FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

September 2, 2018

The Honorable Alex Azar, Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Demonstration Project #11-W-00298/1, amendment to the New Hampshire Health Protection Program

Submitted electronically via Medicaid.gov

Dear Secretary Azar:

Families USA appreciates the opportunity to provide comments on New Hampshire's request to amend its section 1115 waiver, the New Hampshire Health Protection Program, which the state is renaming Granite Advantage.

Families USA is a national health care advocacy organization that supports policies and programs at the state and federal levels to expand access to quality, affordable health care, with a particular focus on policies that affect lower income individuals.

New Hampshire is requesting several changes to its existing demonstration waiver, including:

- Extending the demonstration's "Work and Community Engagement Requirement" for the five year waiver extension period (that program is scheduled to begin January 1, 2019);
- Ending the demonstration's Premium Assistance Program (PAP) for marketplace coverage offered through qualified health plans, and transitioning Medicaid expansion adults into the state's managed care program and aligning benefits for the state's Medicaid expansion population with the State Plan benefits, effective January 1, 2019;
- Removal of existing conditions and limitations on its retroactive coverage waiver;
- Adding citizenship and residency documentation requirements; and,
- Adding an asset test to eligibility determinations.

New Hampshire also notes in its request that it intends to submit a state plan amendment to allow state and correctional facilities to conduct presumptive eligibility determinations for inmates. We support the state's plan to make that amendment.

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We are extremely supportive of New Hampshire's decision to accept federal funds to extend Medicaid eligibility to low-income adults. It is a decision that has extended health insurance coverage to nearly 52,000 state residents. We also support some aspects of New Hampshire's current request. However, several elements of the state's request do not promote Medicaid's objectives. They would fundamentally alter the Medicaid program in ways that are inconsistent with Medicaid's statutory objectives, are outside of the Secretary's authority to approve, and must therefore be denied.

Our comments on specific sections of the waiver request appear below. We request that these comments and all cited sources, in their entirety, be incorporated into the administrative record.

Comments on specific sections of the New Hampshire waiver request

1. Framework for the analysis

The context for our comments is section 1115 of the Social Security Act, the section of the Medicaid statute that governs the Secretary's approval of demonstration waivers.

Section 1115 of the Social Security Act, "Demonstration Projects," outlines the Secretary's authority to grant demonstration waivers. Section 1115 gives the Secretary the authority to "waive compliance with any of the requirements of section …..1902" of the Social Security Act for any experimental, pilot, or demonstration project which, in the judgment of the Secretary, "is likely to assist in promoting the objectives of title….XIX [Medicaid]." [1]

The objectives of the Medicaid program are set forth in section 1901 of the Social Security Act, "Appropriations." That section states that federal Medicaid funds are for the purpose of enabling states "to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care…."[2] In the context of the statute, it is absolutely clear that "independence or self-care" refers to federal funding enabling states to provide care that can help individuals attain or retain independence that has been compromised because of *health related* conditions.

In evaluating waivers affecting any population covered through the Medicaid program, the Secretary must analyze whether it promotes those objectives. In the recent *Stewart v. Azar* decision, which vacated HHS' approval of Kentucky's waiver proposal to take coverage away from adults who did not meet a work requirement, pay premiums, or renew their coverage or

[1] Social Security Act, section 1115 [42 U.S.C. 1315].
[2] Social Security Act Sec. 1901. **[**42 U.S.C. 1396**].**

report changes on time, the court found that Medicaid's primary objective is to provide coverage to people who otherwise wouldn't have it. The court also stated that, at a minimum, the Secretary must adequately analyze the coverage impacts of waiver approvals: would the project cause recipients to lose coverage and would the project help promote coverage.[3]

2. Moving enrollees from premium assistance to Medicaid manage care

We support the state's proposal to move enrollees to the state's Medicaid managed care system and to align the alternative benefit plan with the State Plan benefit, which the state notes in its application is not changing. This is clearly an area in which state flexibility is consistent with the legal limits on section 1115 authority.

We do, however, urge that you require submission of and adherence to a more detailed transition plan that minimizes disruptions in care. Continuity in care is particularly important for individuals in active treatment for serious conditions.

The state outlines a two-phase transition process, one in January 2019 when enrollees would be transitioned from their current QHP to an MCO. A second transition will take place in July 2019, when the state's new managed care contracts begin. Both transitions will use auto-assignment with opportunities for enrollees to select different physicians within 90 days.

Provider transitions create a high potential for enrollee confusion, missed appointment, and disruptions in care. For individuals with serious conditions, those disruptions can be disastrous to their health and ultimately costly to the program. In this case, that potential for disruption is even greater given that enrollees may have to transition providers twice in a short period.

The state should be required to take all steps to use careful provider matching to minimize enrollees' care disruptions with each transition. In addition, we urge HHS to work with the state to develop robust enrollee educational efforts to inform enrollees of both transitions. Outreach should include multiple communication methods, incorporating communication strategies that have been shown to be most effective reaching low-income populations. We urge special communication efforts targeting those enrollees engaged in active treatment. Clear, frequent communications with enrollees will be essential to minimize confusion, particularly given that two transitions are planned.

3. Extending the Work and Community Engagement Requirement

The state's request to implement and extend its plan to take health insurance coverage away from Medicaid expansion enrollees who do not meet a work or community service requirement is inconsistent with the requirements of section 1115 of the Social Security Act. Such a program would not further the objectives of the Medicaid program and must be denied.

[3] *Stewart v Azar,* United States District Court for the District of Columbia, civil action number 18-152 (JEB).

The work and community service requirement are inconsistent with Medicaid's objectives.
As outlined above in the section "Framework for the analysis," the objective of the Medicaid program is to furnish medical assistance.

While HHS has recently updated its Medicaid.gov website to redefine the objectives of the Medicaid program to include work, that website change has no legal import. Statutory language has precedence over any website language, no matter how official the website.

- A work requirement is unrelated to Medicaid's objectives as defined in statute. The language in the statute is clear. Medicaid's objective is to help states *furnish* medical, rehabilitation, and long-term services. Requiring work or community service as a condition of program participation is not in any way related *to the state furnishing* medical services or *to the state furnishing* rehabilitation or other services—indeed it achieves the opposite goal by withdrawing medical and rehabilitation services from otherwise eligible low-income people if they do not meet the work mandate. It is, therefore, outside of the Secretary's authority to approve under 1115 authority, the earlier approval of the state's request to add a work requirement notwithstanding.

- Taking health care access away from otherwise eligible New Hampshire residents will not in any way promote the statute's objectives. New Hampshire's extension request does not include an analysis of the impact the work requirement is projected to have on enrollment. There was similarly no such analysis in its initial waiver application for this program.[4] Such an analysis is critical for HHS to determine for a complete assessment of the impact that this proposal will have on the target population. As noted in *Stewart v Azar,* before waiver approval, the Secretary must consider coverage effects, at a minimum.

  Even though New Hampshire's application lacks basic supporting data on coverage impact, one can infer the impact from analyses from other states that have submitted work requirement requests. Those have all estimated large coverage losses.[5] In fact, early evidence from Arkansas, which began implementing its work requirement in June, suggests coverage loss will be much higher than what states have projected.[6]

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[4] State of New Hampshire, "Amendment to the New Hampshire Health Protection Program Premium Assistance," October 24, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa3.pdf.

[5] For examples of state analyses on this point, see waiver applications for Kentucky, Arkansas, Mississippi, Kansas and Indiana. Kentucky projected that its program would result in more than 95,000 people leaving Medicaid by demonstration year 5.

[6] Judith Solomon, "Commentary: Administration Can't Justify Re-Approving Waiver Taking Coverage Away from Kentuckians," Center on Budget and Policy Priorities, August 23, 2018, https://www.cbpp.org/health/commentary-administration-cant-justify-re-approving-waiver-taking-coverage-away-from, Sara Rosenbaum, Vikki Wachino, Rachel Gunsalus, Maria Velasquez, and Shyloe Jones, "State 1115 Proposals to Reduce Medicaid Eligibility: Assessing Their Scope and Projected Impact," January 11, 2018, The Commonwealth Fund,

One can assume that New Hampshire would experience large coverage losses as well, particularly given that it is requiring more work hours per month than other states submitting similar requests, which will make the requirement more difficult to satisfy.[7] The coverage loses will result in an increase in the state's uninsured population, lost health care access, and worse health for low-income adults in New Hampshire.[8] These predictable outcomes are the polar opposite of Medicaid's objectives. (The fact that we can make assumptions about the impact of New Hampshire's proposal based on other state analyses does not in any way excuse HHS from requiring that New Hampshire submit an analysis of the coverage impact.)

- The community service requirement's paperwork/work documentation requirements will make it harder for all enrollees to keep Medicaid. New Hampshire's proposal would require paperwork from a broad swath of adults in the state's Medicaid program. Enrollees who are already working will need to document hours worked at regular intervals. Those who are exempt from the work requirement will need to prove that they are exempt. Those who are not currently working will need to document hours in community service, job training, or hours spent applying for jobs. All stand to lose coverage if they don't keep up with the paperwork requirement.

  When states add paperwork requirements to Medicaid, enrollment falls.[9] That will happen with New Hampshire's proposed work requirement as well, and enrollment will fall across the board—including for working adults, people with medical conditions who cannot work but do not qualify for SSI disability, and family caregivers.

  The resulting coverage losses will be across the board, an outcome that is not only contrary to the objectives of the Medicaid program, but inconsistent even with the state's articulated theory for this aspect of its waiver.

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https://www.commonwealthfund.org/blog/2018/state-1115-proposals-reduce-medicaid-eligibility-assessing-their-scope-and-projected?redirect_source=/publications/blog/2018/jan/state-1115-proposals-to-reduce-medicaid-eligibility, and Jennifer Wagner, "Eligible Arkansas Medicaid Beneficiaries Still Struggling to Meet Rigid Work Requirements," Center on Budget and Policy Priorities, August 21, 2018, https://www.cbpp.org/blog/eligible-arkansas-medicaid-beneficiaries-still-struggling-to-meet-rigid-work-requirements.

[7] New Hampshire is requiring enrollees work 100 hours per month, whereas most other proposals require 80 hours or less.

[8] As noted, New Hampshire's Medicaid expansion has resulted in over 50,000 residents gaining health insurance and, since expansion, its uninsured rate has fallen by 45 percent. Individuals losing Medicaid coverage because of these program changes are all but guaranteed to rejoin the ranks of the uninsured. See Jessica Schubel, *New Hampshire Medicaid Waiver will Reduce Coverage and Access to Care* (Washington, DC: Center on Budget and Policy Priorities, ay 2018) online at https://www.cbpp.org/blog/new-hampshire-medicaid-waiver-will-reduce-coverage-and-access-to-care.

[9] Margot Sanger-Katz, "Hate Paperwork: Medicaid Recipients will be Drowning in It," *New York Times*, January 18, 2018 online at https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html.

The Secretary does not have authority to add new, unrelated requirements to the Medicaid program.

Adding a work requirement to Medicaid is beyond the Secretary's authority to "waive" requirements in section 1902. Section 1115 gives the Secretary authority to waive requirements in Section 1902. It does not grant the Secretary the authority to add new program requirements that are not mentioned in 1902 and that are unrelated to the program's statutory purpose of furnishing medical or rehabilitative services. Section 1902 does not mention engaging in work or community service. The Secretary does not have the authority to add new requirements unrelated to the program's objective of *furnishing* medical care.

A mere nexus between an activity and health is not a sufficient basis for the Secretary to use 1115 authority to make Medicaid eligibility conditional upon participation in that activity.

In its application, New Hampshire asserts that the work requirement will test whether "requiring participation in work and community engagement activities…..will lead to improved health outcomes and greater independence through improved health and wellness."[10] The data showing a positive connection between work and health is far from conclusive.[11] However, even if there were a conclusive positive connection, the mere connection between an activity and health status is not a basis to make Medicaid eligibility conditional upon an individual's participation in that activity.

This entire line of reasoning was conclusively rejected on legal grounds in the recent Stewart v Azar decision. Medicaid's core purpose is to pay for medical assistance. Moreover, there are numerous activities that have been shown to improve physical and mental health with far more conclusive data than is available connecting work and health: diet[12]; exercise[13]; marital status[14];

[10] New Hampshire "Granite Advantage 1115 Waiver Amendment and Extension Application," dated July 23, 2018, page 17.

[11] Larisa Antonisse et al., The Relationship Between Work and Health: Findings from a Literature Review (Washington, DC: Kaiser Family Foundation, August 2018) online at https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

[12] See the U.S. Dietary Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between diet and health, at https://health.gov/dietaryguidelines/2015/guidelines/introduction/nutrition-and-health-are-closely-related/.

[13] See the U.S. Physical Activity Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between physical activity and health, at https://health.gov/paguidelines/

[14] For a summary of the copious data on this topic, see the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Research Brief,* 7/01/2007 online at https://aspe.hhs.gov/report/effects-marriage-health-synthesis-recent-research-evidence-research-brief.

social engagement/friendships,[15] to list only a few of the near endless activities that can impact individual health.

It is gross regulatory overreach and a misuse of federal funds for this, or any subsequent administration, to go down the path of adding any extra-statutory conditions on Medicaid eligibility that are not within the program's objectives simply because one or more of those activities has been shown to be related to individual health.

Medicaid is a program to furnish medical assistance and physical rehabilitation and health related supports: it is a *health insurance* program. Health insurance protects people from financial loss associated with medical costs. That is not synonymous with health. That distinction holds true for Medicaid, Medicare, employer sponsored coverage, and any health *insurance* program. Following a path of adding requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a Christmas tree of extra-statutory requirements approved at any administration's whim. It sets up a dynamic that could lead to near unending government micromanagement of the lives of Medicaid enrollees.

Access to affordable health insurance and health care promotes individuals' ability to work.
In its original waiver application, New Hampshire asserted that the aim of its work program is promote work opportunities, improve individuals' financial health and put them on a path out of poverty. Setting aside the fact that these objectives, while laudable, are not objectives of the Medicaid program, threatening to or taking health insurance away from people who do not meet a work mandate will not increase their employment opportunities. It will however, reduce their health coverage and access to health care. That can negatively affect individuals' ability to get and keep employment.

New Hampshire's proposed program, ostensibly about connecting people with work may, in fact, make it more difficult for people to obtain and retain employment.

- Medicaid coverage makes it easier for individuals to keep work. In a comprehensive assessment of Ohio's Medicaid expansion program, 52.1 percent of expansion enrollees said that Medicaid coverage made it easier for them to get and keep employment.[16] A

[15] For a summary of the data on the connection between social relationships and health see Debora Umberson, et al., "Social Relationships and Health: A Flashpoint for Health Policy," Journal of Health and Social Behavior, 2010; 51 (Suppl): S55-S66, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150158/; Mayo Clinic's section on Healthy Lifestyles and Adult Health, "Friendships Enrich Your Life and Improve Your Health," online at https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/friendships/art-20044860; and,

[16] Loren Anthes, "The Return on Investment in Medicaid Expansion: Supporting Work and Health in Rural Ohio," *Say Ahhh! Blog,* Georgetown University Health Policy Institute, January 2017 online at https://ccf.georgetown.edu/2017/01/10/the-return-on-investment-of-medicaid-expansion-supporting-work-and-health-in-rural-ohio/.

more recent report on Ohio's Medicaid expansion population found that many enrollees reported that Medicaid coverage allowed them to get medical care that made it possible for them to keep working.[17]

- Medicaid coverage supports work search activities. In surveys of unemployed Medicaid expansion enrollees in Ohio and Michigan, the majority (74.8 percent in Ohio and 55 percent in Michigan) said that having Medicaid coverage made it easier for them to look for work.[18]

Access to affordable health insurance can be a pathway out of poverty.

"Independence" in the context of New Hampshire's request, refers to financial independence for enrollees, which is not an objective of the Medicaid program. However, even if it were, arguments that a work requirement linked to coverage disenrollment will help improve individuals' economic security do not hold up.

Like all insurance, Medicaid helps protect people from medical costs and debt. That helps improve enrollees' financial security. Data indicates that health insurance coverage through Medicaid can be a pathway to greater financial security and economic independence. Taking Medicaid away will hurt families' financial security.

- Medicaid is associated with improved finances for people covered by the program. Two studies of the impact of Medicaid expansion on financial health found that Medicaid expansion is associated with a significant reduction in unpaid medical bills, a decline in credit card debt, and a decline in debts sent to collections.[19]

- Medicaid coverage improves finances and reduces fiscal stress. Ohio's assessment of Medicaid expansion enrollees found that Medicaid coverage helped enrollees' finances: 22.9 percent of expansion enrollees said their financial situation improved. Medicaid also made it easier for enrollees to afford other life essentials: 58.6 percent said Medicaid coverage made it easier for them to purchase food; 48.1 percent said it made it easier for them to pay rent or a mortgage; and 44.8 percent of enrollees with medical debt said that with Medicaid expansion, they saw that debt end.[20]

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[17] The Ohio Department of Medicaid *2018 Ohio Medicaid Group VIII Assessment, August 2018,* online at http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[18] Jessica Gehr, "The Evidence Builds: Access to Medicaid Helps People Work," CLASP, December 2017 online at https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf.

[19] Dee Mahan, et al., "Medicaid Expansion Improves People's Financial Stability, Families USA blog September 2016, online at http://familiesusa.org/blog/2016/09/medicaid-expansion-improves-people's-financial-stability

[20] Lauren Anthes, *op cit.*

- Medicaid coverage can be a path out of poverty. When Oregon extended Medicaid coverage to previously uninsured low-income adults in 2008 (before the Medicaid expansion), the individuals gaining coverage reported improved financial security.[21] Greater financial security and stability reduces individuals' risk of homelessness and is a foundation for moving out of poverty.[22]

Even in terms of its stated goals, the program would not necessarily increase sustained employment

Evidence from work requirements in other social services programs indicates that they do not result in sustained employment and any employment increases faded over time.[23] In fact, individuals with the most significant barriers to employment often do not find work.[24] There is no reason to believe that results will be any different in a work requirement attached to New Hampshire's Medicaid program. There is no data supporting the theory that taking health insurance away from low-income people will improve their health, finances, or employment prospects. In fact, data indicates that the outcomes would be the opposite.

The community service requirement may violate other federal laws.

The proposed community service requirement may violate additional laws. In many cases, particularly in economically challenged areas where unemployment is high and jobs are scarce, individuals may have no option other than engaging in community service to maintain health coverage. Essentially New Hampshire's program would require those individuals to work without pay in exchange for health insurance. Health insurance is a non-cash benefit, the use of which is unpredictable and depends on health care needs at any given time, and when used, payments are made to health providers, not the covered individual. We continue to urge HHS to solicit input from the Department of Labor regarding this aspect of this, and other, community engagement proposals. In addition to being contrary to Medicaid law, the community service requirement in the request may be in violation of the Fair Labor Standards Act.

4. Removing conditions associated with the state's retroactive coverage waiver

New Hampshire is seeking removal of conditions on its retroactive coverage waiver to allow it

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[21] Katherine Baicker, et al., "The effects of Medicaid Coverage—Learning from the Oregon Experiment," *New England Journal of Medicine,* 2011; 365:683-685, online at https://www.nejm.org/doi/full/10.1056/NEJMp1108222.

[22] *Oregon Study Shows Obtaining Medicaid Improves Financial Security*, National Health Care for the Homeless Council online at https://www.nhchc.org/2013/05/oregon-study-s.

[23] LaDonna Pavette, *Work Requirement Don't Cut Poverty, Evidence Shows* (Washington, DC: Center of Budget and Policy Priorities, June 2016) online at https://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf.

[24] *Ibid.*

to fully omit this important aspect of Medicaid coverage.[25]

Retroactive coverage has been part of the Medicaid program since 1972. It helps prevent medical bankruptcy and provides financial security by making Medicaid payments available for expenses incurred during the three-month period before application if the beneficiary was eligible for Medicaid during that period. This is a vital financial benefit for Medicaid eligible individuals and for the providers who treat them.

Medicaid is the only type of health insurance that requires annual documentation for redetermination of eligibility. This process can result in many people briefly losing Medicaid coverage until they resolve documentation or mailing address issues connected to the renewal process. This is often called "churn." Percentages of people churning on and off Medicaid at renewal generally range from 25 percent to as high as 50 percent. Retroactive coverage helps to fill these gaps in coverage. Omitting this coverage will increase medical debt for Medicaid eligible individuals, as well as uncompensated care costs for the state's health care providers.

These effects are well documented.[26] There is no experimental or demonstration purpose this waiver would serve.

The state contends that eliminating retroactive coverage will encourage beneficiaries to "maintain and retain health coverage even when they are healthy." Eliminating retroactive coverage will not support early enrollment or increased continuity of care absent a significant education and outreach program, which is not anticipated here. Furthermore, when coupled with other aspects of this request which are guaranteed to have the effect of creating gaps in coverage and care for many enrollees (work requirement and associated paperwork requirements, added eligibility documentation), the state's commitment to coverage continuity seems erratic at best.

The state has failed to demonstrate how it will ensure that eliminating retroactive coverage will in fact reduce gaps in care, particularly when viewed in the context of all the requests in this waiver application.

[25] The demonstration includes a conditional retroactive coverage waiver, predicated on a showing that the state's coverage system provides seamless eligibility determinations that ensure that individuals will not have periods of uninsurance.

[26] MaryBeth Musumeci, et al., *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers and States* (Washington, DC: Kaiser Family Foundation, November 2017) online at https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/

5. Imposing an asset test

New Hampshire proposes imposing a $25,000 asset test on individuals eligible through the Medicaid expansion [1902(a)(10)(A)(i)(VIII)]. Section 1902(e)(14)(A) of the Social Security Act requires states to use modified gross income to determine Medicaid eligibility for most populations, including Medicaid expansion eligible adults. That section is quite explicit that the Secretary does not have the authority to waive this requirement except for enumerated populations, which do not include the Medicaid expansion group.

By statute, the Secretary is prohibited from using waiver authority to add an asset test. This request must be denied.

6. Additional citizenship and residency documentation requirements

New Hampshire proposes requiring Medicaid expansion applicants to verify United States citizenship with two forms of paper identification and New Hampshire residency with either a driver's license or non-picture state-issued ID.

This request is extremely burdensome, would cause excessive enrollment delays, effectively eliminates eligibility for qualified immigrants, and violates the Medicaid statute. This request must be denied.

The request violates the Medicaid statue.

Requirements governing documentation for proof of citizenship and immigration status are in Social Security Act sections 1137 ("Income and Eligibility Verification System") and 1903(x) ("Payment to States"). The state's request exceeds the processes outlined in those sections. The Secretary's waiver authority is limited to section 1902, and does not include sections 1137 or 1903. Therefore, this request must be denied.

The request would add administrative burden and is not supported.

Existing Medicaid regulations require verification of citizenship and noncitizen status for Medicaid enrollees. Applicants must provide their names, dates of birth, and Social Security or relevant immigration numbers, and attest to citizenship status. This information is matched against information held by the Social Security Administration (SSA) which verifies U.S. citizenship and the Department of Homeland Security (DHS) which verifies immigration status and U.S. citizenship for certain individuals. This data match system verifies eligibility status quickly, accurately and efficiently for the majority of applicants. In cases where instant verification cannot be obtained, individuals must provide additional information or documents to prove their status. Individuals do not have to provide two forms of documentation in those cases. Sections 1137 and 1903(x) outline documentation that is sufficient.

Moving back to a paper system will add administrative burden and costs, as well as verification delays. In its application, New Hampshire states the rationale for this request is to test whether requiring documentation will improve the accuracy of eligibility determinations. The state does not provide any compelling evidence (or any evidence whatsoever) that there are any issues

with accuracy under the current data match system. Proposing that a paper system will be superior to the current system strains credulity.

The request would be excessively burdensome to enrollees and delay eligibility.
The required documentation not only adds administrative red tape, but places an added burden on applicants, one that will delay eligibility determinations and may deter some from applying in the first place (there are additional barriers for qualified immigrants, addressed separately below). The waiver specifies that paper proof of citizenship is required, although the documents accepted are not listed. For residency, driver's license or non-driver id would be required.

Gathering documents for citizenship verification will take time and money. It takes time to obtain paper copies of birth certificates. Assuming some applicants will be required to provide a passport as one of the proofs of citizenship, processing time is 4 to 6 weeks, and fees are, at a minimum, $50 for a passport card, a fee that is excessive for low-income individuals who are eligible for Medicaid.[27]

The fees, added time, and documentation collection burdens will not only delay applicants' eligibility processing, but may deter many from applying in the first place. The state asserts that its infrastructure and approach will be monitored to not cause "excessive burdens to applicants or unreasonable delays." First, it is not possible that this system will not cause burdens to and delays compared to electronic data match system. Second, the anticipated "monitoring" does not anticipate measuring the up-front, pre-submission delays and costs imposed on applicants, which will be excessive and unnecessary.

The request would deny access for qualified immigrants.
The state's proposal requires verifying United States citizenship and residency. Whether intentional or not, the United Citizenship requirement effectively eliminates Medicaid eligibility for qualified immigrants because they will not be able to prove that they are United States citizens. Section 1137 of the Social Security Act governs verification determinations and section 1903(x) governs citizenship and immigration status verification. The state's request is in conflict with those sections, neither of which can be waived under 1115 authority.

There is not any experimental purpose.
Section 1115 specifies that waivers serve a demonstration purpose. There is no demonstration purpose to this request. The impact of added documentation requirements is to slow the application process. No further study of this issue is needed.

[27] US Department of State, Travel.State.Gov. A passport card is the least expensive passport document an adult can purchase. Fees for a passport book are $145. https://travel.state.gov/content/travel/en/passports/apply-renew-passport/apply-in-person.html

- Experience with the Deficit Reduction Act of 2005. The Deficit Reduction Act of 2005 placed added citizenship documentation requirements on children and low-income families applying for Medicaid. Because immigration verification was governed by existing federal law, the law did not affect application processes for qualified immigrants. Data from New Hampshire Healthy Kids, which processed child applications for New Hampshire's CHIP program, shows that during the first six months after this requirement took effect only 16 percent of applicants had all the documents needed to verify eligibility.[28] Large numbers of incomplete application submissions meant that application processing, and insurance coverage, was delayed for uninsured U.S. citizen children. There is no reason to believe that the effect on coverage and access to care would be any different here.

The request would create barriers to care. Without doubt, the request would place burdens on applicants, shut-out an entire group of eligible applicants, dampen enrollment and slow application processing. All of these foreseeable outcomes are in conflict with Medicaid's objectives. Furthermore, the state offers no plausible rationale for this request. This request must be denied.

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For the reasons outlined above, HHS must deny the state's request to extend the work requirement approval granted by HHS, which has never comported to Medicaid law; the request to add an asset test; the request to eliminate retroactive coverage; and, the request to add documentation requirement to the application process.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Dee Mahan at Families USA, 202-628-3030 or at dmahan@familiesusa.org.

Respectfully submitted,

Dee Mahan
Director, Medicaid Initiatives

[28] Tricia Brooks, "Why is NH Choosing to Replace Proven Electronic Citizen Verification with Burdensome Medicaid Paperwork Requirements," Georgetown Center for Children and Families, June 28, 2018 online at https://ccf.georgetown.edu/2018/06/28/why-is-nh-proposing-to-replace-proven-electronic-citizenship-verification-with-burdensome-medicaid-paperwork-requirements/.