IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MONTE A ROSE, JR., *et al.*, Plaintiffs, v. **ALEX M. AZAR II, *et al.*,** Defendants.	Civil Action No. 1:19-cv-2848 (JEB)

FEDERAL AND STATE DEFENDANTS' JOINT MOTION FOR A STAY PENDING RESOLUTION OF D.C. CIRCUIT APPEAL

In accordance with Federal Rule of Civil Procedure 7(b) and Local Civil Rule 7, the federal defendants, Alex M. Azar II, Secretary of Health and Human Services, *et al.*, and state intervenor defendant, Indiana Family and Social Services Administration, jointly move to stay all proceedings pending the issuance of the mandates in *Stewart v. Azar*, No. 19-5096 (D.C. Cir.) and *Gresham v. Azar*, No. 19-5094 (D.C. Cir.). In support of this Motion, the federal and state defendants respectfully refer the Court to the attached Memorandum of Points and Authorities and Proposed Order.

Dated: October 31, 2019

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Plaintiffs,

v.

ALEX M. AZAR II, *et al.*,

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Civil Action No. 1:19-cv-2848 (JEB)

FEDERAL AND STATE DEFENDANTS' JOINT MEMORANDUM IN SUPPORT OF MOTION FOR A STAY PENDING RESOLUTION OF D.C. CIRCUIT APPEALS AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR AN EXPEDITED SCHEDULE

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I. INTRODUCTION

Plaintiffs' motion to set an expedited schedule should be denied and this case should be stayed pending resolution of the appeals in *Stewart v. Azar*, No. 19-5096 (D.C. Cir.), and *Gresham v. Azar*, No. 19-5094 (D.C. Cir.). As in those cases, the instant action involves a challenge to a Section 1115 Medicaid demonstration project approved by the Secretary of Health and Human Services ("HHS"). Called the Healthy Indiana Plan ("HIP"), the project here was proposed by the state of Indiana and approved as an extension and amendment of a preexisting demonstration in February 2018.

Like the demonstrations challenged in *Stewart* and *Gresham*, HIP was approved in part to test the efficacy of a work and community engagement requirement. The project includes other components as well, including a waiver of retroactive eligibility, a monthly premium requirement; lockout periods; and limitations on non-emergency medical transportation ("NEMT"). But with the exception of the community engagement requirement and certain lockouts for individuals who fail to complete the annual redetermination process, the components of HIP that plaintiffs now challenge have generally been in place in Indiana in some form for several years, without prior legal challenge.

This case should be stayed pending resolution of the appeals in *Stewart* and *Gresham* for several reasons. To start with, the work and community engagement requirement was the focus of this Court's decisions in *Stewart* and *Gresham* and is the focus of the appeals. This Court vacated the demonstrations in those cases because it concluded that the Secretary did not adequately weigh the potential benefits of the requirements against the risk that coverage would be lost due to noncompliance. But Indiana recently announced that it will not disenroll any beneficiary for noncompliance with the work and community engagement requirement during the pendency of this lawsuit, and, as plaintiffs concede, the state has already paused implementation of lockouts for failure to complete redetermination. *See* Ind. Family & Soc. Servs. Admin. News Release, "Pending resolution of federal lawsuit, FSSA will temporarily suspend Gateway to Work reporting requirements," (Oct. 31, 2019) (Exh. 1); Pls.' Mot.

2. As a result, plaintiffs and other beneficiaries in Indiana will suffer no harm from newly added components during the pendency of a stay.

In addition, there is little question that the D.C. Circuit's decisions in *Stewart* and *Gresham* will provide guidance on, if not resolve entirely, the issues raised in this case relating to the work and community engagement requirement. And to the extent the D.C. Circuit specifically addresses other components of the Kentucky and Arkansas demonstrations, such as premiums or the waivers of retroactive eligibility, its reasoning on those points will control here as well. Accordingly, proceeding with this case at this time would result only in unnecessary and duplicative briefing or, worse, rulings that are potentially overcome in the near future by controlling authority.

On the other hand, staying proceedings here would preserve the status quo in Indiana. The challenged components of HIP other than the community engagement requirement and lockouts for individuals who fail to complete redetermination have generally been in place in Indiana in some form—and remained unchallenged—for years. And, as noted, neither the community engagement requirement nor the redetermination lockouts will result in harm to the plaintiffs through the pendency of this lawsuit, including through any stay granted by the Court. A stay would also avoid significant disruption to the state and confusion for beneficiaries, as an immediate ruling could result in the Court vacating HHS's approval now, only to have the D.C. Circuit thereafter rule in a way that may require a different result.

Because plaintiffs did not bring this lawsuit until more than a year and a half after the Secretary's February 2018 approval, and significantly longer since most of the challenged components of the demonstration were put in place, plaintiffs' motion for an expedited schedule should be denied and this case should be stayed pending resolution of the appeals in *Stewart* and *Gresham*.

II. FACTUAL BACKGROUND

A. The Healthy Indiana Plan ("HIP")

In 2007, the Centers for Medicare & Medicaid Services ("CMS") approved a Section 1115 demonstration project that provided health care coverage to certain low-income adults in Indiana who were not otherwise eligible for coverage under the Medicaid Act.[1] Compl. ¶¶ 68–69, ECF No. 1. That project, HIP, coupled its optional provision of healthcare coverage with several features, including a monthly premium requirement; termination of coverage and a 12-month lockout period for enrollees who did not pay their premiums; a lockout period for beneficiaries who did not complete the annual redetermination process by the deadline; elimination of retroactive eligibility; and elimination of non-emergency medical transportation ("NEMT"). Compl. ¶ 72.

In July 2014, Indiana submitted an application to extend HIP for five additional years, with certain modifications ("HIP 2.0"). In particular, Indiana proposed to include parents and caretakers and the entire Medicaid expansion population in the project.[2] Compl. ¶ 78. In January 2015, CMS approved HIP 2.0 for three years, effective February 1, 2015.[3] Compl. ¶ 79.

As Plaintiffs themselves acknowledge, HIP 2.0's features "mirrored those of the initial HIP project" that CMS approved in 2007. Compl. ¶ 81. For example, HIP 2.0's approved features allowed Indiana to charge enrollees monthly premiums, terminate coverage for individuals with household

[1] Given the early stage of the proceedings, these facts are largely taken from the allegations in the Complaint.

[2] HIP was originally approved through December 31, 2012. Compl. ¶ 72. After the Affordable Care Act became law in 2010, the Indiana legislature gave the Secretary of Indiana's Family and Social Services Administration permission to amend HIP "in a manner that would allow Indiana to use the plan to cover" the Medicaid expansion population. Compl. ¶ 75 (citation omitted). Between 2012 and 2015, CMS approved several short-term extensions of HIP while it negotiated with Indiana regarding the State's plan to cover the expansion population. Compl. ¶ 76. The extensions included some minor modifications. *See id.*

[3] Also effective February 1, 2015, Indiana amended its state plan to cover the Medicaid expansion population. Compl. ¶ 80.

incomes above 100% of FPL who did not pay their premiums and impose a lockout on re-enrolling in the project for six months, eliminate retroactive eligibility, and eliminate NEMT for the expansion population.[4] Compl. ¶ 81. One new component the Secretary approved in 2015 was a "Gateway to Work" initiative, through which the State referred certain eligible HIP participants—adults who did not have a disability, were working fewer than 20 hours per week, and were not full time students—to its workforce training and work search resources. Compl. ¶ 83. Participation in Gateway to Work was voluntary. Compl. ¶ 84.

On February 1, 2018, CMS approved the State's request to amend HIP and extend it through December 31, 2020. Compl. ¶ 100; *see also* Letter from Demetrios Kouzoukas to Allison Taylor (Feb. 2018), ECF No. 1-10.[5] Much like the earlier approvals of HIP and HIP 2.0, this most recent approval permitted Indiana to charge monthly premiums, terminate coverage for individuals with household incomes above 100% of FPL who do not pay their premiums and impose a lockout on re-enrolling in the project for six months, eliminate retroactive eligibility, and eliminate NEMT for the expansion population. Compl. ¶¶ 117–42. Like the initial approval of HIP in 2007, the 2018 approval also expanded the lockout periods to apply to beneficiaries who did not complete the annual redetermination process by the deadline. Compl. ¶¶ 131–36. However, as plaintiffs concede, the state has paused implementation of that component. Pls.' Mot. 2; *see also* HIP Monitoring Plan, Q4 Quarterly Report 5 (Exh. 2) ("Effective October 18, 2018, FSSA decided to pause the implementation of the HIP lockout provision for failure to comply with the annual redetermination process . . ."). Moreover, the intervenor state defendant commits that the redetermination lockout will remain paused during the pendency of this case. In addition, the 2018 approval included a new substance

[4] Unlike the original approval of HIP in 2007, the 2015 approval of HIP 2.0 did not include a lockout for failure to complete annual redetermination by the deadline.

[5] Upon Indiana's application for, and CMS's approval of, the program's renewal in 2018, the program is now simply referred to as "HIP."

abuse disorder program. Letter from Demetrios Kouzoukas to Allison Taylor (Feb. 2018) 3, ECF No. 1-10.

The 2018 approval also permitted Indiana to reformulate the "Gateway to Work" component into a mandatory work and community engagement requirement, which the State began implementing on January 1, 2019 and has phased in over time. *See* Compl. ¶ 108. According to the terms of the program, every December the State will review enrollees' compliance with the community engagement requirements over the course of the calendar year. If an enrollee who was subject to the requirements failed to meet them in more than four months of the year, the State will suspend coverage on the first day of the next calendar year. Beneficiaries can regain coverage if they complete the required hours for one month, qualify for an exemption, or become eligible for Medicaid under a population group not included in HIP. Compl. ¶¶ 112–13. Originally, the state planned to begin suspending coverage for non-compliant beneficiaries on December 31, 2019. Compl. ¶ 10.

B. This Lawsuit

On September 23, 2019, Plaintiffs filed this lawsuit, challenging the Secretary's 2018 extension and amendment of the HIP program. *See* Compl. In particular, Plaintiffs challenge the following aspects of the approval: (1) the work and community engagement component; (2) the premium requirements; (3) lockouts for failure to comply with the Medicaid redetermination procedures; (4) the waiver of the retroactive coverage requirement; and (5) the waiver of the NEMT benefit. *See* Compl. ¶¶ 241–73. Plaintiffs also challenge the project as a whole, as well as a state Medicaid Director letter that HHS issued in January 2018. Compl. ¶¶ 227–40, 274–91.

C. D.C. Circuit Appeals

In a suit brought by fifteen Medicaid recipients, this Court vacated CMS's approval of a similar demonstration project in the state of Kentucky on the ground that the agency had not adequately considered whether the project "would in fact help the state furnish medical assistance to its citizens,

a central objective of Medicaid." *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (*Stewart I*). Like Indiana's current demonstration, Kentucky's project included work and community engagement requirements, premiums, limits on retroactive eligibility, lockout periods for failure to pay premiums or timely complete redetermination, and limited coverage of non-emergency medical transportation (though Indiana and Kentucky do have different implementation processes and program specifications). *Id.* at 246. After an additional period of public comment, HHS issued a new approval letter in November 2018 that explained why it determined that Kentucky's demonstration project is likely to help the State furnish medical assistance to its citizens. On March 27, 2019, several days before Kentucky's project was due to begin, this Court again vacated HHS's approval of the project. *See Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019) (*Stewart II*). This Court concluded that the approval was contrary to the Medicaid Act and arbitrary and capricious because the Secretary "failed to 'adequately analyze'" the issue of whether the project would promote or lead to a decrease in health care coverage. *Id.* at 140 (citation omitted).

On the same day that this Court vacated the approval of the Kentucky demonstration project, it also vacated HHS's approval of the amendments to Arkansas's Section 1115 Medicaid demonstration project, entitled Arkansas Works. The amendments to Arkansas Works included a work and community engagement requirement as well as a waiver of retroactive eligibility. *See Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019). This Court similarly concluded that the Secretary "had not adequately considered whether the program would in fact help the state furnish medical assistance to its citizens." *Id.* at 169(citation omitted). The Government appealed both cases.

Both appeals are now fully briefed, and oral argument was heard on October 11, 2019. *See Gresham v. Azar*, No. 19-5094 (D.C. Cir.), ECF No. 1811072; Dkt. 1811077, *Stewart v. Azar*, No. 19-5096 (D.C. Cir.), ECF No. 1811077. The government has requested an expedited decision in both

cases.[6] *See* Mot. Expedite Case, *Stewart v. Azar*, No. 19-5096 (D.C. Cir.), ECF No. 1782525.

D. Recent Developments

On October 31, 2019, Indiana announced that its Family and Social Services Administration will not suspend the benefits of any Medicaid beneficiary for failure to comply with the Gateway to Work program until this lawsuit is resolved. *See* Exh. 1. While beneficiaries can still report their qualifying community engagement activities and hours to the state, no consequences will flow from a beneficiary's failure to do so. *Id.* Further, "[b]efore the program is reinitiated, participating members would receive substantial advance notice." *Id.*

Prior to plaintiffs filing their motion to set an expedited schedule, counsel for the federal defendants and counsel for Indiana conferred with plaintiffs regarding whether plaintiffs would consent to a motion to stay this case in light of Indiana's forthcoming announcement that it would not suspend benefits on December 31, 2019 due to noncompliance with the community engagement requirement, as originally planned. Plaintiffs indicated that they opposed such a motion.

III. STANDARD OF REVIEW

This Court has the inherent authority to "control the disposition of the causes on its docket with economy of time and effort for itself, for counsel, and for litigants." *Landis v. N. Am. Co.*, 299 U.S. 248, 254 (1936). That broad discretion includes the "inherent power to control the sequence in which it hears matters on its calendar." *United States v. W. Elec. Co.*, 46 F.3d 1198, 1207 n.7 (D.C. Cir. 1995). Such authority applies "especially in cases of extraordinary public moment," when "a plaintiff may be required to submit to delay not immoderate in extent and not oppressive in its consequences if the public welfare or convenience will thereby be promoted." *Clinton v. Jones*, 520 U.S. 681, 707

[6] On October 25, 2019, the Government filed a notice of appeal in *Philbrick v. Azar*, *see* Notice of Appeal, No. CV 19-773 (JEB) (D.D.C.), ECF 54, in which this Court vacated New Hampshire's Section 1115 Medicaid demonstration project, *Philbrick v. Azar*, 2019 WL 3414376 (D.D.C. July 29, 2019). That project, as approved by the Secretary, also contained work and community engagement requirements, as well as a waiver of retroactive eligibility. *See id.* at *3–*4.

(1997) (citation omitted). In evaluating a stay motion, the "key interests to consider" are "hardship to the parties and benefits to judicial economy." *Nat'l Indus. for the Blind v. Dep't of Veterans Affairs*, 296 F. Supp. 3d 131, 137 (D.D.C. 2017). Discretion to stay proceedings "may be appropriately exercised where a separate proceeding bearing upon the case is pending." *Hulley Enterprises Ltd. v. Russian Fed'n*, 211 F. Supp. 3d 269, 276 (D.D.C. 2016).

IV. ARGUMENT

Plaintiffs' motion to set an expedited briefing schedule should be denied and this case should be stayed pending resolution of the appeals in *Stewart* and *Gresham*. The resolution of the issues in those appeals will impact, if not resolve entirely, the issues here. As a result, a stay would prevent potentially needless and duplicative litigation and promote judicial economy. Moreover, in light of (1) Indiana's announcement that it will not suspend Medicaid benefits for non-compliance with its work and community engagement requirement during the pendency of this lawsuit, and (2) its longstanding decision, made in October 2018, to pause implementation of lockouts for failure to complete redetermination, a stay preserves the status quo: it allows the State to continue the new components of its demonstration other than mandatory community engagement and redetermination lockouts (such as substance use disorder treatment), as well as components which have been in place in various forms for many years. And in the meantime, no beneficiary will suffer harm from the new requirements. Plaintiffs waited more than a year and a half after HHS approved the extension of HIP to bring this lawsuit, and given the State's recent announcement, there is no cause for an expedited schedule or for any further proceedings before resolution of the appeals in *Stewart* and *Gresham*.

A. A Stay Would Promote Judicial Economy Because The D.C. Circuit's Decision In *Stewart* And *Gresham* Will Provide Controlling Guidance On The Issues In This Case.

District courts routinely stay proceedings where resolution of an appeal in another matter may provide guidance to the district court in deciding issues before it. *See Landis*, 299 U.S. at 254; *see, e.g.*, *Fed. Home Loan Mortg. Corp. v. Kama*, 2016 WL 922780, at *8-*9 (D. Haw. Mar. 9, 2016) (granting stay

where circuit court's resolution of related cases "w[ould] likely involve an analysis of" issues that would "provide further guidance" to the district court). Doing so not only preserves resources for both the parties and the court, but also "reduce[s] the risk of inconsistent rulings that the appellate court[] might then need to disentangle." *Washington v. Trump*, 2017 WL 1050354, at *5 (W.D. Wash. Mar. 17, 2017) (citation omitted). Indeed, "litigating essentially the same issues in two separate forums is not in the interest of judicial economy or in the parties' best interests." *Naegele v. Albers*, 355 F. Supp. 2d 129, 141 (D.D.C. 2005) (citation omitted).

The plaintiffs here bring the same claims as the plaintiffs in *Stewart* and *Gresham* and seek the same relief. As noted, Indiana's HIP contains a work and community engagement requirement, just as did the projects in *Stewart* and *Gresham*. And while implementation processes and program specifications differ considerably between Indiana and other states, the Secretary approved the project here for reasons substantially similar to the original Kentucky demonstration and the amendments to Arkansas Works. *Compare* Letter from Demetrios Kouzoukas to Allison Taylor (Feb. 2018), ECF 1-10, *with* Letter from Seema Verma to Cindy Gillespie (March 5, 2018), *Gresham v. Azar*, Civ. No. 1:18-cv-1900-JEB (D.D.C.), ECF No. 1-3, *and* Letter from Demetrios Kouzoukas to Stephen P. Miller (Jan. 2018), *Stewart v. Azar*, No. 1:18-cv-152-JEB (D.D.C.), ECF No. 1-3. Notably, plaintiffs themselves designated this case as "involv[ing] common issues of fact" and "grow[ing] out of the same event or transaction" as *Stewart* and *Gresham* (and *Philbrick*). *See* Notice of Related Case, ECF No. 2.

More fundamentally, the central issue on appeal in *Stewart* and *Gresham* substantially overlaps with the central issue raised here: namely, the scope of the Secretary's authority to approve demonstration projects that contain work and community engagement requirements. In resolving that issue, questions such as what level of deference should be afforded to the Secretary's approval of Section 1115 demonstrations, what findings the Secretary must make in approving such demonstrations, and what purposes such demonstrations may further, all may be addressed by the

D.C. Circuit. *See generally* Br. for the Fed. Appellants, *Gresham v. Azar*, No. 19-5094 (D.C. Cir.), ECF No. 1787676, *Stewart v. Azar*, No. 19-5096 (D.C. Cir.), ECF No. 1787677 (raising these and other issues). If the D.C. Circuit rules on these issues, as it is likely to do, such a ruling plainly will impact the issues before this Court. In fact, "it is possible that the D.C. Circuit will resolve th[is] case in its entirety"—by, for instance, holding that approvals of Section 1115 demonstrations are committed to agency discretion by law, or, alternatively, holding that work and community engagement requirements can never further the purposes of Medicaid. *Owner-operator Indep. Drivers Ass'n, Inc. v. Lahood*, 2013 WL 12330195, at *2 (D.D.C. Sept. 25, 2013) (citation omitted). These considerations cut sharply in favor of a stay while the *Stewart* and *Gresham* appeals are resolved. *See Fairview Hosp. v. Leavitt*, 2007 WL 1521233, at *3 (D.D.C. May 22, 2007) (granting stay of proceedings pending related case where the complaints were "strikingly similar" and the defenses raised were "nearly identical").

Given that the *Stewart* and *Gresham* appeals were fully briefed and argued weeks ago and the government has requested an expedited decision from the D.C. Circuit, it would make little sense to proceed with this case now, before controlling guidance is obtained. *Cf. Fonville v. D.C.*, 766 F. Supp. 2d 171, 173 (D.D.C. 2011) (granting stay pending state court appeals involving state law issues that were "likely to be extremely persuasive to, if not binding upon" the district court). Indeed, proceeding with this case at this time would likely invite only further litigation, as any briefing or rulings would soon be overtaken by the D.C. Circuit's decision. And "[a]lthough a stay would immediate[ly] delay the resolution of the parties' dispute, it would still likely be shorter than the possible delay that would occur if this Court were to [rule on plaintiffs' APA claims] and the [D.C. Circuit] were to then [provide contrary guidance]." *Matter of Arbitration of Certain Controversies Between Getma Int'l & Republic of Guinea*, 142 F. Supp. 3d 110, 114 (D.D.C. 2015) (citation omitted). These considerations of judicial economy, which plaintiffs can hardly dispute, counsel that a stay is warranted.

B. A Stay Pending Resolution of the *Stewart* and *Gresham* Appeals Preserves The Status Quo.

The Court should stay this case for the additional reason that a stay would preserve the status quo. Other than the mandatory work and community engagement requirement and lockouts for failure to complete redetermination, none of the components of HIP that Plaintiffs challenge are new features. And because Indiana has paused both of the new components that plaintiffs challenge, neither will cause plaintiffs harm during through the pendency of this lawsuit. Accordingly, a temporary stay while the *Stewart* and *Gresham* appeals are resolved would not leave plaintiffs or other beneficiaries in a materially different position than they have been in previously. They would continue to receive Medicaid coverage on terms similar to those existing before the 2018 approval that plaintiffs now challenge in this action. In such circumstances, any purported harms to plaintiffs flowing from the preexisting requirements of HIP during resolution of the *Stewart* and *Gresham* appeals is outweighed by the Court's and the parties' interests in avoiding unnecessary litigation.

This is all the more true given that plaintiffs waited more than a year and a half from the Secretary's February 2018 approval of the HIP amendment and extension to bring this lawsuit. Plaintiffs cannot seriously contend they now face significant or imminent harm from the demonstration after sitting on their hands for such an extended period. Indeed, plaintiffs' dilatory approach extends even earlier than 2018, as the components of HIP that plaintiffs challenge and would remain in effect during the stay have been in place in some form for years before 2018 and were part of the program at the time Indiana decided to expand Medicaid. Given plaintiffs' delay, it seems apparent that plaintiffs brought this action when they did only because of the impending start date for disenrollment based on noncompliance with the work and community engagement requirement, which was set to begin on December 31, 2019. Plaintiffs' own motion makes this clear. *See* Pls.' Mot. 2 (noting that their proposed expedited schedule "could allow this Court to make a decision in advance of December 31, 2019"). This leaves little doubt that the real object of plaintiffs' lawsuit is the work

and community engagement requirement, not the other components. But now that disenrollment for noncompliance with that community engagement requirement will not occur through the pendency of this lawsuit—including through any stay granted by the Court—there is no reason to enter an expedited schedule or proceed in this case *at all* until the D.C. Circuit provides controlling guidance.

On the other hand, if the Court were to proceed with this case and ultimately vacate Indiana's demonstration project, and the D.C. Circuit were then to issue guidance demanding a different result, the harms to the state would be significant. The state's demonstration project and data collection efforts would be interrupted, and beneficiaries would face serious confusion, as the terms by which they receive coverage are altered and then potentially changed back again. *See Gresham*, 363 F. Supp. 3d at 183 (recognizing "practical concerns" and "probable disruptions" from pausing enforcement of Arkansas's demonstration). In light of the fact that a stay pending resolution of the *Stewart* and *Gresham* appeals would promote judicial economy, preserve the status quo, and result in minimal, if any, harm to plaintiffs, plaintiffs' motion to set an expedited schedule should be denied and the state's and federal defendants' cross-motion for a stay should be granted.

V. CONCLUSION

The federal defendants and the state respectfully request that proceedings in this case be stayed pending resolution of the appeals in *Stewart v. Azar*, No. 19-5096 (D.C. Cir.) and *Gresham v. Azar*, No. 19-5094 (D.C. Cir.). Within fourteen days of the mandates issuing from those appeals, the parties should be required to file a joint status report proposing further proceedings.[7]

Dated: October 31, 2019

JOSEPH H. HUNT
Assistant Attorney General

[7] In the event that the Court denies the state's and federal defendants' cross-motion for a stay, the federal defendants would not be prepared to produce an administrative record by plaintiffs' proposed date of November 1, 2019, and would respectfully request that they be given until November 21, 2019 to do so.

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Exhibit 1

FSSA News Release

FOR IMMEDIATE RELEASE
October 31, 2019

Pending resolution of federal lawsuit, FSSA will temporarily suspend Gateway to Work reporting requirements

INDIANAPOLIS—The Indiana Family and Social Services Administration announced today that it will temporarily suspend the reporting requirements of the Gateway to Work program due to a pending legal challenge.

Last month, the lawsuit *Rose v. Azar* was filed in federal court challenging Gateway to Work along with several other components of the Healthy Indiana Plan that have been in operation for several years – potentially jeopardizing the HIP program as a whole.

Gateway to Work is a part of the Healthy Indiana Plan that helps connect HIP members with job training, education or help finding the right job or volunteer activity. Some HIP members are required to participate, and those not in compliance had been at risk of potential benefit suspensions starting in January.

To help ensure the continued operation of HIP, FSSA will temporarily suspend enforcement of the provision whereby some members could have their benefits suspended beginning in January for not meeting their annual Gateway to Work requirement. FSSA is doing so to allow time for the *Rose* lawsuit to be resolved and so that the court can address the challenge to HIP after similar legal challenges to programs like Gateway to Work in other states have worked their way through the appeals process.

“We remain committed to operating the Gateway to Work program and to continuing to build on the early successes of the program, through which HIP members are reporting successful engagements in their workplaces, schools and communities,” Indiana Medicaid Director Allison Taylor said.

FSSA will continue to encourage HIP members to report their activities to the state or their health plan so they can be connected to resources such as the state’s Next Level Jobs program, Ivy Tech, WorkOne and local job training and advancement programs. HIP members will still have a Gateway to Work status of “exempt,” “reporting met” or “reporting,” and be referred to opportunities to work, learn and serve in their communities. However, no benefit suspensions will be considered until after *Rose v. Azar* is resolved. Before the program is reinitiated, participating members would receive substantial advance notice regarding the timeline.

The state also continues to seek approval for the HIP Workforce Bridge program to help support the transition for any members moving to employer insurance or other health coverage.

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Exhibit 2

1. Preface

1.1 Transmittal Title Page

State	Indiana
Demonstration Name	Healthy Indiana Plan
Approval Date	February 1, 2018
Approval Period	February 1, 2018 – December 31, 2020
Demonstration Goals and Objectives	Improving quality, accessibility, and health outcomes.

2. Executive Summary

In this reporting period the program continued stable operations and did not experience any policy or programmatic changes. We do continue to see some decline in enrollment. We explain this further in section 3 below. Each section is clearly marked as a quarterly (Q4) or an Annual update.

3. Enrollment

☒ (Required) The state has attached the required enrollment metrics in Appendix X.

☐ (If applicable) The state does not have any issues to report related to enrollment metrics in Appendix X and has not included any narrative on this topic in the section that follows.

Q4: In this quarter, total enrollment in HIP was stable but we saw a 3.9% reduction in the number of HIP Basic enrollees. We continue to attribute this to the change in eligibility processing that requires members to verify income when the state receives information that the member has new or a change in income.

As of December 31, 2018, 69.4% of overall HIP enrollees are enrolled in the PLUS program compared to 25.5% who are enrolled in the HIP-Basic program. This is an increase in PLUS enrollment from 68.5% in the last quarter.

Annual: Total enrollment in HIP has decreased by 3.4% over 2018, but the percent change from quarter to quarter has continued to decrease. In Q1 2018, there was a 2.2% reduction in the total number of HIP enrollees when compared to Q4 2017.

HIP Plus enrollment increased from 66.8% in Q1 to 69.4% in Q4. We saw a reduction in HIP Basic enrollment from 30.9% in Q1 to 25.5% in Q4. We attribute this change in eligibility processing that requires members to verify income when the state receives information that the member has new or a change in income. Pregnant women enrolled in HIP has increased by 123% over the course of DY4. This increase is attributed to a policy change implemented with the waiver extension that allows pregnant women to be enrolled into HIP.

3.2 Anticipated Changes to Enrollment

☒ The state does not anticipate changes to enrollment at this time.

4. Benefits

☒ (Required) The state has attached completed the benefit metrics in Appendix X.

☒ (If applicable) The state does not have any issues to report related to the benefits metrics in Appendix X and has not included any narrative.

4.1 Anticipated Changes to Benefits

☒ The state does not anticipate changes to benefits at this time.

5. Demonstration-related Appeals

☒ (Required) The state has attached completed the appeals metrics in Appendix X.

☒ (If applicable) The state does not have any issues to report related to the appeals metrics in Appendix X and has not included any narrative.

5.1 Anticipated Changes to Appeals

☒ The state does not anticipate changes to appeals at this time.

6. Quality

☒ (Required) The state has attached the quality measures in Appendix X.

☐ (If applicable) The state does not have any issues to report related to the quality measures in Appendix X and has not included any narrative.

Q4: There are no issues to report.
Annual: There are no issues to report.

6.2 Anticipated Changes to Quality

☐ The state does not anticipate changes related to quality at this time.

Q4: Based on the recommendation from the 2018 External Quality Review, the State started to conduct a wholesale review of the reporting that the state requires from the Managed Care Entities. The state has contracted with Burns & Associates to facilitate the review and potential revisions. These revisions could include the additions, removal, or changes to any existing reports and report designs and formatting. This may affect the quality metrics that are reported in the future.

7. Other Demo Specific Metrics

No other demo specific metrics to report in this quarter.

8. Financial/Budget Neutrality

Q4: Through Q4, the program appears in compliance with budget neutrality targets specified in the STCs. The projected waiver margin has decreased compared to the Q3 report due to actual experience for the year being higher than projected in the Q2 report, ultimately driving up projections for DY4 as well as DY05 and DY06. This is due to an increase in claims submitted for residential treatment as well as IMD. The current budget neutrality demonstration has one MEG, for Substance Use Disorder (SUD). Indiana has not developed CMS 64 waiver logic for identification of expenditures for the SUD MEG. Values in this report were developed using a two-step process. Under current system constraints, CMS reporting must be performed using a one-step process. This requires SUD MEG members to be identified before CME reporting is run. A process has not yet been developed to accomplish this and do not currently have a timeline for remediation.

Annual: Table 17 summarizes the actual cumulative experience by when the claim was reported and paid by quarter for SUD expenditures. Q1 SUD expenditures are larger from what was provided in the Q1 monitoring report due to the 90 day claims lag.

☒ (Required) The state has attached completed the budget neutrality workbook in Appendix X.

8.1 Anticipated Changes to Financial/Budget Neutrality

The state anticipates that Institution of Mental Disease (IMD) and residential treatment utilization will continue to grow as the program matures and additional providers are identified. Residential treatment for members meeting ASAM Levels 3.1, 3.3, 3.5, or 3.7 was authorized effective March 1, 2018.

☐ The state does not anticipate future changes to budget neutrality at this time.

9. Demonstration Operations and Policy

Q4: Effective October 18, 2018, FSSA decided to pause the implementation of the HIP lockout provision for failure to comply with the annual redetermination process as we continue enhancements to our eligibility processes and system.

Annual: The waiver extension was approved, allowing for the Healthy Indiana Plan to continiue operation for the next three years. These changes included:

- POWER Account contribution from a calculated 2% of income to tiered amounts (Q1).
- Pregnant women with an incomes less than 138% FPL are enrolled directly in HIP and remain in HIP for the entirety of their pregnancy and post-partum period (Q1).
- HIP Plus benefit package was updated to add six chiropractic spinal manipulation visits (Q1).

10. Implementation Update

Q4:

Item	Date and Report in Which Item Was First Reported	Implementation Status
As approved in the STCs, Indiana will make participation in community engagement activities mandatory for some HIP beneficiaries.	7/19/17 – amendment to the HIP 1115 Demonstration Waiver Extension Request	This change is on track to be implemented January 1, 2019. Systems and operational design were completed. Members received preliminary notification of the program and their participation status in this quarter.

Annual:

Item	Date and Report in Which Item Was First Reported	Implementation Status
Transitional Medicaid Assistance change as documented in the waiver request and STCs.	7/19/17 – amendment to the HIP 1115 Demonstration Waiver Extension Request	This change has been implemented.
Pregnant women eligible under 42 CFR 435.116 with income under 133% of the FPL will be enrolled into HIP.	1/31/17 - the HIP 1115 Demonstration Waiver Extension Request	This change has been implemented.
Calendar Year Benefit Period as approved in the STCs.	1/31/17 - the HIP 1115 Demonstration Waiver Extension Request	This change has been implemented.
POWER Account contributions will be calculated based upon a tiered contribution structure established by the state	7/19/17 – amendment to the HIP 1115 Demonstration Waiver Extension Request	This change has been implemented.
Redetermination compliance change, as approved in the STCs individuals will be prohibited from re-enrolling in HIP for a period of time.	1/31/17 - the HIP 1115 Demonstration Waiver Extension Request	This change has been implemented.

11. Demonstration Evaluation Update

Annual: In April 2018 (Q1), the State posted and distributed a request for proposals (RFP) to acquire an independent party to evaluate the HIP Program in which the state received and reviewed proposal responses (Q2). Following its review, the State selected to work with The Lewin Group, Inc. (Lewin) for the evaluation (Q3).

Q4: In October 2018, Lewin kicked-off the HIP Program evaluation with the State. The majority of the evaluation work between October and December 2018 focused on administrative tasks, including finalizing the contract between Lewin and the State and between Lewin and its subcontractors. In addition, Lewin worked closely with the State to review and finalize the Draft Evaluation Design for submission to CMS on November 13, 2018. The State and Lewin anticipate feedback from CMS in Q1 2019.

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Draft Evaluation Design	11/13/18		Pending CMS evaluation guidance may require adaptations to evaluation design. Receiving timely feedback will be critical to the State meeting its deadline for its waiver renewal application.

12. Other Demonstration Reporting

Q4: The State completed delivery of Monthly and Annual Enrollment file layouts to Mathematica in October 2018.

Annual: In Q3, the State completed its assistance with the federal evaluation of HIP conducted by Social & Scientific Systems' (S3), regarding the identification of focus group participants.

The State met regularly with Mathematica to discuss the completion of their federal evaluation. On August 20, 2018, the State completed the delivery of the requested sample Disenrollment file layouts for Mathematica to use to review and develop inquiries to ensure that their intended methodology to evaluate member disenrollment from HIP is sound. In Q4, the State completed the delivery of the requested files for the Mathematica evaluation. The State continues to support these evaluators should further analyses, questions, or member identification be needed.

12.1 Post Award Public Forum

If applicable within the timing of the demonstration, the state should provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicate any resulting action items or issues. A summary of the post-award must be included in the monitoring report for the period during which the forum was held and in the annual report pursuant to 42 CFR § 431.428 .

☒ The state has provided the summary of the post-award forum (due for the period during reporting during which the forum was held and in the annual report).

The 1115 demonstration waiver post award forum was held on July 19, 2018 (Q3) during a special meeting of the Medicaid Advisory Committee and was open to the public. The state presented on HIP eligibility and enrollment as well as presenting on the development of the community engagement program, Gateway to Work. Twelve people provided comments in support of the HIP program, including representatives from Cover Kids and Families of Indiana, the Indiana Minority Health Coalition, the Indiana Hospital Association, St. Vincent Hospital, Indiana Primary Health Care Association, IU Health, MDwise, CareSource, MHS, Anthem, a HIP member, and the Medicaid Advisory Committee.

Most public questions were related to the new Gateway to Work (GTW) program. GTW questions centered around program documentation standards, member reported information, public opportunity to give program feedback, and additional safeguards for members facing challenges. In summary, Indiana addressed questions to satisfaction.

One public commenter proposed holding listening sessions with the community where OMPP would be in attendance. OMPP expressed support for this idea and reiterated commitment to attend public meetings. An MCE commented that the HIP program enhancement has enabled them to further support their members by focusing on social determinants of health through programs addressing such issues as housing, education, and employment, those sentiments were echoed across all the MCEs. The chairman of the Medicaid Advisory Committee stated that he appreciates the sensitivity of the State for rolling out the GTW program with a delayed implementation.

13. Notable State Achievements and/or Innovations

Q4: None to report during this quarter.
Annual: None to report for DY4.

Appendix X

1. Enrollment Metrics

Table 1. Annual HIP Enrollment

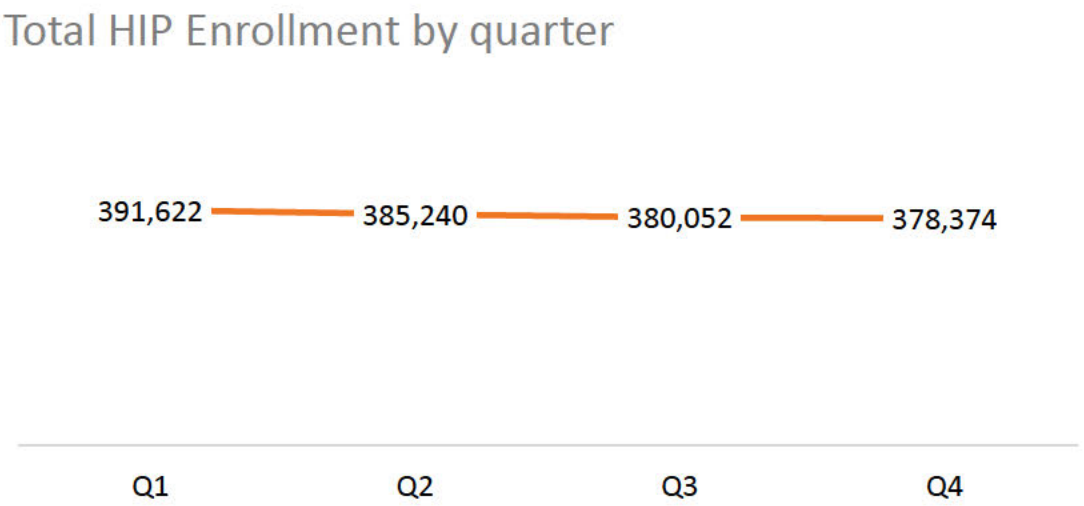
Reporting Period: January 1, 2018 – December 31, 2018

	BASIC				PLUS				MATERNITY		TOTAL PROGRAM	
FPL Levels	State	Regular	Total	Percentage	State	Regular	Total	Percentage	TOTAL	Percentage	TOTAL	Percentage
<5%	32,382	28,168	60,550	30.9%	71,074	55,190	126,264	64.3%	9,417	4.8%	196,231	51.9%
5%-10%	475	199	674	23.4%	1,209	829	2,038	70.9%	164	5.7%	2,876	0.8%
11%-22%	1,210	427	1,637	22.4%	3,311	1,915	5,226	71.6%	435	6.0%	7,298	1.9%
23%-50%	1,358	5,302	6,660	24.7%	4,624	13,971	18,595	69.0%	1,704	6.3%	26,959	7.1%
51%-75%	1,605	7,810	9,415	25.2%	5,780	20,037	25,817	69.1%	2,111	5.7%	37,343	9.9%
76%-100%	1,885	9,163	11,048	24.7%	6,964	24,408	31,372	70.2%	2,299	5.1%	44,719	11.8%
Total <101%	**38,915**	**51,069**	**89,984**	**28.5%**	**92,962**	**116,350**	**209,312**	**66.4%**	**16,130**	**5.1%**	**315,426**	**83.4%**
101%-138%	1,898	4,451	6,349	10.7%	11,624	38,317	49,941	84.2%	2,995	5.1%	59,285	15.7%
>138%	30	96	126	3.4%	2,914	270	3,184	86.9%	353	9.6%	3,663	1.0%
Grand Total	**40,843**	**55,616**	**96,459**	**25.5%**	**107,500**	**154,937**	**262,437**	**69.4%**	**19,478**	**5.1%**	**378,374**	**100.0%**

**Source: FSSA Data & Analytics*

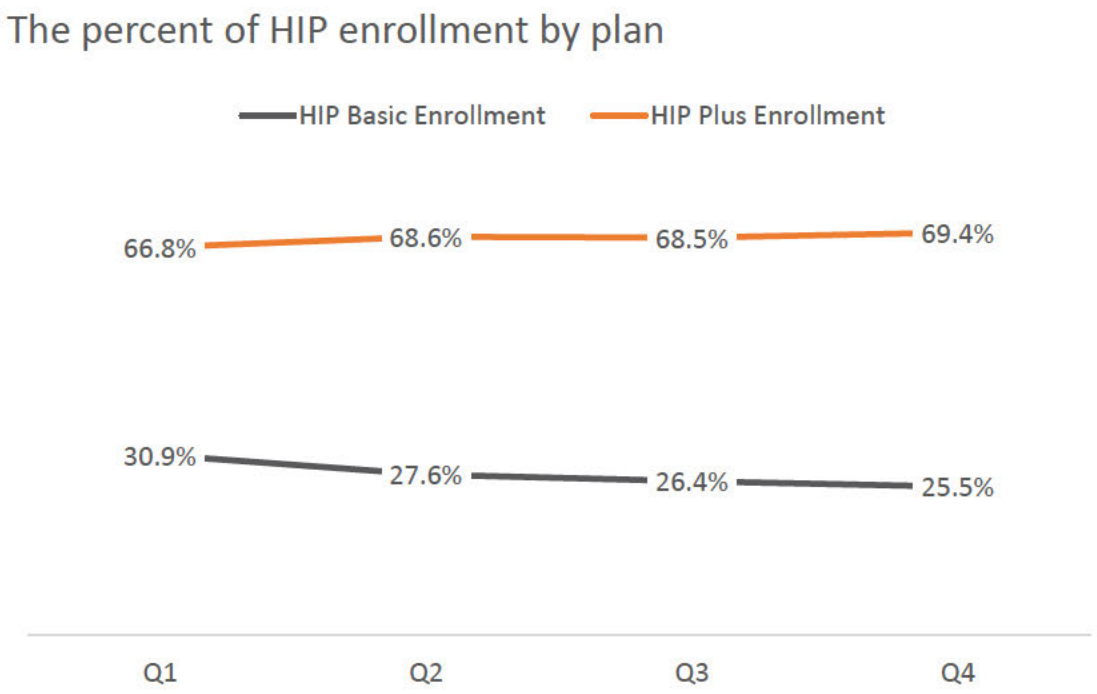
Graph 1A. Total HIP enrollment by quarter

Reporting Period: January 1, 2018 – December 31, 2018



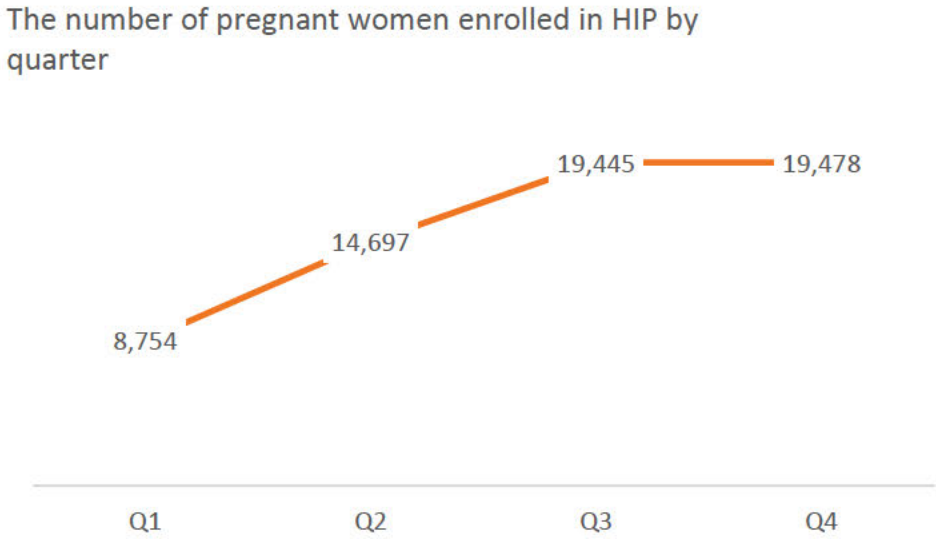
Graph 1B. Percent of HIP enrollment by plan

Reporting Period: January 1, 2018 – December 31, 2018



Graph 1C. Pregnant women enrolled in HIP

Reporting Period: January 1, 2018 – December 31, 2018



2. Benefits Metrics

Table 2. Quarterly Preventive Services and Chronic Care

Reporting Period: October 1, 2018- December 31, 2018

Table 2 data is reported quarterly by Managed Care Entities (MCEs) for a 12 month rolling period.

Service	MCE	Data Description	Basic	Plus	State Plan
Adults' Access to Preventive/ Ambulatory Services	MCE 1	Percentage of Preventive or Ambulatory visits, ages 19 - 44 years	47.76%	75.47%	81.97%
		Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	52.97%	83.86%	92.91%
	MCE 2	Percentage of Preventive or Ambulatory visits, ages 19 - 44 years	22.27%	53.97%	45.01%
		Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	28.43%	67.22%	66.47%
	MCE 3	Percentage of Preventive or Ambulatory visits, ages 19 - 44 years	42.11%	72.28%	80.82%
		Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	42.51%	79.27%	92.57%
	MCE 4	Percentage of Preventive or Ambulatory visits, ages 19 - 44 years	39.92%	70.07%	80.11%
		Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	39.07%	77.52%	92.72%
Preventive Exam (Rollover related)	MCE 1	Percentage of members who received a preventive exam (As described in HIP Preventive Services Policy; Preventive Exam or Alternative Preventive Exam Codes apply)	17.76%	54.46%	55.29%
		Percentage of members who received a preventive service (other than a preventive exam). (Other preventive services are described in HIP Preventive Services Policy)	44.02%	62.72%	71.55%
	MCE 2	Percentage of members who received a preventive exam (As described in HIP Preventive Services Policy; Preventive Exam or Alternative Preventive Exam Codes apply)	18.69%	38.95%	35.62%
		Percentage of members who received a preventive service (other than a preventive exam). (Other preventive services are described in HIP Preventive Services Policy)	18.63%	38.84%	35.49%
	MCE 3	Percentage of members who received a preventive exam (As described in HIP Preventive Services Policy; Preventive Exam or Alternative Preventive Exam Codes apply)	15.51%	47.76%	53.03%
		Percentage of members who received a preventive service (other than a preventive exam). (Other preventive services are described in HIP Preventive Services Policy)	35.19%	55.13%	68.15%

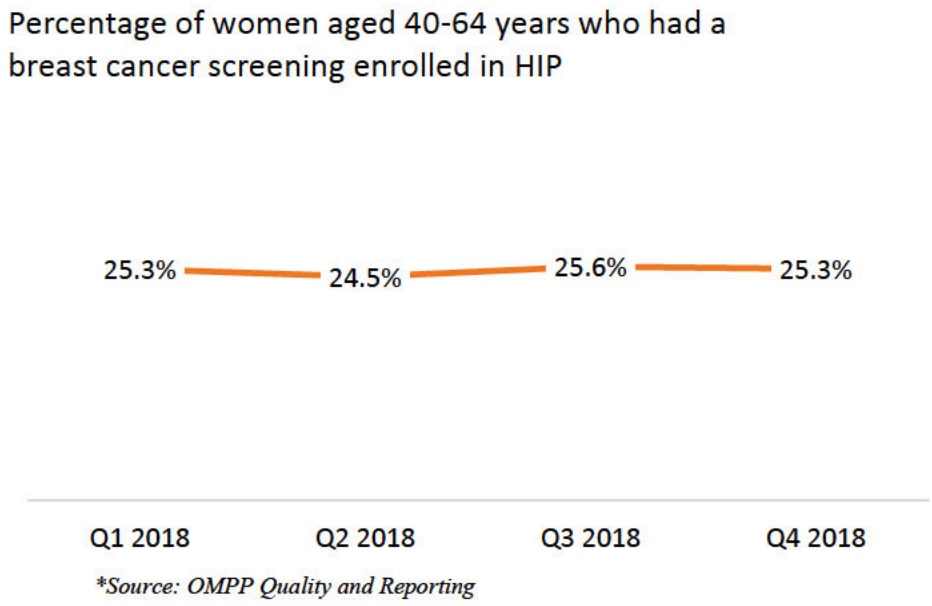
	MCE 4	Percentage of members who received a preventive exam (As described in HIP Preventive Services Policy; Preventive Exam or Alternative Preventive Exam Codes apply)	5.52%	23.88%	28.51%
		Percentage of members who received a preventive service (other than a preventive exam). (Other preventive services are described in HIP Preventive Services Policy)	0.26%	0.67%	1.25%
Breast Cancer Screening	**MCE 1**	Women who had a Mammogram within prior 12 months, ages 40 - 64 years	729	8,270	5,364
		Women enrolled with the MCE, ages 40 - 64 years	10,758	29,806	21,231
		Percentage of women who had a Mammogram during the prior 12 months, ages 40 - 64 years	6.78%	27.75%	25.26%
	MCE 2	Women who had a Mammogram within prior 12 months, ages 40 - 64 years	128	1360	414
		Women enrolled with the MCE, ages 40 - 64 years	3818	7742	3675
		Percentage of women who had a Mammogram during the prior 12 months, ages 40 - 64 years	3.35%	17.56%	11.26%
	MCE 3	Women who had a Mammogram within prior 12 months, ages 40 - 64 years	140	3736	3764
		Women enrolled with the MCE, ages 40 - 64 years	1814	11287	11787
		Percentage of women who had a Mammogram during the prior 12 months, ages 40 - 64 years	7.72%	33.08%	31.93%
	MCE 4	Women who had a Mammogram within prior 12 months, ages 40 - 64 years	76	1,676	1,964
		Women enrolled with the MCE, ages 40 - 64 years	415	3,450	3,290
		Percentage of women who had a Mammogram during the prior 12 months, ages 40 - 64 years	18.31%	48.58%	59.70%
Cervical Cancer Screening	**MCE 1**	Women who had one or more PAP tests, ages 21 - 64 years	3,019	9,903	13,332
		Women enrolled with the MCE, ages 21 - 64 years	34,658	55,438	66,214
		Percentage of women who had one or more PAP tests, ages 21 - 64 years	8.71%	17.86%	20.13%
	MCE 2	Women who had one or more PAP tests, ages 21 - 64 years	694	2552	1961
		Women enrolled with the MCE, ages 21 - 64 years	13516	17226	16796
		Percentage of women who had one or more PAP tests, ages 21 - 64 years	5.13%	14.81%	11.67%
	MCE 3	Women who had one or more PAP tests, ages 21 - 64 years	1123	6568	10532
		Women enrolled with the MCE, ages 21 - 64 years	13890	36919	49776
		Percentage of women who had one or more PAP tests, ages 21 - 64 years	8.08%	17.79%	21.16%
	MCE 4	Women who had one or more PAP tests, ages 21 - 64 years	1,296	5,561	11,457
		Women enrolled with the MCE, ages 21 - 64 years	4,110	12,314	21,758
		Percentage of women who had one or more PAP tests, ages 21 - 64 years	31.53%	45.16%	52.66%
Monitoring for Patients on	**MCE 1**	Members that received at least 180-day supply ACE inhibitor or ARB	765	9,039	7,822
		Members with appropriate follow-up for ACE inhibitor or ARB	75.69%	79.46%	86.68%
		Members that received at least 180-day supply of Diuretics	526	6,564	6,059

Persistent Medications		Members with appropriate follow-up for Diuretics	76.24%	79.59%	87.39%
	MCE 2	Members that received at least 180-day supply ACE inhibitor or ARB	109	1173	536
		Members with appropriate follow-up for ACE inhibitor or ARB	53.21%	74.85%	70.14%
		Members that received at least 180-day supply of Diuretics	3	23	14
		Members with appropriate follow-up for Diuretics	66.66%	65.21%	71.42%
	MCE 3	Members that received at least 180-day supply ACE inhibitor or ARB	246	3621	5174
		Members with appropriate follow-up for ACE inhibitor or ARB	70.73%	78.87%	85.64%
		Members that received at least 180-day supply of Diuretics	205	2634	3998
		Members with appropriate follow-up for Diuretics	69.76%	78.25%	85.89%
	MCE 4	Members that received at least 180-day supply ACE inhibitor or ARB	85	1,378	2,865
		Members with appropriate follow-up for ACE inhibitor or ARB	76.58%	77.99%	88.48%
		Members that received at least 180-day supply of Diuretics	56	1,029	2,206
		Members with appropriate follow-up for Diuretics	76.71%	79.15%	88.92%
Comprehensive Diabetes Care	**MCE 1**	Number of members with diabetes (type 1 and type 2), ages 19-64 years	619	4,239	6,517
		Percentage of members with diabetes who had a HbA1c testing, ages 19-64 years	66.40%	86.51%	85.82%
		Percentage of members with diabetes who received medical attention for Nephropathy, ages 19-64 years	75.61%	83.16%	88.60%
	MCE 2	Number of members with diabetes (type 1 and type 2), ages 19-64 years	493	909	668
		Percentage of members with diabetes who had a HbA1c testing, ages 19-64 years	26.97%	37.95%	30.98%
		Percentage of members with diabetes who received medical attention for Nephropathy, ages 19-64 years	39.75%	44.77%	44.16%
	MCE 3	Number of members with diabetes (type 1 and type 2), ages 19-64 years	178	2179	5067
		Percentage of members with diabetes who had a HbA1c testing, ages 19-64 years	66.29%	85.36%	84.92%
		Percentage of members with diabetes who received medical attention for Nephropathy, ages 19-64 years	78.09%	81.92%	87.11%
	MCE 4	Number of members with diabetes (type 1 and type 2), ages 19-64 years	284	1,496	4,018
		Percentage of members with diabetes who had a HbA1c testing, ages 19-64 years	64.44%	81.89%	86.01%
		Percentage of members with diabetes who received medical attention for Nephropathy, ages 19-64 years	71.48%	81.62%	88.90%

**Source: OMPP Quality and Reporting*

Graph 2A. Breast cancer screening

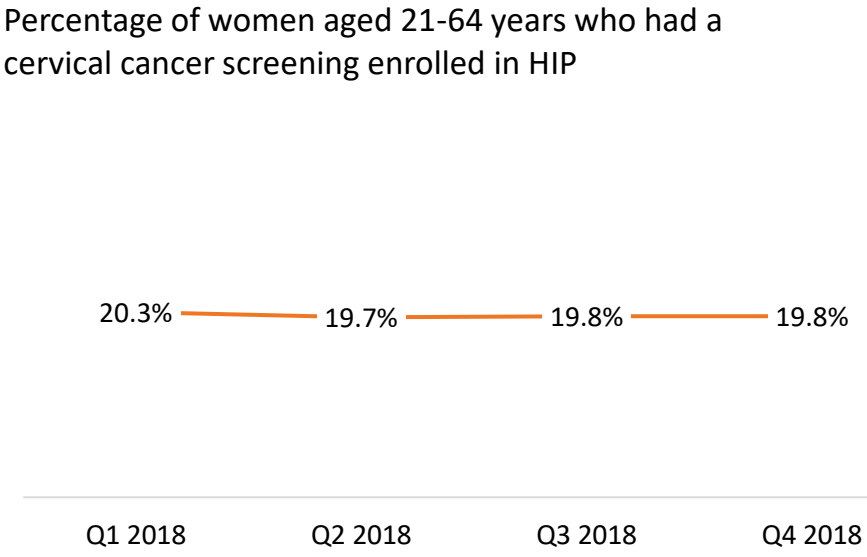
Reporting Period: January 1, 2018 - December 31, 2018



**Source: OMPP Quality and Reporting*

Graph 2B. Cervical cancer screening

Reporting Period: January 1, 2018 - December 31, 2018



**Source: OMPP Quality and Reporting*

Table 3. Quarterly Emergency Room Utilization

Reporting Period: October 1, 2018 – December 31, 2018

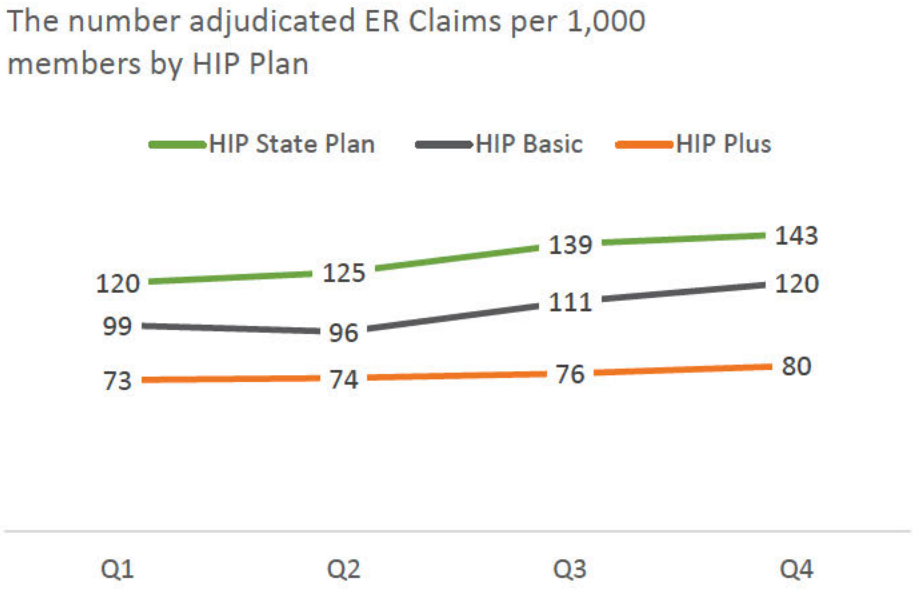
The Emergency Room Utilization data is collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. This table show the claims payment activity for July 1, 2018 – September 30, 2018 for HIP Plus, HIP Basic, and HIP State Plan.

Plan	Number of ER visits adjudicated for the experience period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
HIP Plus	37,929	24,539	13,390	80	64.7%	35.3%
HIP Basic	19,924	13,290	6,634	120	66.7%	33.3%
HIP State Plan	69,717	45,330	24,387	143	65.0%	35.0%

**Source: OMPP Quality and Reporting*

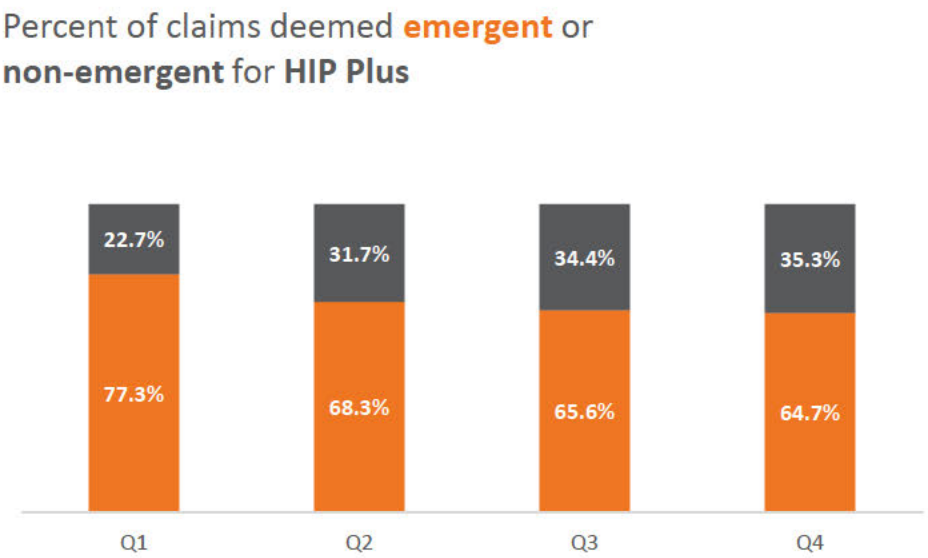
Graph 3A. Annual Emergency Room Utilization—Number of adjudicated ER Claims per 1,000 members by HIP Plan

Reporting Period: January 1, 2018 – December 31, 2018



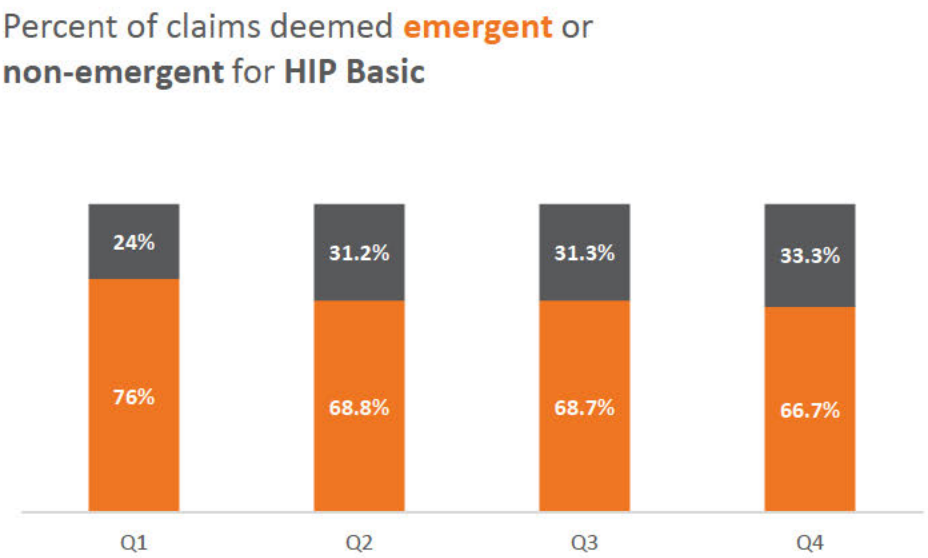
Graph 3B. Annual Emergency Room Utilization—Percent of emergent or non-emergent claims for HIP Plus

Reporting Period: January 1, 2018 – December 31, 2018



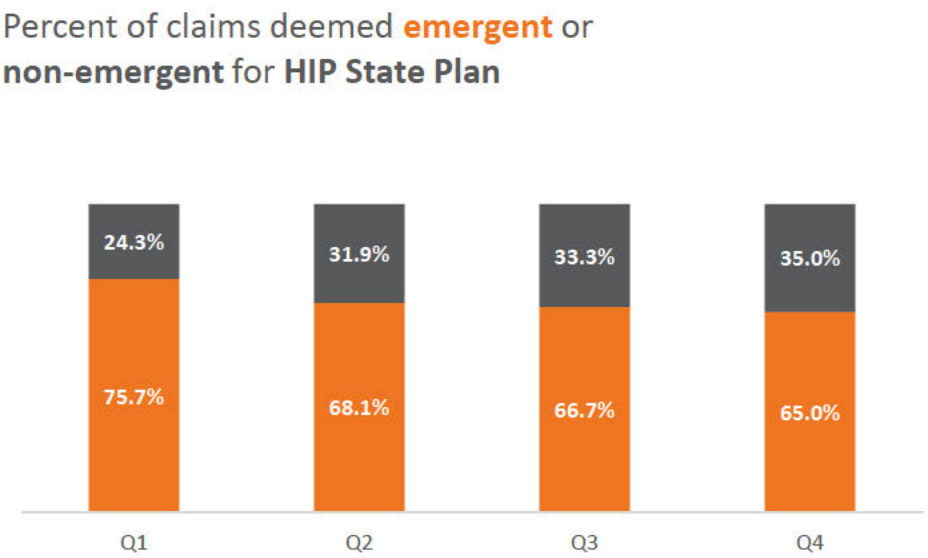
Graph 3C. Annual Emergency Room Utilization—Percent of emergent or non-emergent claims for HIP Basic

Reporting Period: January 1, 2018 – December 31, 2018



Graph 3D. Annual Emergency Room Utilization—Percent of emergent or non-emergent claims for HIP State Plan

Reporting Period: January 1, 2018 – December 31, 2018



3. Appeals Metrics

Table 4. Hearings Opened – Q4

Reporting Period: October 1, 2018 – December 31, 2018

Hearings Opened	Count	Percent of Opened	Average Days
Opened	1,506		
Pending	8	0.5%	
Rejected	37	2.5%	3.6
Accepted	1,461	97.0%	4.4

**Source: FSSA Data & Analytics*

Table 4A. Hearings Opened- Annual

Reporting Period: January 1, 2018 – December 31, 2018

Hearings Opened	Count	Percent of Opened	Average Days
Opened	6511		
Pending	0	0.0%	
Rejected	171	2.6%	3.3
Accepted	6341	97.4%	3.4

**Source: FSSA Data & Analytics*

Table 5. Hearings Accepted – Q4

Reporting Period: October 1, 2018 – December 31, 2018

Hearings Accepted	Count		Average Days
In Process	260	17.8%	
Dismissed	1,059	72.5%	21.7
Hearings Held	142	9.7%	24.5

**Source: FSSA Data & Analytics*

Table 5A. Hearings Accepted – Annual

Reporting Period: January 1, 2018 – December 31, 2018

Hearings Accepted	Count		Average Days
In Process	1	0.0%	
Dismissed	5444	85.9%	21.5
Hearings Held	896	14.1%	26

**Source: FSSA Data & Analytics*

Table 6. Hearings Held – Q4

Reporting Period: October 1, 2018 – December 31, 2018

Hearings Held	Count		Percent of Released	Average Days
Awaiting Decision	24	16.9%		
Released	118	83.1%		43.6
Withdrawn	3		2.5%	
Favorable to State	81		68.6%	
Favorable to Appellant	34		28.8%	

**Source: FSSA Data & Analytics*

Table 6A. Hearings Held – Annual

Reporting Period: January 1, 2018 – December 31, 2018

Hearings Held	Count		Percent of Released	Average Days
Awaiting Decision	0	0.0%		
Released	896	100.0%		46.8
Withdrawn	44		4.9%	
Favorable to State	507		56.6%	
Favorable to Appellant	345		38.5%	

**Source: FSSA Data & Analytics*

Table 7. Top 5 Appeal Reasons – Q4

Reporting Period: October 1, 2018 – December 31, 2018

Count	Reason
607	004 Unable to Determine eligibility
565	001 Financially Ineligible
147	027 Other
79	047 Non Payment of Power Account
58	021 Effective Date of Assistance

**Source: FSSA Data & Analytics*

Table 7A. Top 5 Appeal Reasons – Annual

Reporting Period: January 1, 2018 – December 31, 2018

Count	Reason
2605	004 Unable to Determine eligibility
2319	001 Financially Ineligible
689	027 Other
543	047 Non Payment of Power Account
152	021 Effective Date of Assistance

**Source: FSSA Data & Analytics*

4. Quality Measures

Table 8. New Member Health Needs Screen – Q4

Reporting Period: October 1, 2018 – December 31, 2018

Data Description	MCE 1	MCE 2	MCE 3	MCE 4	Total/Average %
Number of New Members Enrolled During the Reporting Period	13,544	3,999	5,715	6,157	29,415
Number of Members in Item #1 that Terminated Within their First 90 Days of Enrollment	1,112	370	766	389	2,637
New Members Net of Terminated	12,432	3,629	4,949	5,768	26,778
Number of Members in Item #1 that have been Classified as Unreachable	5,867	267	1,165	1,250	8,549
New Members Net of Terminated and Unreachable	6,565	3,362	3,784	4,518	18,229
Number of Members in Item #1 that were Screened Within their First 90 Days of Enrollment	2,517	980	3,681	3,008	10,186
Performance Measure #1: % Screened Within 90 Days (all except Terminated)	20.2%	27.0%	74.4%	52.1%	43.4%
Performance Measure #2: % Screened Within 90 Days (excluding Terminated and Unreachable)	38.3%	29.1%	97.3%	66.6%	57.8%

**Source: OMPP Quality and Reporting*

Graph 8A. New Member Health Needs Screen – Annual

Reporting Period: January 1, 2018 – December 31, 2018

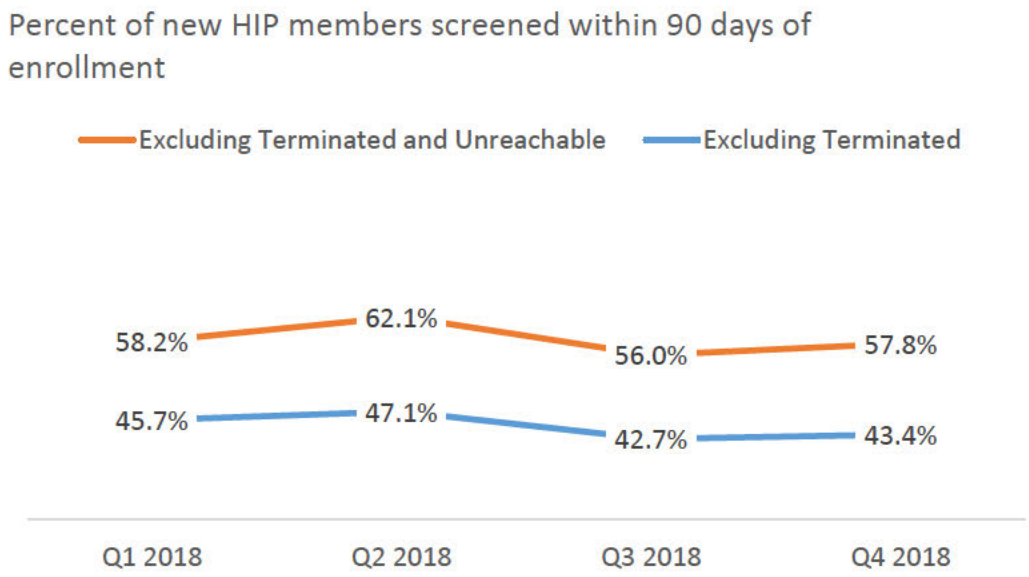


Table 9. Physical Health Complex Care Management

Reporting Period: October 1, 2018 – December 31, 2018

Condition	Total Identified (through any method) in the Reporting Period	Total Identified through HNS or NOP Specifically in the Reporting Period	Total Opt Outs (Refusals) in the Reporting Period	Total Active Ever Enrolled in the Reporting Period	Total Participation Days in the Reporting Period Represented by the Active Ever Enrolled	Total Disenrolled in the Reporting Period	Total Enrolled at the End of the Reporting Period
Asthma	1,908	450	1	525	6,870	128	395
Diabetes	4,657	326	22	1,563	29,744	422	1,141
COPD	1,762	165	12	750	9,414	143	607
Coronary Artery Disease	469	25	1	220	1,224	14	206
Congestive Heart Failure	789	27	8	345	3,209	67	278
Chronic Kidney Disease	679	60	6	272	3,404	61	211

**Source: OMPP Quality and Reporting*

Table 10. Behavioral Health Complex Care Management

Reporting Period: October 1, 2018 – December 31, 2018

Condition	Total Identified (through any method) in the Reporting Period	Total Identified through HNS or NOP Specifically in the Reporting Period	Total Opt Outs (Refusals) in the Reporting Period	Total Active Ever Enrolled in the Reporting Period	Total Participation Days in the Reporting Period Represented by the Active Ever Enrolled	Total Disenrolled in the Reporting Period	Total Enrolled at the End of the Reporting Period
Depression	5,863	379	11	3,275	81,980	673	2,602
ADHD	265	34	0	41	435	3	38
Autism/Pervasive Developmental Disorder	196	4	0	59	662	6	53
Inpatient Discharges from Psychiatric Hospital	2,311	0	0	2,483	123,942	821	1,662
Bipolar Disorder	1,933	13	6	1,220	33,811	286	934

**Source: OMPP Quality and Reporting*

Table 11. Prenatal and Postpartum Care

Reporting Period: October 1, 2018 – December 31, 2018

Table 11 assesses the weeks of pregnancy at the time of enrollment in to the MCE for women who delivered a live birth during the previous 12 months, as well as timeliness of prenatal care and postpartum care among women who delivered a live birth during the previous 12 months.

Report Name	Data Description	MCE 1	MCE 2	MCE 3	MCE 4
Weeks of Pregnancy	Prior to 0 weeks	59.4%	0.5%	65.0%	60.9%
	1-12 weeks	9.1%	11.4%	12.0%	5.5%
	13-27 weeks	17.7%	43.0%	15.9%	16.1%
	28 or more weeks	13.8%	45.1%	7.0%	14.1%
	Unknown	0.0%	0.0%	0.0%	3.4%
Prenatal and Postpartum Care	Percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester OR within 42 days of enrollment	74.2%	88.2%	75.7%	66.4%
	Percentage of deliveries that received a postpartum care visit on or between 21 and 56 days after delivery	58.2%	85.5%	48.4%	56.3%
	Percentage of deliveries with greater than or equal to 81 percent of the expected number of prenatal care visits	54.0%	5.7%	42.7%	49.2%

**Source: OMPP Quality and Reporting*

5. Financial/Budget Neutrality

Table 12. Enrollment and Expenditure Summary - Actual

Actual Experience Incurred and Paid through December 31, 2018

State of Indiana—Family and Social Services Administration Healthy Indiana Plan - 1115 Demonstration Waiver Enrollment and Expenditure Summary Actual Experience Incurred and Paid through December 31, 2018				
Enrollment (Mbr Mos.)	**DY 4**	**DY 5**	**DY 6**	**Total**
SUD	7,829			7,829
Total Enrollment	**7,829**			**7,829**
Expenditures	**DY 4**	**DY 5**	**DY 6**	**Total**
SUD	$ 51,165,996			$ 51,165,996
Total Claim Cost	**$ 51,165,996**			**$ 51,165,996**
Per Member Per Month	**DY 4**	**DY 5**	**DY 6**	**Total**
SUD	$ 6,535.44			$ 6,535.44
Composite PMPM	**$ 6,535.44**			**$ 6,535.44**

**Source: Milliman, Inc.*

Table 13. Enrollment and Expenditure Summary - Projected

Projected Expenditures (Including Enrollment Completion)

State of Indiana—Family and Social Services Administration Healthy Indiana Plan - 1115 Demonstration Waiver Enrollment and Expenditure Summary Projected Expenditures (Including Enrollment Completion)				
Enrollment (Mbr Mos.)	**DY 4**	**DY 5**	**DY 6**	**Total**
SUD	1,736	9,661	9,758	21,155
Total Enrollment	**1,736**	**9,661**	**9,758**	**21,155**
Expenditures	**DY 4**	**DY 5**	**DY 6**	**Total**
SUD	$ 12,894,963	$ 67,871,951	$ 71,909,622	$ 152,676,536
Total Claim Cost	**$ 12,894,963**	**$ 67,871,951**	**$ 71,909,622**	**$ 152,676,536**
Per Member Per Month	**DY 4**	**DY 5**	**DY 6**	**Total**
SUD	$ 7,426.58	$ 7,025.37	$ 7,369.61	$ 7,217.08
Composite PMPM	**$ 7,426.58**	**$ 7,025.37**	**$ 7,369.61**	**$ 7,217.08**

**Source: Milliman, Inc.*

Table 14. Enrollment and Expenditure Summary – Actual and Projected

Actual and Projected Experience

State of Indiana—Family and Social Services Administration Healthy Indiana Plan - 1115 Demonstration Waiver Enrollment and Expenditure Summary Actual and Projected Experience				
Enrollment (Mbr Mos.)	DY 4	DY 5	DY 6	Total
SUD	9,565	9,661	9,758	28,984
Total Enrollment	**9,565**	**9,661**	**9,758**	**28,984**
Expenditures	DY 4	DY 5	DY 6	Total
SUD	$ 64,060,958	$ 67,871,951	$ 71,909,622	$ 203,842,531
Total Claim Cost	**$ 64,060,958**	**$ 67,871,951**	**$ 71,909,622**	**$ 203,842,531**
Per Member Per Month	DY 4	DY 5	DY 6	Total
SUD	$ 6,697.21	$ 7,025.37	$ 7,369.61	$ 7,032.96
Composite PMPM	**$ 6,697.21**	**$ 7,025.37**	**$ 7,369.61**	**$ 7,032.96**

**Source: Milliman, Inc.*

Table 15. Budget Neutrality Summary

Includes Experience Incurred and Paid through December 31, 2018

State of Indiana—Family and Social Services Administration Healthy Indiana Plan - 1115 Demonstration Waiver Budget Neutrality Summary Includes Experience Incurred and Paid through December 31, 2018			
Enrollment (Mbr Mos.)	**DY 4**	**DY 5**	**DY 6**
SUD	7,829		
Total Enrollment	**7,829**		
PMPM (Without Waiver)	**DY 4**	**DY 5**	**DY 6**
SUD	$ 6,834.71	$ 7,169.61	$ 7,520.92
Composite PMPM	**$ 6,834.71**	**$ 7,169.61**	**$ 7,520.92**
Without Waiver Expenditures	**$ 53,508,945**		
PMPM (Actual)	**DY 4**	**DY 5**	**DY 6**
SUD	$ 6,535.44		
Composite PMPM	**$ 6,535.44**		
With Waiver Expenditures			
	$ 51,165,996		
Waiver Margin*	**$ 2,342,949**		
*The state will not be allowed to obtain budget neutrality "savings" from the SUD MEG, as stipulated in Section XIV.3.e of the STCs			

**Source: Milliman, Inc.*

Table 16. Budget Neutrality Summary

Budget Neutrality Projected - Includes Experience Incurred and Paid through December 31, 2018

State of Indiana—Family and Social Services Administration Healthy Indiana Plan - 1115 Demonstration Waiver Budget Neutrality Summary Includes Experience Incurred and Paid through December 31, 2018			
Enrollment (Mbr Mos.)	**DY 4**	**DY 5**	**DY 6**
SUD	9,565	9,661	9,758
Total Enrollment	**9,565**	**9,661**	**9,758**
PMPM (Without Waiver)	**DY 4**	**DY 5**	**DY 6**
SUD	$ 6,834.71	$ 7,169.61	$ 7,520.92
Composite PMPM	**$ 6,834.71**	**$ 7,169.61**	**$ 7,520.92**
Without Waiver Expenditures	**$ 65,376,226**	**$ 69,265,450**	**$ 73,386,043**
PMPM (Actual and Projected)	**DY 4**	**DY 5**	**DY 6**
SUD	$ 6,697.21	$ 7,025.37	$ 7,369.61
Composite PMPM	**$ 6,697.21**	**$ 7,025.37**	**$ 7,369.61**
With Waiver Expenditures	**$ 64,060,958**	**$ 67,871,951**	**$ 71,909,622**
Waiver Margin*	**$ 1,315,268**	**$ 1,393,500**	**$ 1,476,421**
*The state will not be allowed to obtain budget neutrality "savings" from the SUD MEG, as stipulated in Section XIV.3.e of the STCs			

Source: Milliman, Inc.

Table 17. Annual Budget Neutrality Summary

Actual expenditures based on quarter reported and incurred

State of Indiana Family and Social Services Administration HIP 1115 Waiver SUD Expenditures Actual expenditures based on quarter reported and incurred					
Quarter	**Q1 2018**	**Q2 2018**	**Q3 2018**	**Q4 2018**	**Total by Incurred**
Q1	$ 6,565,447.52	3,553,857.43	875,415.27	$913,477.20	$ 11,908,197.42
Q2		7,589,952.63	5,736,039.38	1,877,615.38	15,203,607.39
Q3			6,591,442.02	8,530,921.26	15,122,363.28
Q4				8,931,827.58	8,931,827.58
Total Reported	**$ 6,565,447.52**	**$ 11,143,810.06**	**$ 13,202,896.67**	**$ 20,253,841.42**	**$ 51,165,995.67**
Cumulative	**$ 6,565,447.52**	**$ 17,709,257.58**	**$ 30,912,154.25**	**$ 51,165,995.67**	

**Source: Milliman, Inc.*

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MONTE A ROSE, JR., *et al.*,

Plaintiffs,

v.

ALEX M. AZAR II, *et al.*,

Defendants.

Civil Action No. 1:19-cv-2848 (JEB)

[PROPOSED] ORDER

The Court having considered plaintiffs' motion regarding a proposed briefing schedule and the federal and state defendants' joint motion for a stay pending resolution of the D.C. Circuit appeals in *Stewart v. Azar*, No. 19-5096 (D.C. Cir.) and *Gresham v. Azar*, No. 19-5094 (D.C. Cir.), and the parties submissions relating thereto, it is hereby:

ORDERED that plaintiffs' motion regarding a proposed briefing schedule is DENIED. It is further ORDERED that the state and federal defendants' joint the motion for a stay is GRANTED. All proceedings in this case are hereby STAYED pending issuance of the mandates in *Stewart v. Azar*, No. 19-5096 (D.C. Cir.) and *Gresham v. Azar*, No. 19-5094 (D.C. Cir.). Within fourteen days of the mandates issuing from those appeals, the parties shall file a joint status report proposing further proceedings.

_____
Date

_____
James E. Boasberg
United States District Judge