS responsibilities such as improving maternal-infant health and providing economic assistance to low-income families.

10. If the HMP Demonstration is vacated, many beneficiaries would have their care disrupted, if the State and the impacted beneficiaries do not have sufficient time to plan for the transition.

I make this declaration under penalty of perjury.

Robert Gordon, Director
Michigan Department of Health and Human Services

March 3, 2020