



August 18, 2018

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

Dear Secretary Azar:

Thank you for the opportunity to comment on the Kentucky Medicaid 1115 waiver proposal that would impose work reporting requirements and premiums on low-income Medicaid enrollees, penalizing those who are unable to comply by taking away their health care and locking them out of coverage for a period of time.

My name is Tricia Brooks and I currently serve as an associate research professor at the Georgetown University McCourt School of Public Policy and senior fellow at the Georgetown University Center for Children and Families (CCF). Before joining the faculty at Georgetown University a decade ago, I served as the founding chief executive of New Hampshire Healthy Kids Corporation (NHHK), a legislatively created non-profit charged with crafting an affordable health coverage program for uninsured children. In less than one year after the corporation was created in 1994, NHHK started covering children and was designated by then Governor Jeanne Shaheen as the vehicle for launching New Hampshire's Children's Health Insurance Program (CHIP) in 1998. In addition to administering CHIP, NHHK coordinated outreach and served as the mail-in application processing unit for both Medicaid and CHIP. As a mission-oriented non-profit, our goal was to enroll eligible children and reduce the rate of uninsured children in the state. In the nearly 15 years that I led this effort, the uninsured rate among children dropped from over 14 percent to less than 5 percent. *The comments that follow are based on my direct experience both as a program administrator and policy researcher and will focus exclusively on how onerous administrative procedures and documentation requirements will negatively impact enrollment.* These comments supplement those submitted by my colleague Joan Alker, also a Research Professor at Georgetown's McCourt school and the Executive Director of CCF.

*Before offering specific examples and citing the research, let me summarize my comments. Ample evidence points to simplifying application and renewal processes and removing onerous reporting and documentation requirements as critical elements in advancing coverage. The evidence works both ways – that is, while simplifications increase enrollment and coverage, reversing simplifications and increasing paperwork requirements decrease enrollment and coverage. Importantly, it is the suppression of enrollment that is at the heart of the debate over whether work requirements and other restrictive measures in Kentucky or any state further the purposes of the Medicaid program. **Regardless of intent, there is no question that the outcome of imposing red tape barriers and onerous reporting***

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requirements on beneficiaries is in direct conflict to Medicaid's purpose of providing health care.

The comments below include numerous graphs and footnotes with direct links to research for the benefit of HHS in reviewing our comments and I request that the full text of each of the studies cited, along with the full text of comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Over the past two decades, CMS and states have worked to modernize eligibility, enrollment, and renewal processes to promote enrollment of eligible, uninsured individuals in Medicaid. Many of the innovations emerged from efforts to advance children's coverage and were codified in the 2009 CHIP Reauthorization Act and the Affordable Care Act (ACA) as efficient and accurate methods for administering eligibility and enrollment. CMS continues to prioritize easing administrative burdens on physicians, for example, as noted in its "patients over paperwork" initiative by streamlining regulations to "reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience."¹ The agency specifically cites "simplifying documentation requirements" in order to reduce the paperwork burden.² In fact, CMS has done a great deal to promote simplification of eligibility and enrollment, particularly as it worked with states to implement high-performing, data-driven systems and implement streamlining measures as part of the ACA.³ So, it is incongruent that the agency has approved state waiver requests to do the opposite in regard to beneficiaries with work reporting requirements and other administrative barriers.

I have experienced first-hand the impact that simplifying enrollment and renewal processes, as well as implementing new documentation requirements, has on Medicaid enrollment. During my tenure at NHHK, we participated in several national learning collaboratives to increase enrollment and retention of eligible, uninsured children in Medicaid and CHIP. States' experience in expanding coverage and the various strategies tested as part of these collaboratives clearly illustrated that red tape and excessive reporting requirements were barriers to enrollment and retention. After joining the faculty at Georgetown, I served as a technical advisor for the Maximizing Enrollment⁴ collaborative, a joint venture of the National Academy of State Health Policy and the Robert Wood Johnson Foundation. Later, I served as a member of the national advisory committee to the Ford Foundation's Work Support Strategies,⁵ aimed at better integration of health and human service programs. These initiatives continued to build the case that streamlining and simplifying procedures support enrollment and retention.

The enactment of CHIP ushered in a pro-child coverage environment. At the time nearly five million uninsured children were eligible but not enrolled in Medicaid and CHIP. In the two decades since CHIP was enacted, children's health insurance rates have dramatically improved from 85.1 percent in 1997 to 95.2 percent in 2015.⁶ A key multi-state effort in expanding children's coverage was a two-part initiative funded by the Robert Wood Johnson Foundation – known as Covering Kids, followed by Covering Kids and Families (CKF). The focus of these efforts was to address issues raised in a survey conducted by the research firm Wirthlin Worldwide in 2000. The survey found that six out of 10 families with eligible but uninsured children were not aware that their children could be covered by Medicaid or CHIP. Even when families recognized their eligibility and tried to sign up, they faced significant barriers such as long and complicated forms; eligibility requirements that

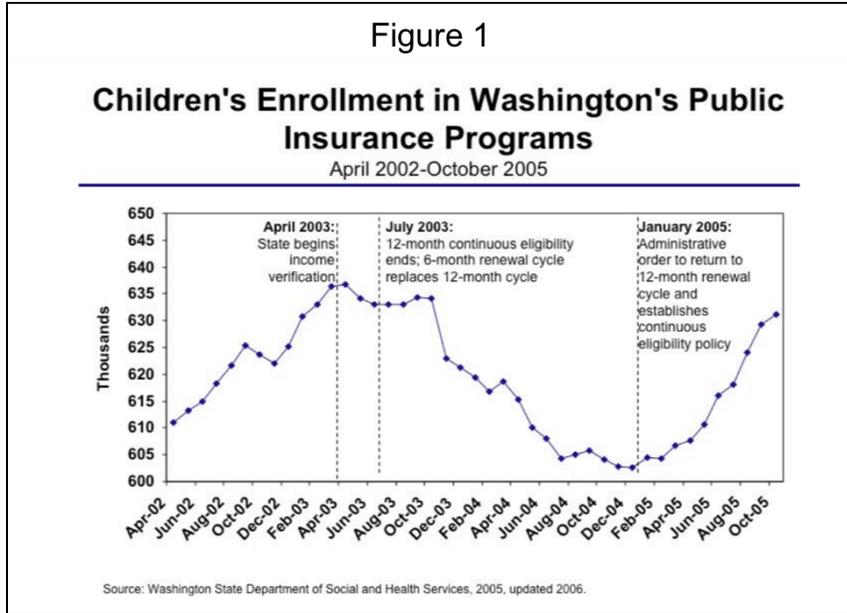
varied among programs and changed frequently, and onerous documentation requirements.⁷ The CKF initiatives enabled state government and child health policy experts and advocates to collaborate on addressing the barriers that inhibited enrollment and retention. Strategies included conducting outreach; promoting policies and procedures for simplifying the eligibility, application and renewal processes; encouraging better coordination between Medicaid and CHIP; and coordinating with federally subsidized meals to determine potential eligibility.

The results speak for themselves. From 2000 to 2007, the number of children enrolled in CHIP doubled from 2.2 million to 4.4 million, while total Medicaid enrollment increased from 32.4 million in December 2000 to 42.1 million in December 2006.⁸

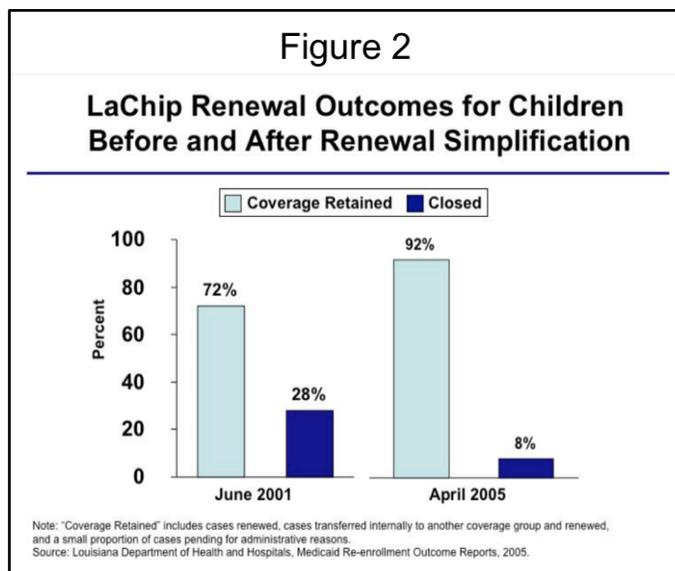
Ample evidence points to simplifying application and renewal processes and removing onerous reporting and documentation requirements as critical elements in advancing coverage. A 2012 Georgetown CCF and Kaiser Family Foundation report that looked at four states at the forefront of expanding children's coverage found that adoption of simplification strategies was one of four common themes contributing to the success of covering children.⁹ A more recent literature review conducted by the Kaiser Family Foundation concluded that changes in paperwork and reporting requirements in Medicaid/CHIP are associated with a change in enrollment between 3 percent and 20 percent.¹⁰ This estimate is based on a collection of studies that illustrate how specific enrollment policy changes (such as adding or dropping reporting requirements) affected enrollment, generally using a pre-post research design.

The evidence works both ways – that is, simplifications increase enrollment and coverage while reversing simplifications and increasing paperwork requirements decrease enrollment and coverage. Importantly, it is the suppression of enrollment that is at the heart of the debate over whether work requirements and other restrictive measures further the purposes of the Medicaid program. Regardless of intent, there is no question that the outcome of imposing red tape barriers and onerous reporting requirements is in direct conflict to Medicaid's purpose of providing health coverage to vulnerable and low-income populations. There is ample evidence to support this statement.

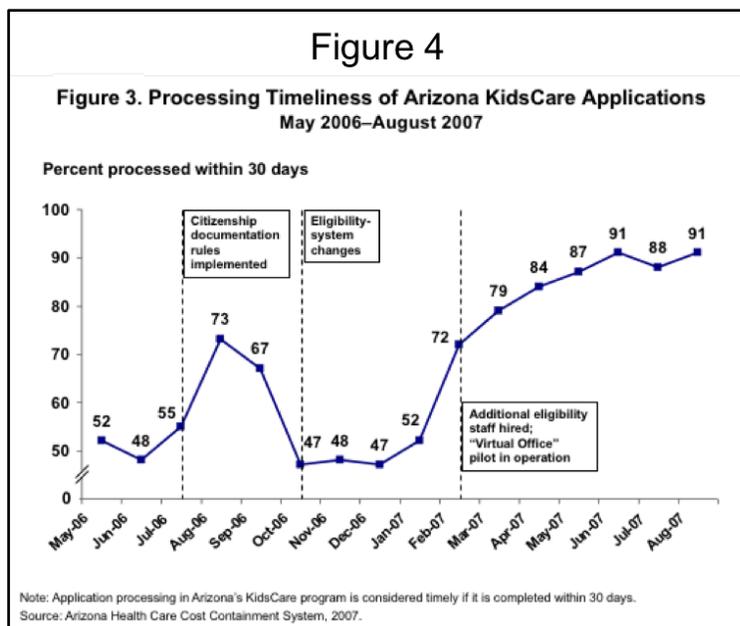
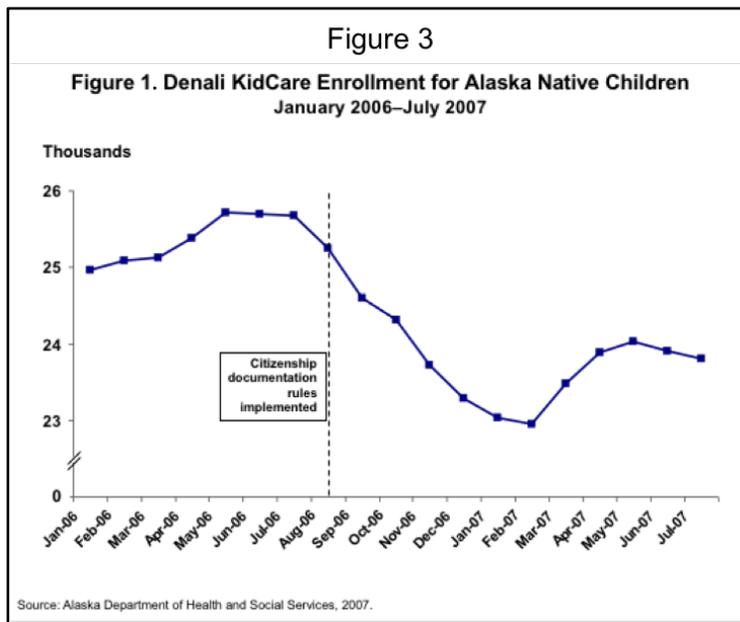
Take for example, the experience of Washington state. In April 2003, Washington began requiring families to provide income documentation. Three months later, renewal frequency was changed from twelve to six months. The graph below (Figure 1) shows that both actions were associated with enrollment declines. In January 2005, when the renewal cycle was changed back to annual and 12-month continuous eligibility was implemented, enrollment increased.¹¹



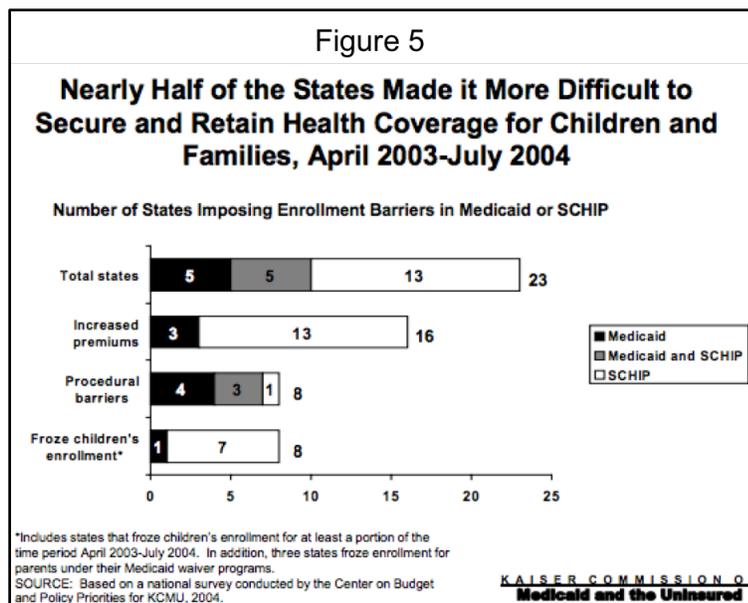
Another example of how important removing reporting and documentation requirements is to enrollment is the improvement of renewal outcomes following simplification efforts in Louisiana (Figure 2).¹² While some children are disenrolled at renewal because they are no longer eligible, many children lose coverage due to procedural reasons – that is, their ongoing eligibility could not be determined because of missing information. This is evidenced by studies showing that as many as one quarter to one-third of uninsured, eligible children had been enrolled in Medicaid or CHIP in the past year.^{13,14} In 2001, 28 percent of children enrolled in Louisiana’s CHIP program LaCHIP lost coverage at renewal due to procedural reasons. That rate dropped to eight percent by April 2005 and to less than one percent in 2008 due to a progressive strategy to streamline the renewal process through ex parte review – that is, using data from other benefit programs to confirm ongoing eligibility rather than requiring families to return forms along with paper verification.



As noted above, when eligibility requirements are added, they have a negative impact on enrollment. The 2005 Deficit Reduction Act (DRA) required states to implement new documentation requirements to prove U.S. citizenship. The new requirements wreaked havoc on state processes, resulting in increased processing times, higher rates of denials for new applications and renewals, and reduced enrollment, as the data from Alaska and Arizona reflect in Figures 3 and 4, respectively. We experienced a similar result in New Hampshire, which I articulated in a recent commentary in the state's only statewide newspaper.¹⁵ Ironically, this rule did not impact immigrant children as electronic verification processes were already in place to verify qualified immigration status.



States know that introducing red tape and paperwork requirements and increasing premiums result in decreased enrollment. An annual survey of Medicaid eligibility, enrollment, renewal and cost-sharing policies conducted by the Kaiser Commission on Medicaid and the Uninsured noted that, in the early 2000's, states were beset by a weak economy, rising health care costs, and declining rates of employer sponsored insurance. The 2004 survey revealed that "Income-eligibility levels for Medicaid and SCHIP were relatively stable that year, but the reintroduction of procedural barriers to coverage — a significant development that was just beginning to unfold in 2002 — had intensified. In the last year, nearly half the states (23 states) took some action to make it more difficult for eligible children and families to acquire and retain health coverage."¹⁶ In other words, states were taking steps to reverse the simplifications they had put into place to encourage enrollment and retention.



Another study concluded that: "Empirical research has shown that the compliance burdens associated with means-tested programs have a real impact in limiting access to benefits. While almost all individuals eligible for universal programs (such as Medicare and Social Security) receive benefits, only 40–60 percent of those eligible for means-tested Supplemental Social Insurance and about 25 percent of those who qualify for Medicaid receive benefits."¹⁷ The data in these reports are dated but they reflect many years of accumulated administrative know-how. Based on this extensive operational experience, states, including Kentucky, know that increasing reporting and documentation requirements will suppress enrollment. Doing so does not further the central purpose of Medicaid to furnish coverage for low-income children and adults.

Again, thank you for the opportunity to provide input. Please contact Tricia Brooks (pab62@georgetown.edu) or Joan Alker (jca25@georgetown.edu) for additional information.

Tricia Brooks
Associate Research Professor

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- ¹ “Patients Over Paperwork,” Centers for Medicare & Medicaid Services, <https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html>.
- ² “Simplifying Documentation Requirements,” Centers for Medicare & Medicaid Services, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/SimplifyingRequirements.html>.
- ³ “Strengthening Coverage, Improving Health,” Centers for Medicare and Medicaid Services. <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>.
- ⁴ “Maximizing Enrollment: Transforming State Health Coverage,” National Academy for State Health Policy (NASHP) and Robert Wood Johnson Foundation, <http://www.maxenroll.org/>.
- ⁵ “Work Support Strategies: Streamlining Access, Strengthening Families,” Urban Institute, <https://www.urban.org/work-support-strategies>.
- ⁶ J. Gates, M. Karpman, G. M. Kenney, and S. McMorrow, “Uninsurance among Children, 1997–2015: Long-Term Trends and Recent Patterns” (Washington: Urban Institute, April 2016), available at <https://www.urban.org/research/publication/uninsurance-among-children-1997-2015-long-term-trends-and-recent-patterns>.
- ⁷ K. Menahan, “Covering Kids & Families” (Princeton, New Jersey: Robert Wood Johnson Foundation, May 2013), available at <https://www.rwjf.org/en/library/research/2011/01/covering-kids---families.html>.
- ⁸ Ibid.
- ⁹ T. Brooks, “Secrets to Success: An Analysis of Four States at the Forefront of the Nation’s Gains in Children’s Health Coverage” (Washington: Center for Children and Families, January 2012), available at <https://ccf.georgetown.edu/2012/01/18/secrets-to-success-an-analysis-of-four-states-at-the-forefront-of-the-nations-gains-in-childrens-health-coverage/>.
- ¹⁰ R. Garfield, R. Rudowitz, and M. B. Musumeci, “Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses” (Washington: Kaiser Family Foundation, June 2018), available at <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>.
- ¹¹ T. Brooks, “Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP” (Washington: Center for Children and Families, January 2009), available at <https://ccf.georgetown.edu/wp-content/uploads/2012/03/Data-reporting.pdf>.
- ¹² Ibid.
- ¹³ B. Sommers, “Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-Up,” *Health Affairs* 26, no. 5 (2007): 560-7.
- ¹⁴ B. Sommers, “Enrolling Eligible Children in Medicaid and CHIP: A Research Update,” *Health Affairs* 29, no. 7 (2010): 1350-5.
- ¹⁵ T. Brooks, “Another View – Tricia Brooks: Citizenship Paperwork Would Turn Back NH Medicaid,” *New Hampshire Union Leader*, July 8, 2018, available at <http://www.unionleader.com/Another-View-Tricia-Brooks-Citizenship-paperwork-would-turn-back-NH-Medicaid-07092018>.
- ¹⁶ D. Cohen Ross and L. Cox, “Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families: A 50 State Update on Eligibility, Enrollment, Renewal and Cost-Sharing Practices in Medicaid and SCHIP” (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2004), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/beneath-the-surface-barriers-threaten-to-slow-progress-on-expanding-health-coverage-of-children-and-families-pdf.pdf>.
- ¹⁷ D. P. Moynihan, P. Herd, and E. Rigby, “Policymaking by Other Means: Do States Use Administrative Barriers to Limit Access to Medicaid?” (Madison, Wisconsin: prepared for the 2013 Public Management Research Conference), available at <https://pdfs.semanticscholar.org/fc41/59ee4e3b745fb09ef52c1d5cd50735ce2dcf.pdf>.