ORAL ARGUMENT NOT YET SCHEDULED

IN THE
UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 24-5172

MONTE ROSE, JR., *et al.*,
Plaintiffs-Appellees
v.
ROBERT F. KENNEDY, JR., Secretary of Health and Human Services, *et al.*,
Defendants-Appellees,
and
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION,
Intervenor-Appellant.

AMICUS BRIEF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION AND 67 DEANS, CHAIRS AND SCHOLARS IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

All parties, intervenors and *amici* appearing before the District Court and, other than *amici* herein, appearing before this Court, are listed in the Brief for Intervenor-Appellant. All references to the rulings at issue appear in the Brief for Intervenor-Appellant. *Amici* do not believe this case has been previously before this Court.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Rule 26.1 of the United States Court of Appeals for the District of Columbia Circuit (the "D.C. Circuit"), *amici curiae* submit the following corporate disclosure statement:

The Deans, Chairs and Scholars are individuals and as such do not have a parent company and no publicly held company has a ten percent or greater ownership interest in any *amici*.

For its part, *amicus* American Public Health Association ("APHA") does not have a parent company and no publicly held company has a ten percent or greater ownership interest in it.

STATEMENT OF CONSENT AND SEPARATE BRIEFING

Pursuant to Rule 29(a)(2) of the Federal Rules of Appellate Procedure and Rule 29(b) of the D.C. Circuit, counsel for all parties have consented on the

parties' behalf to the filing of this *amici curiae* brief by Deans, Chairs and Scholars and the APHA.

Pursuant to Rule 29(d) of the D.C. Circuit, the APHA and the Deans, Chairs and Scholars, certify that a separate brief is necessary to provide appropriate insight into how Federal-Appellee U.S. Department of Health and Human Services' use of Section 1115 of the Social Security Act, 42 U.S.C. § 1315, to allow Intervenor-Appellant to impose harmful premiums on Medicaid beneficiaries and eliminate retroactive coverage eligibility and nonemergency medical transportation ("NEMT"), is inconsistent with the history and purpose of the Medicaid program and Section 1115, demonstration evaluation principles, and evidence establishing how premiums and retroactive coverage and NEMT waivers harm enrollees.

STATEMENT OF IDENTITY, INTEREST IN CASE, AND SOURCE OF AUTHORITY

The APHA is a non-partisan, non-profit organization that champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 23,000 individual members and has 52 state and regional affiliates. APHA's membership also includes organizational members, including groups interested in health, state and local health departments, and

health-related businesses. APHA is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

The 67 Deans, Chairs, and Scholars are researchers and academics who are experts in the fields of health law, public health, and healthcare policy and research, including Medicaid's role as the leading insurer for low-income people and other populations that face systemic barriers to essential healthcare services. Their expertise includes the history and purpose of Social Security Act § 1115, 42 U.S.C. § 1315, the essential elements of Medicaid demonstration evaluations, and the body of research establishing the adverse impact of premiums and the elimination of retroactive coverage and NEMT on Medicaid enrollees.

Pursuant to Rule 29(a)(4)(e) of the Federal Rules of Appellate Procedure, *amici* certify that no party or counsel for a party authored this brief in whole or in part. *Amici* further certify that no party, counsel for a party, or any other person contributed money that was intended to fund preparing or submitting this brief.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

Other Authorities

GLOSSARY OF ABBREVIATIONS OR ACRONYMS

Centers for Medicare and Medicaid……..CMS

Healthy Indiana Plan……...HIP

NEMT……...Non-Emergency Medical Transportation

Personal Wellness and Responsibility Account……POWER Account

Social Security Act……SSA

U.S. Department of Health and Human Services……..HHS

U.S. Government Accountability Office ……GAO

SUMMARY OF THE ARGUMENT

Congress enacted Section 1115 of the Social Security Act to allow demonstrations in which states may test new approaches to federally-assisted programs that would otherwise be impermissible under the Act. From Section 1115's inception, Congress intended these demonstrations to benefit, not penalize, the low-income people served by these programs. Congress subsequently amended federal law to include additional safeguards to protect Medicaid enrollees from harm and ensure sound demonstration evaluations. To approve a demonstration, the Secretary must consider the impact on enrollees and find that the state's proposed experiment will promote Medicaid's core objective of providing medical assistance to people who cannot afford necessary healthcare.

The U.S. Department of Health and Human Services' ("HHS") Centers for Medicare and Medicaid Services ("CMS") (collectively "Federal Appellees") disregarded the research and evaluation principles that undergird Section 1115 when it renewed the Healthy Indiana Program 2.0 ("HIP 2.0") demonstration in 2020, allowing Indiana to continue to impose premiums and eliminate retroactive eligibility and non-emergency medical transportation ("NEMT") for Medicaid enrollees. Federal Appellees again allowed Indiana's premiums to continue in 2023, despite substantial evidence of enrollee harm. Both of these decisions are

arbitrary and capricious and therefore violate Federal Appellees' Section 1115 authority.

Federal Appellees' 2020 renewal of Indiana's demonstration violates research norms by failing to ensure a methodologically sound evaluation. Federal Appellees did not approve the accompanying evaluation design until 2023, a decision which ignored fundamental flaws and conflicted with Federal Appellees' own best research practices. The current evaluation design also is tainted by unsound research methodology contained in earlier evaluation designs. Federal Appellees' 2020 and 2023 decisions also disregarded the readily available comprehensive body of research that shows that the imposition of premiums and elimination of retroactive coverage and NEMT harms Medicaid enrollees. Consequently, thousands of people have lost healthcare coverage and benefits and experienced financial harm, without a sound experiment's essential safeguards.

ARGUMENT

I. Congress Enacted Section 1115 to Permit States to Test New Approaches to Expand Access, Provide Better Services, and Strengthen Social Programs.

A. Section 1115 Authorizes Demonstrations That Benefit, Not Penalize, Low-Income People.

In 1962, Congress enacted Social Security Act ("SSA") § 1115, authorizing HHS to waive certain provisions of federal law "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to

assist in promoting [program] objectives." Public Welfare Amendments of 1962, Pub. L. No. 87–543, § 122, 76 Stat. 172, 192 (1962); *see also* S. Rep. No. 1589, at 1 (1962), *reprinted in* 1962 U.S.C.C.A.N. 1947. President Kennedy requested this authority to address "needed improvements" in safety net programs, including liberalization of eligibility and benefit rules. *See Letter to the President of the Senate and to Speaker of the House Transmitting Bill to Amend the Social Security Act,* SOCIAL SECURITY ADMINISTRATION, SOCIAL SECURITY HISTORY (Feb. 20, 1961). This new authority would help, not penalize, low-income people: "[c]ommunities which have – for whatever motives – attempted to save money through ruthless and arbitrary cutbacks in their welfare rolls have found their efforts to little avail. The root problems remained…." *Id.*, *President's Special Message to the Congress on Public Welfare Programs* (Feb. 1, 1962). Moreover, "[a]t the committee hearing, no witness suggested – nor did the Finance Committee ever intimate – that § 1115 was to be used to reduce benefits by varying eligibility criteria…. In short… Congress and the Administration intended this section to be a narrow, technical, and beneficent research option." Williams, Lucy, *The Abuse of Section 1115 Waivers: Welfare Reform in Search of a Standard*, 12 YALE L. & POL'Y REV. 1, 12, 13 (1994), https://www.jstor.org/stable/40239415. Consequently, early demonstrations sought to augment and strengthen services, not eliminate them. *Id.* at 14.

Congress extended Section 1115 demonstration authority to Medicaid when it created the program in 1965. 42 U.S.C. § 1396 *et seq*. *See* Social Security Amendments of 1965, Pub. L. No. 89–97, sec. 121(c)(3), § 1115, 79 Stat. 352 (42 U.S.C. § 1315 (Supp. I 1965)). Subsequent federal agency policy guidance reaffirmed that these demonstrations should strengthen programs by "provid[ing] assistance to needy individuals *who would not otherwise be eligible*; increas[ing] the level of payments; provid[ing] social services not presently available…; [and] experiment[ing] with new patterns and types of medical care…." *Handbook of Public Assistance Administration*, H.T. No. 109, pt. IV, § 8432, U.S. DEP'T OF HEALTH, EDUC. & WELFARE, (Feb. 17, 1967) (emphasis added) (*cited* in Williams, *supra*, at 14, n.29).

B. Since 1965, Congress Has Added Safeguards to Protect Medicaid Enrollees and Ensure Sound Demonstration Evaluations.

As more states sought Medicaid demonstrations, Congress adopted provisions to protect Medicaid enrollees from harm. In 1982, Congress added SSA § 1916 to restrict Section 1115 demonstrations that compel enrollee participation in premium or cost-sharing demonstrations. *See* Tax Equity and Fiscal Responsibility Act, Pub. L. 97–248, Title I, Subtitle B, § 131(b), 96 Stat. 367 (1982); 42 U.S.C. § 1396o. Congress amended Section 1115 in 2010 to require that, prior to approving demonstrations, the Secretary ensure public notice and comment at the state and

federal levels. *See* Patient Protection and Affordable Care Act, Pub. L. 111–148, § 2601(b)(2), § 10201(i), 124 Stat. 119, 922 (2010); 42 U.S.C. § 1315(d)(2).

The 2010 amendments also establish reporting and evaluation requirements for Medicaid demonstrations "that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." 42 U.S.C. § 1315(d). Implementing regulations require that demonstrations must serve a legitimate experimental purpose and require states to submit evaluation plans to CMS for approval. 42 C.F.R. Part 431, subpart G; *see also Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency* at 23, n.28, U.S. GOV'T ACCOUNTABILITY OFFICE ("GAO"), GAO–19–315 (Apr. 2019) https://www.gao.gov/products/gao-19-315 ("In the development of demonstration evaluations, states are to include hypotheses that will be tested through the demonstrations, which align with the demonstration's objectives or goals."). Section 1115 demonstrations must abide by basic research practices to ensure that these experiments produce valuable information, facilitate "true research data[,] and serve interests beyond state fiscal concerns." *Ninth Circuit Holds Statutory Waivers for Welfare Experiments Subject to Judicial Review,* 108 HARV. L. REV. 1208, 1212 (1995), https://www.jstor.org/stable/1341878.

C. When Approving Section 1115 Demonstrations, the Secretary Must Consider the Impact on Medicaid Enrollees.

Courts reviewing Section 1115 demonstrations have held that the Secretary is "obligat[ed]. . . to 'consider the impact of the state's project on the' persons the Medicaid Act 'was enacted to protect.'" *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011). "[T]he Secretary must make at least some inquiry into the merits of the experiment—she must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration." *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). The text and history of Section 1115 show that this experimental authority is not a blank check for federal authorities to rewrite law by stripping eligibility from enrollees; it is unlikely "that Congress would enact such comprehensive [SSA] regulations, frame them in mandatory language, require the Secretary to enforce them, and then enact a statute [Section 1115] allowing states to evade these requirements with little or no federal agency review." *Beno*, 30 F.3d at 1068-69; *see also Newton–Nations,* 660 F.3d. at 380.

II. Federal Appellees' Renewals of HIP 2.0's Eligibility and Coverage Restrictions Violated Research Norms by Failing to Ensure a Methodologically Sound Evaluation.

By design, HIP 2.0 restricts Medicaid eligibility and coverage by imposing premiums and eliminating retroactive eligibility and NEMT. Federal Appellees'

2020 and 2023 decisions to allow these restrictions to continue lack the necessary basis in a valid experimental purpose and violate basic research principles.

A. Indiana's 2015-2018 Evaluation Plan Was Fundamentally Flawed.

The 2020 demonstration renewal is tainted by fundamental flaws that originate in Indiana's initial HIP 2.0 demonstration evaluation plan for 2015-2018.[1] Two of the goals that Indiana proposed to measure in its 2015-2018 demonstration evaluation include promoting value-based decision making and personal health responsibility; and promoting private market coverage.[2] These goals do not align with Medicaid's core purpose of providing health coverage to low-income people and instead have served to erect barriers to care based on subjective judgments about a patient's responsibility or "worthiness." *Cf.* 42 U.S.C. § 1396-1.

Furthermore, several outcome measures in the 2015-2018 evaluation plan are invalid. Outcome measure 2.2 purports to evaluate Indiana's goal of promoting value-based decision-making and personal health responsibility by positing that

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[1] *See* Ind. Fam. & Soc. Servs. Admin., Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver at 11 (2020), in-healthy-indiana-plan-support-20-pa8.pdf; Supplemental Administrative Record ("SAR"), *Rose v. Becerra*, No. CV 19-2848, 2024 WL 3202342 (D.D.C. June 27, 2024), Vol. 3 at 8245 ("Under this renewal request, HIP will continue to operate under goals that are in alignment with the prior goals of the demonstration.").

[2] *See* HIP 2.0 Final Evaluation Plan at 41, 59 (Dec. 28, 2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-final-eval-dsgn-122815.pdf.

enrollees who pay premiums exhibit more "cost-conscious healthcare consumption" behavior (*i.e.*, more use of primary and specialty care and less use of the emergency department) than enrollees who are not subject to premiums.[3] This measure is fundamentally flawed because it attempts to compare two groups that are inherently non-comparable. Research has consistently shown that people with less ability to pay premiums (i.e., those with the lowest income) also have less access to care, compared to people with greater ability to pay premiums.[4] Thus, outcome measure 2.2 is not a valid assessment of "cost-conscious healthcare consumption." Instead, it simply confirms that people with a greater ability to pay receive more primary care.

Outcome measure 2.1 is flawed in two respects. First, this measure posits that enrollees who pay premiums have "embraced the value of personal responsibility," which incorrectly conflates "personal responsibility" with "ability to pay."[5] Having enough money to pay premiums is not a valid measure of

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[3] *See Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report*, THE LEWIN GROUP, INC. at 14-16 (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-demo-app-02152017.pdf, (*cited in* Ind. Fam. & Soc. Servs. Admin., Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application (Jan. 2017), SAR 2019 Administrative Record at 2577).

[4] *See generally*, *National Healthcare Quality and Disparities Report*, NATIONAL LIBRARY OF MEDICINE, NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION, (Dec. 2021), https://www.ncbi.nlm.nih.gov/books/NBK578537/.

[5] *See Interim Evaluation Report*, *supra* note 3 at 12.

"embracing personal responsibility." Second, this measure incorrectly claims that premiums provide "incentives" for enrollees to use "value-based care." However, HIP 2.0 does not offer incentives (such as cash payments or vouchers[6]); instead, it penalizes enrollees who do not pay premiums either by terminating coverage or demoting them to a less comprehensive benefit package. Thus, this measure makes the faulty assumption that premium payment is due to incentives rather than fear of incurring penalties.

Likewise, outcome measures 1.1 and 1.2 are unreliable because they fail to isolate the impact of premiums and other eligibility restrictions from the impact of expanding Medicaid financial eligibility. These measures assess whether the demonstration will reduce the number of uninsured low-income Indiana residents and increase access to healthcare services.[7] Based on these measures, Indiana considers the demonstration a success, noting that 60% of HIP 2.0 enrollees were previously uninsured. *Id.* at 2. However, this outcome is likely due to Indiana's Medicaid eligibility expansion, and not to the demonstration's imposition of premiums. The evaluation design fails to measure how many more people might

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[6] Bradley, Cathy & Neumark, David, *Small Cash Incentives Can Encourage Primary Care Visits By Low-Income People With New Health Care Coverage*, HEALTH AFFAIRS (Aug. 2017), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1455.

[7] *See Interim Evaluation Report*, *supra* note 3 at 13.

have enrolled in Indiana Medicaid if the demonstration did not include deterrents such as premiums.

By contrast, the federal demonstration, a robust multi-state empirical study evaluation created regression models examining how Indiana's demonstration may have deterred people from enrolling.[8] That evaluation found that significantly fewer people enrolled in Indiana Medicaid following the demonstration, compared to states that expanded Medicaid *without* restrictions such as premiums. *Id.* Beyond Indiana, the federal evaluation found that premiums significantly decreased the probability of enrolling in Medicaid across all demographic groups. *Id.* Another study found that Indiana's demonstration was associated with a four percent lower coverage rate compared to states that expanded Medicaid without a waiver.[9]

B. Indiana's 2018-2020 Evaluation Plan Was Fundamentally Flawed.

The flawed assumptions and outcome measures in the 2015-2018 demonstration evaluation carried forward into the 2018-2020 evaluation. Additionally, Indiana's 2018 demonstration renewal application did not include the

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[8] *See Medicaid Section 1115 Demonstrations Summative Evaluation Report, Premium Assistance, Monthly Payments, and Beneficiary Engagement*, MATHEMATICA at xviii (January 17, 2020), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/alt-medicaid-exp-summ-eval-report.pdf.

[9] Stimpson, Jim; Wang, Yang & Wilson, Fernando, *Association of Indiana's Section 1115 Waiver With Medicaid Enrollment*, JAMA NETWORK (Oct. 9, 2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2752569.

required new research hypotheses or a new evaluation design plan to reflect its new goals, which included a community engagement requirement and a tobacco use surcharge.[10] Moreover, Federal Appellees did not approve the 2018-2020 evaluation design until November 2020,[11] over a month *after* they renewed the demonstration for a subsequent ten-year term (2021-2030).

C. Federal Appellees' 2020 Renewal Lacks Evidence to Ensure the Demonstration's Methodological Soundness.

In 2020, Federal Appellees renewed the demonstration for an unprecedented 10 years, without evidence of a reliable evaluation. Indiana's 2019 renewal application included community engagement and tobacco cessation goals but again lacked the accompanying evaluation design.[12] Instead, Indiana briefly stated that it would provide an initial report on the renewal's first three years by 2025, an interim report by 2029, and a final report by 2032. *Id*. at 31.

Federal Appellees allowed Indiana to proceed with implementing the 2020 renewal without an evaluation design in place; they did not approve the 2021-2030

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[10] Letter from Ruth Hughes, CMS, to Allison Taylor, Ind. Fam. & Soc. Servs. Admin. (Feb. 1, 2018), in-healthy-indiana-plan-cms-amend-appvl-02012018.pdf, SAR 2019 Administrative Record at 1.

[11] Letter from Danielle Daly & Andrea J. Casart, CMS, to Allison Taylor, Ind. Fam. & Soc. Servs. Admin. (Nov. 30, 2020), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-20230321.pdf, SAR Vol.1 at 1078-79.

[12] *See* Renewal Request, SAR Vol. 3 at 8235.

evaluation design until over three years later, on March 21, 2023.[13] The hypotheses and outcomes in the 2021-2030 evaluation design continue to rest on the same flawed assumptions and outcome measures contained in the 2015 and 2018 evaluation designs. The 2021-2030 evaluation design also lacks a logic model that explains why each demonstration hypothesis is expected to achieve the identified outcomes, contrary to CMS's identified best research practices.[14] In short, HIP 2.0 has never had a valid reliable evaluation design in place throughout the life of the demonstration. Federal Appellees' decisions to continue the demonstration violate basic research principles that Congress required to safeguard enrollees.

III. Federal Appellees' Renewals of HIP 2.0's Eligibility and Coverage Restrictions Lacked an Evidentiary Basis and Ignored Proven Harm to Enrollees.

A. Requiring Premiums Harms Medicaid Enrollees.

1. Premiums are Unaffordable and Confusing for Enrollees.

Premiums have created financial hardship for enrollees throughout HIP 2.0. In a 2017 report, Indiana found that more than half (55%) of people required to pay premiums during the first two years of the demonstration (2015 and 2016) failed to

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[13] Letter from Danielle Daly, CMS, to Allison Taylor, Ind. Fam. & Soc. Servs. Admin. (March 21, 2023), Approval Letter - Indiana SUD-SMI Monitoring Protocol 20210722_Signed.pdf, SAR Vol. 1 at 417.

[14] *See generally*, *Conducting Robust Implementation Research for Section 1115 Demonstration Evaluations*, MATHEMATICA (Oct. 2020), https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/Implementation-rsch.pdf.

do so.[15] The top two reasons for non-payment were: (1) affordability and (2) confusion about the process. *Id*. Indiana's interim demonstration evaluation found that 30% of enrollees who paid premiums needed help making payments from family or friends.[16] Forty-five percent of enrollees subject to premiums worried about affording their payment "always" (16%) or "usually or sometimes" (29%). *Id*. at 41-42.

Federal evaluation through 2017-2018 focus groups of enrollees who were subject to premiums revealed that many found premiums financially burdensome.[17] Both demonstration enrollees and those who were disenrolled reported challenges paying monthly premiums due to confusion over how much they owed or when they had to pay, or difficulty affording payment. *Id*. Another study found that seasonal or temporary workers may have to pay inflated premiums compared to their annual incomes.[18] Because premiums are based on quarterly income reviews,

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[15] *See Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, THE LEWIN GROUP, INC. at 8 (March 2017), in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf, SAR Vol. 3 at 5970; (*cited in Digging Into the Data*, *infra* note 21.

[16] *See Interim Evaluation Report*, *supra* note 3 at 40.

[17] *See Federal Evaluation of Indiana's Healthy Indiana Plan—HIP 2.0*, SOCIAL & SCIENTIFIC SYSTEMS (Nov. 30, 2020) at 6. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-indiana-2020.pdf, SAR, Vol. 2 at 4269.

[18] *See Health Equity, Urban Congregations, and HIP*, INDIANA MINORITY HEALTH COALITION at 27, (Oct. 2019),

the "boom and bust nature of their work means their earnings may rise above their monthly average for several months before dropping to zero." *Id*.

2. Premiums Caused Enrollees to Lose Access to Coverage and Benefits.

Premiums consistently pose a barrier to healthcare coverage for Medicaid enrollees. Indiana has been "testing" the impact of conditioning Medicaid eligibility on premium payment since its HIP 1.0 demonstration in 2008.[19] A Kaiser Family Foundation report found that "[a]bout 8% of HIP 1.0 members ever enrolled in the program between 2008 and 2010 were disenrolled due to failure to make POWER account payments." *Id.*

Premiums continued to be a barrier to enrolling in or maintaining coverage in HIP 2.0. In HIP 2.0's first two years (2015 and 2016), over half (51%) of people with income above poverty were never fully enrolled (46,000 people did not pay their initial premium) or subsequently lost coverage for failure to pay premiums (13,500 people).[20] Over half (53%) of those who enrolled but then lost coverage

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https://scholarworks.indianapolis.iu.edu/items/2b969803-dac4-4ae1-8495-caff296d2c2a.

[19] See *Healthy Indiana Plan and the Affordable Care Act*, THE HENRY J. KAISER FAMILY FOUNDATION at 3 (December 2013), https://www.kff.org/wp-content/uploads/2013/12/8529-healthy-indiana-plan-and-the-affordable-care-act1.pdf.

[20] *See* Rudowitz, Robin; Musumeci, MaryBeth & Hinton, Elizabeth, *Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums*, THE HENRY J. KAISER FAMILY FOUNDATION at 1 (March 2018),

for failure to pay premiums became uninsured, and 59% of those who were unable to pay their initial premium went uninsured. *Id*. The federal evaluation 2017-2018 focus groups also revealed that most people who were disenrolled from HIP 2.0 became uninsured.[21] Furthermore, inability to pay premiums resulted in 57% (nearly 287,000) of people with income at or below the federal poverty level losing access to vision and dental benefits in HIP 2.0's first two years (2015-2016).[22] Additionally, as noted above, empirical studies have found that significantly fewer individuals enrolled in Indiana Medicaid under its demonstration compared to other states that expanded Medicaid without premiums or other restrictions.

In 2018, Indiana adopted a tiered premium structure, which the state's interim evaluation found may have decreased disenrollments due to premium non-payment. However, interim evaluation enrollee interviews noted continued barriers to premium payments, including navigating the online payment system, inaccurate statements, and financial burden.[23]

Evaluations of other states' Section 1115 demonstrations show that premiums cause low-income people to lose coverage. For example, nearly two-

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https://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums.

[21] *See Federal Evaluation*, *supra* note 17 at 64, SAR Vol. 2 at 4337.

[22] See *Digging Into the Data*, *supra* note 20.

[23] *See Federal Evaluation*, *supra* note 17 at 6-7, SAR Vol. 2 at 4279-80.

thirds (65%) of people disenrolled for failing to pay premiums in Iowa were not re-enrolled in any form of insurance.[24]

A study published in the *New England Journal of Medicine* found a 12% increase in Medicaid disenrollment in Michigan's demonstration among those required to pay premiums, compared to the program's baseline attrition rate.[25] Michigan's demonstration evaluation found that enrollees with income just above the federal poverty level (who were subject to premiums) had a higher rate of disenrollment compared to those with incomes just below the federal poverty level (who were not subject to premiums).[26]

Arkansas' demonstration evaluation found that the share of enrollees experiencing a gap in coverage of at least 30 days more than doubled (9.2% as opposed to 19.8%) after premiums were imposed and concluded that premiums

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[24] Askelson, Natoshia et. al, *Purged from the Rolls: A Study of Medicaid Disenrollment in Iowa*, HEALTH EQUITY, (Dec. 16, 2019), https://www.liebertpub.com/doi/10.1089/heq.2019.0093.

[25] Cliff, Betsy; Hirth, Richard & Ayanian, John, *Enrollee Premiums in Medicaid—Insights from Michigan,* THE NEW ENGLAND JOURNAL OF MEDICINE (June 18, 2022), https://www.nejm.org/doi/abs/10.1056/NEJMp2201059.

[26] *Healthy Michigan Plan Evaluation Final Summative Report*, UNIVERSITY OF MICHIGAN INSTITUTE FOR HEALTHCARE POLICY & INNOVATION (Mar. 12, 2020), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder24/HMP_Eval_Final_Evaluation_Report_31220.pdf.

"may have contributed to these beneficiaries experiencing more frequent coverage gaps than individuals not enrolled in the demonstration."[27]

Montana's demonstration evaluation found that among enrollees with incomes above the federal poverty level who lost coverage in 2018, over one-third (34%) were disenrolled for failure to pay premiums.[28] Only 23% of those disenrolled for failure to pay premiums were subsequently re-enrolled in coverage. *Id.*

Multi-state research studies also confirm that premiums result in significant coverage loss among low-income people. One study found that a premium increase enhances the probability of disenrollment by about 13%, and that disenrollment increases one percent for every one dollar increase in monthly premiums.[29] A 2012 study found that "higher public premiums are associated with a decrease in the probability of having public insurance, and an increase in the probability of being

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[27] *Arkansas Works Program Evaluation for Section 1115 Interim Evaluation Report*, ARKANSAS DEPT. OF HUMAN SERVS. (Oct. 22, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-appvd-interim-eval-rprt-03062023.pdf.

[28] *Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Summative Evaluation Report*, SOCIAL & SCIENTIFIC SYSTEMS (Nov. 30, 2020), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-montana-2020.pdf.

[29] Cliff, Betsy et al., *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules*, NATIONAL BUREAU OF ECONOMIC RESEARCH (May 2021), https://www.nber.org/papers/w28762.

uninsured."[30] Another study examining four states with sliding-scale premiums found that participation in public programs fell from 57% when premiums were equal to 1% of family income to 35% when premiums grew to 3% of family income.[31] "Participation continued to fall to 18% when premiums rose to 5% of family income." *Id.*

Despite this long-standing body of research, Federal Appellees' 2020 HIP 2.0 demonstration renewal does not explain why it is methodologically sound to design experiments that contradict the lessons of past demonstrations restricting eligibility and coverage. Moreover, Federal Appellees' 2023 decision includes numerous citations to published research demonstrating the harmful effects of premiums but nevertheless allowed Indiana's premiums to continue.

3. Enrollees Who Were Unable to Pay Premiums Had Substantially Worse Access to Care Compared to Those Who Could Pay Premiums.

Research consistently shows that premiums reduce access to necessary healthcare. Indiana's interim demonstration evaluation included a December 2015-January 2016 enrollee survey which found decreased healthcare utilization among

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[30] Guy, Gery; Adams, Kathleen & Atherly, Adam; *Public and Private Health Insurance Premiums: How do they Affect Health Insurance Status of Low-Income Childless Adults?*, NATIONAL LIBRARY OF MEDICINE (2012), https://pubmed.ncbi.nlm.nih.gov/22650017/.

[31] Ku, L. & Coughlin, T.A., *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, NATIONAL LIBRARY OF MEDICINE (1999), https://pubmed.ncbi.nlm.nih.gov/10711321/.

those disenrolled from HIP 2.0, compared to those who were able to maintain coverage. Just 44% of those who were disenrolled accessed routine care in the past six months (as opposed to 71% of those who maintained coverage), 16% accessed a specialist (as opposed to 41%), and 35% accessed prescriptions (as opposed to 72%).[32] In focus groups in 2017-2018, most people who were disenrolled from HIP 2.0 reported forgoing needed care because they could not afford the out-of-pocket cost.[33]

Access to care was worse for the poorest HIP 2.0 enrollees. Indiana's 2018 HIP 2.0 annual report found that those with income at or below the federal poverty level who were unable to pay premiums (and therefore required to pay point-of-service copays) had far fewer preventive and ambulatory visits compared to those who were able to pay premiums (and not subject to copays).[34] On average, health plans reported that use of preventive care among HIP 2.0 enrollees with income below the federal poverty level (who did not pay premiums and were required to pay co-pays) was a full 30-40 percentage points lower than enrollees with income above the federal poverty level (who paid premiums). *Id.* Moreover, Indiana's

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[32] *See Interim Evaluation Report, supra* note 3 at 73-77.
[33] *See Federal Evaluation*, *supra* note 17 at 7, SAR, Vol. 2 at 4280.
[34] *See* Medicaid Section 1115 Monitoring Report at 5-7 (March 26, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-dy4-20190411.pdf.

interim evaluation found that between February 2015 and December 2018, preventive care usage *decreased* among enrollees with incomes below the federal poverty level (who did not pay premiums and were required to pay co-pays).[35] Another study found that these co-pays likely serve as a barrier to accessing preventive care.[36] People below the federal poverty level already have less access to care compared to those with higher incomes,[37] and the structure and penalties contained in Indiana's demonstration may be exacerbating those access disparities.

Research in other states shows that people who lose Medicaid for failure to pay premiums have reduced access to care. For example, individuals who were disenrolled for premium nonpayment in Iowa reported being unable to refill prescriptions or see a doctor for new medications, skipping doses, or stopping medications.[38] Similarly, individuals who were "locked out" of Medicaid after failure to pay a premium in Wisconsin reported that they were less likely to receive needed medical care and more likely to receive fair or poor quality care and

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[35] *See Healthy Indiana Plan Interim Evaluation Report Final*, THE LEWIN GROUP, INC. at 53 (April 29, 2020), SAR Vol. 3 at 4663, https://www.in.gov/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf.
[36] *See* Fusco, Nicole et al., *Cost-Sharing and Adherence, Clinical Outcomes, Health Care Utilization, and Costs: A Systematic Literature Review,* JOURNAL OF MANAGED CARE & SPECIALTY PHARMACY (April 7, 2022), https://www.jmcp.org/doi/full/10.18553/jmcp.2022.21270.
[37] *See Disparities Report*, *supra* note 4.
[38] *See Purged from the Rolls*, *supra* note 24.

needing to borrow money, skip other bills, or pay other bills late to pay medical bills.[39]

4. Premiums Did Not Positively Influence Enrollees' Healthcare Decisions.

Indiana's demonstration provides that, after 12 months of premium payments, HIP 2.0 enrollees can roll over any unused funds to offset the next year's premiums; the amount of rollover funds is doubled if enrollees receive certain preventive services. However, demonstration evaluations reveal confusion among enrollees about these features.[40] Only 35% of enrollees below the federal poverty level and 52% of enrollees above the federal poverty level understood that their future premiums could be reduced by receiving a preventive visit. *Id*. In one study, a health plan executive said, "[t]he intent of the rollover is to reward people for healthy behaviors. But it doesn't happen until so long after those healthy behaviors that it doesn't have the impact that I think was really intended."[41]

Focus groups consistently confirmed that enrollees did not report making decisions about whether to use healthcare services based on their account balance

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[39] Saloner, Brendan; Dague, Laura & Friedsam, Donna, *Access to Care Among Individuals who Experienced Medicaid Lockouts After Premium Nonpayment*, JAMA NETWORK (Nov. 6, 2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2753978.
[40] *See Interim Evaluation Report*, *supra* note 3 at 65-70.
[41] *See Federal Evaluation*, *supra* note 17 at 62, SAR, Vol. 2 at 4335.

or potential rollover funds.[42] Instead, researchers found that HIP 2.0's structure was extremely difficult for enrollees to navigate and "counterproductive to supporting members' personal responsibility for health and wellness."[43] Researchers also concluded that, in HIP 2.0, "personal responsibility looks less like responsible use of available resources for good health outcomes and more like blame-shifting" responsibility for coverage loss from the state to the individual. *Id.*

Research demonstrates that premiums, particularly those tied to obtaining and maintaining coverage, pose barriers for low-income people, the very population Medicaid is intended to serve. Federal Appellees' decisions to renew HIP 2.0 with state-imposed premiums and disenrollment penalties, despite the known harms to enrollees as demonstrated in numerous studies, were arbitrary, capricious, and contrary to law.

B. Eliminating Retroactive Coverage Harms Medicaid Enrollees.

Retroactive coverage is a "long-standing safeguard[] built into [Medicaid]."[44] It protects enrollees from unaffordable unpaid bills, ensures providers are paid for services, and encourages provider participation. *Id*. CMS'

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[42] *Id.* at 57-58, SAR Vol. 2 at 4330-4331; *see also Health Equity, Urban Congregations, and HIP*, *supra* note 18.
[43] *See Health Equity, Urban Congregations, and HIP*, *supra* note 18 at 44.
[44] *See* Musumeci, MaryBeth & Rudowitz, Robin, *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States,* KFF (Nov. 10, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/.

2015 approval of HIP 2.0's initial retroactive coverage waiver required Indiana to implement a transition program as a safeguard to reimburse providers for services to low-income parents within three months prior to their HIP 2.0 eligibility.[45] The transition program was implemented in August 2015, and by October 2015, just two months later, Indiana reported that over 10% of those eligible for the program had incurred retroactive bills.[46]

In 2016, CMS denied Indiana's request to discontinue the transition program, "noting that 13.9% of beneficiaries eligible for the program incurred costs averaging $1,561 per person based on the latest data available."[47] In other words, HIP 2.0 enrollees needed retroactive coverage and were at risk of financial harm without it. The actual need is likely greater as the data do not reflect retroactive bills for HIP 2.0 expansion adults. Other features of Indiana's demonstration increase the likelihood that enrollees will need retroactive coverage: because "Indiana may delay effectuating beneficiaries' coverage until a premium

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[45] *See* HIP 2.0 Final Evaluation Plan, s*upra* note 2 at 23.
[46] *See* Healthy Indiana Plan Prior Claims Payment Program Report (Oct. 27, 2015) at 4, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-prior-claims-pymt-rpt-10272015.pdf).
[47] *See* Letter from Vikki Wachino, CMS, to Tyler Ann McGuffee, Indiana Office of the Governor, Demonstrations Group (July 29, 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-lockouts-redetermination-07292016.pdf.

payment is made (for some, a delay of up to 60 days), the amount of time that individuals who are newly applying for coverage may incur personal healthcare bills is lengthened." *Id.* Despite this known risk, Federal Appellees' 2020 HIP 2.0 renewal ended the transition program without examining data about enrollee harm.

HHS has continued to approve retroactive coverage waivers in other states without a reliable assessment of their impact.[48] Evaluation designs have been weak or entirely missing, resulting in limited understanding of how these waivers affect providers' uncompensated care costs for physicians and enrollees' access to care.[49] Even where retroactive eligibility waivers were in place for decades, state officials were unable to provide any information about the policy's impact. *Id.*

C. Eliminating Non-Emergency Medical Transportation Harms Medicaid Enrollees.

Lack of transportation is a well-demonstrated barrier to healthcare for Indiana Medicaid enrollees. In the state's NEMT evaluation, HIP 2.0 enrollees and providers cited transportation challenges as a key reason for patients missing

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[48] Rosenbaum, Sara, *Demonstrations to Limit Retroactive Eligibility in Medicaid Lack Evidence and Threaten Access to Care,* THE COMMONWEALTH FUND (Oct. 21, 2021), https://www.commonwealthfund.org/blog/2021/demonstrations-limit-retroactive-eligibility-medicaid-lack-evidence-and-threaten-access.

[49] Courtot, Brigette; Blavin, Fredric; Allen, Eva & Arnos, Diane, *Section 1115 Waivers of Retroactive Medicaid Eligibility*, URBAN INSTITUTE (July 9, 2021), https://www.urban.org/research/publication/section-1115-waivers-retroactive-medicaid-eligibility.

appointments.[50] Providers described these missed appointments as impacting patient access to preventive care and overall care quality. *Id*. at 50. Enrollees with income at or below the federal poverty level and those with greater health needs were more likely to cite transportation as a reason for missing an appointment, compared to those with higher incomes. *Id*. at 23. These results are consistent with other research finding that "adults who lack transportation to medical care are more likely to have chronic health conditions that can escalate to a need for emergency care if not properly managed" and "are disproportionately poor, elderly, and disabled and more likely to have multiple health conditions."[51] Another study revealed that Indiana community health centers and other community-based organizations are "helping enrollees with transportation to medical appointments by providing bus tokens and taxi vouchers," indicating unmet need for NEMT.[52]

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[50] *See generally*, *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver*, THE LEWIN GROUP, INC. (Feb. 26, 2016), https://www.medicaid.gov/Medicaid-CHIP-Progra m-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-eval-nonemerg-med-transport-02262016.pdf, SAR Vol. 3 at 6027.

[51] *See* Musumeci, MaryBeth & Rudowitz, Robin, *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers* (Feb. 24, 2016), https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/view/footnotes/#footnote-177328-33.

[52] Musumeci, MaryBeth; Rudowitz, Robin; Ubri, Petry & Hinton, Elizabeth, *An early look at Medicaid expansion waiver implementation in Michigan and Indiana,*

Although Indiana's NEMT waiver evaluation found that "the availability of NEMT did not affect whether beneficiaries miss medical appointments due to a lack of transportation," it is notable that the "state's evaluation asked beneficiaries if they had missed an appointment only if they first reported that they had scheduled an appointment; it did not ask whether beneficiaries had not scheduled a needed appointment due to a lack of transportation." *Id.* Moreover, enrollees indicated a widespread lack of awareness about the availability of NEMT, including those who did and did not have access to the benefit.[53]

Research shows that NEMT increases enrollees' access to necessary healthcare. For example, an NEMT provider serving 32 states reported that Medicaid enrollees' most frequently cited reasons for using NEMT are accessing mental health and substance abuse treatment, dialysis, preventive services, specialist visits, physical therapy, and adult day healthcare services.[54]

Preliminary data evaluating the impact of Iowa's NEMT waiver, which is similar to Indiana's, indicate potential adverse implications for enrollee access to care. *Id*. Iowa's evaluation found that enrollees without NEMT were more likely to

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KFF (Jan. 2017), https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/.

[53] *See Evaluation of Non-Emergency Medical Transportation*, *supra* note 50 at 28-30, SAR Vol. 3 6063-6065.

[54] *See Medicaid Non-Emergency Medical Transportation*, *supra* note 51.

need assistance with travel to a healthcare visit, compared to those with NEMT.[55] Among enrollees without NEMT, transportation problems were the third most common reason for having an unmet routine or preventive medical care need. *Id.* A GAO report similarly identifies decreased access to care as a highly likely implication of NEMT waivers.[56] Officials from nine of the ten groups that GAO interviewed indicated that eliminating NEMT would impede enrollees' ability to access healthcare services – especially for people in rural or underserved areas and people with chronic health conditions. *Id.* at 15.

Finally, research shows that providing NEMT is cost-effective. One study estimated that at least 3.6 million people miss or delay medical care each year because they lack available or affordable transportation, concluding that "improved access to NEMT for this population [was] cost-effective or cost-saving for all 12 medical conditions analyzed, including preventive services such as prenatal care,

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[55] *See Evaluation of the Waiver of Non-Emergency Medical Transportation Coverage in the Iowa Health and Wellness Plan*, UNIVERSITY OF IOWA PUBLIC POLICY CENTER at 27 (2023), https://iro.uiowa.edu/view/pdfCoverPage?instCode=01IOWA_INST&filePid=13903425190002771&download=true.

[56] *See generally, Medicaid: Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage,* U.S. GOVERNMENT ACCOUNTABILITY OFFICE (Jan. 15, 2016), https://www.gao.gov/assets/gao-16-221.pdf.

and chronic conditions such as asthma, heart disease, and diabetes."[57] The GAO report also identifies increased care costs as a probable outcome from NEMT waivers.[58] Numerous officials interviewed by GAO noted that eliminating NEMT can have cost implications "because patients without access to transportation may forgo preventive care or health services and end up needing more expensive care, such as ambulance services or emergency room visits." *Id.*

Like the harmful impacts of premiums and the elimination of retroactive coverage, the elimination of NEMT creates burdensome barriers to enrollees' access to necessary healthcare. Federal Appellees' decisions to allow Indiana to continue to waive NEMT is contrary to established research, the purposes of the Medicaid statute, and Section 1115 demonstration authority, and are therefore arbitrary, capricious, and contrary to law.

CONCLUSION

For the foregoing, this Court should affirm the decision of the U.S. District Court for the District of Columbia.

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[57] *Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation,* TRANSIT COOPERATIVE RESEARCH PROGRAM (Oct. 2005), http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

[58] *See Efforts to Exclude Nonemergency Transportation*, *supra* note 56.

July 2, 2025

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CERTIFICATE OF SERVICE

I certify that on July 2, 2025, I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit through the appellate CM/ECF system, and the document is being served on all counsel of record via transmission of Notice of Electronic Filing generated by CM/ECF.

July 2, 2025 /s/ Phillip A. Escoriaza

CERTIFICATE OF COMPLIANCE

Pursuant to Rules 29(a)(5), 32(a)(7)(B) and 32(g)(1) of the Federal Rules of Appellate Procedure and D.C. Circuit Rule 28(c), I hereby certify that the foregoing Brief of the APHA, Deans, Chairs and Scholars as Amici Curiae in Support of Plaintiffs-Appellees and Affirmance, which consists of 5,886 words, complies with the type-volume limitation.

July 2, 2025 /s/ Phillip A. Escoriaza