UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No.

ANDREA YOUNG
3023 Woodland Hill Dr., Apt. 7
Ann Arbor, MI 48108

MARIA YAKOVCHIK
1921 Sixth Ave
Norway, MI 49870

JAMIE ARDEN
Homeless

KATINA PETROPOULOS
1800 Mershon Dr.
Ann Arbor, MI 48103

Plaintiffs,

v.

ALEX M. AZAR
SECRETARY, UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES
in his official capacity
200 Independence Avenue, S.W.
Washington, DC 20201

SEEMA VERMA
ADMINISTRATOR, CENTERS FOR
MEDICARE AND MEDICAID SERVICES
in her official capacity
7500 Security Boulevard
Baltimore, MD 21244

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES
200 Independence Avenue, S.W.
Washington, DC 20201

CENTERS FOR MEDICARE AND MEDICAID SERVICES
7500 Security Boulevard
Baltimore, MD 21244

Defendants.

CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

PRELIMINARY STATEMENT

1. This case challenges the ongoing efforts of the Executive Branch to bypass the legislative process and act unilaterally to fundamentally transform Medicaid, a cornerstone of the social safety net. Purporting to invoke a narrow statutory waiver authority that allows experimental projects "likely to assist in promoting the objectives" of the Medicaid Act, the Executive Branch has instead effectively rewritten the statute, ignoring congressional restrictions, overturning a half-century of administrative practice, and threatening irreparable harm to the health and welfare of the poorest and most vulnerable in our country.

2. The Medicaid Act establishes a health insurance program that covers more than 65 million people in the United States. Medicaid enables states to provide a range of federally specified preventive, acute, and long-term health care services and supports to individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1. As described below, the core populations covered by Medicaid include children; pregnant women; the aged, blind, or disabled; and, as added by the Affordable Care Act ("ACA"), adults with household incomes less than 133% of the federal poverty level ("FPL") (currently $22,490 for a family of two).

3. The Medicaid program offers a deal for states. If a state chooses to participate, the federal government will contribute the lion's share of the cost of providing care. In return, the state

agrees to pay the remaining portion of the costs of care and to follow all federal requirements, including those regarding the scope of coverage and eligibility for the program. States may not impose additional eligibility requirements other than those set forth in the Medicaid Act, and states must cover all individuals who come within a covered population group.

4. Section 1115 of the Social Security Act does permit the Secretary of Health and Human Services ("Secretary") to waive certain federal Medicaid requirements, but only in narrow circumstances – when necessary to allow a state to carry out a time-limited, experimental project that is likely to promote the objectives of the Medicaid Act.

5. On January 11, 2018, the Centers for Medicare & Medicaid Services ("CMS") announced a new approach to Medicaid waivers. Reversing decades of agency guidance, and consistent with the administration's expressed view of the need to "fundamentally transform Medicaid," CMS issued a letter to State Medicaid Directors announcing its intention to, for the first time, approve waiver applications containing work requirements and outlining "guidelines" for states when submitting such applications.

6. The State of Michigan implemented the ACA Medicaid expansion in 2014. In June 2018, the Michigan Legislature passed a law directing the State to request permission under Section 1115 to condition Medicaid eligibility for the expansion population on mandatory work requirements and, for a subset of the expansion, on heightened and mandatory premiums. The State submitted the corresponding Section 1115 waiver application on September 10, 2018 as an amendment to a pending application to extend the Healthy Michigan Plan waiver ("HMP amended extension application"). The Secretary approved the amended extension application on December 21, 2018, with Special Terms and Conditions.

7. On February 8, 2019, as required by the state law, Michigan Governor Gretchen Whitmer accepted the Special Terms and Conditions, noting that between 61,000 and 183,000 individuals will lose health coverage as a result of the work requirements.

8. Michigan will begin implementing the work requirements on January 1, 2020. The State will begin suspending the coverage of individuals who have not met the work requirements on May 1, 2020.

9. The Secretary's approval will harm Plaintiffs and other individuals throughout the State—teachers, social workers, students, and caregivers—who need a range of health services, including treatment for heart conditions, asthma, high blood pressure, sleep apnea, cancer, arthritis, migraines, and mental health services. Without access to Medicaid coverage, people across Michigan will be forced to forgo treatment for their conditions or will incur significant medical debt when their conditions become so severe that they have no choice but to seek treatment in acute care and emergency department settings.

10. The Secretary's issuance of the letter to State Medicaid Directors and approval of the HMP amended extension application are unauthorized attempts to re-write the Medicaid Act, and the use of the Social Security Act's waiver authority to "transform" Medicaid is an abuse of that authority. Defendants' approval thus violates both the Administrative Procedure Act and the Constitution and should be vacated.

JURISDICTION AND VENUE

11. This is a class action for declaratory and injunctive relief for violation of the Administrative Procedure Act, the Social Security Act, and the United States Constitution.

12. The Court has jurisdiction over Plaintiffs' claims pursuant to 28 U.S.C. §§ 1331 and 1361 and 5 U.S.C. §§ 702 to 705. This action and the remedies it seeks are further authorized by 28 U.S.C. §§ 1651, 2201, and 2202, and Federal Rule of Civil Procedure 65.

13. Venue is proper under 28 U.S.C. § 1391(b)(2) and (e).

PARTIES

14. Plaintiff Andrea Young is 54 years old and lives in Ann Arbor, Michigan. Ms. Young is enrolled in the Healthy Michigan Plan.

15. Plaintiff Maria Yakovchik is 53 years old and lives in Norway, Michigan. Ms. Yakovchik is enrolled in the Healthy Michigan Plan.

16. Plaintiff Jamie Arden is 42 years old and, until recently, lived in Flushing, Michigan. She is currently homeless. Ms. Arden is enrolled in the Healthy Michigan Plan.

17. Plaintiff Katina Petropoulos is 39 years old and lives with her aunt in Ann Arbor, Michigan. Ms. Petropoulos is enrolled in the Healthy Michigan Plan.

18. Defendant Alex M. Azar is Secretary of the United States Department of Health and Human Services ("HHS") and is sued in his official capacity. Defendant Azar has overall responsibility for implementation of the Medicaid program, including responsibility for federal review and approval of state requests for waivers pursuant to Section 1115.

19. Defendant Seema Verma is Administrator of the Centers for Medicare & Medicaid Services ("CMS") and is sued in her official capacity. Defendant Verma is responsible for implementing the Medicaid program as required by federal law, including as amended by the ACA. Defendant Verma approved the HMP amended extension application.

20. Defendant HHS is a federal agency with responsibility for overseeing implementation of provisions of the Social Security Act, of which the Medicaid Act is a part.

21. Defendant CMS is the agency within HHS with primary responsibility for overseeing federal and state implementation of the Medicaid Act as required by federal law.

CLASS ACTION ALLEGATIONS

22. Plaintiffs bring this suit individually and on behalf of a statewide class of persons similarly situated pursuant to Federal Rules of Civil Procedure 23(a) and (b)(2). The class consists of all residents of Michigan enrolled in the Healthy Michigan Plan on or after January 1, 2019.

23. The prerequisites of Federal Rule of Civil Procedure 23(a) are met in that:

a. The class is so numerous that joining all members is impracticable. According to the State's enrollment data, as of November 18, 2019, more than 656,000 individuals are enrolled in Healthy Michigan Plan waiver ("HMP waiver"). *See* Michigan Dep't of Health & Human Servs., *Healthy Michigan Plan*, MICHIGAN.GOV, https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html (under heading "Healthy Michigan Plan Enrollment Statistics") (last visited Nov. 22, 2019). The State has projected that between 61,000 and 183,000 individuals will lose health coverage as a result of the work requirements contained in approved Section 1115 waiver project. *See* Ltr. from Gov. Gretchen Whitmer to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (Feb. 8, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-state-acceptance-ltr-20190608.pdf (citing Manatt Health, *Potential Enrollment Impacts of Michigan's Medicaid Work Requirement* (Feb. 2019), https://www.manatt.com/Insights/White-Papers/2019/Potential-Enrollment-Impacts-of-Michigans-Medicaid). The class

members are geographically dispersed throughout the State, have limited financial resources, and are unlikely to institute individual actions;

b. There are questions of fact and law, particularly as to the legality of the Defendants' policies and decisions with respect to issuance of the letter to State Medicaid Directors and approval of the HMP amended extension application, that are common to all members of the class;

c. The claims of the named plaintiffs are typical of the claims of the class; and

d. The named plaintiffs and their counsel will fairly and adequately protect the interests of the class. Each plaintiff is an adult resident of Michigan who is enrolled in the Healthy Michigan Plan and will be subject to the requirements of the HMP waiver.

24. The requirements of Federal Rule of Civil Procedure 23(b)(2) are met in that the Defendants have acted or refused to act on grounds that apply generally to the class, making final declaratory and injunctive relief appropriate with respect to the class as a whole.

STATUTORY AND REGULATORY BACKGROUND

A. The Medicaid Program

25. Title XIX of the Social Security Act establishes the cooperative federal-state medical assistance program known as Medicaid. *See* 42 U.S.C. §§ 1396 to 1396w-5. Medicaid's stated purpose is to enable each state, as far as practicable, "to furnish [ ] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id*. § 1396-1.

26. The statute defines "medical assistance" to include a range of care and services that participating states must cover or are permitted to cover. *Id*. § 1396d(a).

27. Although states do not have to participate in Medicaid, all states do.

28. Each participating state must maintain a comprehensive state Medicaid plan for medical assistance that the Secretary has approved. *Id*. § 1396a.

29. The state Medicaid plan must describe the state's Medicaid program and affirm its commitment to comply with the requirements of the Medicaid Act and its associated regulations.

30. States and the federal government share responsibility for funding Medicaid. Section 1396b requires the Secretary to pay each participating state the federal share of "the total amount expended . . . as medical assistance under the State plan." *Id*. §§ 1396b(a)(1), 1396d(b). The federal reimbursement rate is based on the state's per capita income.

B. Medicaid Eligibility and Coverage Requirements

31. Using household income and other specific criteria, the Medicaid Act sets forth who is eligible to receive Medicaid coverage. *Id*. §§ 1396a(a)(10)(A), (C). The Act identifies required coverage groups as well as options for extending Medicaid to additional groups. *Id*.

32. To be eligible for federal Medicaid funding, states must cover, and may not exclude from Medicaid, individuals who: (1) are part of a mandatory population group; (2) meet the minimum financial eligibility criteria applicable to that population group; (3) are residents of the state in which they apply; and (4) are U.S. citizens or certain qualified immigrants. *Id*. §§ 1396a(a)(10)(A), 1396a(b)(2), (3); 8 U.S.C. §§ 1611, 1641.

33. Before the Affordable Care Act, the mandatory Medicaid population groups included children; parents and other caretaker relatives; pregnant women; and the elderly, blind, and disabled. 42 U.S.C. § 1396a(a)(10)(A)(i).

34. In 2010, Congress passed, and the President signed, comprehensive health insurance reform legislation, the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010), *as amended by* the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. "The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012).

35. As part of the ACA, Congress amended the Medicaid Act to add a mandatory population group. Effective January 1, 2014, the Medicaid Act requires states to cover adults who are under age 65, are not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household income below 133% of the FPL. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14). This group, often called the "expansion population," includes adults in a variety of family circumstances: parents living with children (whose incomes exceed the state-established limit for the mandatory parent/caretaker population group); parents of older children who have left the home; and adults without children.

36. States receive enhanced federal reimbursement for medical assistance provided to the Medicaid expansion population: 93% federal reimbursement in 2019, and 90% in 2020 and each year thereafter. *Id*. § 1396d(y).

37. In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court held that HHS could not terminate all Medicaid funding to states if they fail to extend Medicaid coverage to the expansion population. 567 U.S. 519 (2012).

38. States that cover the expansion population submit state plan amendments electing to provide this coverage. To date, 34 states (including D.C.) have implemented the Medicaid expansion.

39. Michigan has an approved state Medicaid plan that covers the expansion population. *See* State Plan Amendment MI-14-0170, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-14-0170.pdf.

40. Once a state elects to expand coverage to the expansion population, it becomes a mandatory coverage group.

41. As noted above, the Medicaid Act allows states to extend Medicaid eligibility to certain optional population groups, including children and pregnant women with incomes between 133% and 185% of FPL, *see* 42 U.S.C. § 1396a(a)(10)(A)(ii)(IX), limited-income aged, blind, and/or disabled individuals receiving home and community-based services, *id.* § 1396a(a)(10)(A)(ii)(VI), and "medically needy" individuals who would fall within a mandatory population but for excess income or resources. *Id.* § 1396a(a)(10)(C).

42. The Medicaid Act requires a participating state to cover *all* members of a covered population group. The state may not cover subsets of a population group described in the Medicaid Act. *See id.* § 1396a(a)(10)(B). This requirement applies to optional and mandatory population groups. *Id.*

43. States cannot impose additional eligibility requirements that are not explicitly allowed by the Medicaid Act. *See id.* § 1396a(a)(10)(A).

44. In addition to addressing *who* is eligible for medical assistance, the Medicaid Act delineates how states must make and implement eligibility determinations to ensure that all eligible people who apply are served and get coverage.

45. States must determine eligibility and provide medical assistance to all eligible individuals with "reasonable promptness." *Id.* § 1396a(a)(8); 42 C.F.R. § 435.912(c)(3) (requiring states to determine eligibility within 90 days for individuals who apply on the basis of disability

and 45 days for all other individuals). An individual may apply for and enroll in Medicaid at any time. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.

46. The Medicaid Act sets forth mandatory services that participating states must include in their Medicaid programs and optional services that states may include. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a).

47. The Medicaid Act establishes the states' options for imposing premiums and cost sharing on enrollees. To ensure affordability, the Act permits states to impose premiums and cost sharing only in limited circumstances.

48. Congress amended the Medicaid Act in 1982 to remove the substantive premium and cost sharing provisions from 42 U.S.C. § 1396a, amend them, and place them in a new provision, Section 1396*o*. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.

49. As a result of that amendment, Section 1396a, which generally lists the requirements that a state plan must satisfy, provides that "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges" may be imposed "only as provided in section 1396*o*." 42 U.S.C. § 1396a(a)(14).

50. With respect to premiums, Section 1396*o* of the Medicaid Act provides that "no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c))." *Id*. § 1396*o*(a)(1). Subsection (c), in turn, authorizes limited premiums, but generally prohibits a state from imposing any premiums on individuals whose income falls below 150% of the federal poverty line. *Id*. § 1396*o*(c)(1).

51. Section 1396*o*-1, which Congress passed in 2006 to give states additional flexibility to impose premiums and cost sharing on enrollees, likewise prohibits a state from imposing any

premiums on individuals with household income below 150% of FPL. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4, 82 (codified at 42 U.S.C. § 1396o-1(b)(1)(A)).

52. Nothing in Section 1396*o* or 1396*o*-1 gives the Secretary authority to waive these limits on premiums.

53. The Medicaid Act requires states to "provide such safeguards as may be necessary to assure that eligibility … and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

C. The Secretary's Section 1115 Waiver Authority

54. Section 1115 of the Social Security Act, codified at 42 U.S.C. § 1315, grants the Secretary authority to waive a state's compliance with certain requirements of the Medicaid Act under certain conditions.

55. The Secretary may grant a Section 1115 Medicaid waiver only in the case of an "experimental, pilot, or demonstration project which . . . is likely to assist in promoting the objectives" of the Medicaid Act. *Id*. § 1315(a).

56. The Secretary may only waive requirements of Section 1396a of the Medicaid Act. *Id*. § 1315(a)(1).

57. The Secretary may not waive compliance with requirements that Congress has placed outside of Section 1396a.

58. The Secretary may grant a Section 1115 waiver "only to the extent and for the period necessary" to enable the state to carry out the experimental, pilot, or demonstration project. *Id*.

59. The costs of such a project, upon approval, are included as expenditures under the state Medicaid plan. *Id*. § 1315(a)(2).

60. The Secretary must follow certain procedural requirements before approving a Section 1115 project. *Id*. § 1315(d); 42 C.F.R. §§ 431.400 to 431.416. In particular, after receiving a complete application from a state (following a state-level public comment period), the Secretary must provide a 30-day public notice and comment period. *See* 42 U.S.C. § 1315(d); 42 C.F.R. § 431.416.

61. The Secretary does not have the authority to waive compliance with the United States Constitution or other federal laws.

62. For example, the Fair Labor Standards Act ("FLSA") requires that all individuals, including individuals receiving public benefits, be compensated at least the minimum wage in exchange for hours worked. *See* 29 U.S.C. § 206(a)(1)(C); Dep't of Labor, *How Workplace Laws Apply to Welfare Recipients* at 2 (1997), http://nclej.org/wp-content/uploads/2015/11/LaborProtectionsAndWelfareReform.pdf. Notably, the Supplemental Nutrition Assistance Program ("SNAP") and Temporary Assistance for Needy Families ("TANF") statutes specifically refer to work requirements and describe how the benefits interact with the FLSA minimum wage protections. *See* 7 U.S.C. § 2029(a)(1) (SNAP); 42 U.S.C. § 607 (TANF). In contrast, there is no such reference or description in the Medicaid Act. And according to the Department of Labor, medical assistance, unlike SNAP and TANF cash benefits, may not be substituted for a wage. *See How Workplace Laws Apply to Welfare Recipients* at 4.

D. Medicaid in Michigan and the Healthy Michigan Plan

63. Michigan, like all other states, has elected to participate in Medicaid. *See* Mich. Comp. Laws §§ 400.105-400.112k; Mich. Admin. Code § 400.3401-.3425, 400.7171-.7173. The Michigan Department of Health and Human Services ("DHHS") administers the program at the state level.

64. The federal government generally reimburses Michigan for approximately 64% of the cost of providing medical assistance through its Medicaid program. *See* 83 Fed. Reg. 61157-60 (Nov. 28, 2018) (fiscal year 2020).

65. Before the Affordable Care Act, Michigan operated a project called the "Adult Benefits Waiver," which provided coverage to childless adults with incomes below 35% FPL who were not otherwise eligible for Medicaid.

66. In 2013, Michigan passed legislation to expand Medicaid coverage to the Medicaid expansion group. Mich. Pub. L. No. 107 § 106(c) (2013) (codified at Mich. Comp. Laws § 400.106(c)).

67. Effective April 1, 2014, Michigan amended its state plan to cover the Medicaid expansion population. *See* State Plan Amendment MI-14-0170, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-14-0170.pdf.

68. Large numbers of individuals in the expansion population have used their Medicaid coverage, receiving critical care and treatment. Nearly half of individuals enrolled in the Medicaid expansion reported better physical health, and nearly 40% reported better mental and dental health since enrolling. *See* Renuka Tipirneni et al., *Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: a Mixed Methods Study*, 34 J. Gen. Internal Med. 272 (Feb. 2019), https://link.springer.com/article/10.1007/s11606-018-4736-8. Nearly one-third of individuals enrolled in the expansion discovered they had an undiagnosed chronic illness. *See* Ann-Marie Rosland, *Diagnosis and Care of Chronic Health Conditions Among Medicaid Expansion Enrollees: a Mixed-Methods Observational Study*, 34 J. Gen. Internal Med. 2549 (Nov. 2019), https://link.springer.com/article/10.1007/s11606-019-05323-w.

69. Michigan's Medicaid expansion has also had positive effects for individuals' financial well-being. One study found a 27% reduction in unpaid debt, a 52% reduction in medical bills sent to collections, and an 11% decrease in bankruptcies. *See* Sarah Miller et al., Nat'l Bureau of Econ. Research, *Working Paper 25053: The ACA Medicaid Expansion in Michigan and Financial Health*, 4 (2019), https://www.nber.org/papers/w25053.pdf.

70. The 2013 state law authorizing the Medicaid expansion also directed the State to request authority under Section 1115 to require the expansion population to pay premiums and copayments that could be reduced, but not eliminated, if individuals engaged in certain "healthy behaviors" identified by the State. Mich. Pub. L. No. 107 § 105d(1) (2013).

71. To implement that legislation, Michigan submitted an application to amend the existing Adults Benefits Waiver to include the entire Medicaid expansion population, to charge individuals copayments and premiums, and to rename the project the "Healthy Michigan Plan" or "HMP." State of Michigan, *Healthy Michigan Plan: A Waiver Amendment Request Submitted Under Authority of Section 1115 of the Social Security Act* (Nov. 8, 2013), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-waiver-amend-req-11082013.pdf

72. The application was approved on December 30, 2013, effective through December 31, 2018. *See* Ltr. from Marilyn Tavenner, Ctrs. for Medicare & Medicaid Servs. to Stephen Fitton, Dir. Mich. Medical Servs. Admin (Dec. 30, 2013); CMS Special Terms and Conditions ("2013 STCs"), collectively available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-cms-amend-appvl-12302013.pdf.

73. The approval permitted Michigan to charge all HMP enrollees copayments, called "average copayment amounts." The average copayment amount is calculated by tracking the copayments an individual incurred during the prior six months of enrollment and calculating an average monthly amount. The Secretary directed that these average copayments be billed to the enrollee at the end of each quarter. *See* 2013 STCs ¶¶ 28, 29.

74. In addition to the average copayments, the Secretary permitted Michigan to charge enrollees with incomes between 100% and 133% FPL a monthly premium equal to two percent of the individual's annual income. *Id.* ¶ 28.

75. Enrollees pay both their average copayment amounts and monthly premiums into a "MI Health Account" account. *Id.* The copayments and premium amounts can be reduced by up to half if the individual completes a health risk assessment ("HRA") or other "healthy behavior" identified by the State, such as receiving a vaccine or completing a cancer screening. *Id*. ¶¶ 28, 32.

76. At the time, the Secretary specified that "[n]o individual may lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a Healthy Michigan health plan, or be denied access to services for failure to pay premiums or copayment liabilities." *Id.* ¶ 29(a).

E. Extension and Amendment of the Healthy Michigan Plan

77. In December 2017, the State submitted an application to extend the HMP waiver, which was set to expire on December 31, 2018. *See* Mich. Dep't of Health & Human Servs., *Section 1115 Demonstration Extension Application, Healthy Michigan Plan* (Dec. 6, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa2.pdf ("HMP Extension Application").

78. The HMP Extension Application did "not seek[] any additional program changes." *Id.* at 4.

79. In a cover letter attached to the HMP Extension Application, then Governor Rick Snyder noted that approximately 650,000 people had enrolled in the Medicaid expansion, and expansion coverage had reduced uncompensated care costs for hospitals by almost 50%, from $7.21 million to $3.77 million. *See* Letter from Governor Rick Snyder to Eric D. Hargan, Acting Secretary, U.S. Dep't of Health & Human Servs. (Dec. 6, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa2.pdf.

80. In June 2018, the Michigan Legislature passed a law directing the State to seek an amendment to its Section 1115 project that would add work requirements for the Medicaid expansion population. That law also required the State to seek two additional eligibility requirements for enrollees with incomes above 100% FPL who had maintained coverage under the HMP for 48 cumulative months: (1) required healthy behaviors and (2) increased premiums. S.B. 897, 99th Leg. Reg. Sess. (Mich. 2018), http://www.legislature.mi.gov/(S(kesuvjxu51w1gk2d2aeswx5m))/mileg.aspx?page=GetObject&objectname=2018-SB-0897.

81. Michigan submitted the amended HMP extension application on September 10, 2018. *See* Letter from Governor Rick Snyder to Alex Azar, Sec'y, Dep't of Health & Human Servs. (Sept. 10, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf ("HMP Amended Extension Application").

82. Governor Snyder explained that the HMP Amended Extension Application "is designed to promote accountability, self-sufficiency, and independence from public assistance." *Id.* at 1.

83. The HMP Amended Extension Application further stated, "Michigan seeks to promote work and community engagement and provide incentives to beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work. MDHHS workforce engagement requirements are designed to assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from governmental interference." HMP Amended Extension Application at 5.

84. During the State comment period for the amended extension application, Michigan's application explained that "MDHHS expects the annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." *See* Mich. Dep't of Health & Human Servs., *Section 1115 Demonstration Extension Application - Healthy Michigan Plan, Amended: July 9, 2018*, at 14 attached as Exhibit A.

85. In its HMP Amended Extension Application, the State estimated that approximately 400,000 of the 655,000 enrollees would be subject to the new eligibility conditions but did not estimate the number of individuals who might lose coverage as a result of the proposed amendments. HMP Amended Extension Application at 16.

86. The federal public comment period on the HMP Amended Extension Application ran from September 26, 2018 through October 26, 2018. *See* Medicaid.gov, Healthy Michigan - Amendment Request, https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1898787 (last visited Nov. 22, 2019).

87. On December 21, 2018, the Secretary approved the HMP Amended Extension Application, effective January 1, 2019 through December 31, 2023. *See* Ltr. from Seema Verma, Admr., Ctrs for Medicare & Medicaid Servs., to Kathy Stiffler, Acting Dir., Mich. Dep't of Health & Human Servs. (Dec. 21, 2018) ("HMP Approval Letter"); CMS, HMP Waiver List ("Waiver List"); CMS, HMP Special Terms and Conditions ("2018 STCs"), collectively available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf.

88. In the cover letter of the approval, Defendant Verma stated that CMS is dedicated to reforms that "improve health and help lift individuals out of poverty." Letter from Seema Verma, Adm'r., Ctrs. for Medicare & Medicaid Servs., to Governor Rick Snyder (Dec. 21, 2018) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf.

89. The approval letter described the project as having two objectives: to "promote[] beneficiary health and financial independence" and to "furnish medical assistance in a manner that improves the sustainability of the safety net." HMP Approval Letter at 5, 8; *see also id*. at 3 (listing the factors examined in considering the project).

90. The Secretary did not provide an estimate of how many people would lose Medicaid with the HMP Amended Extension Application in place, stating that "[i]t is not possible to predict the percentage of this group of beneficiaries who will not comply with the demonstration amendments affecting eligibility." HMP Approval Letter at 13.

91. The Secretary's approval extended the average copayment amounts and premium components, *see* ¶¶ 73-74, *supra*., that were set to expire on December 31, 2018. *See* 2018 STCs ¶¶ 22-24; ¶ 22(c) (now referring to premiums as "monthly contributions").

92. As in the original waiver, individuals subject to the average copayments and individuals subjected to the premiums may not lose eligibility or be denied services for failure to pay. *Id.* ¶ 22(d). The Secretary granted Michigan authority to attempt to collect unpaid premiums. *Id.* ¶ 26.

93. The HMP Amended Extension Approval added three new conditions on coverage:

Work and Community Engagement Requirements

94. Under the Secretary's approval, HMP enrollees aged 19 to 62 must engage in specified work or work-related activities for 80 hours per month. 2018 STCs ¶¶ 28, 30.

95. The work requirements do not apply to pregnant women, medically frail individuals, or individuals with a disability or other condition that prevents them from working, as verified by a licensed medical professional. *Id.* ¶ 29.

96. In addition, enrollees who meet certain other criteria are exempt from the requirements, such as being a full-time student, serving as the primary caregiver for a child under age six, caring for an individual with a disability, having been incarcerated within the last six months, or current receipt of unemployment benefits. *Id*. Individuals who comply with or are exempt from SNAP or TANF work requirements are deemed compliant with or exempt from the work requirements. *Id.*

97. Enrollees who are not exempt must report their work activities monthly. *Id*. ¶ 31.

98. Enrollees who do not report the required hours for three months in a 12-month period will lose coverage at the end of the fourth month, unless during the fourth month, the individual completes 80 hours of qualifying activities or demonstrates that they qualify for a good cause or other exemption. *Id.* ¶ 32. There is one good cause exemption: individuals who are unable

to meet the requirement for reasons related to their own or an immediate family member's disability or serious illness. *Id.* ¶ 32(c).

99. An individual who is dis-enrolled at the end of the fourth month is not permitted to re-enroll for one month. Thereafter, an individual can re-enroll by completing 80 hours of qualifying activities in one month. *Id*.

100. In approving the work requirements, the Secretary stated that the project will help the Secretary "evaluate whether the community engagement requirement helps adults in HMP transition from Medicaid to financial independence, thus reducing dependency on public assistance" and that the work requirements are "intended to encourage beneficiaries to attain greater levels of financial independence." HMP Approval Letter at 7.

101. The Secretary did not estimate the coverage loss that would result from the work requirements.

102. The Secretary approved the project without an evaluation design for the experiment in place. On information and belief, that is still missing.

103. Michigan will begin implementing the work requirements on January 1, 2020. HMP Approval Letter at 4; 2018 STCs ¶ 28; *see also* Healthy Michigan Plan, Changes Coming in January 2020, https://www.michigan.gov/healthymiplan/0,5668,7-326-90904---,00.html (last visited Nov. 22, 2019).

104. The State has projected that between 61,000 and 183,000 individuals will lose health coverage as a result of the work requirements. *See* Ltr. from Gov. Gretchen Whitmer to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (Feb. 8, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-state-acceptance-ltr-20190608.pdf (citing

Manatt Health, *Potential Enrollment Impacts of Michigan's Medicaid Work Requirement* (Feb. 2019), https://www.manatt.com/Insights/White-Papers/2019/Potential-Enrollment-Impacts-of-Michigans-Medicaid).

Heightened Premiums and Penalties for Failure to Pay

105. HMP enrollees with 48 or more months of cumulative enrollment in HMP and incomes above 100% FPL are not subject to the average copayments. Instead, the Secretary has approved the State to charge these individuals premiums of up to five percent of their income. 2018 STCs ¶ 23(a).

106. Individuals who do not pay the five percent premium will be terminated from coverage 60 days after the "invoice date of the missed premium." *Id.*

107. Individuals who are disenrolled for failure to pay premiums may not re-enroll until they pay the missed premiums or demonstrate they are exempt from premiums or eligible under another Medicaid eligibility category not subject to the premium requirements. *Id.*

108. Certain individuals are exempt from the premium requirements: pregnant women, individuals who are medically frail, children under 21 years of age, individuals enrolled in a Flint-specific Section 1115 project, and American Indian/Alaskan Natives. *Id.* ¶ 25.

109. The Secretary described the purpose of the premiums and associated consequences for inability to pay as "prepar[ing] beneficiaries to participate in the commercial market." HMP Approval Letter at 7.

110. The HMP Approval Letter cited an "interim" report that assessed a similar Section 1115 premium project that has been in place in Indiana since January 1, 2008. HMP Approval Letter at 6, 17 notes 4 and 11. That interim report found the premiums and associated consequences for failure to pay reduced enrollment in Medicaid in Indiana. *See, e.g.*, Lewin Group, *Indiana HIP*

2.0: POWER Account Contribution Assessment, ii, 8-12 (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.

111. Comments submitted during the federal comment period cited numerous previous studies of the effects of premiums on low-income individuals' enrollment. This redundant research consistently concludes that such premiums reduce enrollment in Medicaid.

112. The HMP Amended Extension Approval granted Michigan permission to implement the premiums starting January 1, 2020. 2018 STCs ¶ 23. On September 23, 2019, the Governor of Michigan announced that the State will defer implementation of the new premium requirements until October 1, 2020. *See* Letter from Governor Gretchen Whitmer to Mich. Senate (Sept. 23, 2019), https://content.govdelivery.com/attachments/MIEOG/2019/09/23/file_attachments/1290341/190923%20-%20Letter%20from%20Gov.%20Whitmer%20to%20MI%20Senate_signed.pdf.

Healthy Behavior Requirements as a Condition of Eligibility

113. Like all other HMP enrollees, enrollees with 48 or more months of cumulative enrollment in HMP and incomes above 100% FPL must complete either an HRA or a specified healthy behavior, such as receiving a vaccine or cancer screening, as a condition of eligibility. 2018 STCs ¶ 24(c).

114. In approving the HMP Amended Extension Application, the Secretary granted Michigan permission to impose new restrictions on certain beneficiaries. The State may terminate coverage for beneficiaries with incomes above 100% FPL and 48 cumulative months of enrollment if it cannot confirm completion of the healthy behavior or HRA in the 12 months preceding the individual's annual redetermination. *Id.*

115. An individual who loses coverage for failure to complete the required healthy behavior must complete an HRA prior to re-enrolling, unless they demonstrate that they are exempt from the healthy behavior requirement or are eligible for another Medicaid eligibility category that is not subject to the requirement. *Id.* If an individual does not answer all of the required questions on the HRA, eligibility will be denied. *Id.*

116. Individuals in this category also do not receive any reductions in their premium obligations for completion of the healthy behaviors. *Id.*

117. Certain individuals are exempt from the healthy behavior requirements: pregnant women, individuals who are medically frail, American Indian/Alaska Natives, and individuals enrolled in a Flint-specific § 1115 demonstration waiver. 2018 STCs ¶ 25.

118. On September 23, 2019, the Governor of Michigan announced that the State will defer implementation of the new healthy behavior requirements until October 1, 2020. *See* Letter from Governor Gretchen Whitmer to Mich. Senate (Sept. 23, 2019), https://content.govdelivery.com/attachments/MIEOG/2019/09/23/file_attachments/1290341/190923%20-%20Letter%20from%20Gov.%20Whitmer%20to%20MI%20Senate_signed.pdf.

F. Action Taken by the Defendants to Allow Work Requirements

119. Prior to 2017, CMS's website stated that the purpose of Section 1115 waivers is to "demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs."

Medicaid.gov, *About Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited September 5, 2017). The "general criteria" CMS used when assessing waiver applications looked at whether the demonstration would:

> 1. Increase and strengthen overall coverage of low-income individuals in the state;
>
> 2. Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
>
> 3. Improve health outcomes for Medicaid and other low-income populations in the state; or
>
> 4. Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Id. (last visited November 21, 2019).

120. Prior to 2017, CMS recognized that work requirements do "not support the objectives of the [Medicaid] program" and "could undermine access to care." Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., HHS to Thomas Betlach, Dir. Airz. Health Care Cost Containment System (Sept. 30, 2016); *see also* Sec'y of Health & Human Servs. Sylvia Burwell, Hearing on The President's Fiscal Year 2017 Budget, Responses to Additional Questions for the Record, U.S. House of Rep. Energy & Commerce Health Subcommittee, 13 (Feb. 24, 2016), http://docs.house.gov/meetings/IF/IF14/20160224/104521/HHRG-114-IF14-Wstate-BurwellS-20160224-SD002.pdf.

121. The current HHS abruptly reversed course to authorize work requirements in Medicaid as part of President Trump's vow to "explode" the ACA and its Medicaid expansion. Amy Goldstein & Juliet Eilperin, *Affordable Care Act Remains "Law of the Land," but Trump Vows to Explode It*, Wash. Post, Mar. 24, 2017, https://wapo.st/2Do6m8v.

122. On the day he took office, President Trump signed an Executive Order calling on federal agencies to undo the ACA "[t]o the maximum extent permitted by law." Executive Order

13765, Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 82 Fed. Reg. 8351 (Jan. 20, 2017), https://www.federalregister.gov/documents/2017/01/24/2017-01799/minimizing-the-economic-burden-of-the-patient-protection-and-affordable-care-act-pending-repeal.

123. On March 14, 2017, Defendant Seema Verma was sworn in as the Administrator of CMS. Defendant Verma and former Secretary Price immediately issued a letter to state governors announcing CMS's disagreement with the ACA's Medicaid expansion, stating that "[t]he expansion of Medicaid through the Affordable Care Act ('ACA') to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program." Sec'y of Health & Human Servs., Dear Governor Letter 1, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

124. Since then, Defendant Verma has made repeated public statements criticizing the expansion of Medicaid to "able-bodied individual[s]," advocating for lower enrollment in Medicaid, and outlining plans to "reform" Medicaid through agency action. Casey Ross, *Trump health official Seema Verma has a plan to slash Medicaid rolls, Here's how*, Stat, Oct. 26, 2017, https://www.statnews.com/2017/10/26/seema-verma-medicaid-plan/ (last visited Nov. 22, 2019).

125. On November 7, 2017, at a speech before the National Association of Medicaid Directors, Defendant Verma declared that the ACA's decision to "move[] millions of working-age, non-disabled adults into" Medicaid "does not make sense" and announced that CMS would resist that change by approving state waivers that contain work requirements. Speech: Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference, CMS.gov (Nov. 7, 2017), https://go.cms.gov/2PELxLW.

126. On November 10, 2017, Defendant Verma gave an interview in which she declared that one of the "major, fundamental flaws in the Affordable Care Act was putting in able bodied adults," declaring that Medicaid was "not designed for an able bodied person," and announcing that CMS is "trying" to "restructure the Medicaid program." Wall Street Journal, *The Future of: Health Care* (Nov. 10, 2017), https://on.wsj.com/2AMeGMW (last visited Nov. 22, 2019).

127. In early November 2017, CMS revised its website to invite states to submit Section 1115 waivers that would:

1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;

2. Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;

3. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;

4. Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;

5. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and

6. Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

Medicaid.gov, *About Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Nov. 22, 2019).

128. CMS has explained that "[t]he revised website content signals a new, broader view of these demonstrations in which states can focus on evidence-based approaches that drive better health outcomes, and quality of life improvements, and support upward mobility and self-sufficiency." Ctrs. for Medicare & Medicaid, Press release: *CMS announces new policy guidance for states to test community engagement for able-bodied adults* (Jan. 11, 2018),

https://www.cms.gov/newsroom/press-releases/cms-announces-new-policy-guidance-states-test-community-engagement-able-bodied-adults.

129. On January 11, 2018, Defendant CMS issued a letter to State Medicaid Directors titled "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries." Letter from Brian Neale, Dir., Ctr. for Medicaid & CHIP Servs., to State Medicaid Directors (Jan. 11, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf ("Dear State Medicaid Director Letter").

130. The nine-page document "announc[es] a new policy" that allows states to impose "work and community engagement" requirements on certain Medicaid recipients – specifically, "non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability." *Id*. at 1.

131. The Dear State Medicaid Director Letter acknowledges that allowing states to implement work requirements "is a shift from prior agency policy." *Id*. at 3.

132. The Dear State Medicaid Director Letter was not submitted for notice and comment and was not published in the Federal Register.

133. The same day CMS issued the Dear State Medicaid Director Letter, it received several letters critical of this novel policy position, including from members of Congress and nonprofit organizations. The National Health Law Program ("NHeLP") explained that the Dear State Medicaid Director Letter "entirely ignore[d] the wealth of literature regarding the negative health consequences of work requirements, which was repeatedly cited by NHeLP and others in those state-specific comments." Letter from Jane Perkins, Legal Dir., Nat'l Health Law Program, to Brian Neale, Dir., Ctrs. for Medicare & Medicaid Servs. (Jan. 11, 2018),

https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/01/NHeLP-Letter-Re-Work-DSMD.pdf.

134. On or about January 18, 2018, CMS further emphasized that it disagrees with the legislative expansion of Medicaid under the ACA and that it had announced the "new policy guidance" to support state implementation of work requirements intended to target that expansion population. CMS, Community Engagement Initiative Frequently Asked Questions, https://www.medicaid.gov/medicaid/section-1115-demo/community-engagement/index.html (last visited Nov. 22, 2019).

135. CMS included terms and conditions when approving the HMP Amended Extension Application that require Michigan to follow requirements set out in the State Medicaid Letter. *See*, *e.g.*, 2018 STCs ¶ 29 (exempting from work requirement enrollees with a medical condition that would prevent compliance); *id.* (exempting individuals identified by the state as medically frail); *id.* (exempting enrollees who are exempt or complying with from SNAP/TANF work requirements); *id.* (counting compliance with SNAP/TANF requirements as compliance with Medicaid work requirements); *id.* ¶ 30 (treating participation in substance use disorder treatment as a qualifying activity); *id.* ¶ 33 (requiring reasonable modifications for enrollees with ADA-protected disabilities, including exemption from participation); *id.* ¶ 34(k) (promising that Michigan will assess areas with limited economies and/or educational activities or higher barriers to participation to determine whether further exemptions or modifications are needed).

136. The Secretary has also implemented the policy guidance in the Dear State Medicaid Director Letter by approving similar work requirements in several other states: Kentucky, Arkansas, Indiana, Wisconsin, New Hampshire, Maine, Arizona, Ohio, and Utah. *See*, *e.g.*, Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (@Seema CMS), Twitter (Mar. 5, 2018,

9:45 AM), https://twitter.com/SeemaCMS/status/1076221399390478336 (last visited Nov. 22, 2019) ("Maine marks the 7th community engagement demonstration we have approved since announcing this important opportunity earlier this year.").

137. The Defendants have continued to express their opposition to the Medicaid expansion and their intent to transform the Medicaid program through work requirements. For example, Defendant Verma stated: "As you know, Obamacare put millions of people, millions of able-bodied individuals, into a program that was built for our most needy, for our most vulnerable citizens. And so, we think that the program needs change. It needs to be more adaptable and more flexible to address the needs of the newly-covered population." Interview by Bertha Coombs, CNBC, with Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., (May 1, 2018).

138. In July 2018, after *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018) vacated and remanded HHS's approval of the Kentucky HEALTH project, which included work requirements, Defendant Verma reiterated that CMS is "very committed" to work requirements and wants "to push ahead with our policy initiatives and goals." Dan Goldberg, *Verma: Court ruling won't close door on other Medicaid work requests*, Politico, July 17, 2018, https://www.politico.com/story/2018/07/17/trump-medicaid-work-requests-states-verma-726303.

139. In July 2018, Defendant Azar similarly stated: "We are undeterred. We are proceeding forward. . . . We're fully committed to work requirements and community participation in the Medicaid program. . . . we will continue to litigate, we will continue to approve plans, we will continue to work with states. We are moving forward." Colby Itkowitz, *The Health 202: Trump administration 'undeterred' by court ruling against Medicaid work requirements*, Wash. Post, July 25, 2018, https://www.washingtonpost.com/news/powerpost/paloma/the-health-

202/2018/07/27/the-health-202-trump-administration-undeterred-by-court-ruling-against-medicaid-work-requirements/5b5a10bb1b326b1e64695577/?utm_term=.7ba76e8a0719.

140. Defendant Azar commended Defendant Verma, stating that she "is now overseeing the next great generation of transformation in Medicaid, through our efforts to encourage work and other forms of community engagement." Alex M. Azar II, Sec'y, U.S. Dep't of Health & Human Servs., Remarks on State Healthcare Innovation at the American Legislative Exchange Council Annual Meeting (Aug. 8, 2018).

141. In a speech on September 27, 2018, Defendant Verma explained that the Dear State Medicaid Director Letter "guidance was followed by four approvals of innovative Medicaid demonstrations" and elaborated that "[w]e are committed to this issue and we are moving closer to approving even more state waivers. As such, I'm happy to share with you today that we have finalized the terms for our next innovative community engagement demonstration, which we expect to deliver to the state very soon." SPEECH: Remarks by Administrator Seema Verma at the 2018 Medicaid Managed Care Summit, CMS.gov (Sep. 27, 2018), https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-2018-medicaid-managed-care-summit.

142. On December 21, 2018, the Secretary approved the Michigan HMP Amended Extension Application.

143. That same day, Administrator Verma tweeted, "The Christmas sleigh has made deliveries to Kansas, Rhode Island, Michigan, and Maine to drop off signed #Medicaid waivers. Christmas came early for these Governors. . . ." Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (@Seema CMS), Twitter (Dec. 21, 2018, 1:13 PM), https://twitter.com/seemacms/status/1076224135037108224?lang=en.

144. On March 11, 2019, President Trump issued his 2020 budget. That budget proposes legislation to impose work requirements nationally and estimates they will save $130 billion over ten years. *See* Dep't of Health & Human Servs., *FY 2020 Budget in Brief*, 100 (Mar. 11, 2019), https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf.

145. On March 14, 2019, CMS issued new guidance, further implementing the policies announced in the Dear State Medicaid Director Letter. The new guidance provides "standard monitoring metrics" that states must use to evaluate projects that require work or community engagement among working age adults. *Press Release: CMS Strengthens Monitoring and Evaluation Expectations for Medicaid 1115 Demonstrations*, CMS.gov (Mar. 14, 2019), https://www.cms.gov/newsroom/press-releases/cms-strengthens-monitoring-and-evaluation-expectations-medicaid-1115-demonstrations.

146. The guidance repeatedly notes CMS will continue to apply the guidelines set forth in the January 11, 2018 Dear State Medicaid Director Letter and clarifies that the letter communicates "CMS's expectation that states test the effects of community engagement requirements on health, well-being, independence, and the sustainability of the Medicaid program." Ctrs. for Medicare & Medicaid Servs., *Evaluation Design Guidance for Section 1115 Eligibility and Coverage Demonstrations*, 2, https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ce-evaluation-design-guidance.pdf; *see also* Ctrs. for Medicare & Medicaid Servs., *Appendix to Evaluation Design Guidance for Section 1115 Eligibility & Coverage Demonstrations: Community Engagement*, 1, https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ce-evaluation-design-guidance-appendix.pdf; Seema Verma, *Good Ideas Must Be Evaluated*, Ctrs.

for Medicare & Medicaid Servs. Blog (Mar. 14, 2019), https://www.cms.gov/blog/good-ideas-must-be-evaluated (last visited Nov. 22, 2019).

147. On March 27, 2019, after *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019) and *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019) vacated and remanded HHS's approval of work requirements and other restrictions in Kentucky and Arkansas, Defendant Verma said: "We will continue to defend our efforts to give states greater flexibility to help low income Americans rise out of poverty." Abigail Abrams, *Medicaid Work Requirements Stall in Several States*, Time, March 28, 2019, https://time.com/5560629/medicaid-work-requirements-arkansas-kentucky/.

148. A CMS spokesperson issued an identical statement on July 29, 2019 in response to *Philbrick v. Azar*, 2019 WL 3414376 (D.D.C. 2019), which vacated and remanded HHS's approval of New Hampshire's Section 1115 project containing work requirements. Amy Goldstein, *Federal judge strikes down New Hampshire's Medicaid work requirements*, Wash. Post, July 29, 2019, https://wapo.st/2YyegXf.

149. On November 12, 2019, Defendant Verma again reiterated her commitment to the work requirements policy announced in the Dear State Medicaid Director Letter. She highlighted CMS's approval of "10 community engagement programs," explaining that the goal of these programs for "abled bodied adults," is to "help them live happier and healthier lives . . . infused with meaning and purpose . . . that knows the dignity of a job." CMS Administrator Seema Verma's Speech to the National Association of Medicaid Directors in Washington, D.C, CMS.gov (Nov. 12, 2019), https://www.cms.gov/newsroom/press-releases/cms-administrator-seema-vermas-speech-national-association-medicaid-directors-washington-dc.

G. Effects of the HMP Amended Extension Approval on the Plaintiffs

150. **Plaintiff Andrea Young** is 54 years old and lives alone in an apartment that she rents in Ann Arbor Michigan.

151. Ms. Young is currently working two part-time jobs and attending Washtenaw Community College part-time, where she is working towards a bachelor's degree in sociology. She is currently taking two classes and hopes to graduate next year after completing an algebra course.

152. Ms. Young relies on the bus to get to work and to school because she does not have a car. Depending on where she is going, travel can take between 45 minutes and two hours. She often needs to take more than one bus and the routes do not always connect.

153. Ms. Young is currently employed as a contingent residential support worker at Avalon Housing, a residential care facility for the elderly and disabled, where she assists with client care and paperwork. As a contingent employee, she is not on the regular schedule. Instead, she is on call if the facility needs extra help or if someone needs a shift covered. She makes $14.02 per hour.

154. Her hours vary week to week depending on Avalon's staffing needs. The shifts are eight hours, and she typically works two shifts. Some weeks, she only gets one shift. She has rarely worked three shifts in a week. Ms. Young's schedule is not within her control. Sometimes shifts are taken away and assigned to another contingent worker. Other times, she is not able to take on a last minute or midnight shift, because public transportation would take too long or is unavailable. The buses in her area do not run after 11 pm.

155. Ms. Young also works occasionally as a library assistant at Washtenaw Community College as part of a work-study program. She makes $11.22 per hour. She is not on the regular

schedule but covers shifts for other workers when needed. She has to turn down shifts that conflict with her classes. Moreover, when the school is closed for breaks or holidays, work-study is not available. In the last month, she has not had any shifts.

156. Ms. Young used to work at a Chrysler plant as a packer in the parts division. Her left arm was severely injured when she was hit by a hub. The accident required her to have surgery and wear a cast. While she was in the cast, Chrysler assigned her to a "one-arm" job. That increased the stress on her right arm and led to adhesive capsulitis, or "frozen shoulder." Now, Ms. Young needs to have surgery on her right arm to treat this condition. She also experiences lateral epicondylitis (tennis elbow) and osteophytes (bone spurs).

157. Her arm and shoulder conditions cause severe pain and limit Ms. Young's ability to perform certain tasks. For instance, she cannot lift objects more than ten pounds, do repetitive activities, or drive a car because it is too painful to hold the steering wheel. Her doctors have told her that her conditions will continue to worsen over time.

158. Ms. Young has been enrolled in the Healthy Michigan Plan since winter of 2017. She relies on Medicaid to cover weekly physical therapy and medications to help with pain and inflammation. She is also planning to start occupational therapy for her arms soon. These treatments lessen her pain so that she is able to go to work and attend school.

159. Ms. Young also suffers from asthma. Medicaid covers her albuterol to manage her symptoms.

160. Ms. Young will be required to complete 80 hours of work or other activities each month. She received a letter from DHHS stating that she must comply with the work requirements starting January 1, 2020. She is worried she will not be able to comply because she will not be able to complete the required activities consistently.

161. Ms. Young is also concerned about reporting her work hours. On two occasions in the past, her Medicaid coverage was terminated and she had to go to the health department in Wayne County to get it reinstated. Both times, she discovered that DHHS had sent her notices requesting additional information but she did not receive them because the notices did not include her apartment number on the address.

162. Without Medicaid coverage, Ms. Young would not be able to pay for her health care, including physical therapy and medications. She is worried that if she loses Medicaid her health will deteriorate and she would not be well enough to go to work or finish school.

163. If Ms. Young had known about the Dear State Medicaid Director letter, she would have wanted to submit a comment to explain that she needs Medicaid to be able to take care of her health, and without medical treatment, her old injuries would prevent her from earning an income.

164. **Plaintiff Maria Yakovchik** is 53 years old and lives alone in Norway, Michigan, a small town in the Upper Peninsula close to the Michigan-Wisconsin border.

165. Ms. Yakovchik has a teaching degree from the University of Wisconsin-Green Bay and has been teaching for over 20 years. She loves working with children and seeing them learn and grow. She taught kindergarten full time until 2008, when her health problems made it difficult for her to work a full day. Since then, she has been substitute teaching.

166. Ms. Yakovchik primarily works at three schools in her area. One is a short drive from her house, another is approximately a 30-minute drive away, and the third is across the border in Wisconsin. The teachers at these schools know Ms. Yakovchik and value her contributions in their classrooms. Teachers often request her specifically when they need to take time off.

167. As a substitute teacher, Ms. Yakovchik's schedule varies widely and depends on how many shifts are available. A shift may be a full day or only a half-day. Some weeks, she may

work three shifts a week, but during other weeks, only one shift. In September 2019, she worked only four days because there are not many shifts available at the beginning of the school year. The weather can also dramatically change her schedule. For instance, in February 2019, the local schools closed for five days due to inclement weather.

168. Ms. Yakovchik also has several health conditions that can interfere with her ability to work. She suffers from a Coronary Artery Vasospasm, Gastroesophageal Reflux Disease (GERD), post-concussion syndrome, sleep apnea, insomnia, chronic sinusitis, and high blood pressure. Additionally, she struggles with anxiety and depression.

169. Coronary Artery Vasospasm causes the arteries to spasm. It can feel like a heart attack. The condition regularly causes tightness in her chest, chest pain, and shortness of breath. During particularly bad episodes, it can feel like she is dying. Stress and anxiety make these symptoms worse. She is currently treating with a cardiologist for this condition.

170. Ms. Yakovchik's post-concussion syndrome has led to problems with her short-term memory, and she has been experiencing headaches.

171. As a result of these health conditions, Ms. Yakovchik cannot work full time. If she works two days in a row, she needs the third day off to recuperate. She enjoys substitute teaching because she can continue to work with children and has flexibility to accept shifts only when she is well enough to work.

172. Ms. Yakovchik has been enrolled in Michigan's Medicaid program since 2014. She relies on Medicaid coverage to see her cardiologist and a sleep doctor. Medicaid also covers medications for her heart condition and GERD, as well as a continuous positive airway pressure (CPAP) machine to treat her sleep apnea.

173. She is planning to see a neurologist for an initial visit to treat her post-concussion syndrome, but the closest one is in Green Bay, Wisconsin, which is nearly a two-hour drive from her home. She is having difficulty affording the gas for a four-hour round trip.

174. Ms. Yakovchik pays average copayments to her MI Health Account every quarter. The amounts vary depending on what medical services she received, but are typically around $20.

175. Ms. Yakovchik does her best to keep her expenses low. She typically spends around $150 per month in utilities, though heat in the winter can add another $80 per month. She pays $93 per month for car insurance. She also spends approximately $100 on food each month, and regularly attends a church where they provide free meals, because she cannot afford to spend more money on food.

176. In October 2019, Ms. Yakovchik received a letter from the State informing her that she would have to comply with the work requirements.

177. It would be challenging for Ms. Yakovchik to comply with the work requirements because she does not regularly work 80 hours each month as a substitute teacher. She is afraid that she will have to give up being a substitute teacher and try to find a different job if she has to comply with the work requirements. There are not many jobs or volunteer opportunities close to her house, and she is concerned about her ability to drive long distances.

178. Shortly after she received the letter, she called the Michigan Department of Health and Human Services and requested an exemption based on her medical conditions. She was told that she will not know whether she is exempt until sometime in December, right before the requirements go into effect January 1, 2020. She does not expect she will have enough time to make other arrangements if her exemption request is denied.

179. The uncertainty about whether she will have Medicaid coverage in the future is causing Ms. Yakovchik severe stress and anxiety, which is exacerbating her health conditions and is currently making it harder for her to work more shifts.

180. If she loses Medicaid coverage, Ms. Yakovchik's health will deteriorate and she will be unable to pay for the treatment she needs. She believes that without her Medicaid coverage she might as well make her final arrangements.

181. If Ms. Yakovchik had known about the Dear State Medicaid Director letter, she would have wanted to submit a comment to explain that she does not think it is right that she is at risk of losing health coverage because she has health conditions that make it hard for her to work. She also would have explained that the work requirements are especially hard for people like her who rely on part-time work to survive and that access to health care is incredibly important to her because it allows her to be healthy enough to work, contribute to society, and live her life.

182. **Plaintiff Jamie Arden** is 42 years old. She lived in Flushing, Michigan until recently when she had to flee her boyfriend's house due to domestic violence. She is currently homeless.

183. Ms. Arden has two children, ages 10 and 18. They are living temporarily with their father until Ms. Arden finds stable housing.

184. Ms. Arden has a master's degree in social work and is a licensed social worker. She recently started a new job as a social worker on an independent contractor basis. She is providing outpatient therapy to patients suffering from bipolar disorder, schizophrenia, depression, and other mental health conditions. She makes $35 per hour. Although she is contracted to work 40 hours per week, she only works and is paid when she has appointments scheduled and her clients show up for their appointments. For instance, one week in November 2019, she had one day with no

scheduled appointments and another day where patients only completed four out of seven scheduled appointments.

185. She was hoping to earn between $2,000 and $3,000 per month, but given the variability in her schedule, it is unlikely this will happen.

186. Her new job does not provide health insurance.

187. She has been enrolled in the Healthy Michigan Plan since 2016. She has been enrolled continuously, except for one time, in 2017, when she did not receive the redetermination paperwork in the mail and was dis-enrolled. At that time, she was recovering from thyroid surgery and was unable to obtain her medications for her thyroid or her anxiety for four days. She was ultimately able to reinstate her coverage by filling out a paper application.

188. Ms. Arden has had a hard time communicating with DHHS in the past. It has sometimes taken her over an hour to reach a caseworker by phone.

189. Ms. Arden has several ongoing health conditions, including skin cancer, thyroid cancer, hyperglycemia, attention deficit hyperactivity disorder, anxiety, severe fatigue, vitamin deficiencies, high calcium levels, fibromyalgia, arthritis, neuropathy, muscle weakness in hands and legs, migraines, and allergies. She treats her conditions with an appropriate diet and medications including Levothyraxine, Duloxetine, Concerta, and allergy medications which are covered by Medicaid.

190. Medicaid also covers her appointments with health care specialists, including an endocrinologist, urologist, psychiatrist, dermatologist, neurologist, optometrist, and an ear, nose, and throat specialist. She also had an outpatient surgery for urology issues earlier in 2019.

191. Ms. Arden received a letter from DHHS indicating that she will be subject to the work requirements beginning January 1, 2020. She believes she should be exempt due to her health

conditions, and because she is currently homeless and has experienced domestic violence. She applied for an exemption with DHHS but was told that she would not know if the request was approved until sometime in December.

192. The uncertainty about whether she will have to comply with the work requirements is causing her anxiety. She is concerned that she will not always be able to complete 20 hours per week, depending on her caseload at work. She is also concerned that she will have difficulty reporting her hours because she has had trouble communicating with DHHS in the past.

193. Ms. Arden is also worried about having to pay premiums if she is able to increase her caseload at work. She understands that the premiums could be up to 5% of her income by October 2020 because she will have been enrolled in HMP for at least 48 months by then.

194. Without Medicaid coverage, Ms. Arden would not be able to afford her medications or appointments with her specialists.

195. If Ms. Arden had known about the Dear State Medicaid Director Letter she would have wanted to submit comments to explain that people need to first be healthy in order to work to be able to meet their basic necessities of food, water and shelter.

196. **Plaintiff Katina Petropoulos** is 39 years old and lives with her aunt in Ann Arbor, Michigan.

197. Ms. Petropoulos grew up in Florida and was placed in foster care at age 14. She was diagnosed with schizophrenia around that time and, over the course of several weeks, was institutionalized in a mental health facility, a specialized foster care home, and another residential facility. She was ultimately placed with her aunt in Michigan when she was 15. She has lived with her aunt ever since.

198. Ms. Petropoulos is not currently working. Her mental illness makes it difficult for her to work. In the past, she has had a few steady jobs that did not last. She worked during the elections in the local polling places, as a home health aide, the head cleaner in a mall, and as an office cleaner. Her most recent job was cleaning offices for ACP Facility Services. She has applied for multiple jobs but has not found a position. She finds the process very difficult.

199. She has no income. Her mother sends money to her aunt to cover rent and her boyfriend will sometimes help her pay for things, like gas for her car. Every month it is a struggle to make ends meet.

200. She applied for Social Security Disability Insurance in 2017 and was denied. She requested a hearing, which was scheduled for the summer of 2019. She was unable to find an attorney, however, and ultimately withdrew her appeal.

201. She relies on Medicaid to cover annual physical exams, blood work, mental health treatment, and treatment as needed when she gets sick. It also covers her prescriptions and appointments with a therapist twice a month.

202. Sometime in the fall, Ms. Petropoulos received a letter from DHHS stating that she would have to comply with the work requirements beginning January 1, 2020. She did not understand the letter, so she went to her local DHHS office to find out more about it.

203. Ms. Petropoulos knows that she will not be able to meet the work requirements. She has applied for many jobs and gone on interviews but has not been offered a job. Volunteering is difficult for the same reasons that keeping a job is a struggle; she has a hard time keeping a schedule and doing what is asked of her.

204. She thinks she applied for an exemption when she went to DHHS after receiving the letter, but is not sure. She has not heard anything back from DHHS about the exemption and she is worried she might not qualify because she is not getting Social Security disability benefits.

205. The uncertainty about her Medicaid coverage is causing stress and anxiety. She is worried that she will lose her Medicaid coverage. Without coverage she will not be able to get medical care or her prescriptions and is anxious about what would happen if she gets sick.

206. She also would not be able to afford to see her therapist. Although she has not been institutionalized since she was a teenager, she is worried that without being able to see her therapist, her mental health could deteriorate and she could need institutionalization again.

207. Had Ms. Petropoulos known about the Dear State Medicaid Director Letter, she would have wanted to submit comments to explain that she wants to work and has worked in the past, but had a very hard time keeping a job because her mental health interferes. She would have wanted to say that she is doing her best and it is not fair to take away her health coverage.

CLAIMS FOR RELIEF

COUNT ONE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (DEAR STATE MEDICAID DIRECTOR LETTER)

208. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

209. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

210. The HMP Amended Extension Application Approval was based in substantial part on the policy announced in the January 11, 2018 Dear State Medicaid Director Letter. 2018 Approval Letter at 2, 4.

211. The Dear State Medicaid Director Letter was required to be, but was not, issued through notice and comment rulemaking. *See* 5 U.S.C. § 553.

212. In issuing the Dear State Medicaid Director Letter, the Defendants purported to act pursuant to Section 1115 of the Medicaid Act.

213. Authorization of work and community engagement requirements is categorically outside the scope of the Secretary's Section 1115 waiver authority.

214. In the Dear State Medicaid Director Letter, the Defendants relied on factors that Congress has not intended them to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for their decision that runs counter to the evidence.

215. The Defendants' issuance of the Dear State Medicaid Director Letter exceeded the Secretary's Section 1115 waiver authority, otherwise violated the Medicaid Act, and was arbitrary and capricious and an abuse of discretion.

COUNT TWO: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (PROJECT AS A WHOLE)

216. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

217. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

218. In approving the HMP Amended Extension Application, the Secretary purported to waive various requirements of the Medicaid Act pursuant to Section 1115.

219. The approved project is not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

220. In approving the project, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

221. The Secretary's approval of the HMP Amended Extension Application exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and was arbitrary and capricious and an abuse of discretion.

COUNT THREE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (WORK AND COMMUNITY ENGAGEMENT REQUIREMENTS)

222. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

223. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

224. In approving the work requirements of the HMP Amended Extension Application, the Secretary purported to waive 42 U.S.C. § 1396a(a)(8) and (a)(10) pursuant to Section 1115.

225. Authorization of work and community engagement requirements is categorically outside the scope of the Secretary's Section 1115 waiver authority.

226. In addition, the work requirements in the HMP project are not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

227. In approving the work requirements in the HMP project, the Secretary relied on factors which Congress has not intended it to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for its decision that runs counter to the evidence.

228. The Secretary's approval of the HMP project's work requirements exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and was arbitrary and capricious and an abuse of discretion.

COUNT FOUR: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (PREMIUM, COST SHARING, AND SIMILAR CHARGE REQUIREMENTS)

229. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

230. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

231. In approving the HMP project's average copayments, "monthly contributions," premiums, and associated penalties for failure to pay, the Secretary purported to waive 42 U.S.C. §§ 1396a(a)(10)(B), (a)(17), and (a)(14) pursuant to Section 1115.

232. The Secretary's approval of these components is not authorized by the Medicaid Act. 42 U.S.C. §§ 1396o, 1396o-1.

233. The Secretary's approval of these components is categorically outside the scope of the Secretary's Section 1115 waiver authority.

234. In addition, the Secretary's approval of these components is not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

235. In approving the average copayments, "monthly contributions," premiums, and associated penalties for failure to pay in the HMP project, the Secretary relied on factors which Congress has not intended it to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for its decision that runs counter to the evidence.

236. The Secretary's approval of these components exceeded his Section 1115 waiver authority, otherwise violated the Medicaid Act, and was arbitrary and capricious and an abuse of discretion.

COUNT FIVE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (HEALTHY BEHAVIOR REQUIREMENTS)

237. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

238. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

239. In approving the healthy behavior requirements as a condition of eligibility for the HMP project, the Secretary purported to waive 42 U.S.C. § 1396a(a)(8) and (a)(10) pursuant to Section 1115.

240. Termination of Medicaid coverage for failing to successfully complete healthy behavior requirements is categorically outside the scope of the Secretary's Section 1115 waiver authority.

241. In addition, the healthy behavior requirements in the HMP project are not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

242. In authorizing Michigan to terminate coverage for individuals failing to complete healthy behaviors as set forth in the HMP project, the Secretary relied on factors Congress has not intended it to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for its decision that runs counter to the evidence.

243. The Secretary's approval of the project's termination of Medicaid coverage for failing to complete healthy behavior requirements exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and was arbitrary and capricious and an abuse of discretion.

COUNT SIX: VIOLATION OF THE TAKE CARE CLAUSE, ARTICLE II, SECTION 3, CLAUSE 5

244. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

245. Plaintiffs have a non-statutory right of action to have enjoined and declared unlawful official action that is ultra vires.

246. The United States Constitution provides that "All legislative Powers herein granted shall be vested in a Congress of the United States." U.S. Const., art. I, § 1. Congress is authorized to "make all laws which shall be necessary and proper for carrying into Execution" its general powers. *Id.* §§ 1, 8.

247. The Defendants' actions, as described herein, seek to undermine the ACA, including its expansion of Medicaid, and represent a fundamental alteration to those statutes.

248. After a federal law is duly enacted, the President has a constitutional duty to "take Care that the Laws be faithfully executed." *Id.* art. II, § 3.

249. The Take Care Clause is judicially enforceable against presidential action that undermines statutes enacted by Congress and signed into law. *See, e.g., Angelus Milling Co. v. Comm'r*, 325 U.S. 293, 296 (1945) ("Insofar as Congress has made explicit statutory requirements, they must be observed and are beyond the dispensing power of [the Executive Branch]."); *Kendall v. United States ex rel. Stokes*, 37 U.S. (12 Pet.) 524, 612-13 (1838).

250. The Take Care Clause limits the power of the President and the officers he personally appoints, including Defendant Azar, and ensures that the President and his officers will faithfully execute the laws that Congress has passed.

251. Under the Constitution, the President and his officers lack the authority to rewrite congressional statutes or to direct federal officers or agencies to effectively amend the statutes he is constitutionally required to execute.

252. The Secretary has expressed his intention to "oversee the next great generation of transformation in Medicaid."

253. The power to "transform" a congressional program is a legislative power vested in Congress. An effort to "transform" a statute outside that legislative process is at odds with the President's constitutional duty to take care that the laws be faithfully executed.

254. The Medicaid population targeted by the HMP project is the expansion population, which Congress added to Medicaid by passing the Affordable Care Act. The Executive Branch has repeatedly expressed its hostility to the Affordable Care Act and its desire to undermine its operation. An effort to undermine the Affordable Care Act by undoing the extension of Medicaid to the expansion population is at odds with the President's duty to take care that the laws be faithfully executed.

255. The President's Executive Order set out herein directs agencies to take action contrary to the ACA, Medicaid, and other laws passed by Congress.

256. The Defendants' actions, as described herein, followed that Executive Order.

257. The Defendants' actions, as described herein, seek to redefine the purposes and objectives of the Medicaid Act, including through the approval of the HMP Amended Extension Application represent a fundamental alteration of Medicaid.

258. The Defendants' actions, as described herein, seek to undermine the ACA, including its expansion of Medicaid, and represent a fundamental alteration to those statutes.

259. The Defendants' actions are in violation of the Take Care Clause and are ultra vires.

260. Plaintiffs will suffer irreparable injury if the Secretary's actions following the President's Executive Order are not declared unlawful and unconstitutional because those actions have injured or will continue to harm Plaintiffs.

261. Plaintiffs are in danger of suffering irreparable harm and have no adequate remedy at law.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully ask that this Court:

1. Certify this case as a class action pursuant to Federal Rule of Civil Procedure 23(a) and (b)(2);
2. Declare that Defendants' issuance of the Dear State Medicaid Director Letter violates the Administrative Procedure Act, the Social Security Act, and the United States Constitution in the respects set forth above;

3. Declare that Defendants' approval of the Michigan HMP Amended Extension Application violates the Administrative Procedure Act, the Social Security Act, and the United States Constitution in the respects set forth above;

4. Preliminarily and permanently enjoin Defendants from implementing the practices purportedly authorized by Dear State Medicaid Director Letter and the approval of the Michigan HMP Amended Extension Application;

5. Award Plaintiffs their reasonable attorneys' fees and costs pursuant to 28 U.S.C. § 2412; and

6. Grant such other and further relief as may be just and proper.

November 22, 2019

Respectfully submitted,

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Exhibit A

Section 1115 Demonstration Extension Application

Healthy Michigan Plan
Project No. 11-W-00245/5

Submission Date: December 6, 2017
AMENDED: JULY 9, 2018

State of Michigan
Rick Snyder, Governor

Nick Lyon, Director
Michigan Department of Health and Human Services
333 S. Grand Avenue
Lansing, MI 48913

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Section I – Executive Summary

The Michigan Department of Health and Human Services (MDHHS) respectfully requests approval to extend its highly successful Healthy Michigan Plan demonstration waiver. Michigan has a proven record of efficiently managing health care costs and improving the State's Medicaid program. As part of these efforts, MDHHS implemented the Michigan Medicaid expansion program, known as the Healthy Michigan Plan (HMP) administered under the §1115 Demonstration Waiver authority (Project No. 11-W-00245/5) on April 1, 2014. Through HMP, MDHHS has extended health care coverage to over ~~650,000~~ 1,000,000 low-income Michigan residents who were previously either uninsured or underinsured. HMP is built upon systemic innovations that improve quality and stabilize health care costs. Other key program elements include: (a) the advancement of health information technology, (b) structural incentives for healthy behaviors and personal responsibility, (c) encouraging use of high value services, and (d) promoting the overall health and well-being of Michigan residents.

HMP is predicated on the establishment of the Healthy Behaviors Incentives Program and the MI Health Account (MIHA) which support beneficiary participation in healthy behaviors and awareness of personal health care utilization costs. The Healthy Behaviors Incentives Program encourages beneficiaries to achieve and maintain healthy behaviors in collaboration with their primary care providers, primarily through completion of a standardized Health Risk Assessment (HRA) and attesting to a healthy behavior. All HMP beneficiaries enrolled in Medicaid Health Plans (MHPs) have the opportunity to earn program incentives which are applied consistently across the participating plans.

HMP also implements innovative approaches to beneficiary cost-sharing and financial responsibility for health care expenses. For the subset of HMP beneficiaries with an income above 100% of the federal poverty level (FPL), there is a requirement to pay monthly contributions toward the cost of their health care. The MIHA is a vehicle to collect cost sharing and also serves to increase beneficiary awareness of health care costs and promote engagement in their health service utilization.

On December 17, 2015, the Centers for Medicare & Medicaid Services (CMS) approved an amendment to the HMP Demonstration Waiver which was referred to as the "Marketplace Option." Beneficiaries who were scheduled to be impacted by that amendment were those:

- With income above 100% of the FPL,
- Enrolled in an MHP for twelve (12) consecutive months or more,
- Who did not complete a healthy behavior,
- Who ~~are~~ were not medically frail in accordance with 42 CFR 440.315, and
- Who ~~are~~ were not exempt from premiums and cost-sharing pursuant to 42 CFR 447.56

~~These beneficiaries will be transferred to the Marketplace Option beginning April 1, 2018. Marketplace Option enrolled beneficiaries will be receiving their health coverage through the Marketplace issuers.~~

~~At this time, MDHHS is not seeking any additional program changes with this demonstration renewal application request. With the approval of an extension of the HMP waiver, which is currently set to expire on December 31, 2018, MDHHS seeks to continue to build on program successes.~~

Through this demonstration extension application process, MDHHS seeks to amend certain elements of the HMP to comply with Public Act 208 of 2018. Specifically, MDHHS seeks approval to amend the HMP waiver eligibility coverage and cost-sharing requirements applicable to individuals between 100% and 133% of the FPL who have had 48 months of cumulative eligibility coverage through HMP. MDHHS also seeks provisions to address exemptions related to cost-sharing, medically frail individuals, and beneficiary hardship. Additionally, MDHHS seeks to add workforce engagement requirements as a condition of HMP eligibility for able-bodied adults ages 19 to 62. The intent of adding workforce engagement requirements to the medical assistance program is to assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from governmental interference. Finally, MDHHS seeks to end the Marketplace Option benefit.

In furtherance of Medicaid program objectives, Michigan seeks to promote work and community engagement and provide incentives to beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work. Approval of this demonstration extension application request would allow the State of Michigan to continue to provide comprehensive health care coverage while incorporating new innovative approaches and structural incentives to increase beneficiary engagement in healthy behaviors and to promote personal responsibility in maintaining health care coverage. Furthermore, approval of an extension of the HMP waiver, which is currently set to expire on December 31, 2018, allows MDHHS to continue to build on program successes.

Approval for this extension amendment request is being sought effective January 1, 2019 with up to 6 months to implement the 48 months of cumulative coverage change in cost-sharing and healthy behaviors, and up to 12 months to implement the workforce engagement provisions.

Section II – Program History and Overview

A. HMP Program History

In January 2004, the State of Michigan's Adult Benefits Waiver (ABW) was approved by CMS as a §1115 Demonstration Waiver. The ABW program provided a limited ambulatory benefit package to low-income, childless adults between the ages of 19-64, with incomes at or below 35% FPL and who were not otherwise eligible for Medicaid. The programmatic goals for the ABW demonstration were to improve the access and quality of appropriate healthcare services.

The Michigan legislature passed Public Act 107 of 2013, which permitted MDHHS to augment its ABW program by expanding the eligibility criteria for this adult population overall, from 35% to 133% of the FPL, utilizing the Modified Adjusted Gross Income (MAGI) methodology.

Concurrently, program benefits were expanded to include all federally mandated Essential Health Benefits (EHBs) under an Alternative Benefit Plan (ABP) State Plan Amendment. In December 2013, CMS approved the state's request to amend the ABW waiver, which was subsequently renamed HMP. HMP was implemented on April 1, 2014.

In September 2015, MDHHS sought CMS approval of a second HMP waiver amendment to implement additional directives contained in the state law (Public Act 107 of 2013). The request was made to continue the provision of affordable and accessible health care coverage for approximately 600,000 Michigan residents receiving HMP benefits at that time. CMS approved the second waiver amendment on December 17, 2015, which effectuated the Marketplace Option program updates.

The Marketplace Option amendment provided that beneficiaries with incomes greater than 100% of the FPL who had been enrolled in an HMP health plan for 12 consecutive months could be required to receive their health benefits through the Marketplace Option if they had not completed a healthy behavior. ~~As required by state law, individuals who determined medically frail in accordance with 42 CFR 440.315 not eligible for the Marketplace Option. Details on MDHHS' three-pronged strategy for the identification of these individuals detailed in the HMP Marketplace Option Protocol included in the HMP §1115 Demonstration Waiver Special Terms and Conditions. Additionally, individuals exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 exempt from the Marketplace Option..~~

In June 2018, Governor Snyder signed into law Public Act 208 of 2018. PA 208 of 2018 directs MDHHS to seek new innovative approaches in administering the HMP with the goal of removing health related obstacles inhibiting or prohibiting enrollees from achieving their highest level of personal productivity. Through the implementation of these new activities, it is believed that the changes will more effectively encourage beneficiaries to engage in healthy behaviors and increase awareness of personal responsibility. A copy of PA 208 of 2018 is included as Attachment M.

~~The transition of the HMP beneficiaries who qualify for the Marketplace Option will begin on April 1, 2018. Beneficiaries enrolled in the Marketplace Option will receive the health benefits in accordance with the Marketplace Option ABP. Beneficiaries who do not qualify for the Marketplace Option will continue to receive their health benefits through HMP managed care.~~

B. HMP Goals & Objectives

The overarching goals of the HMP Demonstration are to increase access to quality health care, encourage the utilization of high-value services, promote beneficiary adoption of healthy behaviors, and implement evidence-based practice initiatives. Organized service delivery systems are utilized to improve coherence and overall program efficiency.

MDHHS' initial and continued goals for HMP include:

- Improving access to healthcare for uninsured or underinsured low-income Michigan residents;

- Improving the quality of healthcare services delivered;
- Reducing uncompensated care;
- Encouraging individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Assisting, encouraging, and preparing an able-bodied adult for a life of self-sufficiency and independence;
- Helping uninsured or underinsured individuals manage their health care issues;
- Encouraging quality, continuity, and appropriate medical care; and
- Studying the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
    - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
    - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
    - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
    - The extent to which beneficiaries feel that HMP has a positive impact on personal health outcomes and financial well-being.
    - Whether a possible suspension of HMP eligibility coverage encourages beneficiaries to complete a healthy behavior and comply with the cost-sharing requirements;
    - The extent to which workforce engagement requirements impact individuals who transition from Medicaid obtain employer sponsored or other health insurance coverage and how such transitions affect health and well-being.

C. HMP Program Overview

1. Eligibility

HMP targets individuals who are eligible in the new adult group under the State Plan.

Table 1: Eligibility				
Medicaid State Plan Group Description	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure Group Reporting Name**	**Demonstration Specific Name**
Adults 19 through 64 described in §1902(a)(10((A)(i)(VIII), except as specifically excluded.	Income up to 133% FPL receiving ABP benefits, not disabled and not pregnant.	Title XIX	Healthy MI Adults	Healthy Michigan Plan (Project No. 11-W-00245/5)

As part of this extension application for HMP, MDHHS seeks approval to continue certain demonstration provisions for individuals with an income at or below 100% of the FPL. In addition, the state seeks to amend the HMP waiver eligibility and cost-sharing requirements for individuals with income between 100% and 133% of the FPL as described below:

a) *Beneficiaries with an income at or below 100% of the FPL*

HMP beneficiaries who are at or below 100% of the FPL will continue to have eligibility coverage and cost-sharing responsibilities consistent with the process outlined in the Operational Protocol for the MI Health Accounts and the Healthy Behaviors Incentives Program Protocol, included as attachments C and D.

b) *Beneficiaries with an income between 100% and 133% of the FPL*

(1) After 48 months of HMP Eligibility Coverage

In order to maintain eligibility for HMP, individuals with an income between 100% and 133% of the FPL who have had 48 months of cumulative HMP eligibility coverage must:

- Complete or commit to an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and
- Pay a premium of 5% of their income (no copays required), not to exceed limits defined in 42 CFR 447.56(f).

After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost sharing reductions and their MI Health Account will no longer be utilized for cost sharing liabilities.

(2) Suspension of Eligibility Coverage

Beneficiaries who have not met the program's healthy behavior or cost-sharing requirements will be notified 60 days before the end of their 48th month that their coverage under the HMP program will be ending. Their HMP eligibility will be suspended until the individual comes into compliance with the healthy behavior and cost-sharing requirements, at which point they will be re-enrolled the first day of the next available month.

(3) Medically Frail Exemption

Individuals described in 42 CFR 440.315 will be exempt from the 48 months cumulative enrollment suspension of coverage and from the 5% premium provision. Individuals will be given the option to self-report his or her medically frail status as

indicated in the Medically Frail Identification Process document included as Attachment L.

(4) Cost-Sharing Exempt Status

Individuals who are exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 will be exempt from the 48 months cumulative enrollment suspension of coverage provision and will remain in HMP. This includes, but is not limited to, pregnant women, Native Americans, and children under 21 years of age. In the event an individual's exemption status changes (e.g. they turn 21 years old), he or she will be required to maintain compliance with HMP healthy behavior and cost-sharing requirements, assuming other eligibility criteria are met.

(5) Hardship Exemption

MDHHS will consider hardship exemptions for the following:

- Cost-sharing responsibilities
- Suspension of coverage

Examples of hardship exemptions may include the birth or death of a family member living with the beneficiary, a family emergency or other life changing event (divorce, domestic violence, etc.), or a temporary illness or injury.

2. Benefits

All beneficiaries covered by HMP are eligible for comprehensive services consistent with the ABP as described in the Medicaid State Plan. These benefits include the federally mandated 10 EHBs and many additional services which align with state plan services, such as dental, hearing aids, and vision services.

~~The Marketplace Option enrollees will also have access to the 10 EHBs in accordance with the Affordable Care Act and its implementing regulations. Enrollees will receive coverage of these EHBs from the defined Marketplace issuer provider network. All participating issuers must meet the network and service area requirements as required by the Michigan Department of Insurance and Financial Services (DIFS), including all essential community provider requirements specified by CMS.~~

3. Cost-Sharing

All HMP beneficiaries are required to adhere to the cost-sharing requirements outlined in the MIHA protocol. The HMP has a unique MIHA vehicle where beneficiary cost-sharing requirements are satisfied, monitored and communicated to the beneficiary. Moreover, HMP incorporates the Healthy Behaviors Incentives Program which was created to reward beneficiaries for their conscientious use of health care services. Incentives, which are defined in the waiver protocol, include both reductions in cost-sharing responsibilities and select financial

rewards. Participating HMP beneficiaries who are enrolled in an MHP may earn incentives on the basis of their active, appropriate participation in the health care delivery system. After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost-sharing reductions related to healthy behavior completion incentives.

Beneficiaries who are exempt from cost-sharing requirements by law, regulation, or program policy will be exempt from cost-sharing obligations via the MI Health Account (e.g. individuals receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, Native Americans in compliance with 42 CFR 447.56, etc.). Similarly, services that are exempt from cost sharing by law, regulation or program policy (e.g. preventive and family planning services), or as defined by the State's Healthy Behaviors Incentives Program Protocol, will also be exempt for HMP beneficiaries. Beneficiaries who are at or below 100% of the FPL will continue to pay cost-sharing consistent with the process outlined in the Operational Protocol for the MI Health Accounts.

The HMP program has undergone some positive changes based on stakeholder and evaluator input over the course of MDHHS' experience with HMP. Some changes, such as revisions to the MIHA statement, have been implemented to improve beneficiary understanding of cost-sharing responsibilities. Other changes, such as revisions to the program HRA tool and submission process, seek to increase the promotion of beneficiary engagement in the Healthy Behavior Incentive Program. The program has also expanded the scope of services and medications associated with chronic medical condition which are deemed exempt from cost-sharing as a way to reduce any potential financial barriers to important primary care.

4. Delivery Systems

Services for HMP beneficiaries are provided through a managed care delivery system. ~~After April 1, 2018, when HMP has been operational for 48 months, beneficiaries with incomes above 100% of the FPL will receive services through either an HMP Medicaid Health Plan (MHP) or the Marketplace Option.~~

~~Healthy Michigan Plan~~

All HMP eligible beneficiaries are initially mandatorily enrolled into a Medicaid Health Plan (MHP), with the exception of those few beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria.

MDHHS utilizes two different types of managed care plans to provide the HMP ABP for the HMP demonstration population:

- Comprehensive Health Plans: The State's contracted MHPs provide acute care, physical health services and most pharmacy benefits.

- Behavioral Health Plans: Prepaid Inpatient Health Plans (PIHPs) provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration.

~~Individuals who are enrolled in HMP on or after April 1, 2018, or who come into the higher income level (above 100% of the FPL) on or after April 1, 2018, will have one year of enrollment in HMP in order to allow time for completion of healthy behaviors before alternative contributions and cost sharing are applicable.~~

~~Marketplace Option~~

~~The Marketplace Option will be effective as of April 1, 2018, with monthly rolling enrollment thereafter. HMP beneficiaries who have incomes above 100% of the FPL and have not completed the healthy behavior requirements of the Healthy Behaviors Incentive Program must transition to the Marketplace Option, absent an applicable exception such as medical frailty, as outlined in the Marketplace protocol.~~

~~MDHHS will also provide or arrange for wrap-around benefits that are included in the Marketplace ABP but not covered by the Marketplace issuers. These benefits, covered as Fee-For-Service, are non-emergency medical transportation (NEMT); family planning services and supplies including access to out-of-network family planning providers; and access to Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services.~~

5. Workforce Engagement Requirements

Beginning January 1, 2020, MDHHS seeks to implement workforce engagement requirements for able-bodied adults as a condition of eligibility consistent with PA 208 of 2018. Once implemented, beneficiaries who are between the ages of 19-62 must work or engage in specified educational, job training, or community service activities for at least 80 hours per month to remain covered through the HMP unless they qualify for an exemption. HMP beneficiaries who are subject to workforce engagement requirements will be required to demonstrate that they are meeting the requirements through monthly verification. Beneficiaries who fail to meet the requirements will have their HMP coverage suspended until they comply.

Workforce engagement requirements include the following:

- Participation in an average of 80 hours per month of qualifying activities or a combination of any qualifying activities; and
- Self-attestation of compliance with, or exemption from, workforce engagement requirements to MDHHS on a monthly basis

The following is the list of qualifying activities:

- Employment, self-employment, or having income consistent with being employed or self-employed (makes at least minimum wage for an average of 80 hours per month);
- Education directly related to employment (including, but not limited to, high school equivalency test preparation, postsecondary education);
- Job training directly related to employment;
- Vocation training directly related to employment;
- Unpaid workforce engagement directly related to employment (including, but not limited to an internship);
- Tribal employment programs;
- Participation in a substance use disorder treatment (court ordered, prescribed by a licensed medical professional, or a Medicaid-funded Substance Use Disorder (SUD) treatment;
- Community service completed with a non-profit 501(c)(3) or 501(c)(4) organization (can only be used as a qualifying activity for up to 3 months in a 12-month period); and
- Job search directly related to job training.

A beneficiary is allowed three months of noncompliance within a 12-month reporting period. After three months of noncompliance, a beneficiary who remains noncompliant will not receive coverage for at least one month and will be required to come into compliance before coverage is reinstated. If a beneficiary is found to have misrepresented his or her compliance with the workforce engagement requirements as identified in PA 208 of 2018, he or she shall not be allowed to participate in the HMP for a one-year period.

The following individuals are exempt from workforce engagement requirements:

- A caretaker of a family member under 6 years of age (only one parent at a time can claim this exemption);
- Beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government;
- Full-time student who is not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid;
- Pregnant women;
- A caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order (this exemption is allowed one time per household);
- A caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker;
- Beneficiaries who have proven they meet a good cause temporary exemption (as defined in PA 208 of 2018);
- Beneficiaries designated as medically frail;
- Beneficiaries with a medical condition that results in a work limitation according to a licensed medical professional order;
- Beneficiaries who have been incarcerated within the last 6 months;

- Beneficiaries currently receiving unemployment benefits from the State of Michigan; and
- Beneficiaries under 21 years of age who had previously been in foster care placement in this state.

Additionally, beneficiaries in compliance with or exempt from the work requirements of the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families Program are deemed compliant with or exempt from the workforce engagement requirements outlined above. Additional reporting will not be required.

Individuals described in 42 CFR 440.315(f) will be exempt from the workforce engagement requirements. Individuals will be given the option to self-report his/ her medically frail status as indicated in the Medically Frail Identification Process document found in Attachment L.

MDHHS shall enforce the provisions of this section by conducting the compliance review process on medical assistance recipients under HMP who are required to meet the workforce engagement requirements of this section. If an individual is found, through the compliance review process, to have misrepresented his or her compliance with the workforce engagement requirements in this section, he or she shall not be allowed to participate in the HMP for a one-year period.

Section III – Waivers and Expenditure Authorities

A. Waiver Authorities

MDHHS requests the ~~continuation of the~~ following waivers of state plan requirements contained in §1902 of the Social Security Act, subject to the Special Terms & Conditions for the HMP §1115 Demonstration:

- *Premiums, § 1902(a)(14), insofar as it incorporates § 1916 and 1916A* - To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have income between 100 and 133 percent of the FPL.

- *State-wideness § 1902(a)(1)* - To the extent necessary to enable the state to require enrollment in managed care plans only in certain geographical areas for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.

- *Freedom of Choice § 1902(a)(23)(A)* - To the extent necessary to enable the state to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act. No waiver of freedom of choice is authorized for family planning providers.

- *Proper and Efficient Administration § 1902(a)(4)* - To enable the State to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.

- *Comparability § 1902(a)(17)* - To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in the terms and conditions.

- ~~*Payment of Providers §§ 1902(a)(13) and 1902 (a)(30)* - To the extent necessary to permit the state to limit payment to providers for individuals enrolled in the Marketplace Option to amounts equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services under the Marketplace Option.~~
- ~~*Prior Authorization § 1902(a)(54), as it incorporates §1927(d)(5)* - To permit the state to require that requests for prior authorization for drugs in the Marketplace Option be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.~~

- *Provision of Medical Assistance §1902(a)(8) and § 1902(a)(10)* - To the extent necessary to enable the state to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with healthy behavior incentive program or workforce engagement requirements unless the beneficiary is exempted.

- *Eligibility §1902(a)(10) or § 1902(a)(52)* - To the extent necessary to enable the State to prohibit re-enrollment, and deny eligibility, for beneficiaries with income above 100 percent of the FPL who are disenrolled for failure to complete a healthy behavior and cost-sharing requirements, subject to the exceptions and qualifying events described herein.

- *Reasonable Promptness §1902(a)(3) and § 1902(a)(8)* - To the extent necessary to enable the State to prohibit re-enrollment for up to one year for HMP beneficiaries who are disenrolled for falsely reporting workforce engagement requirements, an exemption qualification, or for any other actions that would fall under the definition of Medicaid fraud.

B. Expenditure Authorities

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- Expenditures for Healthy Behaviors Program incentives that offset beneficiary cost sharing liability.
- ~~Expenditures for part or all of the cost of private insurance premiums, and for payments to reduce cost sharing, for individuals enrolled in a Marketplace issuer health plan through the Marketplace Option, to the extent that such expenditures do not meet cost effectiveness requirements or include amounts for benefits that are not otherwise covered under the approved state plan (but are incidental to coverage of state plan benefits).~~
- ~~To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.~~

Section IV – Reporting

MDHHS has routinely documented the progress of HMP since its inception in 2014 and submits quarterly and annual reports to CMS. These reports can be found at www.medicaid.gov. MDHHS also contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare annual technical reports on the quality and timeliness of, and access to, care furnished by the state's MHPs. The quality and performance reports can be found at: http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860---,00.html.

MDHHS completes Performance Monitoring Reports (PMR) for all MHPs that were licensed and approved to provide coverage to Michigan's Medicaid beneficiaries during reporting periods. These reports are based on data submitted by the MHPs and include the following items: grievance and appeal reporting; a log of beneficiary contacts; financial reports, encounter data; pharmacy encounter data; provider rosters; primary care provider-to-member ratio reports; and access to care reports.

MDHHS developed HMP Performance Monitoring Specifications beginning with the initiation of the program in 2014. Many of the measures for fiscal year (FY) 2015 were informational as MDHHS refined its data collection and analysis process. Performance standards were set for these measures in FY 2016 and will continue in FY 2017 and beyond. Performance areas include Adult Access to Ambulatory Health Services, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Generic Drug Utilization, Plan All-Cause Acute 30-Day Readmissions, and Timely Completion of Initial Health Risk Assessment. Please see Attachment A for the full PMR and EQRO reports.

Section V – Program Financing

MDHHS expects the annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time.

Historical HMP demonstration expenditures for all eligible groups are included in the budget neutrality monitoring table below as reported in the CMS Medicaid and Children's Health Insurance Program Budget and Expenditure System. Total expenditures include those that both occurred and were paid in the same quarter in addition to adjustments to expenditures paid in quarters after the quarter of service. HMP demonstration expenditures have historically remained under per-member-per-month (PMPM) budget neutrality limits as defined by the demonstration special terms and conditions. The following table includes expenditures and member months by demonstration year (DY) starting April 1, 2014 through June 30, 2017.

Table 2: Healthy Michigan Demonstration Budget Neutrality Monitoring

	DY 5 - 2014	DY 6 - 2015	DY 7 - 2016	DY 8 - 2017
Approved HMP PMPM	$667.36	$602.21	$569.80	$598.86
Actual HMP PMPM (YTD)	$475.72	$480.41	$492.93	$446.22
Total Expenditures (YTD)	$1,776,995,398.00	$3,492,109,239.00	$3,824,569,481.00	$1,839,545,788.00
Total Member Months (YTD)	3,735,411	7,269,012	7,758,811	4,122,536

Healthy Michigan demonstration expenditure and enrollment projections developed by Milliman, Inc., an MDHHS actuarial contractor, are detailed in the following table:

Table 3: Healthy Michigan Demonstration Budget Neutrality Projections					
	DY 9 -2018	**DY 10 - 2019**	**DY 11 - 2020**	**DY 12 - 2021**	**DY 13 - 2022**
Approved HMP PMPM	$629.40	TBD	TBD	TBD	TBD
Projected HMP PMPM	$550.55	$569.30	$588.87	$609.30	$630.64
Projected Expenditures	$4,438,896,588.00	$4,604,748,464.56	$4,778,374,610.65	$4,960,115,373.92	$5,150,547,789.10
Projected Enrollment	8,062,644	8,088,468	8,114,496	8,140,716	8,167,140

Section VI – Evaluation Report

Demonstration Evaluation Activities

The HMP Demonstration Waiver is being independently evaluated by the Institute for Healthcare Policy & Innovation (IHPI) at the University of Michigan. This evaluation began in mid-2014 and will be completed in 2020. A final report will be available in mid-2020. For more information about evaluation activities, timelines, and deliverables, please see Attachment B for the §1115 Demonstration Waiver Amendment Evaluation Plan. This interim evaluation summary provides an overview of the evaluation, presents highlights from work completed to date, and describes the timeline for upcoming reports.

MDHHS will ensure that its evaluation design for the current Section 1115 demonstration is updated to reflect the changes described herein. Specifically, the Department will evaluate how increased cost-sharing impacts utilization as well as the choice of coverage for the subset of beneficiaries affected by the above changes. Updates and additions will also be incorporated into the State's quality strategy as appropriate, and timely and accurate reporting on the implementation process will occur through the State's existing Section 1115 waiver reporting process, consistent with directives from the CMS.

A. Overview

The HMP Demonstration's program objectives and hypotheses, as identified in the waiver Special Terms and Conditions, are being assessed consistent with the CMS-approved evaluation plan. The evaluation examines multiple hypotheses associated with the following ~~seven specific~~ domains:

1. The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;

2. The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
3. Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes;
4. The extent to which beneficiaries believe that HMP has a positive impact on personal health outcomes and financial well-being;
5. Whether requiring beneficiaries to make contributions toward the cost of their health care has an impact on the continuity of their coverage, and whether collecting an average co-pay from beneficiaries in lieu of copayments at the point of service, and increasing communication to beneficiaries about their required contributions (through quarterly statements) affects beneficiaries' propensity to use services;
6. Whether providing an MIHA into which beneficiaries' contributions are deposited, that provides quarterly statements that include explanation of benefits (EOB) information and details utilization and contributions, and allows for reductions in future contribution requirements, deters beneficiaries from receiving needed health services or encourages beneficiaries to be more cost-conscious;
7. ~~Whether the preponderance of the evidence about the costs and effectiveness of the Marketplace Option when considered in its totality demonstrates cost effectiveness taking into account both initial and longer-term costs and other impacts such as improvements in service delivery and health outcomes.~~
8. Whether a possible suspension of HMP eligibility coverage encourages beneficiaries to complete a healthy behavior and comply with the cost-sharing requirements; and
9. The extent to which workforce engagement requirements impact beneficiaries who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being.

B. Overview of Evaluation Methods

As described below, the evaluation uses a wide variety of data sources, including: hospital cost reports; Medicaid enrollment, utilization, and cost data from the MDHHS Data Warehouse; provider survey data; enrollee survey data (the annual Healthy Michigan Voices survey); and interviews with enrollees and providers.

C. Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan

Methods

IHPI conducted 19 semi-structured telephone interviews with PCPs caring for HMP patients in five Michigan regions selected to provide racial/ethnic diversity and a mix of urban and rural communities. Interviews informed the development of survey items and guided the interpretation of survey findings. The evaluation team also surveyed all PCPs in Michigan with ≥12 HMP patients about practice changes and their experiences caring for patients with HMP. The final response rate was 56% with 2,104 respondents.

IHPI calculated descriptive statistics without survey weighting because the cohort included all PCPs with ≥12 HMP patients. Bivariate and multivariable logistic regression analyses assessed

the association of personal, professional and practice characteristics with practice changes reported since Medicaid expansion. Multivariable models and chi-square goodness-of-fit tests calculated. Quotes from PCP interviews have been used to expand upon key survey findings.

Key Findings

Key findings from the Interim Report on Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan (Attachment I ⊂.1) are highlighted below.

Providers expressed varying degrees of familiarity with features of HMP.

- 71% were very/somewhat familiar with completing an HRA.
- 25% reported being very/somewhat familiar with enrollee cost-sharing.
- 36% reported being very/somewhat familiar with healthy behavior incentives for patients.

Most providers reported accepting new Medicaid/HMP patients.

- 78% reported accepting new Medicaid/HMP patients. PCPs who are female, racial minorities, or non-physician PCPs, internal medicine specialists, have salaried income, report a Medicaid predominant payer mix, or previously provided care to the underserved were more likely to report accepting new Medicaid/HMP patients.
- 73% felt a responsibility to care for patients regardless of their ability to pay.
- 72% agreed all providers should care for Medicaid/HMP patients.
- 52% reported an increase in new patients to a great or to some extent.
- 57% reported an increase in new patients who had not seen a PCP in many years.
- 51% reported established patients who had been uninsured gained insurance.
- Most practices hired new clinicians (53%) and/or staff (58%) in the past year.
-

Most providers reported completing Health Risk Assessments.

- 79% completed at least one HRA with a patient; most of those completed >10.
- 65% did not know if they or their practice has received a bonus for completing HRAs.
- 58% reported that financial incentives for patients and 55% reported that financial incentives for practices had at least a little influence on completing HRAs.
- Most PCPs found HRAs useful for identifying and discussing health risks, persuading patients to address important health risks, and documenting behavior change goals.

Providers felt responsibility to decrease non-urgent emergency room (ER) use and identified facilitators and barriers to doing so.

- 30% felt that they could influence non-urgent ER use by their patients a great deal.
- 88% accepted major or some responsibility as a PCP to decrease non-urgent ER use.
- Many reported offering services to avoid non-urgent ER use, such as walk-in appointments, 24-hour telephone triage, weekend and evening appointments, and care coordinators or social work assistance for patients with complex issues.

Providers described positive benefits in terms of access though access challenges remain.

- PCPs with previously uninsured HMP patients reported some or great impact on health, health behavior, health care and function for those patients, particularly for control of chronic conditions, early detection of illness, and improved medication adherence.
- PCPs reported that HMP enrollees, compared to those with private insurance, more often had difficulty accessing specialists, medications, mental health care, dental care, and treatment for substance use and counseling for behavior change.

Providers expressed the many ways HMP had an impact on their patients.

- PCPs noted HMP has allowed patients to get much needed care, improved financial stability, provided a sense of dignity, improved mental health, increased accessibility to care and compliance (especially medications), and helped people engage in healthy behaviors such as quitting smoking.

Limitations

Survey responses were self-reported and may be prone to social desirability bias. The sample included only PCPs who cared for at least 12 HMP enrollees. Decision making regarding acceptance of new patients, practice changes, and experiences of the impact of HMP may differ for PCPs with fewer or no Medicaid patients or for specialists. IHPI developed a set of survey items not used in previous studies to assess PCP attitudes toward various factors related to their Medicaid acceptance decision. These items were developed based on prior literature and the evaluation team's qualitative interviews with PCPs caring for HMP patients and were cognitively tested with physician and non-physician PCPs serving HMP patients to ensure understanding and accuracy of responses. Performance of these items (e.g. whether they predict actual acceptance of HMP/Medicaid patients) should be validated in future studies. Finally, the qualitative interviews were limited to 19 PCPs in select regions of the state.

Conclusions

PCPs shared experiences from within the health system and thus provided valuable information about how Medicaid expansion is playing out for patients and providers. PCPs reported improved detection and management of chronic conditions (such as diabetes and hypertension) in patients who gained coverage due to Medicaid expansion, and better adherence to medical and medication regimens as well as improvements in health behaviors, better ability to work or attend school, and improved emotional well-being.

PCPs reported an increase in new patients, including some who had not sought primary care in many years. They reported hiring clinicians and staff; changing workflow for new patients; co-locating mental health services in primary care; and consulting with care coordinators, case managers, and community health workers.

Coverage for dental services, prescription drugs, and mental health services were specifically noted as previously unmet needs being addressed by HMP. Access to these services were described as "a lifesaver." Yet access to some services remains challenging for enrollees and lags behind access for those with private insurance.

PCPs varied substantially in their understanding of HMP features and, therefore, their ability to navigate or help patients obtain services. PCPs reported general familiarity with HRAs, but less familiarity with enrollee cost-sharing and rewards. Most surveyed PCPs felt they could, and should, influence ER utilization trends for their Medicaid patients.

IHPI survey results and interviews indicate that PCPs believe HMP has improved access to care; detection of serious health conditions; medication adherence; and management of chronic conditions and healthy behaviors – especially for previously uninsured patients.

D. 2016 Healthy Michigan Voices Enrollee Survey

Methods

Sampling for the Healthy Michigan Voices (HMV) enrollee survey was conducted in 2016. At the time of sample selection, inclusion criteria for enrollees included: at least 12 months total HMP enrollment in fee-for-service or managed care, including enrollment in 10 of the past 12 months and managed care enrollment in 9 of the past 12 months, age 19-64, complete Michigan contact information and income level in the MDHHS Data Warehouse, and preferred language of English, Arabic, or Spanish. The sampling plan was based on four state regions (Upper Peninsula/North West/North East; West/East Central/East; South Central/South West/South East; Detroit) and three income categories (0-35%, 36-99%, ≥100% of the FPL). In total, 4,099 HMP enrollees participated in the 2016 HMV survey, and the weighted response rate was 53.7%.

Many survey items were drawn from large national surveys. Items specific to HMP (e.g. about HRAs, understanding of HMP) were developed by the evaluation team based on 67 semi-structured interviews with HMP enrollees. New items underwent cognitive testing and pre-testing before being included in the survey instrument. Responses were recorded in a computer-assisted telephone interviewing (CATI) system. Descriptive statistics with weights were calculated to adjust for selection and nonresponse bias. Bivariate and multivariate analyses were performed.

Key Findings

Key findings from the Interim Report of the 2016 Healthy Michigan Voices Enrollee Survey (Attachment I~~C~~.2) are highlighted below.

Many enrollees did not have insurance prior to HMP.

- 57.9% did not have insurance at any time in the year before enrolling in HMP. About half of those who did have health insurance reported having Medicaid or other state insurance.

Enrollees reported improvements in their health status with HMP.

- 47.8% said their physical health had improved, 38.2% said their mental health had improved, and 39.5% said their dental health had improved since enrolling in HMP.

Many enrollees have chronic health conditions.

- 69.2% reported they had a chronic health condition, with 60.8% reporting at least one physical health condition and 32.1% reporting at least one mental health condition.
- 30.6% reported they had a chronic health condition that was newly diagnosed since enrolling in HMP.

Enrollees expressed their perspectives on HRAs.

- 45.9% of those who said they completed an HRA did so because a PCP suggested it; 33% did so because they received a mailed form; 12.6% completed it by phone at enrollment.
- Most of those who reported completing the HRA felt it was valuable for improving their health (83.7%) and was helpful for their PCP to understand their health needs (89.7%). 80.7% of those who said they completed an HRA chose to work on a health behavior.

Some enrollees reported working on cutting back or quitting tobacco use after HMP.

- 37.7% reported smoking or using tobacco in the last 30 days, and 75.2% of them said they wanted to quit. Of these, 90.7% were now working on cutting back or quitting.

Enrollees were more likely to report a regular source of care after HMP, and less likely to report the ER as their regular source of care.

- 20.6% had not had a primary care visit in five or more years before enrolling in HMP.
- 73.8% said that in the year before enrolling in HMP they had a place they usually went for health care. Of those, 16.8% used an urgent care center, 16.2% used an ER, and 65.1% used a doctor's office or clinic.
- 92.2% reported that in the year since enrolling in HMP they had a place they usually went for health care. Of those, 5.8% said that place was an urgent care center and 1.7% reported the ER, while 75.2% reported a doctor's office or clinic.
- 85.2% of those who reported having a PCP had a visit with their PCP in the last year.
- Those who reported seeing a PCP were more likely to note improved access to preventive care, completing an HRA, health behavior counseling and new diagnoses of a chronic condition since enrollment.

Enrollees reported a reduction in foregone care.

- 33% of enrollees reported not getting care they needed in the year before enrollment in HMP; 77.5% attributed this to cost concerns. Since enrolling in HMP, 5.6% reported foregone care; 25.4% attributed this to cost concerns.
- 83.3% strongly agree or agreed that without HMP they would not be able to go to a doctor.

Enrollees reported on their experiences using the ER for care.

- 28.0% of those who visited the ER in the past year said they called their usual provider's office first. 64% said they were more likely to contact their usual doctor's office before going to the ER than before they had HMP.
- Respondents who used the ER were more likely than those who did not use the ER to report their health as fair/poor (40.1% vs. 23.2%) and to report chronic physical or mental health conditions (79.4% vs. 62.8%).

Enrollees reported on the impact of HMP on employment, education and ability to work.

- 48.9% reported they were employed/self-employed, 27.6% were out of work, 11.3% were unable to work, and 2.5% were retired.
- HMP enrollees were more likely to be employed if their health status was excellent, very good, or good vs. fair or poor (56.1% vs. 32.3%) or if they had no chronic conditions (59.8% vs. 44.1%).
- Among employed respondents, over two-thirds (69.4%) reported that HMP insurance helped them to do a better job at work.
- For the 27.6% of respondents who were out of work, 54.5% strongly agreed or agreed that HMP made them better able to look for a job.
- For the 12.8% of respondents who had changed jobs in the past 12 months, 36.9% strongly agreed or agreed that having HMP insurance helped them get a better job.

Some enrollees were knowledgeable about HMP program features but gaps in knowledge exist.

- The majority of respondents knew that HMP covers routine dental visits (77.2%), eyeglasses (60.4%), and counseling for mental or emotional problems (56%). Only one-fifth (21.2%) knew that HMP covers brand-name as well as generic medications.

Few enrollees reported challenges using their HMP coverage.

- Few (15.5%) survey respondents reported that they had questions or problems using their HMP coverage. Among those who did, about half (47.7%) reported getting help or advice, and most (74.2%) of those said that they got an answer or solution.

Many enrollees reported that problems paying medical bills improved with HMP.

- 44.7% said they had problems paying medical bills in the year before HMP.
- 85.9% said that since enrolling in HMP their problems paying medical bills got better.

Enrollees shared their perspectives on and knowledge about HMP cost-sharing requirements and the MIHA statement.

- 87.6% strongly agreed or agreed that the amount they pay overall for HMP seems fair.
- 88.8% strongly agreed or agreed that the amount they pay for HMP is affordable.
- 68.2% said they received a MIHA statement. 88.3% strongly agreed or agreed they carefully review each statement to see how much they owe. 88.4% strongly agreed or agreed the statements help them be more aware of the cost of health care.
- 75.6% of respondents knew some visits, tests, and medicines have no copays. Only14.4% were aware they could not be disenrolled from HMP for not paying their bill. Only 28.1% were aware they could reduce the amount they owed by completing an HRA.

Limitations

HMV survey responses may be prone to social desirability bias. While the survey was available in three languages, it was not available in all languages spoken by enrollees. While many measures were based on those used in large national surveys, some questions were developed specifically to assess enrollee perspectives on key features of the HMP program.

Conclusions

Three-fifths of respondents did not have insurance at any time in the year before enrolling in HMP and half of those who did were covered by Medicaid or another state program. HMP does not appear to have substantially replaced employer-sponsored insurance.

Most respondents said that without HMP they would not be able to see a doctor. Foregone care, usually due to cost, lessened considerably after enrollment. The percentage of enrollees who had a place they usually went for health care increased significantly with HMP whereas the percentage naming the ER as a regular source of care declined after enrolling in HMP (from 16.2% to 1.7%). There were some areas in which enrollee understanding of coverage (e.g., dental, vision and family planning) and cost-sharing requirements could be improved.

Many HMP enrollees reported improved functioning, ability to work, and job seeking after enrolling in HMP. Chronic health conditions were common among enrollees even though most enrollees were under 50 years old. Almost half of these conditions were newly diagnosed after enrolling in HMP. Overall, HMP enrollees expressed improved access to care, improved health behaviors, better management of chronic conditions, fewer financial barriers to care, and a sense that the amount they pay for HMP seems fair and affordable.

E. Public Act 107 of 2013 §105d(8) 2015 Report on Uncompensated Care

Methods

Each year, Michigan hospitals submit cost reports to the State Medicaid program. Based on data elements contained in these reports, the cost of uncompensated care provided by each hospital can be assessed. The cost reports for state FY 2015 include data on 142 hospitals.

Key Findings

The amount of uncompensated care provided by Michigan hospitals fell substantially after the implementation of HMP. Comparing 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50%. For the average hospital, annual uncompensated care expenses fell from $7.21 million to $3.77 million. As a percentage of total hospital expenses, uncompensated care decreased from 5.2% to 2.9%. Over 90% of hospitals saw a decline in uncompensated care between FY 2013 and FY 2015 (Attachment I~~C~~.3).

Limitations

FY 2015 is the first fiscal year that began after the HMP was in place. Thus, the impact of the HMP is more readily seen by focusing on the 88 hospitals that reported data for 2013 and 2015. In future years, changes in uncompensated care will be examined for all Michigan hospitals.

The full evaluation reports are available at www.michigan.gov/healthymichiganplan.

F. Lessons Learned from IHPI's Evaluation of HMP to Date

Lessons from conducting outreach to HMP enrollees through recruitment for the Healthy Michigan Voices survey:

- To meet the needs of enrollees who are more comfortable speaking Spanish or Arabic, sampling lists were reviewed for names that suggest Hispanic or Arabic ethnicity so that bilingual interviewers could place those calls. This helped put enrollees at ease about the project (e.g. "I only did the survey because you speak Arabic.")
- In the initial HMV survey, many enrollees offered descriptions and anecdotes not captured by fixed-choice or brief response items used with the computer-assisted telephone interview system. For subsequent waves, the evaluation team has asked enrollees if their interview could be recorded and nearly all have agreed, providing additional details about the enrollee experience.

G. Future Evaluation Reports

Domain I: Uncompensated Care
This report will be available in the fall of 2018.

Domain II: Insurance Coverage
Preliminary results from analyses completed thus far:

- The number of uninsured Michigan residents dropped sharply between 2013 and 2015.
- According to data from the U.S. Census Bureau's American Community Survey, the fraction of Michigan's total population that was uninsured was 11.3% in 2013 and 6.7% in 2015. The fraction with Medicaid increased from 19.9% to 23.1% over this period.
- Among non-elderly adults in Michigan (ages 19 through 64), the fraction for uninsured dropped from 16.6% in 2013 to 9.0% in 2015, while the fraction with Medicaid increased from 13.9% to 19.2%.

The full report from this domain will be available in the fall of 2018.

Domain III: Utilization
Interim results were available in the fall of 2017.

Domain IV: Provider and Enrollee Perspectives
Final interim reports for the 2016 HMV survey and Primary Care Provider survey were available at the end of 2017. Reports based on subsequent annual Healthy Michigan Voices surveys will be available in 2018, 2019, and 2020. The report based on interviews with those who are eligible but unenrolled for HMP were available at the end of 2017 and a second report will be completed at the end of 2018.

Domain V/VI: Consumer Behavior
This report will be available in the spring of 2018.

~~*Domain VII: Marketplace Option*~~
~~This report will be available in the spring of 2020.~~

Evaluation Plan for Extension Period

During the extension period, IHPI will continue to field and analyze the data from the Annual HMV Survey. ~~Further, IHPI will conduct the Domain VII – Cost Effectiveness Analysis of the Marketplace Option.~~ For Domain III, IHPI will continue to examine the impact the Healthy Behavior Program's expansion on utilization. Finally, should IHPI continue to provide the Uncompensated Care Analysis as required in PA 107 of 2013, it will contribute to the future assessment of Domain I analysis.

Section VII - Public Notice Process

A. Public Notice, Comment and Hearings Process

For Demonstration Extension Submitted December 6, 2017

MDHHS has been engaged in ongoing discussions with various stakeholders regarding HMP. MDHHS has provided regular updates on the progress of HMP to the Medical Care Advisory Council (MCAC) since the inception of the program. MDHHS began its discussions on the proposed demonstration waiver extension at the MCAC meetings which took place on June 26, 2017 and August 30, 2017. MDHHS extended its public engagement on September 26, 2017 by posting the proposed demonstration waiver extension request on the MDHHS dedicated HMP webpage available at www.michigan.gov/healthymichiganplan. On this webpage, the public was informed about the demonstration waiver renewal process, which included public notice and hearing information and provided opportunities for and instructions on how to submit comments. This is in addition to publishing a public notice in selected newspapers throughout the state on September 29, 2017, which included, among other information, details regarding the proposed demonstration waiver extension, as well as the website, hearing and public comment information. A copy of the notice is included as Attachment H~~D~~.

A public hearing regarding the proposed demonstration waiver extension was be held on October 19, 2017, from 2:00 p.m. – 3:00 p.m. at the Michigan Public Health Institute located at 2436 Woodlake Circle, Suite 380, Okemos, MI 48864. In addition to the notice procedures described above, MDHHS sent email notifications of this event to providers, stakeholders and the media. This public hearing had telephone, webinar and in-person capability (with sign interpretation available for those present). Comments were accepted until October 30, 2017. As required by the existing Special Terms and Conditions, the MDHHS is including a summary of the comments received, with notes of any changes to the proposal, as a result, as Attachment E.

For Demonstration Extension Amendment to be Submitted by October 1, 2018

Additionally, MDHHS began its discussions on the proposed demonstration extension application amendments at the MCAC meeting which took place on June 18, 2018. MDHHS expanded its public engagement by posting the proposed demonstration expansion application amendment request on the MDHHS dedicated HMP webpage available at www.michigan.gov/healthymichiganplan. On this webpage, the public can access the demonstration waiver amendment process, which includes public notice and hearing information and provides opportunities for, and instructions on how to submit, comments. This is in addition to publishing a public notice in selected newspapers throughout the state, which included, among other information, details regarding the proposed demonstration waiver amendment, as well as the website, hearing and public comment information. A copy of the notice is included as Attachment K.

A public hearing regarding the proposed demonstration extension application amendment will be held on July 31, 2018, from 2:00 p.m. – 3:00 p.m. at the Michigan Library and Historical Center located at 702 W Kalamazoo St, Lansing, MI 48915. A second public hearing will be held August 1, 2018 from 2:00 p.m. – 3:00 p.m. at the Cadillac Place located at 3044 West Grand Boulevard Detroit, Michigan. In addition to the notice procedures described above, MDHHS sent email notifications of this event to providers, stakeholders and the media. The public hearing in Lansing will have webinar capability and both public hearings will have telephone capability (with sign interpretation available for those present). As required by the existing Special Terms and Conditions, the MDHHS will include a summary of the comments received, with notes of any changes to the proposal, as a result.

B. Tribal Consultation

Consistent with the State Plan, MDHHS issued a letter on August 16, 2017 notifying the Tribal Chairs and Health Directors of the plan to submit the proposed Demonstration Waiver extension. A copy of the notice is included as Attachment F.

As part of the demonstration extension application amendment process, MDHHS also sent a letter on July 9, 2018 notifying Tribal Chairs and Health Directors of the proposed waiver changes and amended application. A copy of the notice is included as Attachment J.

Additional Tribal Consultation has occurred on the following dates.

- *July 12, 2017 - In person meeting -MI Tribal Health Director's Association Meeting*
- *August 28, 2017 - Quarterly Tribal Health Directors conference call*
- *September 15, 2017 – Pokagon Band of Potawatomi Director of Health Services*
- *October 11, 2017 – Tribal Health Directors Meeting*
- *October 18, 2017 – Tribal Health Directors Conference Call*

C. Post-Award Forums

In accordance with the HMP Waiver Special Terms and Conditions, MDHHS provides continuous updates to the program's MCAC at regularly scheduled meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. A copy of the meeting minutes for the 2016 and 2017 meetings are included as Attachment G.

D. Additional Stakeholder Engagement

MDHHS has also discussed the proposed demonstration waiver extension in additional venues as part of its ongoing outreach and engagement with its stakeholders. The following is a listing of locations and events at which MDHHS addressed the proposed demonstration waiver extension:

- Michigan Association of Local Public Health Administrative Forum, on June 10, 2017, in Lansing, MI
- MDHHS/MHPs Operations Annual Conference, on July 19, 2017, in Acme, MI
- 2017 Michigan Primary Care Association Annual Conference, on July 24, 2017, in Acme, MI
- Michigan Association of Health Plans Meetings, on June 23, 2017 and August 4, 2017, in Lansing, MI
- Durable Medical Equipment Liaison Meeting, on September 11, 2017, in Lansing, MI
- Michigan State Medical Society/Medicaid Quarterly Meeting, September 12, 2017, in Lansing, MI
- Pharmacy Liaison Meeting on September 21, 2017 in Lansing, MI
- Michigan Association of Health Plans on September 29, 2017 in Lansing, MI
- Orthotics and Prosthetics Medicaid Provider Liaison Meeting on October 25, 2017 in Lansing, MI
- MI Marketplace Option Provider Training Webinar on November 7, 2017.
- Pharmacy Liaison Meeting on June 8, 2018, in Lansing, MI
- Durable Medical Equipment Liaison Meeting, June 25, 2018, in Lansing, MI

Attachments

Attachment A:	Monitoring Reports
Attachment B:	Healthy Michigan Plan Evaluation Plan
Attachment C:	Operational Protocol for the MI Health Accounts (Revised July 2018)
Attachment D:	Healthy Behaviors Incentives Program Protocol (Revised July 2018)
Attachment E:	Public Comment Summary (December 2017)
Attachment F:	Tribal Notice (December 2017)
Attachment G:	Medical Care Advisory Council Meeting Minutes
Attachment H:	Public Notice (December 2017)
Attachment I:	Healthy Michigan Plan Evaluation Reports 1. Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan 2. 2016 Healthy Michigan Voices Enrollee Survey 3. Public Act 107 of 2013 §105d (8) 2015 Report on Uncompensated Care
Attachment J:	Tribal Notice –Demonstration Application Amendment (July 2018)
Attachment K:	Public Notice – Demonstration Application Amendment (July 2018)
Attachment L:	Medically Frail Identification Process (July 2018)
Attachment M:	Public Act 208 of 2018