UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

PLAINTIFFS' RESPONSE TO DEFENDANTS' BRIEFS IN RESPONSE TO THE COURT'S NOVEMBER 21, 2019 MINUTE ORDER

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INTRODUCTION

This case challenges the Secretary of the Department of Health and Human Services' 2018 approval of the Healthy Indiana Plan ("HIP") extension, a Section 1115 Medicaid waiver project. HIP includes a number of restrictions on coverage and access to care. The project imposes mandatory premiums, prohibits recipients who fail to complete the redetermination process on time from re-enrolling in coverage for six months, and eliminates retroactive coverage and non-emergency medical transportation (NEMT). Indiana has already "tested" many of these cuts using Section 1115 waivers for more than a decade and has found that they bar tens of thousands of people from obtaining and maintaining coverage and access to care.

The 2018 approval also allows Indiana to introduce a new obstacle to health care coverage: work requirements. Most of those targeted by the work requirements are adults made eligible for Medicaid coverage through the Affordable Care Act—a group whose coverage the current administration announced early on and often that it wanted to scrap. Indeed, the State estimated that 25,000 people would lose coverage every year due to the work requirements.

The rationale the Secretary used to approve the 2018 HIP extension is the very same rationale this Court found insufficient under the Administrative Procedures Act (APA) in *Stewart* and *Gresham*. Consistent with these opinions, if the D.C. Circuit issues a straight affirmance on the merits, the HIP extension project as a whole must fall. Under Supreme Court and circuit court precedents, the presumptive remedy is vacatur. The Court should follow that ordinary course here because, as it has already determined, the legal error committed by the Secretary goes "to the heart" of the approval. *See Gresham v. Azar*, 363 F. Supp. 3d 165, 182 (D.D.C. 2019) (quotation marks omitted), *appeal docketed*, No. 19-5096 (D.C. Cir. Apr. 11, 2019). In addition, as Indiana's own

evaluations of HIP show, allowing the State to continue implementing the project will harm tens of thousands of people.

ARGUMENT

I. The Secretary's Approval of the 2018 HIP Extension Suffers from the Exact Same Deficiencies as His Approvals of the Kentucky and Arkansas Projects.

This case involves another cookie-cutter approval by the Secretary of a Section 1115 waiver project that rolls back Medicaid coverage. The Secretary's HIP extension approval is indistinguishable from the Kentucky and Arkansas approvals that this Court determined violated the APA.

When requesting a stay of briefing in this case, the Federal and State Defendants acknowledged that "the Secretary approved the project here for reasons substantially similar to the original Kentucky demonstration and the amendments to Arkansas Works." ECF No. 18-1 at 9. And in its brief responding to the Court's November 21, 2019 Order, Federal Defendants conceded that if the D.C. Circuit issues a merits affirmance on the grounds set forth by this Court, the approval of the work requirements would be unlawful under circuit precedent. Fed. Def's Br. in Resp. to the Court's Nov. 21, 2019 Minute Order 1 (Fed. Br.), ECF No. 31. The Federal Defendants' statement does not go far enough. As discussed in Section II, below, this Court assessed and invalidated the Secretary's approval of the Kentucky and Arkansas projects *as a whole*. Thus, if the D.C. Circuit affirms on the grounds set forth by this Court, then the Secretary's HIP extension approval—not only his approval of the work requirements—would be unlawful under that precedent.

For its part, Indiana now contends that a merits affirmance by the D.C. Circuit would not render the HIP work requirements unlawful because they are materially different from those at issue in *Stewart* and *Gresham*. Mem. of Intervenor-Def. Ind. Family and Soc. Servs. Admin. 18-

21 (Ind. Br.), ECF No. 30. Indiana argues that, unlike Kentucky and Arkansas, it designed its work requirement to "minimize[] coverage loss." *Id.* But even assuming that *Indiana* has identified meaningful differences between the three states' work requirements, *the Secretary* did not. The Secretary did not cite any of the purported differences Indiana now points to as a basis for approving the HIP extension. *See Michigan v. EPA*, 135 S. Ct. 2699, 2710 (2015) (noting it is a "foundational principle of administrative law that a court may uphold agency action only on the grounds that the agency invoked when it took the action").

Rather, the Secretary used the exact same rationale as in Kentucky and Arkansas. He justified the Indiana project on the grounds that it would promote his stated objectives of using Medicaid to improve health outcomes, increase "upward mobility," and facilitate transitions to private health insurance. AR 6. As this Court has repeatedly held, those are not freestanding objectives of the Medicaid Act and consideration of those goals cannot support approval of a Section 1115 project. *Stewart v. Azar (Stewart II)*, 366 F. Supp. 3d 125, 145-48 (D.D.C. 2019), *appeal docketed*, No. 19-5095 (D.C. Cir. Apr. 11, 2019); *Gresham*, 363 F. Supp. 3d at 179; *Philbrick v. Azar*, 397 F. Supp. 3d 11, 28, 29 (D.D.C. 2019), *appeal docketed*, No. 19-5293 (D.C. Cir. Oct. 31, 2019).

As to the Medicaid Act's *actual* core objective of furnishing health coverage for low-income people, the Secretary "entirely failed" to consider whether the HIP extension was likely to advance this cause, just as he failed to do in the Kentucky and Arkansas approvals. AR 3 (listing the factors the Secretary considered when evaluating Indiana's application); *see Stewart v. Azar*, 313 F. Supp. 3d 237, 261-62 (D.D.C. 2018); *Gresham*, 363 F. Supp. 3d at 176-77. Significantly, the administrative record contains substantial evidence that the Indiana project would reduce health coverage. With respect to the work requirements alone, Indiana acknowledged that close

to 25,000 individuals would lose Medicaid coverage *each year* for failing to work enough hours.[1] AR 3912-13; *see* AR 2864, 2881 (warning that estimate was too low, as it did not capture individuals who fail to claim an exemption or report their work hours).

The Secretary did not address or so much as mention that estimate, *see* AR 1-9, just as he did not address projected coverage losses in the other waiver approvals. *See, e.g.*, *Stewart I*, 313 F. Supp. 3d at 263. He did acknowledge that "commenters expressed concerns" that the work requirements "would be burdensome on families or create barriers to coverage for non-exempt people who might have trouble accessing care." AR 7. But the Secretary did not actually grapple with the issue. Instead, as he later did in Arkansas, he simply asserted that work requirements "create appropriate incentives" for individuals to work. AR 7. The Court described that response as saying "nothing about the risk of coverage loss those requirements create." *Gresham*, 363 F. Supp. 3d at 177; *see also Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) ("Stating that a factor was considered, however, is not a substitute for considering it."). Ultimately, as in his other approvals, the Secretary approved the Indiana project "with no idea of how many people might lose Medicaid coverage." *Stewart I*, 313 F. Supp. 3d at 264. By failing to adequately consider "an important aspect of the problem," the Secretary violated the APA—

[1] Indiana's comparison of coverage losses in the other states is based on false premises. *See* Ind. Br. at 21. Kentucky projected that, over a five-year period, the Kentucky HEALTH project, which imposed work requirements, premiums, administrative lockout penalties, and eliminated retroactive coverage, would cause the equivalent of 95,000 people to lose coverage for one year. *See* Kentucky HEALTH § 1115 Demonstration Modification Request (2017), Att. A, at 11-12, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf. Kentucky did not estimate how many people would lose coverage every year due to the work requirements alone. Thus, it is not possible to compare the Kentucky and Indiana figures directly. Arkansas's application did not provide an estimate of coverage loss due to the work requirement component. The number of people who lost coverage in Arkansas between August and December 2018 is simply not relevant to the question of whether the Secretary used different reasoning to approve Indiana (in February 2018) and Arkansas (in March 2018).

again. *Id*. at 265; *id*. at 261 (ignoring Medicaid's purpose of providing coverage to the expansion population was a "fundamental failure").

In sum, if the D.C. Circuit affirms on the merits, this Court should find that the HIP extension approval as a whole was invalid, as it did with regard to the Kentucky and Arkansas approvals. *See, e.g.*, *Gresham*, 363 F. Supp. 3d at 182-85; *Stewart I*, 313 F. Supp. 3d at 272.

II. If the D.C. Circuit Affirms, the Court Should Vacate the HIP Extension Approval.

Just as nothing about the HIP extension approval warrants a different result on the merits, so, too, nothing about this case requires a different remedy. As in the other cases, vacatur is the appropriate remedy. *See Stewart II*, 366 F. Supp. 3d at 155; *Gresham*, 363 F. Supp. 3d at 184-85; *Stewart I*, 313 F. Supp. 3d at 273; *see also Philbrick*, 397 F. Supp. 3d at 33. Moreover, vacatur will not, as Defendants intimate, upset the substance use disorder (SUD) program. Fed. Br. at 8-9; Ind. Br. at 24-25.

A. There is No Reason to Deviate from the Presumed Remedy of Vacating an Unlawful Agency Action.

When, as here, an agency action violates the APA, the "practice of the court is ordinarily to vacate" the action and remand it back to the agency. *Ill. Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693 (D.C. Cir. 1997). As this Court has noted, under Supreme Court and D.C. Circuit precedent, "vacatur[] is the presumptively appropriate remedy for a violation of the APA." *Gresham*, 363 F. Supp. 3d at 182 (quotation marks omitted). To determine if remand without vacatur is warranted, the Court must consider "the seriousness of the order's 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." *Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993) (internal quotation marks omitted). As discussed

below, Defendants have not provided adequate justification to overcome the presumption of vacatur.

Seriousness of Deficiencies. "Failure to consider an important aspect of the problem is a 'major shortcoming[]' generally warranting vacatur." *Stewart II*, 366 F. Supp. 3d at 155 (citation omitted). Here, the Secretary entirely ignored whether the HIP extension was likely to advance Medicaid's core objective of furnishing medical assistance to low-income people in need. As this Court found with respect to the Secretary's other approvals, that failure goes "to the heart" of his decision. *Stewart I*, 313 F. Supp. 3d at 273 (quotation marks omitted); *Gresham*, 363 F. Supp. 3d at 182 (quotations omitted). It was not isolated to his reasoning on work requirements, as Defendants contend. Fed. Br. at 8. Rather, as in those other approvals, it infected his rationale for approving the project as a whole. *See Stewart I*, 313 F. Supp. 3d at 272; *Gresham*, 363 F. Supp. 3d at 181.

While the Secretary evaluated the project as a whole, AR 3, 6, his consideration of the various components of the project is instructive. *Stewart I*, 313 F. Supp. 3d at 257. Take his treatment of the premium requirements, for example. The administrative record contained substantial, unrefuted evidence that premiums deter and reduce Medicaid coverage. Commenters pointed to almost two decades of research that has concluded, without exception, that premiums create insurmountable barriers to coverage for low-income people. *See* AR 2875, 2878, 2900; *see also* AR 2921 (noting that Indiana's request to switch to income-based tiers will not solve the problem). Notably, at the time of the 2018 approval, Indiana had already evaluated the effects of the premiums in the previous Section 1115 project. *See* Lewin Group, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment* (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-

indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf; AR 2921-22 (describing the results of the evaluation). During just one 22-month period in 2015 and 2016, more than 46,000 individuals found eligible for HIP 2.0 did not receive coverage because they did not pay the initial monthly premium. Only half of those people eventually reapplied and accessed coverage, meaning that roughly 23,000 individuals never received Medicaid coverage due to the premium requirements. Lewin Group, *Indiana HIP 2.0: Power Account Contribution Assessment* 12 (2017). An additional 13,550 individuals who enrolled in Medicaid later lost coverage for failure to pay their premium. *Id*. at ii, 12. Overall, 55 percent of people found eligible for the project did not pay at least once and were denied coverage, lost coverage (and could not re-enroll for six months), lost vision and dental benefits, and/or had to pay cost sharing. *Id*. at 8-11. *See also* AR 3073-74, 3113-14 (describing multiple Indiana reports documenting coverage loss due to premiums).

The Secretary did not adequately consider this substantial evidence. In response to commenters' concerns regarding the negative effects of premiums on coverage, the Secretary first stated that he "continue[s] to believe that the demonstration's premium provisions are appropriate to prepare beneficiaries to participate in the commercial market." AR 7. That amounts to no response at all. The Secretary then justified the premiums by stating that the "demonstration" has reduced the number of uninsured low-income people in Indiana. AR 7. However, it is not the "demonstration" that caused the reduction in the uninsurance rate, but rather the Medicaid expansion, which Indiana implemented through a separate state plan amendment. *Cf. Stewart II*, 366 F. Supp. 3d at 154 (concluding that the baseline for determining whether a particular Section 1115 project will promote coverage is not no coverage at all, but rather coverage as set forth in the Medicaid Act).

Next, the Secretary alludes to survey data showing that a small portion of respondents who were not enrolled in HIP or lost their HIP coverage for failure to pay their premium did not pay because they had a change in income or received insurance from another source. AR 7; *see* Lewin Group, *Indiana HIP 2.0: Power Account Contribution Assessment* 20 (2017). Of course, that response disregarded the far larger portion of survey respondents who indicated they did not pay their premium because they could not afford it or were confused. Finally, in a separate section of the approval letter, the Secretary emphasized that certain "vulnerable" populations are exempt from termination and the lockout penalty. AR 6. The original 2015 HIP 2.0 approval included identical exemptions, ECF No. 1-4 at 35, and Indiana's own evaluations confirmed that substantial coverage loss nevertheless occurred. Thus, nothing in the record indicates that the Secretary actually considered the impact of the premium requirements on coverage. In addition, given the record, the Secretary could not have reasonably determined that the premiums, which Indiana itself has been "testing" since 2008, have any experimental, pilot, or demonstration value as required by Section 1115.[2] *See Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994); *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (questioning whether the Secretary could find cost sharing has any experimental value given the 35-year history of research on the effects of cost sharing on the poor).

[2] Plaintiffs allege that the Secretary does not have the authority to allow Indiana to impose premiums on individuals below 150% of FPL. *See* Compl. ¶¶ 51-55, 251, ECF No. 1. If they succeed on that claim, the Court would have no "doubt whether the agency chose correctly" in waiving the limits on premiums. *Allied-Signal, Inc.*, 988 F.2d at 150; *see also Conservation Law Foundation v. Pritzker*, 37 F. Supp. 3d 254, 271 (D.D.C. 2014) ("[W]here there is no question that the agency has violated the law and absolutely no possibility of the rule's survival on remand—the D.C. Circuit has suggested that the rule ought to be vacated." (citing *Nat'l Res. Def. Coun. v. EPA*, 489 F.3d 1250, 1261 (D.C. Cir. 2007))).

Given that the Secretary used severely deficient reasoning to approve the HIP extension as a whole, vacatur of the project as a whole is appropriate.

Extent of Disruption. The disruptive consequences of vacatur are "weighty only insofar as the agency may be able to rehabilitate its rationale for the regulation." *Comcast Corp. v. FCC*, 579 F.3d 1, 9 (D.C. Cir. 2009). For reasons described above, the approval cannot be rehabilitated. *See Stewart II*, 366 F. Supp. 3d at 156 (noting that on remand, "the Secretary doubled down on his consideration of other aims of the Medicaid Act," leaving the court with "some question" about his "ability to cure the defects in the approval"). As a result, the Court need not reach the second factor. *See Standing Rock Sioux Tribe v. U.S. Army Corps of Eng'rs*, 282 F. Supp. 3d 91, 97 (D.D.C. 2017). But even if the Court were to consider that factor, it supports vacatur. As in *Gresham*, Indiana is continuing to implement portions of the 2018 approval that cause massive coverage loss, and that harm is not outweighed by any temporary disruption to the State. *See Gresham*, 363 F. Supp. 3d at 184-85.

As an initial matter, Indiana incorrectly suggests that vacatur would eliminate Medicaid coverage for those subject to the HIP project. *See.* Ind. Br. at 22-23. All of the populations included in the project—parents and caretaker relatives, pregnant women, individuals receiving transitional medical assistance, and the expansion group—are described in the Medicaid Act, and all of the populations "derive their eligibility through the Medicaid state plan." AR 21. The approval of the HIP extension is not what allows Indiana to provide Medicaid coverage to these groups. Rather, the approval is what allows the State to restrict their access to coverage and services. Thus, vacating the approval would leave the expansion population with Medicaid coverage that meets the requirements Congress set forth in the statute.

Nevertheless, Indiana argues that if the Court were to vacate the HIP extension approval, state law could prevent the continuation of the Medicaid expansion. Ind. Br. at 31. But federal law does not permit Indiana to terminate the Medicaid expansion. While *National Federation of Independent Business* prohibits the federal government from withdrawing all Medicaid funding should a state refuse to cover the expansion population in the first place, the decision did not re-categorize the expansion population as an optional population for states that expand Medicaid. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 585 (2012). In other words, if a state expands Medicaid, the expansion population remains a mandatory population. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). So once a state, like Indiana, extends Medicaid to the expansion population, that state can no more choose to eliminate coverage for that group than it could for pregnant women, caretaker relatives, people with a disability, or any other mandatory population. *Cf. Stewart II*, 366 F. Supp. 3d at 153-54 ("But the privilege Kentucky seeks to exercise here is not to de-expand, but rather to implement the ACA expansion as an *a la carte* exercise, picking and choosing which of Congress's mandates it wishes to implement. *NFIB* did not sanction that.")

Even if Indiana could choose to end the Medicaid expansion, state law would not require it to do so, as Indiana suggests. Ind. Br. at 31. The relevant state law gives the Secretary of the Family and Social Services Administration (FSSA) flexibility to make changes to HIP if they are required by federal law. *See* Ind. Code § 12-15-44.5-10(c). Thus, if the Court were to find that the HIP extension approval violated the APA, that provision would permit FSSA to cover the expansion population without the restrictions on coverage contained in the state law. *See* Ind. Br. at 31 (conceding that if the Court were to vacate the waiver, federal law would bar it from implementing several of the HIP project components); *see also* Ind. Code § 12-15-44.5-3(a)-(c) (requiring FSSA to administer HIP and stating expansion group is eligible for HIP).

What is clear is that Defendants' argument that remand without vacatur will "not harm Plaintiffs in the slightest" is wrong.[3] Ind. Br. at 33; Fed. Br. at 9. Tens of thousands of lives will be disrupted. While Indiana has paused implementation of the work requirements and the redetermination lockout penalty, it is implementing the other components of the 2018 approval – mandatory premiums, elimination of retroactive coverage, and elimination of non-emergency medical transportation (NEMT). Substantial evidence establishes that these features reduce coverage and access to care. As described above, the premium requirements alone result in massive numbers of individuals losing Medicaid coverage every year. During the third year of the HIP 2.0 project, 11,793 enrollees lost Medicaid coverage for failure to pay their monthly premium. *See* State of Ind., *Healthy Indiana Plan Demonstration, Section 1115 Annual Report, Demonstration Year 3 (02/01/17-01/31/18)* 15 (2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2018-043018.pdf.

The waiver of retroactive coverage is similarly harmful to low-income individuals in Indiana. "[R]estricting retroactive eligibility will, by definition, reduce coverage for those not currently on Medicaid rolls." *Stewart I*, 313 F. Supp. 3d at 265. Without coverage, some individuals delay receiving care "to avoid incurring medical bills they cannot pay," *Gresham*, 363 F. Supp. 3d at 179, and individuals who do seek care incur substantial medical debt. In fact, data

[3] Defendants make the paradoxical argument that vacatur will harm Medicaid enrollees because it will confuse them. Fed. Br. at 8-9. However, evidence shows that enrollees are already confused about the terms of their coverage, particularly the POWER account and premium requirements. AR 3116-19 (reviewing evidence showing widespread confusion about the POWER account, including survey data finding that 52% of HIP Plus members (65% of HIP Basic members) had never heard of or incorrectly thought they did not have a POWER account), 3053, 3019-20, 2836-38. It is illogical to suggest that enrollees would prefer these complicated requirements, which restrict their access to care, to continue uninterrupted.

from Indiana show the importance of retroactive coverage to low-income people in the State. While the 2015 HIP 2.0 approval allowed Indiana to eliminate retroactive eligibility, it required the State to continue to pay for services provided to individuals in the parent/caretaker relative eligibility group during the retroactive coverage period. ECF No. 1-4 at 19-20. Over a three month-period in 2016, 455 enrollees used that coverage, averaging $1,561 in claims paid per person. AR 289, 292. In addition, due to the NEMT waiver, many HIP enrollees cannot get to medically necessary health care, which has severe consequences for their health. *See, e.g.*, AR 3054-55, 3075.

Thus, in attempting to distinguish *Gresham* on the basis that Indiana has paused implementation of its work requirements, *see* Fed. Br. at 9, Defendants miss the point. As was the case in Arkansas, Indiana is moving forward with its implementation of waivers that have caused and will continue to cause serious harm to Medicaid enrollees. *See Gresham*, 363 F. Supp. 3d at 184-85 (pointing to the thousands of people who have lost coverage due to the waivers and finding "no reason to think the numbers will be different" moving forward). That harm must be balanced against the disruption to the State. *Id*. at 184. And, as was the case in Arkansas, although vacatur will cause Indiana to make changes to its Medicaid program, it "will have little lasting impact on HHS's or [Indiana's] interests." *Id*. at 183-84. On balance, any temporary administrative burden suffered by the State cannot outweigh the permanent, life-altering harm that individuals will continue to experience if the approval remains in effect. *See id*. at 185.

B. The SUD Program is a Distinct Section 1115 Project Not at Issue Here.

In arguing that vacatur is not appropriate, the Federal Defendants assume that if the Court were to vacate the HIP extension approval, it would also eliminate the SUD program, which like the programs underway in other states, is designed to increase Medicaid coverage of services for

people with SUDs. However, for the reasons articulated in *Stewart I*, the Court "can properly limit its review" to the other portions of the approval.[4] *Stewart I*, 313 F. Supp. 3d at 258. In short, the elimination of the SUD program is a strawman that this Court can and should ignore; the SUD program can remain in place notwithstanding the Court's vacatur of the HIP project as a whole.

"Although packaged inside the same application," the SUD program is "wholly distinct from" the other components of the approval. *Id.* The SUD program is available to all Medicaid enrollees, while the remainder of the approval applies to adults who do not have a disability and are not elderly. *See id.*; AR 21, 42. The start of the SUD program did not coincide with the start of other components of the approval, some of which had been in place for over a decade. *See Stewart I*, 313 F. Supp. 3d at 258; AR 43 (residential treatment services for people with an SUD diagnosis to begin February 1, 2018), AR 25 (work requirements to begin January 1, 2019), ECF No. 1-3 (listing waivers effective January 1, 2008). In addition, the SUD program and the remainder of the HIP approval have different purposes. Indiana designed the SUD program to "add[] critical new evidence-based substance use disorder (SUD) treatment services" and "expand[] access to qualified providers." AR 3961. In contrast, Indiana described the goals of the HIP extension as promoting work to reduce dependence on public assistance, AR 3835-36; preparing consumers to transition to private coverage, AR 3932; and empowering them to become "active consumers of healthcare services." *Id.*

[4] Federal Defendants contend that, unlike the Plaintiffs in *Stewart I*, the Plaintiffs here have not treated the SUD program as a separate project. Fed. Br. at 7. However, the complaint indicates that the key components of the HIP extension approval are the work requirements, monthly premiums and penalties for failure to pay, redetermination lockout penalty, elimination of retroactive coverage, and elimination of NEMT. Compl. ¶¶ 107-142. To resolve any confusion concerning the scope of their challenge, Plaintiffs are simultaneously filing an amended complaint.

While the Secretary did not create a different label for the SUD program as he did in Kentucky, *see Stewart I*, 313 F. Supp. 3d at 258, that is a distinction without a difference. The Secretary treated the SUD program as distinct from the other components of the HIP extension approval. For example, acknowledging that the State was seeking two unrelated Section 1115 projects, the Secretary required Indiana to conduct two separate evaluations—one for the SUD program and one for the other approved provisions. AR 42-50. Indiana hired two contractors and proposed two evaluation design plans—one for the SUD program and one for HIP. To date, HHS has approved a design plan for the SUD program but not for the HIP extension. *Id*. In addition, he required the State to submit separate quarterly reports on each project. *See* Medicaid.gov, *Healthy Indiana Plan, Supporting Documents, Administrative Record*, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=25478 (last visited Jan. 25, 2020).

The Secretary's approach is not surprising, as "[he] has solicited and regularly approved stand-alone SUD demonstrations in other states, without packaging in elements similar to" the other components of HIP. *Stewart I*, 313 F. Supp. 3d at 258. In fact, Indiana is now requesting formal separation of the two projects. In November 2019, the State released for public comment its request to extend the SUD program for five years. Ind. Family & Soc. Servs. Admin, *Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver – Substance Use Disorder & Serious Mental Illness IMD Waiver* (2019), https://www.in.gov/fssa/hip/files/SUD%20Extension.pdf. At the same time, it released a second request to extend the HIP approval challenged here for ten more years. Ind. Family & Soc. Servs. Admin., *Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver* (2019), https://www.in.gov/fssa/hip/files/HIP%20Extension.pdf. *See also* Ctrs. for Medicare & Medicaid Servs., CMCS Informational Bulletin:

Section 1115 Demonstration Process Improvements (2017), https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf (announcing that CMS will approve certain "routine, successful" Section 1115 projects for a period of up to 10 years).

In short, a decision to vacate and remand the HIP project would have no effect on the separate SUD program. As it did in *Stewart I*, the Court should find that the relevant "experimental, pilot, or demonstration" project does not include the SUD program. *Stewart I*, 313 F. Supp. 3d at 259 (quotation marks omitted); *see also id.* at 273 (finding Secretary's decision to approve SUD program was severable from his approval of Kentucky HEALTH as a whole).

CONCLUSION

For the reasons stated above, if the D.C. Circuit issues a straight merits affirmance, the Plaintiffs respectfully ask the Court to vacate the Secretary's approval of the HIP extension. If, however, the Court is inclined to remand the Secretary's approval without vacatur, Plaintiffs request an opportunity to file a brief on the remaining claims in their complaint. *See* Compl. ¶¶ 227-234, 241-291 (Counts I, III-VIII).

Dated: January 27, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 27, 2020, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to the Defendants' attorneys of record.

By: /s/ Jane Perkins
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