UNITED STATES DISTRICT COURT
DISTRICT OF THE DISTRICT OF COLUMBIA

MONTE A. ROSE, JR., *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 1:19-cv-02848-JEB
XAVIER BECERRA, *et al.*,	)	
	)	
Defendants.	)	

MEMORANDUM OF INTERVENOR-DEFENDANT INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION IN SUPPORT OF ITS MOTION TO DISMISS AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The Healthy Indiana Plan (HIP) expands Medicaid coverage to thousands upon thousands of Hoosiers who would not have Medicaid coverage without it—all the while helping Hoosiers take ownership of their health and lead healthier lives. As one beneficiary shared with the Centers for Medicare and Medicaid Services (CMS), HIP "is, by far, the best health insurance experience of my adult life." S.A.R. 7151. It is, another said, "a model for the whole nation." S.A.R. 7150.

Despite the benefits that HIP provides to more than 700,000 Hoosiers, plaintiffs seek to have federal approvals for the project vacated entirely. But plaintiffs lack standing to seek that sweeping relief. Each plaintiff receives healthcare coverage though HIP, and in fact, desires to continue receiving coverage through HIP. So ending HIP would not redress any alleged injury. Plaintiffs may wish that HIP provided more coverage and had fewer restrictions, but that desire does not justify their demand for an end to the entire project. That is especially true considering the scant evidence that plaintiffs are in fact injured by the HIP components challenged here.

There is no legal basis for setting aside the federal approvals either. Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive any Medicaid requirements "to the extent and for the period he finds necessary" for a State to carry out a demonstration project "likely to assist in promoting the objectives" of the Medicaid statute. 42 U.S.C. § 1315(a). And exercising this delegated authority, CMS rationally concluded HIP would do so. HIP serves an important Medicaid objective by expanding the scope of coverage. Through HIP, Indiana covers a population that the State may, but is not required to, cover through Medicaid under the Affordable Care Act and provides benefits that the State may, but is not required, to provide, such as vision and dental coverage.

Plaintiffs focus on a few components of HIP that (they say) do not expand coverage. But Section 1115 requires CMS to focus on the project as a whole—not individual components. And the components that plaintiffs dislike cannot be separated from Indiana's decision to expand Medicaid and provide optional benefits. The components support that objective by preserving scarce resources through mechanisms that encourage personal responsibility, improve health, and prepare beneficiaries to transition from Medicaid to commercial insurance as their finances improve.

Plaintiffs also challenge CMS's decision not to revisit the waiver after the end of the COVID-19 public health emergency. But that decision is committed to agency discretion by law; there is no statutory standard by which to evaluate the action's lawfulness. Besides, it was hardly irrational for CMS to conclude that it would be too disruptive to alter core HIP components while Indiana is busy implementing changes required by the end of the public health emergency. Altering HIP's basic structure—to the extent it is even possible under Indiana law—would entail massive changes to the project and impact many stakeholders. The Court should reject plaintiffs' position, which would significantly constrict the flexibility that States need to deliver Medicaid services.

In all events, the Court should not vacate the waiver for HIP. Vacating the waiver would imperil the future of Medicaid expansion in Indiana and the coverage HIP provides while doing nothing (or at least very little) for the three individuals who have brought this case. And there is a high likelihood that CMS could address any perceived failings in its reasoning on remand.

BACKGROUND

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 populations. *See* 42 U.S.C. § 1396 *et seq*. To receive this funding, States must submit a Medicaid plan for approval by the Secretary of Health and Human Services, whose review is largely conducted by the Centers for Medicare & Medicaid

Services (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* 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, Medicaid provided funding for the most vulnerable Americans: "pregnant women, children, needy families, the blind, the elderly, and the disabled." *NFIB*, 567 U.S. at 575 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.) (citing 42 U.S.C. § 1396a(a)(10)). The Affordable Care Act (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 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.) (citing 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)). The ACA threatened States with the loss of *all* Medicaid funds if they failed to furnish expanded coverage, 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 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.). Accordingly, States can choose to provide coverage to both the original Medicaid population and the expansion population or can "choose to reject the expansion" and cover only the original population. *Id.* at 587 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.).

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 statute, 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

The Healthy Indiana Plan (HIP) is a Section 1115 demonstration project through which Indiana has expanded Medicaid coverage, including to the Medicaid expansion population. Over the years, there have been several versions of HIP. But all have been modeled to foster personal responsibility in health care decisionmaking by empowering beneficiaries.

A. The pre-Medicaid expansion version of HIP

HIP originated in 2007 when the Indiana legislature authorized the Indiana Family and Social Services Administration (FSSA) to seek approval from CMS for a health coverage program for uninsured adult Hoosiers who were aged 17 to 64, who had a household income below 200% of the federal poverty level, and who were not otherwise eligible for Medicaid. *See* Ind. House Enrolled Act No. 1678 (2007) (codified at Ind. Code § 12-15-44.2). CMS approved HIP as a Section 1115 demonstration project in December 2007, for a five-year period beginning January 1, 2008, and ending December 31, 2012. *See* CMS, *Healthy Indiana Plan Special Terms and Conditions*, Pls.' Suppl. Compl. Ex. B, Dkt. 50-1 (2012 STCs).

To promote personal responsibility and empower enrollees, Indiana designed HIP to imitate features of commercial insurance. Letter from Kerry Weems, CMS, to Mitchell Roob, FSSA, at 2 (Dec. 14, 2007), Suppl. Compl. Ex. A, Dkt. 50-1. A cornerstone of this design is the Personal Wellness and Responsibility (POWER) Account, which is similar to a health savings account and is used by beneficiaries to pay for health care expenses. *Id.* at 1. Under the original HIP, each

participant was enrolled in a comprehensive coverage plan, with the first $1,100 in services to be paid as a "deductible" through POWER Accounts. 2012 STCs at 20. POWER Accounts were primarily funded by the State, with additional contributions from participants according to a sliding scale based on income. *Id.* at 1–2, 19–23. To encourage beneficiaries to access and use preventive health services, the first $500 of preventive health services were not charged against the POWER Account, and members could roll over unspent balances at the end of the year—thereby decreasing future contributions—so long as they had obtained certain preventive services. *Id.* at 20. While the original HIP covered a wide range of benefits, including emergency ambulance transportation, it did not include non-emergency transportation to and from providers. Moreover, coverage did not begin until the member made their first POWER Account contribution. *Id.* at 20.

To accommodate these and other features of the original HIP, the 2012 CMS approval provided that various federal statutory and regulatory provisions were "not applicable" to the HIP population "to the extent necessary" for the State to implement the project. 2012 STCs at 47. These included Section 1916(a)(1) of the Social Security Act, which provides that "no enrollment fee, premium, or similar charge will be imposed under the plan"; 42 C.F.R. § 431.53, which provides that a Medicaid agency must "ensure necessary transportation for beneficiaries to and from providers"; and Section 1902(a)(34) of the Social Security Act, which provides up to three months of "retroactive eligibility" prior to the date of application, if an applicant would have been eligible had they applied during the prior period. 2012 STCs at 47–48.

HIP was a success. Early evaluations of the program indicated that its design led to greater patient engagement with health providers, higher utilization of preventative care services, lower emergency department usage, and higher use of generic as opposed to brand name drugs. *See*

Healthy Indiana Plan Successes (2013), https://www.in.gov/fssa/hip/files/Healthy_Indiana_Plan_Successes_Dec2013.pdf. The program was also extremely popular. A 2013 Mathematica Policy Research survey found that approximately 96% of HIP members were either somewhat or very satisfied with their overall experience with HIP. *Id.* The majority of HIP members (83%) reported that they preferred paying a fixed monthly amount up front with the opportunity to have unspent funds rolled over, instead of making a payment each time they visited a health professional, pharmacy, or hospital. Over 93% of HIP members required to contribute to their POWER Account stated they would be willing to pay an additional $5 per month to retain HIP coverage, and 88% were willing to pay an additional $10 per month for coverage. *Id.* Even a majority of enrollees *not* required to contribute to POWER Accounts indicated that they would be willing to pay $5 to $10 per month for HIP coverage. *Id.* The survey also indicated that 76% of members felt their contributions were the right amount and 9% of members felt that they were too low. *Id.*

B. Indiana considers Medicaid expansion through HIP

In March 2010, two years after HIP's implementation, Congress enacted ACA, requiring States to cover the entire nonelderly population with incomes below 133 percent of the poverty level. *See NFIB*, 567 U.S. at 575 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.) (citing 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)). Indiana was one of the States that challenged the ACA's expansion requirement. *Id.* at 527–28. The Supreme Court held the expansion requirement unconstitutional, explaining that the federal government cannot "withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion." *Id.* at 585 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.). It left it up to the States to choose whether to participate in Medicaid expansion. *See id.* at 587 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.).

The CMS responded by offering flexibility. CMS advised that "[a] state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage," and that "States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions." A.R. 314–315. CMS emphasized that "[w]ith respect to the expansion group in particular, states have considerable flexibility regarding coverage for these individuals" with respect to benefit design, and that "States also have significant cost-sharing flexibility for individuals above 100% of the federal poverty level," noting that it "intend[ed] to propose other cost-sharing changes that will modernize and update our rules." A.R. 318. CMS told States that it was "interested in working with states to promote better health and health care at lower costs," and it "invite[d] states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes," reiterating that "states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing." A.R. 318.

Indiana took the federal government at its word. In exploring the possibility of Medicaid expansion, Indiana made clear that HIP would be the vehicle through which any expansion would occur. As then-Governor Mitch Daniels explained to the Secretary of Health and Human Services, "HIP was implemented with bi-partisan support in the Indiana General Assembly and reflects the values of our state." Letter from Gov. Daniels to Sec'y Sebelius, HHS, at 1 (Jan. 14, 2011), https://www.in.gov/fssa/hip/files/011411letter.pdf. Indiana's desire, Governor Daniels explained, is "to promote this program that contains consumer-focused incentives for personal responsibility instead of a traditional Medicaid entitlement program." *Id.* He urged 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.* at 2; *see* Letter from Anne Murphy, FSSA, to Cindy Mann, CMS, at 1 (May 17, 2010), https://www.in.gov/fssa/hip/files/CMS_HIP_letter_May_17_2010.pdf (explaining Indiana's interest in "us[ing] the successful HIP plan as the vehicle for covering the newly eligible population"). Shortly thereafter, the Indiana legislature, on a bipartisan basis, authorized Medicaid expansion via HIP. Ind. P.L. 213-2015, § 134 (codified at Ind. Code § 12-15-44.2-17).

Throughout subsequent discussions with CMS, Indiana repeatedly made clear that any Medicaid expansion would occur through HIP and HIP alone. Shortly after the legislature authorized Medicaid expansion via HIP, Indiana informed CMS that 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, FSSA, to Cindy Mann, CMS, at 1 (July 25, 2012), https://www.in.gov/fssa/hip/files/Healthy_Indiana_Plan_1115_Waiver_07_25_ 2012.pdf. CMS responded by approving a short extension of the HIP demonstration project through 2013, to "allow Indiana to provide continued coverage under its Demonstration while allowing time for the state and CMS to continue our discussions as Indiana considers its options for 2014." Letter from Cindy Mann, CMS, to Michael Gargano, FSSA, at 1 (July 31, 2012), https://www.in.gov/fssa/hip/files/CMS_IN_Letter_7_31_12.pdf.

In February 2013, Indiana, under the leadership of then-Governor Michael Pence, sought to renew a three-year CMS waiver for HIP while the State considered whether to move forward with Medicaid expansion. In the renewal request, Governor Pence again informed CMS that "our administration will not pursue an expansion of traditional Medicaid as permitted under the Afford-

able 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 Gov. Pence to Sec'y Sebelius, HHS, at 1–2 (Feb. 13, 2013), https://www.in.gov/fssa/hip/files/Letter_HIP_Updated246.pdf. This led to almost two years of discussions between Indiana and CMS and continued short-term extensions of the HIP demonstration project, in which both sides strove to accommodate the concerns raised by the other.

Throughout these discussions, Indiana continued to reiterate that it would expand Medicaid through HIP only. As Governor Pence explained in November 2013, "in order to expand the Healthy Indiana Plan" to the Medicaid expansion population, "it is essential that the State be able to maintain the consumer-driven model on which the program is predicated." Letter from Gov. Pence to Sec'y Sebelius, HHS, at 2 (Nov. 15, 2013), https://www.in.gov/fssa/hip/files/Letter_from_Governor_Pence_to_Secretary_Sebelius.pdf. This model includes "the requirement that Healthy Indiana Plan members make monthly account contributions" into "a Health Savings Account-like account." *Id.* "Our data," he explained, "indicates that members like the design of the program," "prefer to pay for their health care costs up-front as opposed to at the time of service," "find the plan to be affordable," and "would be willing to pay more for the plan." *Id.* Similarly, in October 2014, the Governor reiterated the "clear" message "that Indiana will not expand traditional Medicaid." Letter from Gov. Pence to President Obama, at 2 (Oct. 2, 2014), https://www.in.gov/fssa/hip/files/Governor_Pence_Letter_to_President_Obama.pdf. "Our administration will not support efforts to remove or water down the Healthy Indiana Plan's core principles, essentially changing this proven program into an expansion of traditional Medicaid." *Id.*

C. In 2015, Indiana expands Medicaid through HIP 2.0

Ultimately, Indiana and CMS were able to agree on what became known as HIP 2.0, which CMS approved as a three-year demonstration project running from February 1, 2015, through January 31, 2018. Letter from Marilyn Tavenner, CMS, to Joseph Moser, FSSA, at 1 (Jan. 27, 2015) (with enclosures), Dkt. 32-3 (2015 Approval). HIP 2.0 covered the Medicaid expansion population as well as certain adults who would have qualified for "traditional" Medicaid coverage because they were low-income parents or caretakers of Medicaid-eligible children. *Id.* at 19. As with prior versions of HIP, HIP 2.0 sought to expand Medicaid coverage through an approach that fostered personal responsibility, fiscal sustainability, and better health. *Id.* at 12.

To obtain CMS approval, however, Indiana made several changes. It agreed to remove the HIP enrollment cap and to remove the annual and lifetime dollar cap on benefits. The cornerstone of the program continued to be the POWER Accounts, which operate as health savings accounts covering the first $1,100 of expenditures. *See* pp. 4–5, *supra*. In contrast to the earlier version of HIP, however, HIP 2.0 gave members a choice between two benefit packages: HIP Basic and HIP Plus. For HIP Basic, the POWER Account was fully funded by the State without a member contribution; however, for some services, a member would be assessed a co-payment at the time of service as permitted by Medicaid rules. 2015 Approval at 12–13, 27–28. HIP Plus included additional benefits that are not required under Medicaid (primarily, vision and dental) and did not have co-payments; however, members were required to make monthly contributions to the POWER Account, on a sliding scale according to income, between at least $1 and up to 2% of monthly income. 2015 Approval at 1–2. Members who did not make contributions could be disenrolled from HIP Plus, but such individuals with incomes at or below 100% of the federal poverty line would be automatically enrolled in HIP Basic. *Id.* This two-part structure reflected a compromise

between CMS's desire to have a premium-free option for lower-income beneficiaries that covered all essential benefits required by Medicaid (HIP Basic) and the State's desire for a program that requires contributions to the POWER accounts as a condition of eligibility (HIP Plus).

HIP 2.0 retained the original HIP's waiver of non-emergency transportation and the waiver of "retroactive eligibility" (*i.e.*, payment for costs incurred prior to the date an individual applies for Medicaid coverage). As CMS explained in a fact sheet released together with its approval letter, "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." CMS, Healthy Indiana Plan 2.0 Section 1115 Medicaid Demonstration Fact Sheet (Jan. 27, 2015), 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. CMS required the State to evaluate and report on the impacts of the waiver of non-emergency transportation and the waiver of retroactive eligibility, 2015 Approval at 55–56, which the State did in October 2015, [1] and February 2016, [2] respectively.

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[1] *Prior Claims Payment Program Report* 4 (2015), 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 ("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.").

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

D. In 2018, HIP 2.0 is renewed for three years

On January 31, 2017, Indiana applied to continue HIP 2.0 through January 31, 2021. A.R. 2577–2668. In its application, Indiana noted that of those members enrolled in HIP Plus, 92% of members below the poverty line and 94% of those above the federal poverty level make regular contributions to their POWER Accounts, and that HIP members making contributions to their accounts were 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 members who do not make contributions. A.R. 2669. The State also sought to add a component to its demonstration project covering additional benefits and services for serious mental illness (SMI) and substance use disorder (SUD) for all Medicaid recipients, including those enrolled in HIP. A.R. 2670. In July 2017, the State amended its extension request to include a community engagement requirement mandating that able-bodied HIP participants, not meeting an exemption, must (1) work an average of 20 hours per week over eight (8) months; (2) be enrolled in full-time or part-time education; or (3) participate in the State's Gateway to Work program, which would connect unemployed and underemployed HIP members to available job training, work search, and employment programs. A.R. 3836.

CMS renewed the demonstration on February 1, 2018, effective from February 1, 2018, through December 31, 2020. A.R. 1–9, 10–80. In addition to renewing longstanding aspects of HIP—including the two-tier benefit system, the requirement that members make POWER Account contributions to access HIP Plus benefits, the waiver of non-emergency transportation, and the

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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.").

waiver of retroactive eligibility—the 2018 renewal also approved the State's request to implement a community engagement requirement and the new SMI/SUD benefits. *Id.*

After this Court's decisions vacating federal approval of work requirements in Arkansas and Kentucky, *see Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019) (subsequent history omitted); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019), however, Indiana suspended its community engagement requirement pending the outcome of further litigation, *SA News Release* (Oct. 31, 2019), Dkt. 18-2. In March 2020, in response to the beginning of the COVID-19 pandemic, Indiana suspended the requirements for beneficiaries to contribute to POWER Accounts, and maintained this suspension for the duration of the public health emergency pursuant to Indiana Code § 12-8-1.5-7.5 (authorizing FSSA to waive Medicaid requirements as necessary to obtain funding under the Families First Coronavirus Response Act, Pub. L. 116-127, § 6008(b)(2)–(3), 134 Stat. 178, 208 (2020), which provided enhanced federal funding on the condition States did not disenroll persons for non-payment of premiums). S.A.R. 1559.

III. The Current Version of the Healthy Indiana Plan

On January 31, 2020, Indiana applied to renew the CMS waiver for HIP 2.0 until December 31, 2030, without substantial policy changes. S.A.R. 8234, 8238–39. Indiana proposed to continue offering beneficiaries POWER Accounts and a choice between HIP Plus and HIP Basic and to continue imposing community engagement requirements. S.A.R. 8238–39. It also proposed (among other things) not providing benefits retroactively or offering non-emergency transportation. S.A.R. 8256, 8261. And Indiana proposed continuing the SUD and SMI "components of the Medicaid demonstration entitled, 'Healthy Indiana Plan (HIP)'" for five years. S.A.R. 8290.

A. In October 2020, CMS issues the challenged waiver

In October 2020, CMS issued a waiver, approving the SUD/SMI components of HIP 2.0 for 5 years and the remaining components for 10 years (subject to conditions discussed below). S.A.R. 1554–74. CMS concluded that the project would serve an "important objective of the Medicaid program" by "expanding the scope of coverage." S.A.R. 1555. CMS also observed the project was likely to improve the "health and wellness of beneficiaries" and prepare them to "transition to commercial health insurance as their finances allow." S.A.R. 1562, 1565. Those outcomes, in turn, would "reduce the cost of providing . . . health care coverage." S.A.R. 1562, 1565. "Improved fiscal sustainability," CMS observed, will "help Indiana to continue to cover non-mandatory benefits and eligibility groups (such as the Patient Protection and Affordable Care Act (ACA) expansion population and dental and vision benefits)." S.A.R. 1564. CMS added that renewing the waiver for HIP would provide expanded SUD and SMI benefits as well. S.A.R. 1560–61.

As part of approving the project, CMS offered additional comments regarding the project components challenged as part of this lawsuit. "The demonstration's premiums and cost-sharing requirements," CMS observed, "are designed to improve beneficiary health and wellness by encouraging beneficiaries to take ownership of decisions about health care options and determine if it is more cost efficient and practical for them to enroll in an enhanced health package to receive vision and dental benefits." S.A.R. 1563. CMS cited evidence that persons who made POWER Account contributions and enrolled in HIP Plus were "more likely to engage in behaviors that improve health outcomes." S.A.R. 1563. In response to concerns about cost, CMS observed that "beneficiaries generally found premiums and copayments affordable" and that "disenrollment due to non-payment decreased over time." S.A.R. 1570. CMS also observed that a variety of project features capped overall costs for beneficiaries, that beneficiaries with incomes at or below 100

percent of the federal poverty line would not lose essential coverage for nonpayment, and that it would continue monitoring new data. S.A.R. 1564, 1570–71.

Regarding the waiver of retroactive eligibility, CMS observed that this component is "expected to help promote Medicaid's objectives by improving uptake of preventive services, thus improving beneficiary health." S.A.R. 1564. Specifically, it "will encourage them to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible, rather than potentially waiting until they are sick, knowing that the costs of the illness would be covered by a retroactive eligibility period." S.A.R. 1564. CMS also commented that the component would help "prepare beneficiaries for commercial insurance." S.A.R. 1571. In response to concerns about enrollment, CMS observed that Indiana "will continue to provide outreach and education about how to apply for and receive HIP coverage" and noted that Indiana offers "FastTrack and presumptive eligibility." S.A.R. 1571–72. As with the requirement to make POWER Account contributions, CMS promised to monitor the feature "careful[ly]." S.A.R. 1572.

CMS observed the waiver for non-emergency medical transportation is "likely to help promote Medicaid's objectives" as well. S.A.R. 1564. That waiver will help "the state to better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health coverage, thus improving the fiscal sustainability of the Medicaid program" and allowing "Indiana to continue to cover non-mandatory benefits and eligibility groups." S.A.R. 1564. CMS also noted that non-emergency transportation remained a covered service for non-expansion Medicaid beneficiaries, including pregnant women, and that three of the four Managed Care Entities (MCEs) that provide HIP benefits "offer NEMT to HIP Plus and HIP Basic members as an enhanced service," allowing beneficiaries to choose a plan meeting their needs. S.A.R. 1562.

In addition to approving those features, CMS stated that it would approve Indiana's request to implement community engagement requirements and to impose (after the public health emergency had ended) a lock-out penalty for individuals who failed to make a POWER Account contribution, contingent "on the Supreme Court issuing a decision in *Azar v. Gresham*, No. 20-37, that legally authorizes this element of the demonstration." S.A.R. 1576. After CMS issued its decision, however, the Supreme Court determined that *Gresham* was moot. *Becerra v. Gresham*, 142 S. Ct. 1665 (2022). So CMS formally withdrew its conditional approval to implement the community engagement requirements and lock-out penalty, which did not go into effect. S.A.R. 840.

B. The December 2023 determination

When CMS formally withdrew its conditional approval for the community engagement requirement, it notified Indiana that it was reviewing other authorities. S.A.R. 840. In December 2023, CMS concluded its review. S.A.R. 1. Although CMS expressed "concerns" with "premiums," it decided against withdrawing any authorities. S.A.R. 1. CMS "concluded that withdrawing those authorities at this time is too disruptive, particularly in the context of the state needing to maintain focus on keeping people covered through Medicaid unwinding and the resumption of Medicaid renewals" following the COVID-19 public health emergency. S.A.R. 1. CMS observed that additional changes could "affect the state's ability to prioritize the unwinding efforts," "lead to inaccuracies in beneficiary eligibility determinations," and require changes to "eligibility systems and managed care contracts" as well as "beneficiary communications." S.A.R. 2.

IV. The Current Litigation

In September 2019, four individuals filed this lawsuit to challenge the waiver that CMS issued for HIP 2.0 in 2018. Dkt. 1. A major focus of the complaint was CMS's approval of the community engagement requirement. *Id.* ¶¶ 7–12. FSSA intervened as a defendant. Dkt. 12.

In April 2020, this Court stayed litigation on the merits until the end of the COVID-19 public health emergency. Minute Order (Apr. 6, 2020). CMS meanwhile notified Indiana that it was withdrawing approval for the community engagement requirements and reviewing previously approved authorities. S.A.R. 840. The Court ordered the parties to file a joint status report after the end of the public health emergency or the completion of CMS's review. Minute Order (July 8, 2021). The public health emergency ended on May 11, 2023, and as CMS's review remained ongoing, the Court continued the stay until after CMS concluded its review in December 2023. Minute Order (Mar. 28, 2024).

In January 2024, three individuals (including one plaintiff from the original lawsuit) filed a supplemental complaint challenging the waiver CMS issued for HIP 2.0 in October 2020 and CMS's December 2023 decision. Dkt. 50-1. Plaintiffs both sought to end the entire HIP project and the authorities that allowed FSSA to require POWER Account contributions, not provide retroactive eligibility, and not provide non-emergency medical transportation. *Id.* ¶¶ 179–210. The Court set a briefing schedule for cross-motions. Minute Order (Feb. 9, 2024).

Plaintiffs moved for summary judgment, seeking vacatur of CMS's decisions. Dkt. 54.

STANDARD OF REVIEW

Under Federal Rule of Civil Procedure 12(b)(1), a complaint must be dismissed if a court lacks subject-matter jurisdiction. "In deciding a motion to dismiss based upon a lack of subject-matter jurisdiction, the Court 'need not limit itself to the allegations of the complaint.'" *Indigenous People of Biafra v. Sheehan*, 643 F. Supp. 3d 140, 144 (D.D.C. 2022) (quoting *Grand Lodge of the Fraternal Ord. of Police v. Ashcroft*, 185 F. Supp. 2d 9, 14 (D.D.C. 2001)). "Rather, the '[C]ourt may consider such materials outside the pleadings as it deems appropriate to resolve the question [of] whether it has jurisdiction to hear the case.'" *Id.* (quoting *Scolaro v. D.C. Bd. of*

Elections & Ethics, 104 F. Supp. 2d 18, 22 (D.D.C. 2000)). A plaintiff "bears the burden of establishing" jurisdiction. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992).

Under Federal Rule of Civil Procedure 12(b)(6), a complaint must be dismissed if it fails to state a claim upon which relief can be granted. In challenges to agency actions, the Court may consider the administrative record without converting a Rule 12(b)(6) motion into one for summary judgment. *See Marshall Cnty. Health Care Auth. v. Shalala*, 988 F.2d 1221, 1226 (D.C. Cir. 1993); *Gumpad v. Comm'r of Soc. Sec. Admin.*, 19 F. Supp. 3d 325, 328 (D.D.C. 2014). Regardless, Federal Rule of Civil Procedure 56 permits entry of summary judgment if the moving party "shows there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The party opposing summary judgment may defeat it by contesting a factual assertion or pointing to an absence of evidence. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323–25 (1986).

ARGUMENT

The Court should dismiss plaintiffs' challenge to the Section 1115 demonstration waiver that CMS granted for HIP 2.0 in October 2020 and to CMS's decision in December 2023 not to disturb the waiver. Plaintiffs do not have standing to challenge either agency action. There is a lawful, rational basis for both decisions. And a disruptive vacatur is unwarranted regardless.

I. Plaintiffs Lack Standing

As in any lawsuit, the plaintiffs "must plead and—ultimately—prove" standing. *Dep't of Educ. v. Brown*, 600 U.S. 551, 561 (2023). Standing requires the plaintiffs have suffered an injury (1) "that is both concrete and particularized" and "actual or imminent," (2) that is "fairly traceable to the challenged action of the defendant," and that is "likely" to "be redressed by a favorable decision." *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992) (cleaned up). Plaintiffs, moreover,

must demonstrate standing for "each claim . . . press[ed]" and "each form of relief . . . s[ought]." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 431 (2021). They cannot do so here.

A. Plaintiffs lack standing to challenge the waiver

Plaintiffs seek vacatur of the Section 1115 waiver granted in October 2020 that allows Indiana to operate HIP 2.0, arguing the entire HIP demonstration project should be ended. Dkt. 50-1 ¶¶ 179–87; Pls.' Mem. 1–2, 43–44, Dkt. 54-1 ("Mem."). But plaintiffs do not explain how that waiver inflicts an injury in fact. Plaintiffs admit that they use HIP and benefit from the coverage it provides. As plaintiff Emily Rames admits, "HIP provides me with the opportunity to take care of my physical and mental health needs" and "allows me . . . peace of mind." Dkt. 54-4 ¶ 7. "I plan to use HIP in the near future for vision care and primary care." *Id.* ¶ 7. Plaintiff Monte Rose has been enrolled in HIP for years and has "used [his] coverage to obtain new glasses," "dental care," "vaccinations, diagnostic tests, and treatment for . . . chronic health conditions." Dkt. 54-3 ¶ 13. And Plaintiff Chelsey Lang, who enrolled in HIP at least two years ago, Dkt. 54-3 ¶ 6, acknowledges that HIP has "helped [her] access primary care more regularly," obtain dental and vision care, and "receive genetic counseling." *Id.* ¶¶ 7–10.

To be sure, plaintiffs take issue with some HIP components—its requirement to make POWER Account contributions, its elimination of retroactive eligibility, and its elimination of non-emergency medical transportation. Dkt. 50-1 ¶¶ 192–205; Mem. 20–25. But any injury from those components is not "fairly traceable" to the HIP project's existence or the waiver's duration. *See Brown*, 600 U.S. at 564. To the extent plaintiffs' incomes are above 100% of the federal poverty line, plaintiffs would not receive coverage they want to keep without HIP. Indiana law requires Medicaid coverage for the Medicaid expansion population (referred to as the "adult group described in 42 CFR 435.119") to be provided "only" through HIP. Ind. Code § 12-15-44.5-10(a).

So ending the entire HIP demonstration would not redress their alleged injuries. Vacatur would not compel Indiana to continue covering the Medicaid expansion population, much less non-mandatory benefits like vision and dental that plaintiffs wish to keep. Whether Indiana continues to provide Medicaid coverage to the optional population authorized in the Affordable Care Act (ACA) is its choice to make. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 585 (2012) (*NFIB*) (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.). And it has already made that choice, requiring Medicaid expansion "only" through HIP. Ind. Code § 12-15-44.5-10(a).

Additional problems surround plaintiffs' attempts to challenge individual components too. Plaintiffs object to CMS's decision to approve POWER Account contributions and "penalties for failure to pay." Dkt. 50-1 ¶ 194; Mem. 20. By "penalties," plaintiffs appear to mean disenrollment. But plaintiffs do not allege that they are at "actual or imminent" risk of disenrollment for failure to pay. *Lujan*, 504 U.S. at 560. None will be disenrolled if they have incomes at or below 100% of the federal poverty line. S.A.R. 1581. And it appears that plaintiffs intend to make contributions regardless. All three plaintiffs report using or wanting access to "[v]ision and dental coverage," with one even saying that those benefits are "very important." Dkt. 54-3 ¶ 9; *see* Dkt. 54-2 ¶ 13; Dkt. 54-4 ¶ 7. But to receive non-mandatory "vision and dental benefits," plaintiffs must make POWER Account contributions. S.A.R. 1563. Plaintiffs cannot get around the problem by characterizing the loss of vision and dental benefits for failure to make contributions as a "penalt[y]." Indiana is not required to provide vision and dental benefits to the Medicaid expansion population or on the terms that plaintiffs demand; these are "non-mandatory benefits." S.A.R. 1564.

Plaintiffs also challenge waiver of offering non-emergency medical transportation (NEMT). Dkt. 50-1 ¶ 210; Mem. 23. Again, however, plaintiffs do not allege or prove an injury in fact that is both "concrete and particularized" and "actual or imminent." *Lujan*, 504 U.S. at 560.

Chelsey Lang makes no claims about needing non-emergency medical transportation. Emily Rames says she "will have difficulty assessing appointments" only "*[i]f* [her] car breaks down." Dkt. 54-4 ¶ 9 (emphasis added). But no facts establish this breakdown is imminent or will occur at a time in which she needs to attend a medical appointment. And the alleged injury is rendered even more remote by the fact that each of the four managed care entities that serve HIP members offer various transportation benefits. Hurst Decl. ¶ 4; *see* S.A.R. 1562 ("three of the four" managed care entities provided transportation benefits as of 2020). The alleged "risk of future harm" is "too speculative to support Article III standing." *TransUnion*, 594 U.S. at 438.

The same is true of the injury that Monte Rose alleges. He uses a bicycle as his "primary means of transportation," and while he says that some *past* appointments have been "too far to bike," his *current* "primary medical provider" is "close to [his] home." Dkt. 54-2 ¶¶ 8, 15. Any past difficulties with accessing transportation to faraway appointments do not establish standing for prospective relief. *See Lujan*, 504 U.S. at 564. Rose adds that a "hospital and most diagnostic services are not nearby." Dkt. 54-2 ¶ 15. But he does not say these are too far to bike or establish that he will need these services imminently, as is his burden to prove. *See Lujan*, 504 U.S. at 564. Rose, moreover, admits that his "health plan" makes non-emergency "transportation services available." Dkt. 54-2 ¶ 8. In some unspecified number of past instances, Rose alleges, the "arranged transportation" fell through. *Id.* It is, however, not clear that problem is likely to recur or that operational problems with any number of causes are traceable to the waiver or redressable by vacating it. Rides can fall through no matter what entity is providing them.

The third component plaintiffs challenge concerns the waiver for retroactive eligibility. Dkt. 50-1 ¶ 204; Mem. 22. Again, however, plaintiffs introduce no facts showing harm to them. The three plaintiffs have all been enrolled in HIP for some time. Dkt. 54-2 ¶ 13; Dkt. 54-3 ¶ 6;

Dkt. 54-4 ¶ 6. Whether any will ever be disenrolled from HIP, incur medical services at a time when they are eligible for HIP but have not yet re-enrolled, and then seek retroactive coverage is anyone's guess. In passing, two plaintiffs mention past medical expenses. Dkt. 54-3 ¶ 5; Dkt. 54-2 ¶ 13. But they do not explain whether they met HIP eligibility requirements at the time those expenses were incurred or whether those expenses would meet all the requirements for payment through Medicaid absent the waiver challenged. *See* 42 C.F.R. § 435.915 (explaining the retroactive eligibility period is limited to the three-month period prior to application, that the beneficiary must have been eligible—that is, have met all Medicaid eligibility requirements during that period—and that the services must be covered by Medicaid and provided by a Medicaid-enrolled provider). Thus, they have not satisfied their burden of proving an injury fairly traceable to the waiver that would be redressed by vacating the waiver and ending the demonstration project.

A final problem plagues plaintiffs' effort to challenge the purported waiver of 42 U.S.C. §§ 1396o and 1396o-1: Plaintiffs do not claim to be part of the "categorically need groups" impacted. Mem. 39. They accordingly cannot show harm. Standing, furthermore, generally requires a plaintiff to "assert his own legal rights and interests," not the "legal rights or interests of third parties." *Warth v. Seldin*, 422 U.S. 490, 499 (1975). And plaintiffs do not explain why third-party standing is proper in this case.

B. Plaintiffs lack standing to challenge the December 2023 decision

Plaintiffs also lack standing to challenge the December 2023 decision. Their challenge to that decision suffers from all the problems associated with their challenge to the original waiver plus one more: the December 2023 decision does not inflict a distinct injury. CMS's December 2023 decision represents the exercise of the agency's discretionary authority to reevaluate a Section 1115 waiver. *See* 42 U.S.C. § 1315(d)(2)(D)–(E); S.A.R. 837–38, 1073. In that decision, CMS

approved Indiana's continued implementation of HIP. S.A.R. 1. If that decision and that decision only were vacated, however, Indiana would not lack authority to implement HIP. The original waiver would remain in effect. Vacating the December 2023 decision by itself would not redress any alleged injury.

II. The Waiver Accords with Section 1115 and Reasoned Decisionmaking

Plaintiffs' challenge to the October 2020 waiver fails on the merits in any event. CMS rationally concluded a waiver authorizing the HIP 2.0 demonstration project was likely to promote important Medicaid objectives, including by providing coverage to optional populations and providing optional benefits. CMS also rationally concluded the waiver's length was necessary.

A. CMS rationally concluded a waiver is likely to advance Medicaid objectives

Section 1115 authorizes the Secretary to "waive compliance with any of the requirements of . . . section 1396a . . . to the extent and for the period he finds necessary to enable" a State to carry out "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" Title XIX of the Social Security Act. 42 U.S.C. § 1315(a). That language "exudes deference." *Webster v. Doe*, 486 U.S. 592, 600 (1988). By its terms, Section 1115 authorizes "*any* . . . demonstration project" that, "*in the judgment of the Secretary*," is "*likely* to assist in promoting the [Medicaid statute's] objectives." It does not require the Secretary to be correct, to be certain, or to pursue a single objective of the Medicaid statute to the exclusion of other objectives. "The limitation, and the only limitation imposed on the Secretary was that he must judge the project to be 'likely to assist in promoting the objectives' of the designated parts of the Social Security Act." *Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973).

Judicial review of a waiver is accordingly circumscribed. Although this Court has held otherwise, *Stewart v. Azar*, 366 F. Supp. 3d 125, 137 (D.D.C. 2019) (*Stewart II*), *appeal dismissed*, No. 2020 WL 13562855 (D.C. Cir. Jan. 8, 2020), Section 1115's emphasis on the Secretary's

judgment suggests the decision to approve a demonstration project is committed to agency discretion by law, *see Drake v. FAA*, 291 F.3d 59, 71–72 (D.C. Cir. 2002). And to the extent that his judgment is reviewable, the "central question" is whether *he* "*rationally* could have determined" that a project is likely to advance Medicaid's objectives and that the waiver is necessary. *C.K. v. N.J. Dep't of Health & Hum. Servs.*, 92 F.3d 171, 183 (3d Cir. 1996) (emphasis added); *see Stewart II*, 313 F. Supp. 3d at 257. The "statute—speaking in terms of an otherwise unfettered 'judgment'—does not require that, before the Secretary approves an experiment, every i must be dotted and every t crossed." *Aguayo*, 473 F.2d at 1107; *see FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 521 (2009) (observing the "agency's predictive judgment" "merits deference"). Indeed, a function of Section 1115 is to "provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs to particular areas or groups of beneficiaries." 42 C.F.R. § 430.25(b). Section 1115 does not require proof that an idea will succeed before it is tested.

1. CMS rationally concluded a waiver would support the coverage of optional populations and the provision of non-mandatory benefits

CMS rationally concluded that HIP was likely to advance an "important objective of the Medicaid program" by "expanding the scope of coverage." S.A.R. 1555. It both expands coverage to groups that would not otherwise receive coverage and provides non-mandatory benefits.

a. A "core component of health care in Indiana" and a "fixture" of the Indiana health care system, HIP expands Medicaid coverage in Indiana. S.A.R. 8234. Throughout HIP's iterations, Indiana has made clear that it "will not expand traditional Medicaid" to the population made eligible by the Affordable Care Act (ACA), but will only provide coverage to that group through HIP. Letter from Gov. Pence to President Obama (Oct. 2, 2014); *see* pp. 7–9, *supra*. That requirement is reflected in state law. Under state law, the "adult group described in 42 CFR 435.119"—

the Medicaid expansion group—can "only" receive coverage through HIP. Ind. Code § 12-15-44.5-10(a); *see* Ind. Code § 12-15-44.5-3(c); S.A.R. 8240 (observing that, in codifying HIP in 2016, the state legislature "expressly prohibit[ed] the continuation of Medicaid expansion in the State except through HIP, operated in a manner consistent with the statutory provisions"). Thus, CMS could rationally conclude that approving HIP would increase persons covered.

A federal evaluation of HIP 2.0's first three years of operation supports this conclusion. After examining years of collected data, the evaluation observed that the "first and most important lesson learned from Indiana's Section 1115 demonstration" is that the demonstration project "resulted in a program that achieved a key goal of both the ACA and the state—a significant expansion in health insurance coverage." S.A.R. 4308; *see* S.A.R. 4281 ("the demonstration increased coverage to more low-income individuals and increased access to health care services"); S.A.R. 4288 ("HIP 2.0 led to a significant increase in health insurance coverage in Indiana."); S.A.R. 4296 ("[c]hildless adults in Indiana experienced significant gains in coverage"); S.A.R. 4308 ("health insurance coverage in Indiana was significantly higher"). "Across the board, interviewees, and focus group participants emphasized increased health insurance coverage and improved access to health care as major wins for HIP 2.0." S.A.R. 4280. The evidence is unequivocal that HIP serves an "important objective of the Medicaid program" by increasing the persons covered. S.A.R. 1555.

Plaintiffs assert that Indiana could not "terminate coverage for the mandatory expansion population." Mem. 18. But Congress cannot simply order Indiana to expand Medicaid—that would raise a commandeering problem. *See Murphy v. Nat'l Collegiate Athletic Ass'n*, 584 U.S. 453, 474 (2018); *NFIB*, 567 U.S. at 577–78 (opinion of Roberts, C.J.); *NFIB*, 567 U.S. at 677 (joint opinion of Scalia, Kennedy, Thomas, and Alito, JJ.). Nor, as *NFIB* established, can Congress seek to coerce Indiana into expanding Medicaid by withholding funding for pre-expansion Medicaid populations.

See 567 U.S. at 585 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.). Congress is limited to asking for Indiana's voluntary participation by offering it *additional* funds for Medicaid expansion. *See id.* Whether Indiana continues with Medicaid expansion is its choice to make.

That reality has informed consideration of HIP since its inception. As CMS conceded in the wake of *NFIB*, States that expanded Medicaid could "decide later to drop the coverage." A.R. 314–15; *see* S.A.R. 1556 n.2. So CMS sought to entice States into expanding Medicaid by promising "considerable flexibility" as to how they would cover optional populations. A.R. 318. And CMS has approved each iteration of HIP with the knowledge that Indiana would not expand traditional Medicaid, but would cover the expansion population only through HIP. *See* S.A.R. 1555 n.2; pp. 7–9, *supra*. As Indiana reminded CMS not long ago, state law "prohibit[s] the continuation of Medicaid expansion . . . except through HIP." S.A.R. 8240; *see* A.R. 2582. HIP is, and always has been, integral to increasing the number of persons covered by Medicaid in Indiana.

b. HIP also increases the benefits available to covered persons. While Medicaid generally requires different eligibility groups to receive comparable benefits, *see* 42 C.F.R. § 440.240, that rule does not apply to the Medicaid expansion population. That population need only receive a "benchmark" package of benefits that includes ten categories of "essential health benefits." 42 U.S.C. §§ 1396a(k), 1396u-7(b)(2); 42 C.F.R. § 440.300 *et seq.* Through HIP Plus, however, Indiana provides "an enriched benefit package" that "includes all the essential health benefits and adds vision, dental and chiropractic coverage." S.A.R. 1563, 8253. Thus, as the federal evaluation for HIP observed, HIP Plus "enhance[s] . . . access to health care" by providing "expanded benefits." S.A.R. 4279; *see* S.A.R. 1563, 8253. This, too, supports CMS's conclusion that HIP promotes an "important objective of the Medicaid program" by "expanding the scope of coverage" and providing "non-mandatory" benefits. S.A.R. 1555, 1564.

The benefits do not stop with vision and dental. As part of HIP, Indiana provides benefits for persons with Substance Use Disorders (SUD) and Serious Mental Illness (SMI). S.A.R. 1555, 8234. Critical to combating an "epidemic" of prescription drug and opioid abuse, Indiana's SUD benefits "ensure that a broad continuum of care is available" for Medicaid beneficiaries with substance use disorders. S.A.R. 1560–61. Benefits include "residential treatment, crisis stabilization and withdrawal management." S.A.R. 1561; *see* S.A.R. 8291, 8297. And Indiana's SMI program provides additional services to mentally ill persons who are "short-term residents in free-standing psychiatric hospitals." S.A.R. 1561; *see* S.A.R. 8297–98. As the Secretary observed, providing a waiver for HIP "directly supports Medicaid's objectives by improving access to high-quality services" for the mentally ill and persons with substance use disorders. S.A.R. 1561.

Indiana's SUD and SMI benefits are not "distinct" from HIP. *Contra* Mem. 15, 24. The original waiver "include[d]" the components of HIP 2.0 that plaintiffs challenge as well as the "SUD program." A.R. 3; *see* A.R. 1–2, 4; S.A.R. 8234. In applying for a waiver, Indiana submitted a single application packet that treated the SUD/SMI programs as "components of the Medicaid demonstration, entitled 'Healthy Indiana Plan (HIP)' (Project Number 11-W-00296/5)." S.A.R. 8290; *see* S.A.R. 8234; A.R. 2600. In evaluating the project, the federal evaluation considered expanded SUD coverage alongside the other HIP components. S.A.R. 4286. And in granting a waiver, CMS issued a single approval covering all components. S.A.R. 1554. As CMS observed, the "HIP demonstration . . . *includes* a SUD program." S.A.R. 1560 (emphasis added).

To be sure, CMS set different timelines for different HIP components. Mem. 15. But that does not mean the SUD/SMI component is a separate project from HIP. Recall that adults described in 42 C.F.R. § 435.119 cannot receive Medicaid coverage, including coverage for substance use disorders, except through HIP. *See* Ind. Code § 12-15-44.5-10(a); S.A.R. 8240. So a

waiver for HIP is necessary to provide SUD/SMI benefits to that population, distinguishing this project from projects where the benefits were entirely severable. *See Stewart v. Azar*, 313 F. Supp. 3d 237, 259 (D.D.C. 2018) (*Stewart I*). And while CMS's approval for SUD/SMI benefits lasts a shorter time than its approval for other HIP components, Mem. 14–15, it does not follow that Indiana could continue to provide those benefits to the Medicaid expansion population absent HIP. Nor does the SUD/SMI program pursue different goals from HIP. *Contra* Mem. 14–15. One of HIP's overriding goals is to provide services to the Medicaid expansion population and improve their health. A.R. 1, 3, 2580–81; S.A.R. 4276, 8238, 8290–91. Providing additional services to persons with substance use disorders and mental illness furthers that goal. S.A.R. 1561, 8297–98.

2. The challenged components cannot be separated from the project's provision of additional coverage and benefits

Despite the additional benefits and coverage HIP provides, plaintiffs argue that HIP was not likely to advance Medicaid's objectives because the three features they challenge—required contributions to POWER Accounts, elimination of retroactive eligibility, and no assurance of NEMT—do not themselves increase coverage. Mem. 20–25. But Section 1115 requires CMS to ask whether the "project" as a whole is likely to advance Medicaid's objectives, not whether individual components are likely to do so. 42 U.S.C. § 1315(a); *see Stewart I*, 313 F. Supp. 3d at 257. So whether a project advances Medicaid's goals cannot be judged based on whether its component parts all increase enrollment or benefits. Indeed, Section 1115 contemplates that a project may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." 42 U.S.C. § 1315(d)(1). Plaintiffs, moreover, again overlook that Indiana law requires any provision of benefits to the Medicaid expansion population to take place through HIP. It was therefore rational for CMS to approve the challenged HIP components to ensure Indiana would "continue to cover non-mandatory benefits and eligibility groups." S.A.R. 1564; *see* S.A.R. 1556 n.2.

Also misplaced is plaintiffs' suggestion that improving beneficiaries' health, facilitating their transition to commercial insurance, and improving cost efficiencies are antagonistic to the goal of furnishing medical assistance to eligible populations. *See* Mem. 16. As the Secretary observed, government resources are finite. S.A.R. 1561–62. That is why Section 1901—which authorizes federal appropriations for Medicaid—observes that appropriations are "[f]or the purpose of enabling each State" to furnish "medical assistance" and certain "rehabilitation and other services" to needy persons "*as far as practicable under the conditions in such State*." 42 U.S.C. § 1396-1 (emphasis added). That language reflects that every dollar spent on one service (*e.g.*, dental, vision, or SUD benefits) or one population (*e.g.*, the Medicaid expansion population) is one less dollar that can be spent on another service or population. It is therefore "reasonable on its face" to conclude that state efforts to control costs, to improve the health of Medicaid recipients, and to prevent persons from staying on Medicaid rolls unnecessarily can advance the Medicaid statute's goals. *Pharm. Rsch. & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 825 (D.C. Cir. 2004).

As this Court previously observed, the reality of needing to make tradeoffs may not justify every cost-saving or health-promoting measure. *See Stewart II*, 366 F. Supp. 3d at 152. But here CMS offered a reasonable explanation of why the project increases coverage and benefits overall. Recall that state law makes HIP a requirement for "cover[ing] non-mandatory benefits and eligibility groups." S.A.R. 1564; *see* S.A.R. 1555. That makes it rational for CMS to approve components that are needed for HIP to operate and maintain sustainability, whether through improving health, preparing persons to transition off Medicaid, or improving cost efficiencies. Clearly, providing expanded Medicaid coverage to the more than 570,000 Hoosiers covered in 2020, S.A.R. 8238, is superior to not expanding coverage at all, even if a fraction of the population loses

coverage by failing to make POWER Account contributions or is limited to the non-emergency transportation benefits provided through managed care entities.

3. CMS rationally concluded that the challenged features would sustain Medicaid coverage and additional benefits

Even if one focuses on the challenged features, CMS rationally concluded that they support "non-mandatory benefits and eligibility groups." S.A.R. 1564. Start with POWER Accounts. Central to HIP's overall design, POWER Accounts operate similarly to health savings accounts available under high-deductible commercial plans. S.A.R. 8250. While Indiana fully funds POWER Accounts for HIP Basic beneficiaries, both Indiana and beneficiaries enrolled in HIP Plus contribute to POWER Accounts, which can be used to cover deductibles and copays. S.A.R. 8250. A surcharge is added for tobacco use. S.A.R. 1558. This structure not only reduces the fiscal burdens directly, but incentivizes beneficiaries to "make value-based healthcare choices," allows users to decide whether an enhanced benefit package is worth the additional cost, and prepares Medicaid beneficiaries to "transition to commercial health insurance." S.A.R. 1563–65, 8250–84.

As CMS observed, S.A.R. 1564, evidence supports this conclusion. An "independent evaluation reported that HIP Plus members had higher participation and utilization rates for preventative services, primary care, and specialty services, as well as better prescription adherence rates compared to HIP Basic members." S.A.R. 1564; *see* S.A.R. 1543–55, 6384–86. Plaintiffs attempt to muddy the waters, arguing that "costs sharing has deterred utilization of services in HIP Basic." Mem. 25–26. But the point-of-service cost sharing required for HIP Basic members is fully consistent with Medicaid rules, *see* 42 C.F.R. § 447.52, and does not operate under any demonstration authority. Besides, Section 1115 and principles of reasoned decisionmaking do not require CMS to demonstrate that its explanation of data collected through a research project is the only explanation. *See FCC v. Prometheus Radio Project*, 592 U.S. 414, 426 (2021). And it makes no sense

to say that cost sharing deters HIP Basic members from seeking care when they could avoid cost sharing by making the small contribution required—$1 for many of them—to obtain HIP Plus.

Nor did CMS ignore plaintiffs' concern that contributions might lead to loss of eligibility. *Contra* Mem. 21–22. First, CMS observed that contributions—which can be as little as $1—are "generally affordable." S.A.R. 1570; *see* S.A.R. 5960. When Indiana applied for its waiver in 2020, the most recent survey data available showed that "86 percent of contributing members were satisfied with the program," "95 percent" would "re-enroll if they left and became eligible again," and "80% of members . . . would pay more to stay in the program." S.A.R. 8250, 8252. A federal evaluation of HIP 2.0 agreed. "Enrollees in our focus groups generally thought HIP 2.0 was affordable and enhanced their access to health care." S.A.R. 4279. "Most felt their monthly POWER Account contributions . . . were worthwhile to obtain expanded benefits and minimal copayments under HIP Plus," and "[m]any also felt the opportunity to contribute toward their coverage reduced the stigma or personal guilt associated with 'relying on the government.'" S.A.R. 4279.

Second, as CMS observed, other features of HIP limited the potential negative impacts of failure to make required contributions. "It is important to note that beneficiaries with household incomes at or below 100 of the [federal poverty line]" do not lose Medicaid coverage for failing to make contributions. S.A.R. 1570. The same is true for the medically frail and pregnant women. S.A.R. 15665–66, 1570–71. And to promote affordability overall, HIP pegs contributions to income and caps total expenditures beneficiaries can be required to make through contributions and cost sharing. S.A.R. 1570–71. The mere fact that some persons are nevertheless disenrolled for nonpayment does not mean that CMS failed to provide a rational explanation for its judgment that

the entire HIP project was likely to promote Medicaid's goals. *Contra* Mem. 22–23. That is particularly true considering that "disenroll[ment]" for "non-payment decreased over time" and that CMS would continue to monitor new data for any substantial change in trajectory. S.A.R. 1570.

The other HIP components plaintiffs challenge—no retroactive eligibility or non-emergency medical transportation—support the continued coverage of non-mandatory benefits and populations too. They reduce financial strains, prepare beneficiaries for commercial insurance so that they do not return to Medicaid rolls, and in the case of no retroactive eligibility, encourage persons to remain enrolled in Medicaid and obtain preventative coverage thereby reducing costs. S.A.R. 1562, 1564, 1571–72; *see* S.A.R. 8256, 8261. Again, there is initial evidence to support CMS's analysis. Data from the first few years of HIP 2.0 showed "more enrollees . . . obtain[ed] preventative care over time." S.A.R. 4309; *see* S.A.R. 1564. And a 2016 report from a managed-care plan providing coverage to HIP beneficiaries suggested that withholding non-emergency transportation would not impact beneficiaries' ability to attend appointments. S.A.R. 1562.

CMS meanwhile considered and addressed plaintiffs' concerns about potential downsides. As it explained, downsides would be limited. Relatively few beneficiaries ("just 10 percent") used the existing retroactive eligibility program, and to mitigate loss of retroactive coverage, Indiana would provide "outreach and education" about enrollment and an expedited Fast Track enrollment process. S.A.R. 1564–65. To the extent non-emergency transportation made a difference for individual beneficiaries, CMS observed that beneficiaries could obtain it by choosing any of the three managed care plans that offered it as "an enhanced service" and that more vulnerable groups (*e.g.*, pregnant women) would receive transportation regardless. S.A.R. 1562, 1572. Plaintiffs may not believe that these backstops are a sufficient replacement, Mem. 23, but reasoned decisionmaking only requires CMS to address the issue, *see Prometheus Radio*, 592 U.S. at 423.

Plaintiffs' other criticisms are equally unavailing. They quibble with CMS's explanation that HIP facilitates transition to commercial coverage by saying HIP does not "actually mirror commercial coverage." Mem. 27. But plaintiffs offer no reason to suppose that perfect mimicry is required. And whether one accepts Indiana's view of POWER Accounts (as resembling health savings accounts) or plaintiffs' view (as resembling premiums), they resemble commercial insurance. Nor was CMS required "to estimate" the precise number of people who would "successfully transition to commercial coverage." Mem. 27. Indiana's experience suggested that it would be "many." S.A.R. 1565. It "suffice[d]" for CMS to know that being better able to navigate commercial coverage would tend to prevent persons from returning to Medicaid rolls. *Fox Television*, 556 U.S. at 519.

Reasoned decisionmaking did not require more detailed findings regarding cost savings and sustainability either. *Contra* Mem. 28. Plaintiffs themselves admit there is data in the record showing that eliminating retroactive eligibility produces some savings. *See* Mem. 22. To justify its decision, moreover, CMS was not required to produce evidence that Medicaid in Indiana was "'at risk of collapse.'" Mem. 28. Section 1115 does not require such an extreme showing. *See Thompson*, 362 F.3d at 825–27 (upholding a cost-savings measure without evidence of collapse). And CMS never set out to prove collapse was likely. Its point was that improving sustainability would help Indiana cover "non-mandatory benefits and eligibility groups." S.A.R. 1564.

Plaintiffs also argue that it is irrational to require POWER Account contributions because they have high administrative costs. Mem. 28. But they cite a comment discussing pre-2018 data, S.A.R. 7201; in 2018, Indiana made "major administrative improvement[s]" to POWER Accounts' operation, S.A.R. 4281–82. And plaintiffs ignore that the primary mechanism by which POWER Accounts improve sustainability is by changing behavior, not collecting funds. *See* pp. 30–31,

supra. As a parting shot, plaintiffs say that providing non-emergency medical transportation is actually "cost-effective." Mem. 28. If true, however, then managed care entities will provide it, and Indiana need not incur the administrative burden of providing the transportation in parallel.

4. HIP 2.0 promotes other important objectives

Given that CMS rationally concluded HIP is consistent with providing coverage and benefits, there is no need to consider whether it is likely to advance other Medicaid goals. Plaintiffs, however, are incorrect to suggest that CMS must always seek to increase "medical assistance," ignoring competing considerations. Mem. 15–16 (citing *Stewart II*, 366 F. Supp. 3d at 138). "'[N]o law'" pursues a single objective "'at all costs.'" *Luna Perez v. Sturgis Pub. Sch.*, 598 U.S. 142, 150 (2023). And the Medicaid statute is no exception. It reflects that Congress had a variety of goals, including improving the covered population's health, providing quality care, and doing so efficiently. That is one of the reasons that Medicaid covers not only services for acute needs but certain "preventative services." *See* 42 U.S.C. §§ 1396a(k), 1396d(a)(13), 1396u-7(b). That is one of the reasons Medicaid is concerned with the "quality" of care and services. *See* § 1396a(a)(22), (a)(30)(A), (a)(33)(A). And that is one of the reasons that Medicaid contemplates a demonstration project may be successful even if it has "an impact on eligibility, enrollment, benefits, cost-sharing, or financing." § 1315(d)(1). The federal government and States do not spend money on Medicaid simply for the sake of spending money. They care about Medicaid's efficiency and effectiveness.

Just as CMS rationally concluded a waiver for HIP would likely increase coverage and benefits, it could rationally conclude a waiver would likely improve Medicaid sustainability and participant health. As discussed above, HIP as a whole—and the components plaintiffs challenge—are designed to improve sustainability and health by incentivizing beneficiaries to take personal responsibility for their health and seek preventative care. It also prepares beneficiaries to

successfully navigate commercial coverage should their financial situation improve, allowing them to relieve pressure from Medicaid and continue leading healthy lives. Ultimately, however, how one characterizes Medicaid's objectives does not matter for this case because CMS rationally concluded that HIP was likely to increase the benefits and populations covered.

B. CMS rationally concluded the other requirements of Section 1115 were met

The Secretary rationally concluded that Section 1115's other requirements were met too. Plaintiffs argue that HIP does not qualify as a "demonstration project" or experimental pilot because several components "have been in place since 2008." Mem. 29. "[B]y its plain terms," however, Section 1115 "only requires the Secretary to determine that the proposed demonstration project is 'likely to promote the objectives' of Medicaid." *C.K.*, 92 F.3d at 188.

And to the extent a project must have a research element is required, it is present here. Plaintiffs overlook that, while the challenged components have been around in some form since 2008, HIP has undergone many "evol[utions]." S.A.R. 1558. For example, Indiana made several significant changes to POWER Account rules in 2018, and "since 2018[,] has designed, developed and implemented [other] changes." S.A.R. 8250; *see* S.A.R. 1557–58, 8239–42, 8250–53. The impacts of those changes merit study. And while the evidence the Secretary had in 2020 appeared "promising," it proved "challenging" to evaluate "[m]any of the demonstration policies" due to the short length of prior waivers. S.A.R. 1558. Extending HIP would thus allow for "well-designed longitudinal beneficiary surveys to track beneficiary outcomes over time." S.A.R. 1558. Plaintiffs, moreover, overlook that the COVID-19 public health emergency began just two years after HIP underwent major changes in 2018 and was rebranded as HIP 2.0. That emergency introduced a significant, uncontrolled variable that "interrupted" testing, S.A.R. 2; *see* S.A.R. 1555 n.1.

Plaintiffs argue that "HIP policies have been tested repeatedly in other states." Mem. 29. But Indiana's population and program is not identical to what exists elsewhere—and plaintiffs do not so establish. They, for example, do not conduct a side-by-side comparison to demonstrate that Indiana's POWER Accounts—which operate similar to health savings accounts, S.A.R. 8250—are identical in all respects to premiums. And whatever may have been happening elsewhere, the evidence from Indiana in 2020 was "promising." S.A.R. 1558. The Secretary could rationally credit that data as more probative about the likely outcomes of continuing HIP in Indiana.

Plaintiffs also argue that Section 1115(e) and (f) preclude the Secretary from granting a 10-year waiver. Mem. 31. But those statutory provisions only apply to pure "extension[s]" of "State-wide comprehensive demonstration project[s]," 42 U.S.C. § 1315(e)(1)—projects for which a state is "proposing *no* program changes," Vikki Wachino, CMS, *CMCS Informational Bulletin* 2 (July 24, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/cib07242015-fast-track.pdf (emphasis added). When Indiana applied for a waiver in 2020, however, Indiana proposed "a few changes." S.A.R. 1557; *see* S.A.R. 8239, 8250, 8263, 8270. So the Secretary considered and approved Indiana's waiver application under Section 1115(a), S.A.R. 1154, which authorized him to waive compliance "for the period he finds necessary," 42 U.S.C. § 1315(a)(1). CMS (exercising delegated authority) thus had authority to grant a 10-year waiver.

That leaves plaintiffs' objection that a 10-year waiver was unnecessary. Mem. 32. CMS, however, had a rational basis for approving a 10-year waiver for many of the reasons already discussed: HIP had undergone changes, the public health emergency had interrupted the evaluation of recent changes, some components had proven more challenging to evaluate on shorter timetables, a longer waiver would allow for valuable longitudinal studies, and it would reduce administrative burdens. S.A.R. 1, 1555 n.1, 1558, 1572, 8264–65; p. 35, *supra*. The bulk of plaintiffs'

objection to a 10-year waiver hinges on their belief that HIP does more harm than good. *See* Mem. 33–34. As discussed above, however, CMS rationally concluded otherwise. And CMS's commitment to continued monitoring addresses any lingering concerns. S.A.R. 1572–73.

Plaintiffs' final objection to the waiver is that it approves POWER Account contributions for "individuals described in Section 1396a(a)(10)(A) . . . with incomes below 150% of FPL," contrary to 42 U.S.C. §§ 1396o and 1396o-1. Mem. 39. But plaintiffs agree (Mem. 39) that the Secretary or CMS may waive "any" requirement of § 1396a (also known as Section 1902 of the Social Security Act). 42 U.S.C. § 1315(a). And that is what CMS did here: It waived "*Section 1902(a)(14)* insofar as it incorporates Section 1916 and 1916A." S.A.R. 1575 (emphasis added). Plaintiffs object that Section 1902 does not incorporate any portions of §§ 1396o and 1396o-1. Mem. 39. That is incorrect: Section 1902(a)(14) expressly provides that a state plan must "provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916" (*i.e.*, 42 U.S.C. § 1396o), and Section 1916 references Section 1916A (*i.e.*, 42 U.S.C. § 1396o-1). The waiver was lawful.

III. To the Extent the December 2023 Decision Is Reviewable, It Should Be Upheld

The Secretary's decision not to revisit the waiver in December 2023 must stand as well.

A. CMS's exercise of discretionary authority is unreviewable

To start, plaintiffs cannot challenge the decision because it is "committed to agency discretion by law." 5 U.S.C. § 701. Agency actions are unreviewable where a statute is "drawn in such broad terms that in a given case there is no law to apply" or where courts "would have no meaningful standard." *Sec'y of Labor v. Twentymile Coal Co.*, 456 F.3d 151, 156 (D.C. Cir. 2006) (internal citations omitted). One type of action that is "presumptively unreviewable" is an "agency decision not to institute enforcement proceedings." *Id.*; *see Citizens for Resp. & Ethics in Washington v. FEC*, 892 F.3d 434, 439 (D.C. Cir. 2018); *Drake*, 291 F.3d at 70. That rule controls here.

Although Section 1115 provides for the Secretary to establish regulations for review of demonstration projects, 42 U.S.C. § 1315(d)(2)(D)–(E), it does not provide any direction as to what he must do with the information obtained. What the Secretary does is left up to him. To the extent they are even relevant, the regulations promulgated by the Secretary supply no standard either. The Secretary, they explain, "*may* . . . withdraw waivers . . . based on a finding that the demonstration project is not likely to achieve the statutory purpose." 42 C.F.R. § 431.420(d)(2) (emphasis added). The regulations, however, do not *require* action. "To state the obvious, the word 'may' imposes no constraints on the [Secretary's] judgment." *Citizens for Resp.*, 892 F.3d at 439. And while the Secretary may have explained his reasons for declining to pursue action here, an "otherwise unreviewable action" does not become a reviewable action simply because an agency offers some rationale. *End Citizens United PAC v. FEC*, 90 F.4th 1172, 1179 (D.C. Cir. 2024).

B. CMS's decision is rational regardless

CMS rationally declined to withdraw previously approved authorities for HIP regardless. "In general, CMS approves demonstrations for a fixed term." S.A.R. 2. And while CMS retains discretion to withdraw authorities "on a case-by-case basis," CMS rationally declined to exercise its discretion here. When CMS made its decision in December 2023, Indiana's focus was on the "complex and difficult" task of unwinding temporary program changes made during the COVID-19 public health emergency. S.A.R. 2252; *see* S.A.R. 1–2. Whatever one thinks of POWER Accounts, CMS rationally recognized that requiring Indiana to modify a core aspect of HIP during its unwinding efforts would stretch the State's resources too far and add undue "complexity," which could in turn "lead to inaccuracies in beneficiary eligibility determinations . . . and result in beneficiaries being inadvertently disenrolled and delays to new beneficiary enrollment." S.A.R. 2.

Plaintiffs suggest that, as POWER Account contributions were paused during the public health emergency, requiring them again would be more disruptive to state efforts. Mem. 35. But

plaintiffs overlook that POWER Accounts are the "central component of the HIP design" and, post-pandemic, required under state law. S.A.R. 2025, 8240, 8250. Removing POWER Accounts from HIP would require statutory changes, a redesign of the entire project, and modifications to "eligibility systems and managed care plan contracts." S.A.R. 2. Plaintiffs also overlook that HIP beneficiaries had already been told that contributions would be required again and changing course could cause confusion. S.A.R. 2. That CMS may have withdrawn decided not to renew or extend authorities to implement premiums in other States with different programs does not make CMS's decision regarding Indiana irrational. *Contra* Mem. 35–36. The examples plaintiffs cite involved situations in which the waiver had expired, and plaintiffs do not attempt to show that the other state programs were the same as HIP, which provides a premium-free option to many beneficiaries.

Plaintiffs also argue that CMS's decision is contrary to its observations that premiums "may reduce access to coverage and care." Mem. 37 (quoting S.A.R. 4). But plaintiffs cite no standard that requires CMS to make that consideration paramount. And agencies ordinarily have wide discretion as to what they will consider in declining enforcement action—so much so that decisions to decline enforcement are unreviewable. *See Citizens for Resp.*, 892 F.3d at 439–41. Moreover, the suggestion that there is no evidence indicating that requiring contributions to POWER Accounts "facilitates coverage," Mem. 37 (quoting S.A.R. 10), is untenable for the reasons above. Indiana's POWER Account contributions undergird Indiana's optional expansion of Medicaid and provision of "non-mandatory benefits." S.A.R. 1564; *see* pp. 4–5, *supra*. In fact, CMS's December 2023 letter cites a federal evaluation of HIP that agrees the project increases coverage and benefits. S.A.R. 4279, 4308. And it has since become easier to obtain coverage via HIP because failure to make POWER Account contributions no longer triggers a non-eligibility period. S.A.R. 3.

Finally, contrary to plaintiffs' suggestion (Mem. 38), CMS was not required to discuss retroactive eligibility and non-emergency medical transportation in its December 2023 decision. Decisions about whether to rereview the evidence are committed to CMS's discretion.

IV. Vacatur of the HIP Approvals Is Unwarranted

To the extent the Court rules that some relief is warranted, the only appropriate remedy is remand without vacatur. "It is well settled that '[a]n inadequately supported rule . . . need not necessarily be vacated,' because an agency may be able to rehabilitate its [action] on remand, and the consequences of vacatur 'may be quite disruptive.'" *Shands Jacksonville Med. Ctr., Inc. v. Azar*, 959 F.3d 1113, 1118 (D.C. Cir. 2020) (internal citation omitted) (quoting *Allied-Signal, Inc. v. U.S. Nuclear Regul. Comm'n*, 988 F.2d 146, 150 (D.C. Cir. 1993)). Ordinarily, "the decision to remand or vacate hinges upon . . . '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 Com. v. S.E.C.*, 443 F.3d 890, 908 (D.C. Cir. 2006).

Both considerations cut against vacatur here. Plaintiffs' criticisms largely go to the adequacy of CMS's explanation regarding whether HIP was likely to promote Medicaid's goals despite its impacts on coverage. That could be addressed on remand. Declining to prejudge CMS's ability to rehabilitate its reasoning is "consistent with the heightened deference that courts are to accord the Secretary's interpretation of a complex and highly technical regulatory program such as Medicare." *Shands*, 959 F.3d at 1118 (cleaned up). Regardless, even if the agency's decision had "serious deficiencies," *Defs. 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. Vacatur would prove enormously disruptive to the many members who have "relied on [HIP] in good faith" for years, *A.L. Pharma, Inc. v. Shalala*, 62 F.3d 1484, 1492 (D.C. Cir. 1995), as well as others.

HIP provides coverage to hundreds of thousands of Hoosiers. Many are enthusiastic about the coverage they receive. "86 percent of contributing members were satisfied with the program," "95 percent" would "re-enroll if they left and became eligible again," and "80% of members . . . would pay more to stay in the program." S.A.R. 8250, 8252. "Enrollees in our focus groups generally thought HIP 2.0 was affordable and enhanced their access to health care." S.A.R. 4279. "Most felt their monthly POWER Account contributions . . . were worthwhile to obtain expanded benefits and minimal copayments under HIP Plus," and "[m]any also felt the opportunity to contribute toward their coverage reduced the stigma or personal guilt associated with 'relying on the government.'" S.A.R. 4279. As one member says, the "Healthy Indiana Plan is, by far, the best health insurance experience of my adult life." S.A.R. 7151. HIP "is a model," another observed, "for the whole nation." S.A.R. 7150. It is "the best thing." S.A.R. 7150.

Worse, vacating the waiver would undermine Indiana's ability to provide coverage at all. Indiana law requires FSSA to provide Medicaid coverage for the Medicaid expansion population "only" through HIP. Ind. Code § 12-15-44.5-10(a). And 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, POWER Account contributions, and deductible amounts. *See* Ind. Code § 12-15-44.5-10(b)(1)–10(b)(8). (The state statute that authorized FSSA to suspend contribution requirements as necessary to obtain funding under the Families First Coronavirus Response Act, Pub. L. 116-127, § 6008(b)(2)–(3), 134 Stat. 178, 208 (2020), does not authorize suspension on an ongoing basis. *See* Ind. Code § 12-8-1.5-7.5.) And even if there were some legislative solution forthcoming, Indiana's provision of coverage to its Medicaid population could be severely disrupted. Removal of a waiver would require extensive modifications to "eligibility systems and

managed care plan contracts" at a time when FSSA is focused on the complex task of unwinding measures put into place during the public health emergency. S.A.R. 2. The resulting chaos could "lead to inaccuracies in beneficiary eligibility determinations . . . and result in beneficiaries being inadvertently disenrolled and delays to new beneficiary enrollment." S.A.R. 2.

The disruptive consequences of vacatur should be decisive here. Neither *Stewart* nor *Gresham* nor *Philbrick* presented a situation in which vacatur would undermine the entire project. *See Philbrick v. Azar*, 397 F. Supp. 3d 11, 32 (D.D.C. 2019), *aff'd*, No. 19-5293, 2020 WL 2621222 (D.C. Cir. May 20, 2020), *vacated and remanded*, 142 S. Ct. 1665 (2022) (explaining that the change vacated in *Stewart* had "yet to take effect," the disruption in *Gresham* related to a change was "largely administrative," and *Philbrick* concerned requirements "not fully implemented"). By contrast, vacatur would immediately eliminate the very *existence* of Indiana's HIP program—a program that provides coverage to a substantial percentage of its entire Medicaid population. Vacatur would bring about the harm—loss of coverage—that the three individual plaintiffs here say they want to avoid.

CONCLUSION

The Court should deny plaintiffs' motion for summary judgment, grant FSSA's motion to dismiss, and enter judgment in FSSA's favor. In all events, the Court should not vacate the 2020 waiver or 2023 decision.

Respectfully submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF THE DISTRICT OF COLUMBIA

MONTE A. ROSE, JR., *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 1:19-cv-02848-JEB
XAVIER BECERRA, *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF JULENE HURST IN SUPPORT OF MOTION TO DISMISS OF INTERVENOR-DEFENDANT INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

Pursuant to 28 U.S.C. § 1746, I, Julene Hurst declare as follows:

1. I am over the age of 18, have personal knowledge of the matters set forth herein, and am competent to make this declaration.

2. I submit this declaration in support of Intervenor-Defendant Family and Social Services Administration's motion to dismiss and in opposition to Plaintiffs' motion for summary judgment.

3. I am employed with The Family and Social Services Administration in the Office of Medicaid Policy and Planning as the HIP and HHW contract compliance manager.

4. HIP Managed Care Entities provide services to HIP members. Pursuant to the approved member handbooks, the following are the transportation services offered by each entity:

a. Anthem: To assist members in accessing community services and supports, and employment opportunities, eligible HIP State Plan Plus, HIP Regular Plan Plus and HIP Maternity Plan members may choose one of the following: - $50 gas card - $50 rideshare gift card - Up to $50 in bus passes.

b. Caresource: Non-emergency transportation is a specialty service provided under HIP Plus (added Caresource benefit), HIP Basic (added Caresource benefit; copays may apply), HIP Maternity (with enhanced benefits), HIP State Plus, and HIP State Basic (copays may apply).

c. MHS: MHS HIP members receive unlimited transportation to and from doctor visits, to fill prescriptions after a doctor visit, to certain MHS member events, or to re-enroll in HIP.

d. MDWise: MDwise covers transportation to doctor and dentist appointments for HIP State Plan Plus and HIP State Plan Basic. You can get transportation if you are a pregnant HIP member and you have called to let us know you are pregnant. MDwise covers rides to and from your doctor or clinic. You should save your trips for when you cannot get a ride any other way. If available in your area, MDwise may give you a bus pass for your trip to the doctor. . . . If you need transportation outside of Indiana, you will need to call MDwise for prior approval for the trip. This means a nurse will need to approve the trip based on medical necessity. If this is the case, call at least three days before your appointment to schedule your transportation. That allows MDwise time to get your trip approved.

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on April 10, 2024

Julene Hurst

Julene Hurst