UNITED STATES DISTRICT COURT
DISTRICT OF THE DISTRICT OF COLUMBIA

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

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

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## INTRODUCTION

Although plaintiffs oppose a stay of this Court's entire order, they do not oppose a more limited stay. Pls. Stay Resp. 12–13. Plaintiffs do not explain how their proposal can be implemented consistent with the Administrative Procedure Act. But their concession reflects that vacatur of the Secretary's 2020 approval has significant, real-world consequences, some known and others still unknown.

Consider a few of the known consequences. To address the loss of retroactive coverage, non-emergency medical transportation (NEMT), and managed care authorities, Indiana Family and Social Services Administration (FSSA) will need make extensive changes to policies, systems, and contracts. The changes will take at least a year and require new funding. And FSSA will be forced to start transitioning more than 335,000 beneficiaries from Healthy Indiana Plan (HIP) Plus to HIP Basic, which means they will lose enhanced benefits (*e.g.*, vision and dental) and be required to make copayments. These are hardly self-imposed consequences. The language of the state plan that plaintiffs quote confirms that Indiana must make extensive changes to its programs (or the plan itself) without a stay. Meanwhile, as POWER Account contributions remain paused, plaintiffs identify no concrete harms to themselves. Their opposition to a stay largely rests on their view of the merits.

With the equities tilting so decisively one-sided, this Court need only determine that FSSA's arguments are substantial to grant a stay. The arguments clear that low bar. First, as this Court noted, at least one other decision embraces FSSA's position that a waiver promotes coverage where the demonstration project is a condition of Medicaid expansion. That HIP was a condition of expansion distinguishes this case from work-requirement cases as well. Second, even if one assumes this case is on all fours with *Gresham*, *Gresham* did not end with the D.C. Circuit's (now

vacated) decision. The Supreme Court's deemed the position the D.C. Circuit rejected to have sufficient merit to take the rare step of granting certiorari in the absence of a circuit split. Finally, there is a substantial likelihood that another court could think the disruptive consequences of vacatur are sufficient to warrant a remand without vacatur.

The Court should grant a stay.

## ARGUMENT

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

Multiple, independent reasons demonstrate that FSSA has a strong likelihood of success and, at a minimum, a "substantial case." *Hilton v. Braunskill*, 481 U.S. 700, 778 (1987).

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

There are strong arguments that the Secretary reasonably concluded that granting Indiana a waiver for HIP would likely promote Medicaid's objectives, including by providing coverage for non-mandatory populations and delivering enhanced benefits while eliminating copayments. Plaintiffs do not dispute that Indiana agreed to expand Medicaid only on the condition that the expansion population would be covered through HIP. *See* State Stay Mem. 3; Pls. Stay Resp. 5. Instead, plaintiffs repeat this Court's observation that the appropriate baseline for comparison is traditional Medicaid rather than what would have existed without HIP. Pls. Stay Resp. 5–6. But plaintiffs do not explain why Section 1115's text compels the conclusion that the Secretary must compare HIP to a "hypothetical world of condition[-]free expansion" rather than what would exist without the project. *Georgia v. Brooks-LaSure*, No. 2:22-CV-6, 2022 WL 3581859, at *14 (S.D. Ga. Aug. 19, 2022). Simply because this Court reads Section 1115 one way does not prevent it from finding there are sufficiently strong arguments to the contrary to warrant a stay. *See Wash. Metro Area Transit Comm'n v. Holiday Tours, Inc.*, 559 F.2d 841, 843 (D.C. Cir. 1977).

Nor is FSSA's theory as limitless as plaintiffs posit. *Contra* Pls. Stay Resp. 6. As FSSA explained, its theory does not allow the Secretary to approve whatever demonstration project he wishes by saying a State could terminate Medicaid coverage. *See* State Stay Mem. 4–5. Rather, Section 1115's text requires the Secretary to compare the proposed project to what would exist in its absence. *See id.* So a State could not "'transform a coverage-reducing waiver to a coverage-promoting one'" by "'threat[ing] to de-expand Medicaid if its proposed demonstration is not approved.'" *Brooks-LaSure*, 2022 WL 3581859, at *14 n.13. Only where the project is the *condition* for Medicaid expansion is it appropriate to compare a world with the project to a world without expansion. And even then, the Secretary must consider whether the project as a whole is likely to promote Medicaid's objectives. Plaintiffs overlook the limitations that FSSA laid out.

The principle of constitutional avoidance, moreover, provides another reason to construe Section 1115 as requiring the Secretary to compare a project to what would exist in its absence. The Supreme Court has repeatedly insisted that any requirements imposed by Spending Clause programs like Medicaid must be "unambiguous[]." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). Indiana, however, did not have unambiguous notice that any Medicaid expansion would have to follow the path of traditional Medicaid. To the contrary, the federal government promised Indiana "considerable flexibility" in designing its Medicaid expansion program, A.R. 318, and as this Court recognized, Indiana then agreed to expand Medicaid on the condition that the expansion population would be covered "through HIP or not at all," Op. 11. To hold now that any promised flexibility was illusory would raise "serious constitutional doubts" about the voluntariness of Indiana's decision to expand Medicaid. *Clark v. Martinez*, 543 U.S. 371, 381 (2005).

*NFIB* is not to the contrary. As plaintiffs point out, the constitutional problem there was that "states did not have notice" that they would be required to "take of coverage of the adult group" "when they first decided to enter the Medicaid program." Pls. Stay Resp. 7. The same notice problem exists here. Indiana did not have unambiguous notice that its options were traditional Medicaid or nothing when it agreed to expand Medicaid. Indiana and the federal government reasonably read Section 1115 to allow the Secretary greater flexibility to waive certain Medicaid conditions. That, too, supports the conclusion FSSA has substantial arguments.

Additionally, even if traditional Medicaid is the standard against which to evaluate HIP, FSSA has strong arguments that the approval promotes coverage. As FSSA explained, there are strong arguments that the waiver facilitates the provision of non-mandatory benefits (*e.g.*, dental, vision, and eliminating of cost sharing) and ensures Medicaid's sustainability. State Stay Mem. 5–6. Plaintiffs address that point in a footnote, asserting that FSSA's position is incorrect "[f]or the reasons this Court articulated." Pls. Stay Resp. 6 n.2. But whether this Court's reasoning is correct is not the question here. The question is whether FSSA has a likelihood of success, or at least a substantial case, on the merits. *See Wash. Metro*, 559 F.2d at 844. This Court is "not required to find that ultimate success by the movant is a mathematical probability, and indeed . . . may grant a stay even though its own approach may be contrary to movant's view of the merits." *Id.* at 843.

Nor do this Court's and the D.C. Circuit's decisions in litigation over other States' work requirements imply that FSSA lacks strong arguments. First, those decisions did not—and could not—resolve many reasoned decisionmaking questions specific to the 2020 approval, such as whether the Secretary adequately balanced benefits and harms. This case concerns different authorities, a different administrative record, and a different explanation than *Gresham*. And as this Court acknowledged, the reasoning here is a "step up" from the reasoning in *Gresham*. Op. 48.

Second, in invoking *Gresham* and other work-requirement cases, plaintiffs overlook that the litigation did not end with this Court's or the D.C. Circuit's decisions. The Supreme Court granted certiorari. *See Azar v. Gresham*, 141 S. Ct. 890 (2020). That the Supreme Court selected *Gresham* to be one of the few cases it hears despite the absence of a circuit split shows the position the D.C. Circuit rejected is substantial. *See* Pet. for a Writ of Certiroari at 16–17, *Becerra v. Gresham*, No. 20-37 (U.S. filed Jul. 13, 2020) (principally arguing review should be granted because the "court of appeals' decisions are incorrect"). Additionally, while the *Gresham* litigation became moot before the Supreme Court issued a merits decision, the Supreme Court vacated the D.C. Circuit's decision, *see Arkansas v. Gresham*, 142 S. Ct. 1665 (2022), to "clear[] the path for future relitigation of the issues," *United States v. Munsingwear, Inc.*, 340 U.S. 36, 40 (1950).

Third, other D.C. Circuit precedent supports FSSA's position that increasing beneficiary health, preparing beneficiaries for commercial insurance, and reducing unnecessary costs promotes coverage by ensuring Medicaid's sustainability. Plaintiffs argue that *Pharmaceutical Research and Manufacturers of America v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004), is inapposite because it "involved a challenge to a state plan amendment" that "required beneficiaries to receive prior authorization to access coverage for certain prescription drugs." Pls. Stay Resp. 7. Critically, however, the prior authorization program was designed to benefit "non-Medicaid populations." 362 F.3d at 825. Still, the D.C. Circuit held that the program served "serve[d] valid Medicaid goals" because, if the program "'improve[d] the[] health'" of non-Medicaid populations, it would keep them off Medicaid rolls and thus preserve greater resources for Medicaid populations. *Id.* That reasoning supports FSSA's position here. If improving the health of *non-Medicaid* recipients can serve Medicaid's goals, certainly improving the health of *Medicaid* recipients can too. FSSA submits there is a strong likelihood it will prevail on its Section 1115 arguments.

**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. Plaintiffs do not dispute that Rames seeks *both* to keep "'enhanced' benefits specific to HIP Plus" *and* to dispense with any requirement to make POWER Account contributions. Pls. Stay Resp. 3–4. Vacatur, however, will not redress that injury. At most it will allow her to remain on HIP Basic, preventing her from keeping the enhanced benefit package she wishes to retain.

Plaintiffs argue that Rames (and others like her) can keep HIP Plus benefits even if the waiver is vacated. Pls. Stay Resp. 10. But the provisions of the state plan plaintiffs cite refute their position. As plaintiffs concede, the state plan specifies that HIP Plus is for "individuals . . . 'who make a contribution' to their POWER Account." *Id.* In the absence of a waiver, however, Indiana will not have federal authorization to require Rames to make POWER Account contributions. Plaintiffs, moreover, overlook that traditional Medicaid conditions do not require Indiana to provide enhanced benefits to "all beneficiaries." *Id*. Benefits such as dental and vision are "non-mandatory." S.A.R. 1562. So too is HIP Plus's elimination of cost sharing. In the absence of a waiver, Medicaid authorizes co-payments for services. *See* 42 C.F.R. § 447.52(b)(1). Plaintiffs identify no language that requires Indiana to provide non-mandatory benefits to everyone.

Instead, plaintiffs state that Indiana provided HIP Plus benefits to beneficiaries "without requiring them to pay premiums since 2020." Pls. Stay Resp. 9. But that Medicaid worked differently during the COVID-19 public health emergency and the subsequent unwinding period does not imply that Indiana's Medicaid program can continue to operate that way. During the COVID-19 public health emergency, Congress provided States additional funding on the condition that they would treat any individual then "enrolled for benefits under [a state] plan (or waiver)" as "eligible for such benefits" through the emergency's end. Families First Coronavirus Response

Act, Pub. L. No. 116-127, § 6008(b)(2)–(3), 134 Stat. 178, 208 (2020). Congress then gave States 12 months to initiate redeterminations of eligibility, and 14 months to complete them, after the public health emergency's end on April 1, 2023. Consolidated Appropriations Act of 2023, Pub. L. No. 117-382, § 5131, 136 Stat. 5949–5953 (Dec. 29, 2022). And Indiana policymakers accepted the additional funding on these time-limited conditions. *See* Ind. Code § 12-8-1.5-7.5(a). Neither Congress nor Indiana lawmakers authorized the suspension of normal operations past the end of the public health emergency and the unwinding period.

Plaintiffs also argue that Indiana could amend its state plan to provide enhanced benefits for everyone, whether or not they make POWER Account contributions. Pls. Stay Resp. 9. But saying that Indiana could take additional actions to amend its plan (notwithstanding its staunch refusal to expand traditional Medicaid) does not establish that vacatur alone will redress the alleged injury. Rather, it highlights that vacatur will not provide Rames the benefits she wishes. That distinguishes this case from others in which plaintiffs already received the benefits they wished *before* the challenged demonstration project and objected to the project alone. *Contra id.* at 4. Rames would not be eligible for the enhanced benefits she wants absent the challenged project.

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

There also are strong arguments that remand without vacatur is the more appropriate remedy. Plaintiffs argue that the Secretary is unlikely to be able to rehabilitate the approval on remand because he "ignore[d] clear guidance from th[is] Court and the D.C. Circuit." Pls. Stay Resp. 8. There are three problems with that argument. First, it overstates the similarities between this case and *Gresham*. Second, the argument presumes that *Gresham*'s outcome was correct. For the reasons above, however, there is significant reason to think the Supreme Court would have reserved

if the litigation had not become moot. Third, plaintiffs overlook that the errors this Court attributed to the Secretary's decision are errors of explanation—not insurmountable barriers.

Just as important, the disruptive consequences of vacatur are severe. Plaintiffs do not dispute that the Court focused only on POWER Account contributions in evaluating the consequences of vacatur. *See* Pls. Stay Resp. 10. Contrary to plaintiffs' suggestion, however, that is not the only consequence of vacatur that FSSA mentioned. *See id.* FSSA argued that "'removal of a waiver would require extensive modifications to 'eligibility systems and managed care plan contracts.'" State Mem. 41–42 (quoting S.A.R. 2). FSSA also argued that "vacating the waiver undergirding HIP would disrupt coverage for the entire Medicaid expansion population and threaten provision of option[al] benefits" provided through HIP Plus. State Reply 20. Those are the precise consequences that FSSA and beneficiaries now face. *See* Steinmetz Decl. Ex. A at 2–5.

Plaintiffs try to minimize the consequences of vacatur. But the Medicaid statute and state plan defy their assertion that "all beneficiaries" are now entitled to HIP Plus benefits rather than the default benefit package for persons who do not make POWER Account contributions. Pls. Stay Resp. 9; *see* pp. 6–7, *supra*. And even if Indiana can in theory amend its state plan, amendment would take time. FSSA would be required to submit any proposed amendment to the plan to state budget committee for review. *See* Ind. Code § 12-15-1.3-17.5. An amendment along the lines plaintiffs suggest would likely require changes to state statutory provisions governing HIP as well. *See, e.g.*, §§ 12-15-44.5-3.5, 12-15-44.5-4.5, 12-15-44.5-4.7, 12-15.44.5-10. The Indiana legislature is not next in session until January 2025, and in the meantime, the State will elect a new Governor. As with any legislative change, any outcome is far from guaranteed or immediate.

To amend the plan, Indiana also would need to provide "advance notice of the amendment and a reasonable opportunity to comment." 42 C.F.R. § 440.386. A "reasonable opportunity" is

generally considered to be 30 days. Then Indiana would need to submit its proposed amendment to CMS. CMS would then have at least 90 days to consider the amendment—weeks or months longer if CMS stops the clock on the 90-day review by issuing a request for information. § 430.16(a). All of this means that any amendment would not take effect until sometime in 2025, even if Indiana lawmakers are inclined to approve an amendment increasing services when that the State faces a $1 billion shortfall in Medicaid funding. *See* Steinmetz Supp. Decl. ¶ 6.

Even if one sets discussion of benefits to the side, the impact of the waiver on other HIP operations is disruptive. For example, vacatur impacts retroactive coverage and NEMT. Plaintiffs assert (without citation) that, because Indiana has provided retroactive coverage and NEMT to some populations before, it can now provide it to all beneficiaries. Pls. Stay Resp. 10. But that assertion ignores the operational reality of implementing and funding a change in benefits for any Medicaid population. As the State told the Secretary, it would need to make substantial changes to do so. S.A.R. 2. Events since vacatur bear that out. *See* Steinmetz Decl. Ex. A at 3–5. Uncontroverted evidence establishes that making the "extensive" changes required will take at least 12 months, *id.*, burdening FSSA during a time in which it is busy with unwinding efforts, S.A.R. 2.

Additionally, 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." Steinmetz Decl. Ex. A at 5. With the loss of managed care authorities, FSSA anticipates that it will need to make extensive alternations to systems and change how capitation is paid. Steinmetz Supp. Decl. ¶ 5.

## II. The Remaining Stay Considerations Favor a Stay

Equitable considerations support issuing a stay of the Court's order as well. Although plaintiffs argue "Indiana has not established it will suffer irreparable harm absent a stay," Pls. Stay

Resp. 11, they ignore that vacatur prevents Indiana from pursuing innovative Medicaid policies chosen by its legislative and executive branches, State Stay Mem. 11. As the Supreme Court has observed, a State's "inability to enforce its duly enacted plans clearly inflicts irreparable harm on the State." *Abbott v. Perez*, 585 U.S. 579, 602 n.17 (2018); *see Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers) ("'[A]ny time a State'" is prevented "'from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.'").

Without a stay, Indiana will be required to incur "'nonrecoverable'" costs as well. *Ohio v. EPA*, 144 S. Ct. 2040, 2053 (2024) (granting Indiana a stay in part due to such costs); *see Citizens Coal Council v. Babbitt*, No. CIV.A. 00-0274 JR, 2002 WL 35468435, at *1 (D.D.C. June 5, 2002) (granting stay where States will "need to adapt their standards"). As FSSA documented, it must not only transition 335,000 members from HIP Plus to HIP Basic, but it also must alter "eligibility systems and managed care plan contracts" to operate without the waiver. S.A.R. 2; *see* Steinmetz Decl. Ex. A at 3–5. That it will take FSSA at least 12 months to complete modifications to its eligibility systems and contracts does not somehow "cast[] doubt" on the harms' "immedia[cy]." *Contra* Pls. Stay Resp. 12. To the contrary, it reflects that "significant" and "extensive" changes are required to provide retroactive coverage and NEMT. Steinmetz Decl. Ex. A at 4–5.

Plaintiffs are wrong to characterize the harm FSSA will suffer without a stay as "'self-imposed costs.'" Pls. Stay Resp. 11. First, "self-inflicted generally means curable by the moving party." *District of Columbia v. U.S. Dep't of Agric.*, 444 F. Supp. 3d 1, 35 (D.D.C. 2020). FSSA cannot resurrect the waiver that this Court vacated of FSSA's own accord, and if the waiver remained intact, FSSA would not be making the significant changes to systems and contracts that it must now make. Second, many of the extensive changes that FSSA must make have nothing to do with whether members can remain in HIP Plus or must be transitioned to HIP Basic. *Contra* Pls.

Stay Resp. 11. Rather, FSSA must implement "significant system changes" just to provide retroactive coverage and assurance of NEMT and to address the loss of managed care authorities. Steinmetz Decl. Ex. A at 4–5; *see* Steinmetz Supp. Decl. ¶ 5. Even plaintiffs concede that, without a stay, FSSA must make "efforts to reintroduce retroactive coverage and NEMT." Pls. Stay Resp. 13. Additionally, if the Secretary finally determines that HIP "waivers . . . are not approved or cannot be validly implemented," Ind. Code § 16-21-10-6(b), FSSA will lose critical funding, *see* Steinmetz Decl. Ex. A at 5.

Impacts on third parties support a stay as well. Without a stay, FSSA "will be forced to start transitioning over 335,000 Medicaid members" from HIP Plus to HIP Basic. Steinmetz Decl. Ex. A at 2. In arguing otherwise, plaintiffs cherry-pick language from the state plan, ignoring whatever provisions do not support their preferred result. *See* pp. 6–7, *supra*. Nor does the possibility that Indiana might be able to amend its state plan solve the immediate problem and accompanying uncertainty. Since the Indiana legislature does not meet until January 2025, the soonest that the legislature could amend state law governing eligibility and benefits is next year. Most Indiana laws do not take effect until July 1 of the year of enactment. And again, this discussion assumes that Indiana lawmakers would decide to expand benefits for everyone when the State faces a $1 billion shortfall in Medicaid funding. *See* Steinmetz Supp. Decl. ¶ 6.

In response to these impacts, plaintiffs offer little. Their principal complaint seems to be that they "first filed this lawsuit in 2019." Pls. Stay Resp. 12. Even if one sets aside that plaintiffs agreed to a stay of this case during the COVID-19 public health emergency, Dkt. 36 at 1, and afterwards filed an amended complaint with new claims, Dkt. 50, plaintiffs' desire for a decision vindicating their position does not demonstrate a stay will harm them or others. As plaintiffs recognize, FSSA plans to continue to pause collection of POWER Account contributions, and will

not turn them back on without giving plaintiffs and the Court at least six weeks' notice (which would give plaintiffs ample time to seek dissolution of any stay should the issue even arise). Steinmetz Decl. ¶ 7. And plaintiffs themselves have no objection to a state of affairs under which FSSA continues not to provide retroactive coverage or NEMT. *See* Pls. Stay Resp. 12–13. In short, plaintiffs identify no concrete harm to themselves that provides a reason to deny a stay.

## III. Plaintiffs Offer No Authority for Their Proposed Alternative

In a last-ditch effort to avoid a stay, plaintiffs urge the Court to consider a "limited stay" under which the Court "postpone efforts to reintroduce retroactive coverage and NEMT for the pendency of the appeal but would prevent the State from re-imposing premiums or moving people to HIP Basic." Pls. Stay Resp. 13. Plaintiffs, however, do not explain how their proposal can be implemented consistent with this Court's decision to vacate and remand the Secretary's 2020 approval rather than blue pencil portions of it. *See* Op. at 21 (adjudicating plaintiffs' challenge to the entire approval rather than counts "attack[ing] individual features of the program"); Op. at 63 (stating that the APA does not authorize a court "to judicially re-write what the agency did so that it somehow does not apply to a narrow group of people or so that it persists piecemeal"). Nor do plaintiffs identify any authority authorizing an order directing FSSA to act in a particular way.

That said, to the extent the Court can provide partial relief from its order vacating the Secretary's 2020 approval for HIP, FSSA would welcome that development. As detailed in FSSA's submission, reconfiguring policies, systems, and contracts for retroactive eligibility and NEMT will require significant effort over at least a year. *See* Steinmetz Decl. Ex. A at 4–5. But the limited relief that plaintiffs propose would not redress many of the other harms FSSA and beneficiaries now face. Without a stay, the state plan still will require FSSA to transition 335,000 beneficiaries from HIP Plus to HIP Basic. Steinmetz Decl. Ex. A at 2. FSSA still will have to make extensive

alternations to systems, capitation rates, and contracts in response to the loss of managed care authorities. Steinmetz Decl. Ex. A at 5; Steimetz Supp. Decl. ¶ 5. And FSSA still would face risks to a critical source of funding needed for coverage of HIP's 700,000 beneficiaries. Steinmetz Decl. Ex. A at 5. Only a stay of the entire judgment or the portion vacating the approval will redress the harms.

## CONCLUSION

The Court should stay its order and judgment pending appeal.

Respectfully submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF THE DISTRICT OF COLUMBIA

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**SUPPLEMENTAL 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 supplemental 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. On July 12, 2024, I submitted an initial declaration describing the impacts of vacatur on HIP's operations, funding, and sustainability. Since submitting that declaration, FSSA has continued to learn more about the impacts of this Court's decision. Previously, I stated in a letter that "loss of managed care attribution authorities is likely to impact systems design around auto-assignment, coverage start dates, annual benefits periods, and plan change rules." FSSA now anticipates that, without a stay (or reissuance of a waiver), the loss of managed care authorities will require extensive system changes, revisions to existing vendor contracts, notice updates for Medicaid members, and a redesign of how capitation rates are paid.

6. I also indicated that adding retroactive coverage and assurance of non-emergency medical transportation to HIP would take at least 12 months and would require FSSA to secure a funding source. In a forecast presented to the State Budget Committee in December 2023, FSSA forecasted that the State faced a $271.2 million state appropriation shortfall in Medicaid funding during the 2023 fiscal year, a $255.2 million state appropriation shortfall during the 2024 fiscal year, and a $457.9 million state appropriation shortfall during the 2025 fiscal year. Those forecasts do not include any additional expenditures that would be required to provide retroactive coverage and assurance of non-emergency medical transportation.

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

Executed on July 29, 2024

Cora Steinmetz

Cora Steinmetz