UNITED STATES DISTRICT COURT
DISTRICT OF THE DISTRICT OF COLUMBIA

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

MEMORANDUM OF INTERVENOR-DEFENDANT INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION IN SUPPORT OF MOTION FOR ADMINIISTRATIVE STAY AND STAY PENDING APPEAL

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INTRODUCTION

Pursuant to Federal Rule of Appellate Procedure 8(a)(1), Intervenor-Defendant Indiana Family and Social Services Administration (FSSA) requests that the Court issue a stay pending appeal. FSSA also asks that the Court administratively stay its order vacating and remanding the Secretary's 2020 approval pending a ruling on FSSA's motion for a stay pending appeal and, in the event the motion is denied, until the D.C. Circuit can consider a stay request.

The Court's decision to vacate the Secretary's 2020 approval for the Healthy Indiana Plan 2.0 (HIP) will result in serious negative consequences for FSSA's members that go far beyond eliminating FSSA's authority to require POWER Account contributions. Without a waiver allowing the implementation of HIP or a stay of this Court's decision, FSSA will be forced to transition more than 335,000 beneficiaries from HIP Plus to HIP Basic. Transitioned beneficiaries will lose access to benefits for dental, vision, chiropractic, bariatric surgery, and TMJ surgery, along with other increased benefits, and will need to start making co-payments for services as received or utilized—even though many members would prefer to make predictable monthly POWER Account contributions rather than scrounge up money for co-payments whenever they happen to visit the doctor or stay in the hospital. Moreover, in the absence of a waiver or stay, FSSA will need to make extensive changes to systems and contracts, which will tie up substantial resources. And loss of the waiver creates funding risks too.

A stay pending appeal of this Court's decision is appropriate. Although this Court may have rejected the federal government's and FSSA's arguments regarding the waiver, there is a strong likelihood that those arguments could prevail on appeal. As this Court's decision acknowledges, a decision from another district court supports FSSA's position here. And while this Court declined to follow that decision based on its prior decisions regarding work requirements from

Arkansas and Kentucky, the Supreme Court deemed Arkansas's and Kentucky's arguments against those work-requirement decisions to have sufficient merit to grant certiorari. As this Court's opinion acknowledges, moreover, the Secretary's decision in this case is supported by stronger reasoning than the Secretary's decision in the work-requirement cases. There are good reasons to believe that FSSA could prevail on the merits—or at least convince an appeals court that the disruptive consequences of vacatur favor remanding without vacating.

A stay, meanwhile, would have a limited impact on the plaintiffs. FSSA plans on keeping POWER Account contributions requirements paused at this time. A stay will not have immediate impacts for the availability of non-emergency medical transportation (NEMT) and retroactive coverage either.

ARGUMENT

In considering a stay, a court must ask whether the applicant is "likely to succeed on the merits," whether the "applicant will be irreparably injured absent a stay," whether a stay "will substantially injure the other parties interested in the proceeding," and "where the public interest lies." *Nken v. Holder*, 556 U.S. 418, 434 (2009) (quoting *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987)). Those factors must be considered holistically. Where the balance of hardships tilts decidedly towards the stay applicant, "it will ordinarily be enough" that the applicant has raised "serious" or "substantial" questions regarding the merits. *Wash. Metro. Area Transit Comm'n v. Holiday Tours, Inc.*, 559 F.2d 841, 844 (D.C. Cir. 1977). "The court is not required to find that ultimate success by the movant is a mathematical probability, and indeed, as in this case, may grant a stay even though its own approach may be contrary to movant's view of the merits." *Id.* at 843.

I. FSSA Has a Strong Likelihood of Success on the Merits

Although FSSA acknowledges that the Court disagrees with its position on the merits, FSSA respectfully submits that it is likely to succeed on appeal. First, there are strong arguments that the HIP demonstration project is consistent with Medicaid's objectives. Second, there are strong arguments that plaintiffs lack standing. And third, there are strong arguments that the proper remedy for any deficiency in the Secretary's reasoning was remand without vacatur.

A. FSSA is likely to succeed on arguments that the waiver promotes Medicaid's objectives

There are strong arguments that the waiver for HIP is consistent with the Medicaid statute's objectives. As FSSA previously explained, the waiver promotes coverage by allowing Indiana to provide coverage for "non-mandatory benefits and eligibility groups." S.A.R. 1562; *see* State Mem. 24–28; State Reply 8–12. This Court's opinion does not dispute that Indiana expanded Medicaid on the condition that the expansion population would be covered through HIP. *See* State Mem. 6–11, 24–28. Nor does the opinion dispute that, compared to "what coverage would have been" absent Medicaid expansion in Indiana, the waiver expanded coverage. Dkt. 68 at 47. The waiver after all allowed Indiana to expand Medicaid—and provide optional benefits like dental, vision, and chiropractic—to more than 570,000 Hoosiers who lacked any Medicaid benefits before its expansion through HIP. S.A.R. 1557, 1564, 8238. Instead, the Court stated a waiver must "increase coverage as compared to expanded Medicaid with no waivers." Dkt. 68 at 48.

FSSA submits that there is a strong likelihood that an appeals court will view the matter differently—as indeed another district court already has. *See Georgia v. Brooks-LaSure*, No. 2:22-cv-6, 2022 WL 3581859, at *13–15 (S.D. Ga. Aug. 19, 2022); Dkt. 68 at 46–47 (acknowledging that *Brooks-LaSure* "support[s]" the "State's position"). Section 1115 does not require the Secretary to compare a proposed project against "Medicaid with no waivers." Rather, Section 1115

requires the Secretary to evaluate whether the "project" is "likely to assist in promoting the objectives of [the Medicaid statute]." 42 U.S.C. § 1315(a). Logically, then, the appropriate baseline is what would have existed absent the project. *See Brooks-LaSure*, 2022 WL 3581859, at *14. Consequently, where a State has already expanded traditional Medicaid and later proposes a demonstration project, the baseline is traditional Medicaid without waivers. But where the project is the vehicle through which Medicaid is expanded, the baseline is a pre-expansion world. *See id.*

This is a situation in which the baseline should be the pre-expansion world. Critically, HIP is the vehicle through which Indiana expanded Medicaid—it was not simply bolted on after traditional Medicaid was expanded. As Indiana told the federal government, "Indiana will not expand traditional Medicaid." Letter from Gov. Pence to President Obama, at 2 (Oct. 2, 2014), https://www.in.gov/fssa/hip/files/Governor_Pence_Letter_to_President_Obama.pdf. Indiana would expand Medicaid only if it could "maintain the consumer-driven model on which the [HIP] program is predicated," including "the requirement that Healthy Indiana Plan members make monthly account contributions" into "a Health Savings Account-like account." Letter from Gov. Pence to Sec'y Sebelius, HHS, at 2 (Nov. 15, 2013), https://www.in.gov/fssa/hip/files/Letter_from_Governor_Pence_to_Secretary_Sebelius.pdf. Vacating the waiver now changes the terms of the deal on which Indiana and the federal government agreed to Medicaid expansion.

That the HIP project challenged here was the precondition for expanding Medicaid in Indiana both distinguishes this case from work-requirement cases in which those requirements were added *after* Medicaid's expansion and supplies a "limiting principle." Dkt. 68 at 44. Under FSSA's reading, the Secretary cannot approve "whatever" demonstration project he wishes on the theory that the State could "de-expand, or indeed do away with all of, Medicaid." *Id.* at 45. The Secretary

must compare the project to what would exist in its absence. Accordingly, where traditional Medicaid already covers a population, the Secretary's discretion will be more circumscribed. Only where, as here, the project is the condition on which Medicaid is expanded is it appropriate to consider a world without expansion. And even then, the Secretary must consider whether the project is likely to promote Medicaid's objectives. Not every proposal will meet that standard.

This Court may not believe that Section 1115 provides the Secretary discretion to waive some of traditional Medicaid's requirements to induce States to expand Medicaid. Dkt. 68 at 44. But that is precisely how another court and the Secretary have understood Section 1115. *See Brooks-LaSure*, 2022 WL 3518159, at *14–15. In the wake of the Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), that Medicaid expansion was optional, the Secretary enticed States like Indiana to expand Medicaid by offering them "considerable flexibility." A.R. 318. That is why, after the *NFIB* decision, CMS assured all States that "if a state covers the expansion group, it may decide later to drop the coverage." A.R. 314–315. It would raise substantial Spending Clause concerns to hold that States that relied on the Supreme Court's decision and the federal government's representations cannot later decide to reverse course. *See NFIB*, 567 U.S. at 575–76 (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.). That would turn a Spending Clause program into an unconstitutional direct mandate, in violation of anti-commandeering principles. *See id.* Again, FSSA recognizes that this Court construes Section 1115 differently. The Court, however, "may grant a stay even though its own approach may be contrary to movant's view of the merits." *Washington Metro.*, 559 F.2d at 843.

Even if traditional Medicaid is the standard against which to evaluate the project, there is a strong likelihood that an appeals court will conclude that the waiver on the whole promotes coverage. Importantly, HIP provides "non-mandatory benefits" to members who make required

POWER Account contributions. S.A.R. 1569; *see* State Mem. 26–27; State Reply 12–14. The Court faulted the Secretary for not "balanc[ing] the fact that HIP 2.0 furnishes *more* medical assistance than is required to some members of the expansion population with the fact that it furnishes *no* medical assistance whatsoever to other members of that population." Dkt. 68 at 43. Respectfully, FSSA submits that the Secretary did just that. The Secretary discussed both what members gain by making POWER Account contributions (*e.g.*, dental, vision, and chiropractic benefits, plus no cost sharing), S.A.R. 1564, and the potential that some members could not afford or would not make POWER Account contributions, S.A.R. 1565–66, 1570–71. That discussion of those competing considerations suffices. The Secretary was not required to use any particular "magic words." *TransCanada Power Mktg. v. FERC*, 811 F.3d 1, 10 (D.C. Cir. 2015).

There is yet another way in which the waiver promotes coverage—it ensures the Medicaid program's sustainability by increasing beneficiary health, preparing beneficiaries for commercial insurance, and reducing unnecessary costs. S.A.R. 1564; *see* State Mem. 30–34; State Reply 12–13. Citing *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020), *vacated as moot sub nom. Arkansas v. Gresham*, 142 S. Ct. 1665 (2022), a decision addressing work requirements imposed by Arkansas and Kentucky, the Court states that better health is not one of the Medicaid statute's goals. Dkt. 68 at 49–50. In another decision that *Gresham* did not cite, however, the D.C. Circuit ruled that the Secretary reasonably concluded that increasing access to prescription drugs "serves Medicaid goals" because it "'will maintain or improve their health status'" and make them "'less likely to become Medicaid eligible.'" *Pharm. Rsch. & Mfrs. Am. v. Thompson*, 362 F.3d 817, 825 (D.C. Cir. 2004). *Thompson* supports the proposition that the waiver advances Medicaid's purposes, whether health is considered a stand-alone objective or a component of sustainability.

Moreover, even if the D.C. Circuit's decision in *Gresham* (which was vacated) is read to abrogate its decision in *Thompson* (which was never vacated), it is important to recall that the Supreme Court granted certiorari to review the D.C. Circuit's decision in *Gresham*. *See Azar v. Gresham*, 141 S. Ct. 890 (2020). That signals there is a strong likelihood that FSSA will prevail. The Supreme Court would not have granted certiorari in *Gresham* if it perceived Arkansas's and Kentucky's position to have no chance of success. *See* Sup. Ct. R. 10 ("A petition for a writ of certiorari will be granted only for compelling reasons"). And as this Court recognized, the Secretary's reasoning in this case is a "step up" from the Secretary's reasoning in *Gresham*. Dkt. 68 at 48. That, too, is evidence that FSSA has a strong likelihood of prevailing.

The Court also suggested that the Secretary failed to balance health benefits and sustainability relative to harms, even going so far as to say the Secretary failed to make a finding that the waiver would save Indiana money. Dkt. 68 at 50–55. As an initial matter, the Secretary stated eliminating retroactive coverage would "reduce the cost of providing Medicaid coverage" and talked about how the waiver would "improve the fiscal sustainability of the state's safety net." S.A.R. 1561–62, 1572. Those statements can reasonably be viewed as findings of cost savings. Nor is the disconnect between the Secretary's comment about cost savings from non-assurance of NEMT and evidence that NEMT would prepare beneficiaries for commercial coverage as great as the Court supposes. *Cf.* Dkt. 68 at 53. As the D.C. Circuit understood in *Thompson*, efforts to keep borderline populations off Medicaid rolls promotes Medicaid's fiscal sustainability by making "more resources . . . available" for Medicaid beneficiaries. 362 F.3d at 825.

There is a likelihood that an appeals court could conclude the Secretary considered tradeoffs as well. In the 2020 approval, the Secretary took nine pages to explain his determination that the HIP project would be likely to promote the Medicaid statute's goals, S.A.R. 1557–66. For

example, he cited evidence that HIP's design would promote a sustainable program by encouraging members to obtain preventative care and engage in healthy behaviors. S.A.R. 1562, 1564. Concomitantly, the Secretary discussed concerns that the waiver would result in some members being disenrolled for failure to make POWER Account contributions, S.A.R. 1563–64, 1566–71, or that the loss of retroactive coverage would be detrimental, S.A.R. 1564–65, 1571–72. Although this Court may not consider that discussion to suffice, FSSA submits there is a strong likelihood another court could reach a different conclusion on deferential arbitrary and capricious review.

B. FSSA is likely to succeed on arguments that plaintiffs lack standing

There is also a strong likelihood that FSSA will succeed on its standing arguments. The only plaintiff that this Court deemed to have a "concrete injury traceable to the program" is Emily Rames, an adult whose income is between 100% and 133% of the federal poverty line. Dkt. 68 at 24. The Court did not address whether the other plaintiffs have suffered injuries in fact. *See id.* And in evaluating Rames's standing, the Court considered her standing "only" with respect to "Count I." *Id.* at 28–29. It did not address her standing with respect to other claims for relief.

With respect to Rames, the Court reasoned that vacatur of the waiver would redress her alleged injuries in Count I because HIP "could no longer be implemented." Dkt. 68 at 25. One problem with that analysis is that vacatur will not redress Rames's substantive injury because it will not allow her to keep the same level of benefits that she wishes to retain. Even if one assumes that Rames remains eligible for Medicaid under the "state plan," Dkt. 68 at 27, the state plan ties enhanced benefits to POWER Account contributions, State Reply 3–5. For adults who have incomes between 100% and 133% of the federal poverty line and who do not fall into a special category, the state plan makes "contribution[s] to . . . Personal Wellness and Responsibility

(POWER) account[s]" a condition of obtaining enhanced benefits like vision, dental, and chiropractic. CMS, *IN-15-0003, Alternative Benefit Plan Populations*, https://provider.indianamedicaid.com/ihcp/StatePlan/Suffix/ABP/ABP2-1.pdf. In the absence of a waiver for HIP, FSSA's "best interpretation" of the state plan is that adults like Rames are "at most entitled to the 'HIP Basic' benefit plan," Steinmetz Decl. Ex. A at 3—a plan that does not include the vision and dental benefits that Rames desires to keep.

That distinguishes this case from "*Stewart I*." Dkt. 68 at 25. In that case, the plaintiffs challenged a waiver authorizing Kentucky to impose *new* limitations on coverage for populations that the State already covered through Medicaid. *See Stewart v. Azar* (*Stewart I*), 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (noting that Kentucky's Medicaid expansion in 2014 resulted in coverage of "more than 428,000 new residents" before the Secretary approved new restrictions through a Section 1115 waiver in 2018). That meant there was an existing state plan to fall back upon that did not depend upon the challenged waiver. By contrast, this case targets the waiver for the program by which Indiana expanded Medicaid. There is no state plan covering the expansion population that can be separated from HIP. This Court of course may not be persuaded that the distinction matters. But there is nonetheless a likelihood that an appeals court could disagree with *Stewart I* or deem this case distinguishable.

There is a final problem with the standing analysis—there is a mismatch between the Court's standing and merits analysis. As the Court acknowledged, a plaintiff "must demonstrate standing separately for reach form of relief sought" and "for each claim he seeks to press." Dkt. 68 at 28 (cleaned up). The Court ruled that Rames had standing only for Count I. *See id.* at 29. That count sought vacatur of the waiver on grounds that the HIP extension is not experimental, that it cannot be approved for 10 years, and that HHS considered impermissible factors in making

those determinations. Dkt. 50-1 at 34–35 (¶¶ 180–187). Other counts concerned POWER Account contributions, retroactive coverage, and non-assurance of NEMT. The Court, however, did not address the length of the HIP extension or its experimental nature in its opinion. Its merits analysis rests on issues raised by Counts III, IV, and V. *See id.* at 36–39 (¶¶ 192–210).

C. FSSA is likely to succeed on arguments about the proper remedy

In any event, there are strong arguments that vacatur goes too far. The Court itself does not rule out that "HHS could indeed rehabilitate the approval on remand." Dkt. 68 at 58. And while the Court criticized the Secretary for failing to heed the Court's opinions in work-requirement cases, *id.*, there is good reason to think the appeals court could rule those opinions are either distinguishable or incorrect, *see* pp. 2–8, *supra*.

On the other side of the ledger, the disruptive consequences of vacatur are severe. State Mem. 41–42; State Reply 20. The Court dismissed concerns about "inconvenience" on the ground that "premium requirements and associated penalties have not been in effect since March 2020." Dkt. 68 at 60. That understates the impact. Vacatur impacts all aspects of HIP, not just POWER Account contributions. FSSA must now grapple with issues it did not have to address previously, including retroactive eligibility and non-assurance of NEMT. Including one or both of these in the HIP program will be expensive and require extensive changes to the State's systems and contracts. S.A.R. 2; *see* Steinmetz Decl. Ex. A at 3–5 (describing impact in greater detail).

Vacatur adversely impacts beneficiaries as well. State Mem. 41–42; State Reply 20. The Court characterized FSSA's concern as a fear "that vacatur would undermine its ability to provide coverage to the expansion population *at all*." Dkt. 68 at 62. That is one concern, but it is not the only concern. Another problem is that vacatur creates substantial uncertainty about the *level of benefits*, as FSSA pointed out. State Mem. 19–20; State Reply 5. Under the state plan—which

plaintiffs and this Court treat as specifying eligibility for benefits in the absence of a waiver, *see* Dkt. 68 at 27; Pls. Reply 4, 7, 41–42—the basic benefit package *requires* beneficiaries to make co-payments and *excludes* coverage for vision and dental. *See* CMS, *IN-15-0002, Alternative Benefit Plan Populations*, https://provider.indianamedicaid.com/ihcp/StatePlan/Suffix/ABP/ABP1-1.pdf (stating that the Medicaid population receives HIP Basic Plan benefits absent contributions); CMS, *IN-15-0002, Alternative Benefit Plan Cost-Sharing*, https://provider.indianamedicaid.com/ihcp/StatePlan/Suffix/ABP/ABP1-4.pdf. Without a waiver for HIP, FSSA's ability to provide the enhanced level of benefits available under HIP Plus is compromised.

Even if the Court believes POWER Account contributions constitute a barrier to coverage for some share of the Medicaid-expansion population, Dkt. 68 at 62, the vast majority of HIP enrollees believe those contributions worthwhile to obtain expanded benefits and to eliminate otherwise applicable co-payments (which themselves could constitute a barrier to obtaining services, *see* 42 C.F.R. § 447.52(e) (providing that cost-sharing can be made a condition of service for some populations)). S.A.R. 4279, 8250, 8252. Indeed, plaintiffs themselves want dental and vision services, Dkt. 54-3 ¶ 9; *see* Dkt. 54-2 ¶ 13; Dkt. 54-4 ¶ 7. Given that the waiver impacts all aspects of HIP, there is good reason to believe that an appellate court could deem the appropriate remedy to be remand without vacatur. Such a remedy would allow the Secretary to reconsider the evidence without creating substantial uncertainty for the entire HIP project.

II. The Remaining Stay Considerations Favor a Stay

Without a stay, FSSA, many of HIP's 700,000 members, and the public interest will be irreparably injured. Whenever the government is prevented from effectuating its policies, it and the public interest suffer "irreparable harm." *Abbott v. Perez*, 585 U.S. 579, 602 & n.17 (2018); *see Nken*, 556 U.S. at 435 (the government's interest and "public interest" tend to "merge").

Beyond that, the Court's order vacating the waiver creates "substantial uncertainty" for HIP's beneficiaries, operations, and funding. Steinmetz Decl. Ex. A at 1. Under the Medicaid statute, persons in the Medicaid expansion population are entitled only to "alternative benefits" (also known as "benchmark" benefits). 42 U.S.C. §§ 1396a(k), 1396u-7(b)(2); 42 C.F.R. § 440.300. Indiana's state plan specifies two alternative benefit packages: HIP Basic and HIP Plus. Because HIP Plus requires POWER Account contributions from persons whose incomes are between 100% and 133% of the federal poverty level and who do not fall into any special category, CMS, *IN-15-0003, Alternative Benefit Plan Populations*, https://provider.indianamedicaid.com/ihcp/StatePlan/Suffix/ABP/ABP2-1.pdf, FSSA's "best interpretation" is that this group is not entitled to HIP Plus absent a waiver, Steinmetz Decl. Ex. A at 3. Thus, in the absence of a stay (or reissued waiver), FSSA "will be forced to start transitioning over 335,000 Medicaid members" from HIP Plus to HIP Basic. *Id.* at 2.

Not only would it take substantial time and effort on FSSA's part to transfer more than 335,000 beneficiaries from HIP Plus to HIP Basic, but a transition would adversely impact the affected beneficiaries too. Transitioned beneficiaries would lose access to benefits for dental, vision, chiropractic, bariatric surgery, and TMJ surgery, which are not available under HIP Basic. CMS, *IN-22-0009, Benefits Description*, https://provider.indianamedicaid.com/ihcp/StatePlan/Suffix/ABP/ABP1-5.pdf. The affected beneficiaries would also face new requirements to make co-payments for services, which Medicaid regulations authorize even in the absence of a Section 1115 waiver. *See* 42 C.F.R. § 447.52(b), (e); S.A.R. 36.

FSSA will suffer irreparable harm in other ways too. As the Secretary recognized, FSSA must alter "eligibility systems and managed care plan contracts" to operate in a world without a waiver. S.A.R. 2; *see* Steinmetz Decl. Ex. A at 4–5. Vacatur is also "likely to impact systems

design around auto-assignment, coverage start dates, annual benefit periods, and plan change rules." Steinmetz Decl. Ex. A at 5. Those modifications cannot be accomplished overnight. For example, to provide retroactive eligibility coverage, FSSA would first need to determine "whether retroactive coverage would be provided via a fee-for-service or managed care delivery system." *Id*. "From there, extensive system changes would be necessary," member communications would need to be revised, and contracts may need to be revised as well. *Id.* The design and development of changes would take at least 12 months. *Id.* And if the waiver were reinstated on appeal, this significant expenditure of effort would be for naught.

Impacts on other interested parties are minimal. At this time, FSSA plans to continue to pause collection of POWER Account contributions. Steinmetz Decl. ¶ 7. (If FSSA decides to turn POWER Account contributions back on before a final decision on appeal, FSSA will provide the Court and plaintiffs with at least six weeks' notice of its intent to do so.)[1] Granting a stay will not impact, or at least immediately impact, the availability of NEMT and retroactive coverage. The state plan does not provide for assurance of NEMT, which means that it will be offered only if the

[1] Nor are POWER Account contributions the barrier to coverage that plaintiffs would like to make them out to be. Under the waiver, anyone with an income at or below 100% of the federal poverty line would receive all essential health benefits, whether or not they contributed to POWER Accounts. S.A.R. 1570. Contributions were "generally . . . affordable," S.A.R. 1570, "the number and proportion of individuals disenrolled due to non-payment decreased over time," *id.*, and under the Court's view of Indiana law and the approval, anyone disenrolled could immediately reenroll, *see* S.A.R. 1559–60. Of course, there are still some persons who did not make contributions. But that consideration must be balanced against the fact that the Medicaid rules authorize States to require co-payments for services and, for adults above 100% of the federal poverty level who are not pregnant or disabled, to make cost sharing a condition of receiving service. *See* 42 C.F.R. § 447.52(b), (e); S.A.R. 36. For those adults, the choice is not between a world with no financial outlays and one with POWER Account contributions; the choice is between a world with unpredictable time-of-service charges and one with low, predictable monthly contributions. Indeed, the costs that can be incurred by beneficiaries under the traditional cost-sharing rules incorporated into Indiana's state plan can exceed the costs that can be incurred under the provisions governing POWER Account contributions. *Compare* S.A.R. 37 (capping cost-sharing at 5% of household income), *with* S.A.R. 31 (capping POWER Account contributions at 3% of household income).

state plan is amended. Steinmetz Decl. Ex. A at 3–4. Meanwhile, beneficiaries have access to NEMT benefits from managed care entities. *Id.* at 4. And whether a stay will impact retroactive coverage is at best uncertain. State law does not provide for retroactive coverage, and none of HIP's systems are designed to allow processing of retroactive claims. *Id.* It would be at least 12 months before claims could be processed, whether or not a stay issues. *Id.*

Today, the entire Medicaid system in Indiana for non-disabled adults is built around HIP. Vacating the waiver strikes at that system's core. A stay pending appeal is required to prevent the loss of benefits, disruption, and confusion that will otherwise result.

CONCLUSION

The Court should issue an administrative stay sufficient to allow briefing on this motion and, if the motion is denied, sufficient to allow FSSA to seek a stay from the Court of Appeals. The Court also should stay its order and judgment pending appeal.

Respectfully submitted,

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Indiana Attorney General

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UNITED STATES DISTRICT COURT
DISTRICT OF THE DISTRICT OF COLUMBIA

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

DECLARATION OF CORA STEINMETZ

Pursuant to 28 U.S.C. § 1746, I, Cora Steinmetz, declare as follows:

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

2. I submit this declaration in support of Intervenor-Defendant Family and Social Services Administration's (FSSA) motion for a stay pending appeal.

3. I am currently the Medicaid Director at the Indiana Family and Social Services Administration. My responsibilities as Medicaid Director include overseeing the Office of Medicaid Policy & Planning and providing policy and strategic planning leadership to the Indiana Medicaid program, which purchases and administers a full range of health care services for about two million low income and vulnerable Hoosiers through fee for service and managed care systems.

4. FSSA provides Medicaid coverage through the Healthy Indiana Plan (HIP), which operated under a demonstration waiver from the Secretary of the U.S. Department of Health and Human Services (HHS) issued in 2020. I understand that this Court vacated the waiver.

5. The decision vacating the waiver is causing substantial uncertainty about HIP's operations, funding, and sustainability. I have described those impacts in a recent letter to HHS, which is attached as Exhibit A. The letter's description is true and accurate.

6. The decision vacating the waiver is causing substantial uncertainty for HIP beneficiaries and providers as well. Since the decision issued, HIP members and providers have been contacting FSSA with questions and concerns. Answering these questions and concerns requires FSSA to expend resources addressing them that could be put to other purposes.

7. At this time, FSSA will continue to pause collection of POWER Account contributions. If a stay is issued and FSSA decides to resume collection of POWER Account contributions, FSSA will provide the Court and Plaintiffs with at least six weeks' notice of its intent to do so.

I declare under penalty of perjury that the foregoing statements are true and correct.

Executed on July 12, 2024

Cora Steinmetz

Exhibit A

Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W374, MS 07
INDIANAPOLIS, IN 46204-2739

July 10, 2024

Daniel Tsai
Deputy Administrator and Director of Center for Medicaid and CHIP Services (CMCS)
Department of Health and Human Services
Centers for Medicare and Medicaid Services
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RE: Request for Immediate Reissuance of Healthy Indiana Plan 1115 Demonstration

Dear Director Tsai:

On June 27, 2024, the United States District Court for the District of Columbia issued an order in *Rose v. Becerra* vacating the approval of the Healthy Indiana Plan (HIP) section 1115 demonstration and remanding the matter to the U.S. Department of Health and Human Services (HHS). The implications of this removal of the ten-year approval for the HIP section 1115 demonstration ("HIP Demonstration") are expansive. While the underlying litigation primarily took aim at HIP's Personal Wellness and Responsibility ("POWER") account contributions or premium-like payments, the removal of the entire HIP Demonstration approval will shift benefit coverage for many HIP members and creates substantial uncertainty for program operations and funding. The ruling also has implications that conflict with Indiana state law.

To preserve access to services for current HIP members and ensure the stability of program operations, we are seeking a stay of the District Court's order, which we ask CMS to support. In the absence of a stay, we urgently request that CMS reissue the HIP Demonstration approval in its entirety, which we believe CMS has the authority to do under the circumstances.

First enacted in 2007 by bipartisan state legislation, HIP has been approved continually, first as a limited pilot program and then as the vehicle for the State's Medicaid expansion. Three separate gubernatorial administrations have supported and operated this program, which has been approved under both Republican and Democrat federal administrations. The HIP program covers approximately 760,000 Hoosiers today, over 10% of the state's population and nearly 40% of the total Indiana Medicaid enrollment, and has been a successful pillar of Indiana Medicaid programs: health care access and outcomes have improved; medication adherence and preventative screenings have increased; and enrollment and coverage for pregnant women have

been streamlined.[1] Furthermore, HIP served as a critical lifeline to Hoosiers during the public health emergency.

Under the District Court's order that HIP members will be covered under the state plan rather than the HIP Demonstration, hundreds of thousands of HIP members will have fewer benefits along with higher cost-sharing in the form of copayments. In the absence of the waiver being immediately reissued (or the District Court ruling stayed), we will be forced to start transitioning over 335,000 Medicaid members into HIP Basic, resulting in a loss of certain benefits described below. The higher benefits and more predictable cost-sharing provided under the HIP Demonstration project are more than sufficient to establish that the project will expand benefits and meet the test articulated by the District Court for the Secretary's exercise of his Section 1115 authority.

Reissuance of the demonstration approval is appropriate and necessary given that failure to reestablish the waiver authorities will directly decrease coverage of services. That a reapproval of HIP is likely to promote the objectives of Medicaid is also fully consistent with the history of Medicaid expansion in Indiana, which was contingent on approval of HIP 2.0, including POWER account contributions, as the vehicle for expansion. This is evident from the repeated letters from the state officials to the federal government and state legislators in the wake of *NFIB v. Sebelius*,[2] and in the Indiana legislature's codification of key elements of HIP into state law, including the requirement for Indiana Medicaid to collect POWER account contributions and the explicit restriction on the state Medicaid agency's ability to negotiate reductions to contribution amounts. As you are aware, HIP's innovative design – including premium-like payments and the waiver of retroactive coverage – reflects Indiana's commitment to preparing HIP members for a transition to other forms of commercial coverage. By incentivizing HIP members to be health care consumers and maintain year-long coverage, HIP serves as a bridge to commercial insurance.[3]

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[1] *See* 2018-2020 Healthy Indiana Plan Summative Evaluation Report, submitted to CMS on June 30, 2022 and resubmitted on May 18, 2023.

[2] Letter from Gov. Michael R. Pence to President Barack Obama, dated Oct. 2, 2014 (https://www.in.gov/fssa/hip/files/Governor_Pence_Letter_to_President_Obama.pdf); Letter from Gov. Michael R. Pence to HHS Secretary Kathleen Sebelius, dated March 4, 2014 (https://www.in.gov/fssa/hip/files/Secretary_Sebelius_Thank_You_Letter.pdf); Letter from Gov. Michael R. Pence to Indiana House Insurance Committee Ranking Minority Member Rep. Ed DeLaney and Indiana House Public Health Committee Ranking Minority Member Rep. Charlie Brown dated Jan. 16, 2014 (https://www.in.gov/healthcarereform/files/GOV_HIP_201401301514.pdf); Letter from Gov. Michael R. Pence to HHS Secretary Kathleen Sebelius, dated Nov. 15, 2013 (https://www.in.gov/fssa/hip/files/Letter_from_Governor_Pence_to_Secretary_Sebelius.pdf); Letter from Gov. Michael R. Pence to Senate Democratic Leader Sen. Tim Lanane and House Democratic Leader Rep. Scott Pelath dated March 14, 2013 (https://www.in.gov/fssa/hip/files/3.14.13_MRP_Letter_to_Lanane_and_Pelath_re_HIP.pdf).

[3] *See* Healthy Indiana Plan Demonstration Application to Expand (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-exp-app-07022014.pdf); Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report dated July 6, 2016 (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf); Healthy Indiana Plan Sec. 1115 Demonstration Waiver Extension Request dated Jan. 31, 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-demo-app-02152017.pdf); and Healthy Indiana Plan Sec. 1115 Demonstration Waiver Extension Request dated Jan. 31, 2020 (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf).

Without reissuance of the HIP Demonstration, HIP members will see changes to their benefit structure and potentially increased co-payments outside of the POWER account structure, and significant program administration changes will be necessary requiring both financial, staff, and systems resources. These impacts are detailed below but may not represent an exhaustive list given the limited time to review all relevant state laws, the Medicaid State Plan, and the now-vacated HIP Demonstration approval as well as all operational and financial aspects and IT systems of this program.

Coverage Implications and Benefits Analysis

HIP Basic Benefit Package

With the waiver for the HIP Demonstration vacated, covered benefits for HIP members are now derived from the state Medicaid plan. Under the state plan, "HIP Basic" is the alternative benefit package for "individuals up to and including 100% federal poverty level (FPL) as based on MAGI income standards who do not pay a contribution to their HIP Plus Personal Wellness and Responsibility (POWER) account."[4] HIP Basic includes all essential health benefits, but does not include vision, dental, chiropractic visits, bariatric surgery, or temporomandibular joint (TMJ) surgery, and has a cap on therapy visits. These additional benefits are part of our second alternative benefit plan—HIP Plus—but HIP Plus is the benefit option only for "individuals with income up to and including 133% of the federal poverty level (FPL) as based on MAGI income standards who make a contribution to their Personal Wellness and Responsibility (POWER) account."[5]

In addition to more limited benefits, the HIP Basic alternative benefit plan also imposes the copayments described in the HIP Demonstration project; all of those copayments are within Medicaid limits and do not operate under the Secretary's waiver authority, so we believe they continue in effect.

There is also considerable uncertainty as to what, if any, benefits are available to adults with incomes between 100% and 133% of the FPL, because HIP Basic is limited to adults up to 100% of the FPL, and HIP Plus requires a POWER account contribution. At this time, our best interpretation of the state plan is that individuals with income up to and including 133% of the federal poverty level (FPL), and who are not a special category such as pregnant women or individuals with a disability, are at most entitled to the "HIP Basic" benefit plan, since the State is not authorized to collect POWER account contributions. In the absence of a reissued HIP Demonstration approval, HIP Basic will also become the only benefit package available for certain adult Medicaid members; and individuals in this group who previously were required (or willing) to make POWER account contributions to obtain more benefits will no longer have that option.

Non-Emergency Medical Transportation (NEMT)

HIP State Plan members, pregnant members, and those members meeting the medically frail definition receive full non-emergency medical transportation (NEMT) benefits. The alternative benefit plan in our state plan for both HIP Basic and HIP Plus does not include an assurance that

[4] Indiana State Plan, Section H1.1.
[5] Indiana State Plan, Section H2.1.

NEMT will be provided, consistent with the waiver of that requirement in the HIP Demonstration. Because we have not elected that assurance in the state plan, coverage under the alternative benefit plans will not result in the provision of NEMT for HIP members unless and until CMS requires us to amend the state plan to provide that assurance. Our understanding is that 12 other states also have at least one waiver of NEMT coverage.

We note that MCEs can opt to provide the benefit to HIP Basic or HIP Plus members as part of their value-added benefit, and all four HIP managed care entities (MCEs) offer some level of NEMT services to all HIP members. These MCEs also provide transportation benefits outside of medical transportation, such as transportation to Women, Infants, and Children (WIC) clinics, food pantries, and health education events.

If CMS were to require us to amend our state plan to assure NEMT benefits for all HIP Basic and Plus members—in place of the value-added benefit approach currently used—the State would require significant resources, planning, and implementation time. The needed changes could be implemented in no less than 12 months. We are continuing to calculate an estimated fiscal impact. Furthermore, a funding source for the increased program expenditures that would result would need to be identified and secured. From there, MCE capitation rate recalculations and contract amendments would be required which would necessitate certification and approval of the rates and contracts from CMS.

In addition, the State would need to perform an NEMT broker transportation capacity evaluation. With the launch of a new Indiana managed long-term services and supports (mLTSS) program on July 1, 2024, additional capacity would need to be built over time to ensure member access could be appropriately balanced across programs. NEMT broker contracts would need to be renegotiated and amended and would likely require an increased cost to incentivize network expansion. Member materials would need to be updated, including member notices, handbooks, and websites.

These significant changes would result in limited added value for HIP members since most receive this benefit from the MCEs already without a coverage mandate and resulting capitation rate increase.

Retroactive Coverage

Indiana state law specifies that the HIP program does not have retroactive coverage,[6] and all systems and operational processes are built to allow HIP coverage to begin no sooner than the first day of the month of application. This federal authority was also established in the now vacated HIP Demonstration approval. Our understanding is that 23 other states also have at least one waiver of retroactive eligibility.

In addition to addressing the conflict with state law, adding retroactive coverage to HIP would require substantial policy, operational, and systems implementation work and could not be accomplished with less than 12 months of lead time.[7] Similar to the NEMT issue, a funding

[6] Ind. Code § 12-15-44.5-4.7.

[7] While pregnant women covered through HIP do receive retroactive coverage, the process by which this happens cannot be directly replicated for other HIP members without substantial process redesign as that systematic eligibility is linked to the member's pregnancy status indicator.

source for the increased program expenditures that would result from this change would need to be identified and secured. We are continuing to calculate an estimated fiscal impact.

A determination would first need to be made as to whether retroactive coverage would be provided via a fee-for-service or managed care delivery system. From there, extensive system changes would be necessary to interface between the eligibility system and the Medicaid Management Information System (MMIS). Member communications, notices, and benefit manuals would need to be revised. Design and development of these system changes would take a minimum of 12 months and possibly longer given upcoming work needing to be prioritized related to the new federal eligibility final rules.

A fee-for-service design option would also require extensive MMIS changes to develop a retroactive category for HIP to allow for enrollment and payment of claims. While a managed care option would require fewer system changes at the state operation level, capitation would need to be developed and managed care contracts amended. Significant system changes would likely be needed by the MCEs.

Program Financing

The total annual HIP program budget is approximately $5.6B and the vast majority of the 10% state share of this funding comes from Indiana's Hospital Assessment Fee (HAF), a provider-related tax authorized under state law. The fee annually generates over $415M to fund the HIP program and is a fundamental element of Indiana's Medicaid expansion. The authority for the State to collect the HAF ceases if HHS "makes a final determination that the [HIP] waivers are not approved or cannot be validly implemented."[8] A similar provision is triggered in the case of an appellate court final determination. Indeed, Indiana law goes so far as to mandate a "phase out period" of the HIP program upon Indiana Medicaid's receipt of written notice by HHS of its decision to "terminate or suspend the waiver demonstration for the plan" or "withdraw the waiver or expenditure authority for the plan."[9]

While our interpretation is that the specific conditions of the statute – HHS notification and/or an appellate court decision – have not occurred, the vacatur of the HIP demonstration creates a risk that the State's ability to continue collecting the HAF for purposes of funding the HIP program is challenged. Without this funding source, it is difficult to see a path forward for HIP to continue at its current enrollment, utilization, and reimbursement levels. However, immediate reissuance of the waiver in a manner complying with the District Court's ruling would remove this risk and stabilize funding authority for the program.

Other Administrative Authorities

As stated above, there are likely other programmatic impacts that have yet to be identified by removal of the HIP Demonstration approval. At a minimum, the loss of managed care attribution authorities is likely to impact systems design around auto-assignment, coverage start dates, annual benefit periods, and plan change rules. Further, while the District Court's decision attempts to separate Indiana's Substance Use Disorder / Serious Mental Illness (SUD / SMI) 1115 demonstration approval from the HIP program approval, it is unclear procedurally how this

[8] Ind. Code § 16-21-10-6(b).
[9] Ind. Code §§ 12-15-44.5-1, 16-21-10-5.3.

can occur and what this will mean for the SUD / SMI program as it reaches its expiration at the end of 2025.

Although the District Court makes reference in its ruling to the decision being one that attempts to "maintain the status quo", the vacatur of the HIP Demonstration approval makes it impossible for Indiana Medicaid to do so. As detailed here, HIP members will experience loss of benefits with higher copayments, program operations will be significantly impacted, and funding mechanics for the program will be subject to challenges without reissuance of the HIP Demonstration approval in its prior form.

Thank you for your expeditious attention to this matter. We look forward to working with you to resolve this issue for the benefit of Indiana Medicaid members.

Sincerely,

Cora Steinmetz

Cora Steinmetz
Medicaid Director