FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

January 6, 2019

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Virginia's Extension Application for its Section 1115 Virginia COMPASS - Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency Demonstration (No. 11-W-00297/3)

Submitted electronically via Medicaid.gov

Dear Secretary Azar:

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation – improvements that make a real difference in people's lives. In all of our work, we strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers.

Families USA appreciates the opportunity to provide comments on Virginia's request to extend and amend its 1115 waiver referenced above.

We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

In its waiver application, Virginia is asking to extend it Addiction and Recovery Treatment Services (ARTS) benefit and maintain authority for coverage of former foster care youth who age out of foster care in another state. It is asking to add three new programs:

- Create a housing and employment support benefit for high-need populations;
- Add a "Health and Wellness" program that includes premiums and cost sharing for adult enrollees with incomes 100-138 percent of poverty, with coverage suspension for unpaid premiums after a 3 month grace period;
- Add a work and community engagement program, "Training, Education, Employment and Opportunity Program" (TEEOP) for adults with incomes up to 138 percent of poverty, with Medicaid eligibility conditioned upon meeting that program's requirements.

Our comments focus on the latter two bullets above.

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Framework for the analysis

Statutory Requirements for 1115 Waivers

Section 1115 of the Social Security Act (the Act) gives the Secretary broad authority to approve state waiver requests. However, that authority is not unlimited. The Act places specific limits on what the Secretary can and cannot waive.

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] [Emphasis added.]

The Secretary is bound by law to review waiver requests within the parameters of the Act.[2]

Medicaid's Objectives

The purpose of the Medicaid program is 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], whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care…."[3]

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. It refers to Medicaid's role financing nursing home coverage and home and community based services and supports for physically or mentally disabled individuals.

As noted in the recent court decision in *Stewart v. Azar*, helping states furnish medical assistance is a central objective of the Medicaid program.[4]

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[1] Social Security Act, section 1115 [42 U.S.C. 1315].

[2] CMS has made changes to the Medicaid.gov website and issued guidance that includes language expanding the objectives of the Medicaid program. However, it is the statute, not website language or agency guidance that governs the limits on the Secretary's authority.

[3] Social Security Act Sec. 1901. **[**42 U.S.C. 1396**].**

[4] *Stewart v. Azar*, Memorandum Opinion, United States District Court for the District of Columbia, Civil Action No. 18-152 (JEB); opinion dated June 29, 2018.

It is not within the Secretary's (and by extension the agency's) authority to redefine Medicaid's purpose.

CMS is basing its authority to approve work requirement waivers and various other waiver proposals on its own redefinition of Medicaid's purpose, a redefinition it does not have the authority to make.

When Congress drafted the Medicaid statute, it was very clear as to the statute's purpose: to furnish medical assistance. It was also clear that funds appropriated under the statute were to be used to carry out that purpose, i.e., provide medical assistance.[5] In other words, Congress clearly identified the way that the Medicaid program is to help low-income individuals, and that is through the provision of *medical assistance*.

In recent waiver approval documents, CMS has acknowledged that purpose, most recently in its approval of New Hampshire's Granite Advantage Health Care Program. In that document, the agency stated that section 1901, the Medicaid statute's "Appropriations" provision, "makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations."[6] However, CMS then asserts without statutory basis that *in the agency's opinion*, the objective of the statute should be significantly broader, stating, ". . . .we believe an objective of the Medicaid program, in addition to furnishing medical assistance to pay for healthcare services, is to advance the health and wellness needs of its beneficiaries." Then it goes even further, encouraging states to structure demonstration programs "in a manner that prioritizes meeting those ("health and wellness") needs," presumably over providing medical assistance, the undisputed purpose Congress designated in statute.

The agency justifies this astonishingly radical re-interpretation of Medicaid's role by asserting that medical assistance is, in the agency's opinion, "not advancing the health and wellness of the individual receiving (medical services), or otherwise helping the individual attain independence."[7]

CMS offers no support for this astounding conclusion, which is controverted by a substantial number of studies showing that Medicaid improves the health and financial wellbeing of those it serves.[8] Even if it could offer such support, and even if the agency sincerely believes that

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[5] Social Security Act section 1901.

[6] Mary C. Mayhew, Deputy Administrator and Director, Center for Medicaid and CHIP Services, CMS, November 30, 2018 letter to Henry Lipman approving New Hampshire's Granite Advantage Health Care Program waiver request, online at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-granite-advantage-health-care-program-ca.pdf.

[7] Mary C. Mayhew, New Hampshire waiver approval, *op cit.*

[8] Among the many reports showing the health value of Medicaid coverage are: *The Value of Medicaid: Providing Access to Care and Preventive Health Services,* (Washington, DC: AHIP, April 2018) online at

changing the statute's purpose would improve the lives of Medicaid beneficiaries, it is not up to CMS to decide to redefine the statute's objectives. It is not CMS's function to second guess Congress's decision that Medicaid funding is to be used to provide medical assistance.

CMS's reinterpretation of Medicaid's objectives would vastly and inappropriately expand the agency's purview

As noted above, Congress clearly specified the manner in which the Medicaid program would assist low-income people and that is through the provision of medical assistance. That defined purpose stands in stark contrast to the agency's reinterpretation of the statue's objective, to "advance health and wellness needs" of enrollees. This reinterpretation vastly extends the agency's reach, for there is virtually no limit to the things that can advance individual health and wellness.

Congress did not give the agency administering Medicaid boundless, unstructured, and unfettered authority to go on a roving hunt for services or activities that might arguably promote "health and wellness," and then compel enrollees to engage in those activities or lose their health insurance. If it had done that, it would be an astonishingly broad dictate. A list of "health and wellness" promoting activities could include any number of things, from requirements such as: eating five or more servings of fruits or vegetables a day[9]; participating in

https://www.ahip.org/wp-content/uploads/2018/04/ValueMedicaid_Report_4.4.18.pdf ; Laura Antonisse, *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review,* (Washington, DC: Kaiser Family Foundation, 2018) online at https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/ ; Julia Paradise, *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence,* (Washington, DC: Kaiser Family Foundation, 2013) online at https://www.kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/view/print/. Studies showing the personal financial benefits of Medicaid coverage include the following: Loujia Hu, et al., "The Effect of the Patient Protection and Affordable Care Act on Financial Wellbeing," National Bureau of Economic Research, Working Paper 22170, issued April 2016, revised February 2018; Nicole Dussault, et al., "Is Health Insurance Good for Your Financial Health?" Liberty Street Economics, Federal Reserve Bank of New York, June 2016 online at https://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V2fhz_krLct; Emily Gallagher, "Medicaid can Increase Savings by Distressed Households," Federal Reserve Bank of St. Louis, July 2018 online at https://www.stlouisfed.org/publications/in-the-balance/2018/distressed-families-save-medicaid.

[9] Ashley Welch, "For a longer life, researchers say eat this many fruits and vegetables a day," CBS News, February 23, 2017 online at https://www.cbsnews.com/news/for-a-longer-life-researchers-say-eat-this-many-fruits-and-veggies-per-day/.

team sports[10]; owning a pet[11]; getting a college degree[12]; not eating out[13]; knitting[14]; having a spiritual practice[15]; cutting red meat from your diet[16]; doing volunteer work.[17] That final example is already a component of state work requirement requests, including Virginia's.

The construct the agency is proposing is such a broad interpretation of the statute that it could lead down the path of near endless requirements and dictates on the lives of low-income people, with the government interfering in everything they do, from lifestyle choices, to behaviors, to economic activities.

Furthermore, one administration's priority activities for individual "health and wellness" are likely not the same as another administration's. CMS's broad interpretation sets the stage for significant uncertainty in state Medicaid program operations, and for program enrollees, as accepted activities to promote "health and wellness" are likely to shift, possibly dramatically, from administration to administration.

It was not Congress's intent that conditional eligibility for the Medicaid program be used as a social engineering tool to compel individuals to engage in activities any given administration views as arguably health promoting.

The Secretary and the agency must administer the program that Congress passed, not a redefined program they wish Congress had passed. The statute Congress passed has providing medical assistance as its objective.

It was certainly not Congress's intent that medical assistance be taken away from individuals who do not engage in activities unrelated Medicaid's purpose

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[10] Neha John-Henderson, "Team Sports Boost Mental Health," *Greater Good Magazine,* UC Berkley, December 2010 online at https://greatergood.berkeley.edu/article/research_digest/team_sports_boost_mental_health.
[11] Harvard Women's Health Watch, "Why having a pet is good for your health," January 2014, online at https://www.health.harvard.edu/staying-healthy/why-having-a-pet-is-good-for-your-health.
[12] Donna Cardillo, "Can a college degree make you healthier and happier?" *DR. OZ Magazine*, online at https://www.doctoroz.com/blog/donna-cardillo-rn-ma/can-college-degree-make-you-healthier-and-happier.
[13] "Cooking at home tonight? It is likely cheaper and healthier, study finds," *Science Daily*, March 14, 2017 online at https://www.sciencedaily.com/releases/2017/03/170314150926.htm.
[14] Chelsea Ritschel, "Knitting can reduce anxiety, depression, chronic pain, and slow dementia, research reveals," *The Independent,* March 13, 2018 online at https://www.independent.co.uk/life-style/knitting-reduces-anxiety-depression-chronic-pain-slows-dementia-research-knit-for-peace-uk-a8254341.html
[15] Tyler VanderWeele, "Religion may be a miracle drug," *USA Today*, October 28, 2016 online at https://www.usatoday.com/story/opinion/2016/10/28/religion-church-attendance-mortality-column/92676964/?hootPostID=8541c7962aa2fbe685702b610240103d.
[16] "*Cutting red meat for a longer life,"* Harvard Men's Health Watch, June 2012, online at https://www.health.harvard.edu/staying-healthy/cutting-red-meat-for-a-longer-life.
[17] Stephanie Watson, "Volunteering may be good for body and mind," *Harvard Women's Health Watch*, June 26, 2013 online at https://www.health.harvard.edu/blog/volunteering-may-be-good-for-body-and-mind-201306266428.

Virginia is requesting to end Medicaid coverage for individuals who do not meet work mandate requirements.

When Congress specified that the statute's purpose was to provide medical assistance, it certainly did not intend for the administering agency to withhold the statute's essential benefit—medical assistance—from individuals who do not engage in activities unrelated to the statute's core purpose, no matter how laudable those activities might be. That is exactly what CMS is claiming it has the authority to do.

By withholding medical assistance from individuals who do not meet a work requirement, CMS is making a judgment that labor market participation is of greater value than medical assistance. This is entirely a value judgment of this administration, not Congress.

There is nothing in the statute to support CMS's claim that it has the authority to withhold medical assistance from individuals who do not engage in an activity deemed by this, or any other administration, to promote "health and wellness," simply because the agency believes they would be better off if they did.

The work requirement does not meet CMS's own justifications for demonstration approval.

In prior work requirement approval letters, CMS has asserted that work requirements meet Medicaid's objectives and are suitable for demonstration approval because they "seek to improve beneficiary health and financial independence."[18] Not only is that an overly broad and inappropriate reinterpretation of Medicaid's objectives (see above), but Virginia's work requirement, as well as the state's coverage suspension for premium non-payment, fail to meet even that test.

Whether work, particularly low-wage work of the type that Medicaid enrollees are engaged in, promotes "health and wellness" is subject to debate. Some studies show a positive connection between work and health, others show no relationship.[19] Whether work has a positive impact on health is significantly affected by the quality and stability of that work.[20] Low-wage jobs, the

[18] New Hampshire and Wisconsin waiver approvals, *op cit.*

[19] 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/.

[20] Sarah Burgard, et al., "Perceived job insecurity and worker health in the United States,"SocSci Med. 2009 Sep; 69(5): 777–785, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2757283/ ;JG Grzywacz, et al., "Good jobs to bad jobs: Replicated evidence of an employment continuum from two large surveys," Soc Sci Med. 2003 Apr;56(8):1749-60. Online at https://www.ncbi.nlm.nih.gov/pubmed/12639591; and Jeanette Zeockler, *Mapping the Landscape of Low-Wage Work and Health in Syracuse*, (SUNY Upstate Medical University, The Low-Wage Workers' Health Project, Syracuse, NY, 2017) online at http://ohccupstate.org/pdfs/LWWHP%202017.pdf..

type that Medicaid enrollees will by definition be engaged in, are less stable and therefore less likely to promote health.[21]

Even if work does promote health, Virginia's program would still fail to meet CMS's own criteria. The core feature of Virginia's, and other states', work requirement program is terminating Medicaid coverage for individuals who do not meet the work or community service mandate or appropriately report work hours or justify exemptions. There is no doubt that many will lose health insurance as result of the program.[22] Most likely, many who lose coverage will be working or exempt individuals who fail to meet the program's paperwork requirement.[23] Without doubt, the program will increase the number of Virginians without health insurance.

There is no analysis under which being uninsured is associated with improved health or more secure finances.[24]

Cutting individuals off Medicaid coverage will not improve their health. Virginia's work requirement program will reduce the number of individuals receiving Medicaid (see discussion coverage impact, below), and increase the number of uninsured Virginians compared to coverage without the waiver. People without health insurance have worse access to health care and are more likely to go without needed care, treatment for chronic conditions, or receive preventive services.[25] These are not health improving outcomes.

Cutting individuals off Medicaid will not improve their financial independence. A key function of health insurance, which is what Medicaid is, is to protect individuals from unexpected, potentially ruinous, medical costs so that they can access medical care. This concept is core to Medicaid's purpose. Section 1901 of the Social Security Act defines Medicaid's purpose as federal funding to states so that each state can "furnish medical assistance [to those] whose income and resources are insufficient to meet the costs of necessary medical services."[26]

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[21] Robert Roy Britt, "Job Insecurity Worse for Your Health than Unemployment," Live Science, August 2009, online at https://www.livescience.com/7856-job-insecurity-worse-health-unemployment.html.

[22] See Virginia's enrollment projections for the new program features, and the discussion on coverage impact in these comments.

[23] Arkansas is the only example to date of an operational work requirement. During the first three months program disenrollment was in effect, over 12,000 individuals lost coverage, and all assessments indicate that many who lost coverage were likely working or exempt from the requirement, but caught in the program's red-tape. See Robin Rudowitz, *A Look at October State Date for Medicaid Work Requirements in Arkansas* (Washington, DC: Kaiser Family Foundation, November 2018) online at https://www.kff.org/medicaid/issue-brief/a-look-at-october-state-data-for-medicaid-work-requirements-in-arkansas/.

[24] Jennifer deVoe, "Being Uninsured is Bad for Your Health: Can Medical Homes Play a Role in Treating the Uninsured Ailment," Annals of Family Medicine, 2013 Sept; 11(5): 473-476 online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767717/; Centers for Disease Control, "The Medically Uninsured," online at https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/MedicallyUninsured.html.

[25] Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Washington, DC: Kaiser Family Foundation, December 2018, online at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[26] Social Security Act section 1901.

Like other forms of health insurance, Medicaid coverage is associated with improved financial security for those covered. Studies have found Medicaid coverage is associated with significant reductions in individuals' unpaid bills and amounts sent to collection; a decrease in credit card debt; increased household savings; and lower rates of home payment defaults, i.e., greater home security.[27]

Medicaid coverage, in and of itself, promotes financial independence for those covered. Taking health insurance away from low income people will not increase their financial independence.

A work requirement is not part of the Medicaid statute.

The Medicaid statute does not include any requirement that enrollees work in order to receive medical assistance. Prior administrations have found that there is no place in the Medicaid statute to support a work requirement.[28]

That the statute does not allow the addition of a work requirement is further supported by the fact that in 2017, multiple failed Congressional bills to repeal the Affordable Care Act and restructure Medicaid included provisions to add a work requirement to Medicaid.[29] Congress would not have found it necessary to propose adding the authority for CMS to approve work requirements in state Medicaid programs if such authority already existed.

Congress did not pass legislation to add a work requirement to Medicaid in 2017. There is no statutory support to add a work requirement to Medicaid. CMS cannot make an end-run around Congress by unilaterally redefining Medicaid's objectives to invent the authority the agency wishes it had. To do so is a shocking overreach by the Secretary and CMS.

The Secretary must consider the waiver's coverage impact.

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[27] Loujia Hu, et al., "The Effect of the Patient Protection and Affordable Care Act on Financial Wellbeing," National Bureau of Economic Research, Working Paper 22170, issued April 2016, revised February 2018; Nicole Dussault, et al., "Is Health Insurance Good for Your Financial Health?" Liberty Street Economics, Federal Reserve Bank of New York, June 2016 online at https://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V2fhz_krLct; Emily Gallagher, "Medicaid can Increase Savings by Distressed Households," Federal Reserve Bank of St. Louis, July 2018 online at https://www.stlouisfed.org/publications/in-the-balance/2018/distressed-families-save-medicaid; and, Kristin Capps, "For the poor, Obamacare can reduce late rent payments," CityLab, December 4, 2018 online at https://www.citylab.com/equity/2018/12/obamacare-health-insurance-housing-rent-payments/577099/.

[28] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf;

[29] HR 1628, American Health Care Act of 2017, online at https://www.congress.gov/bill/115th-congress/house-bill/1628; Robin Rudowitz,*Medicaid Changes in Better Care and Reconciliation Act (BCRA) Go Beyond ACA Repeal and Replace,* (Washington, DC: Kaiser Family Foundation, July 2017) online at https://www.kff.org/medicaid/issue-brief/medicaid-changes-in-better-care-reconciliation-act-bcra-go-beyond-aca-repeal-and-replace/.

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's 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 report changes on time, the court found that Medicaid's primary objective is to provide coverage to people who otherwise would not 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.[30]

The programs proposed would reduce coverage.

There is no analysis under which Virginia's proposed work requirement and premium/premium suspension in its Health and Wellness program would promote Medicaid's objective of providing coverage to people who otherwise would not have it. Our analysis is based on Virginia's own projections of the impact the waiver's "new features" will have on coverage. The new features that would negatively impact coverage levels are the work requirement and the suspension program for premium non-payment.

<u>Coverage losses anticipated</u>
Virginia estimates that the new demonstration features would result in the equivalent of roughly 27,000 fewer enrollees each year in demonstration years 2 through 5. In year 5, the final demonstration year, the new features are projected to result in a more than six percent reduction from coverage levels projected without the new features.[31]

<u>Coverage losses continue throughout the demonstration period</u>
The state projects the waiver will result in fairly consistent annual decreases in coverage throughout the 5 year demonstration period.[32] The state does not anticipate that disenrollment will be high at first and then decline. Year after year, the program is projected to result in coverage losses of 6 to nearly 7 percent of enrollees from the projections without the new features.[33]

It strains credulity to argue that most of those projected to lose Medicaid coverage will be obtaining employer sponsored coverage, even if they are working. Only 52 percent of Virginia's

[30] *Stewart v. Azar*, Memorandum Opinion, United States District Court for the District of Columbia, Civil Action No. 18-152 (JEB); opinion dated June 29, 2018.
[31] Virginia waiver application pages 22-23; to estimate enrollees affected, Families USA divided member months by 12.
[32] Virginia waiver application, pages 22-23. Coverage losses in DY 2 are projected at 321,780 member months (est. 26,815 enrollees) and 327,498 member months (est. 27,292 enrollees) in DY 5. Enrollee estimates developed by Families USA based on member months divided by 12.
[33] Virginia waiver application, pages 22-23.

private sector employers offer health coverage at all.[34] Significantly fewer employers offer health coverage to part-time workers, and many of the working poor are working part time, erratic hours, or at multiple jobs with none full time.[35] The fact is that most who would lose coverage because of the state's requested work or premium programs will become uninsured.

Therefore, year after the year during the demonstration period, the state projections show over 26,000 individuals losing coverage annually and more than likely becoming uninsured. This is a program that is creating more uninsured individuals, consistently, during the demonstration. It is not projected to promote coverage.

In recent waiver approvals, CMS has noted that waivers may "result in an impact on eligibility, enrollment, benefits, cost-sharing or financing. . . .but in the long term they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence."[36] Demonstration outcomes must be measured within the window of the demonstration, rather than some unspecified "long term." For the duration of this waiver, the work requirement and premium program reduce coverage, create more uninsured Virginians, and lessen the health and financial security of otherwise eligible Virginians (see discussion above). Therefore, both must be denied.

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The law limits the Secretary's waiver approval authority to programs that would promote Medicaid's objectives, to provide medical assistance. Requiring work and ending Medicaid coverage for those who do not work has no connection to the statute's purpose of providing medical assistance.

The Secretary and CMS clearly know that the statute's objectives do not support adding a work requirement to Medicaid, or the agency would not be undertaking a campaign to justify its decision to redefine the program as something other than the program providing medical assistance that Congress passed.[37] Neither this nor any other agency has the authority to unilaterally redefine the statute it is charged with administering.

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[34] Kaiser Family Foundation, "Percent of Private Sector Establishments that Offer Health Insurance," 2017 online at https://www.kff.org/other/state-indicator/percent-of-firms-offering-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[35] Employee Benefit Research Institute, "Trends in Health Coverage for Part-Time Workers," May 2014 online at https://www.ebri.org/docs/default-source/ebri-press-release/pr1078.pdf?sfvrsn=9427362f_0; CLASP, *The Struggles of Low Wage Work,* online at https://www.clasp.org/sites/default/files/publications/2018/05/2018_lowwagework.pdf.

[36] CMS approval documents: New Hampshire's Granite Advantage Health Care Program, November 30, 2018 at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-granite-advantage-health-care-program-ca.pdf.

[37] Sara Rosenbaum, "The Trump Administration Reimagines Section 1115 Demonstrations—And Medicaid," *Health Affairs Blog,* November 9, 2017 online at https://www.healthaffairs.org/do/10.1377/hblog20171109.297738/full/.

Based on the analysis above, the Secretary does not have the authority to add a work requirement to Medicaid and that program must be denied; the premium disenrollment program also fails to further Medicaid's objectives and must be denied.

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,

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Director Medicaid Initiatives