September 2, 2018

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

Dear Secretary Azar:

The undersigned organizations appreciate the opportunity to comment on New Hampshire's requests to extend its New Hampshire Health Protection Program demonstration project under the authority of Section 1115 of the Social Security Act. In its request, New Hampshire proposes to:

1. Continue the demonstration's existing authority to take away Medicaid coverage from adults for not meeting work requirements, with modest changes in the current terms and conditions to align with authorizing state legislation;
2. Sunset the demonstration's Premium Assistance Program (PAP) for marketplace coverage offered through qualified health plans, and transition Medicaid expansion adults into the state's managed care program;
3. Remove conditions and limitations on its existing retroactive coverage waiver;
4. Impose a $25,000 asset test as a condition of Medicaid eligibility for expansion adults; and
5. Impose new citizenship and residency documentation requirements.

Section 1115 of the Act provides authority for the Secretary of the Department of Health and Human Services (HHS) to approve demonstration projects that promote the objectives of Medicaid. States may waive certain provisions of the Medicaid statute to carry out these projects but only to the extent necessary to implement the demonstration project and test new or experimental policies that promote the objectives of Medicaid.

While we support several aspects of the state's proposal, we have significant concerns on others. Specifically, we support New Hampshire's proposal to submit a Medicaid State plan amendment to conduct presumptive eligibility determinations for individuals involved in the criminal justice system, and utilize its managed care plans to incentive healthy behaviors. We also support moving beneficiaries to the state's Medicaid managed care system but urge you to require a more robust transition plan to ensure that beneficiaries do not lose coverage during the transition or experience harmful interruptions in treatment due to discontinuity of care. The transition as currently contemplated includes two stages – first on January 1, 2019 to the managed care system, and a second stage on July 1, 2019 after the state rebids the contracts. Beneficiaries will be auto-assigned with a subsequent 90-day period in both stages to switch plans if they choose to. There is significant potential for beneficiaries to experience interruptions in care due to changes in provider networks and a general lack of awareness about the transition. Careful and robust planning with significant beneficiary education is needed to ensure a smooth transition.

We urge you to reject, however, the state's request to allow it to implement its plan to take away Medicaid coverage for not meeting work requirements, to remove the conditions associated with the state's existing retroactive coverage waiver, and to impose a $25,000 asset test and additional citizenship and residency documentation requirements. Our comments show that New Hampshire's

proposal would make it harder for low-income adults to enroll in Medicaid and would cause large numbers of adults to lose coverage, become uninsured and face greater financial instability.

In the recent *Stewart v. Azar* decision vacating HHS' approval of Kentucky's waiver proposal that would have taken coverage away from adults who didn't 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 wouldn't have it.[1] New Hampshire's waiver proposal would cause thousands of poor adults to lose coverage and become uninsured. Given Medicaid's objective to provide coverage to people who would otherwise be uninsured, New Hampshire's proposal can't be justified as a proper use of section 1115 waiver authority.

New Hampshire's Proposal Would Cause Substantial Numbers of Medicaid Beneficiaries to Lose Coverage and Become Uninsured

New Hampshire is requesting authority to continue implementation of its plan to take Medicaid coverage away from low-income adults who don't meet a work requirement. Implementing a work requirement would threaten the impressive progress New Hampshire has made in extending health coverage to its residents under health reform. Since New Hampshire expanded Medicaid, its uninsured rate has fallen by 45 percent, and the share of adults forgoing care due to costs fell by about a quarter.[2] Medicaid is now an important source of coverage for over 52,000 low-income adults in New Hampshire who weren't eligible before expansion, providing cervical, breast, and colorectal cancer screenings to over 20,000 adults, as well as ensuring access to substance use disorder services to 11,000 adults, which are critical in combatting the opioid epidemic gripping the state.[3] Medicaid expansion has also helped reduce uncompensated care costs, which have fallen by about half as a share of hospital budgets since expansion took effect.[4]

Under New Hampshire's proposal, Medicaid expansion adults who aren't exempt must work, volunteer, search for a job, or participate in job training or other approved activity for at least 100 hours a month to receive their benefits unless they're complying with SNAP or TANF work requirements. Exemptions include medically frail adults, pregnant women, primary caretakers of a

[1] Memorandum in Support of Federal Defendants' Motion to Dismiss or, in the Alternative, for Summary Judgment, *Stewart v. Azar,* Civil Action No. 1:18-cv-152 (JEB), District Court for the District of Columbia, filed April 25, 2018.

[2] Jessica C. Barnett and Edward R. Berchick, "Health Insurance Coverage in the United States: 2016," United States Census Bureau, September 12, 2017, https://www.census.gov/library/publications/2017/demo/p60-260.html, and David C. Radley, Douglas McCarthy, and Susan L. Hayes, "Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance," The Commonwealth Fund, March 2017, https://interactives.commonwealthfund.org/2017/mar/state-scorecard/assets/1933_Radley_aiming_higher_2017_state_scorecard_FINAL.pdf.

[3] New Hampshire Fiscal Policy Institute, "Medicaid Expansion in New Hampshire and the State Senate's Proposed Changes," March 30, 2018, http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html and State of New Hampshire, "New Hampshire Health Protection Program," September 27, 2017, https://www.dhhs.nh.gov/ombp/pap/documents/dhhs-pap.pdf#page=4.

[4] Medicaid and CHIP Payment and Access Commission, "Chapter 3: Annual Analysis of Disproportionate Share Hospital Allotments to States," March 2018, https://www.macpac.gov/wp-content/uploads/2018/03/Annual-Analysis-of-Disproportionate-Share-Hospital-Allotments-to-States.pdf.

child under the age of 6, and beneficiaries who are physically or mentally unable to work. Enrollees who fail to report 100 hours in any month will lose coverage until they come into compliance with the work requirement.

New Hampshire did *not* include an analysis in its extension request to show how its work requirement proposal would affect coverage. This is similar to the state's approach in October 2017 when it first proposed a work requirement.[5] Without an analysis of how this proposal would affect coverage, HHS cannot adequately determine that the proposal will further the objectives of the Medicaid program given Medicaid's primary objective to provide coverage to those who wouldn't otherwise have it. Other states imposing similar requirements have estimated that they will result in large coverage losses, and early evidence from Arkansas, which began implementing its work requirement in June, suggests coverage loss will be much higher than what states have projected from work requirements.[6] The loss of coverage and increase in uninsurance that will result in a loss of access to care and worse health for low-income adults in New Hampshire can't be justified. Simply stated, New Hampshire's waiver proposal doesn't promote the objectives of Medicaid and should not be approved.

While the supposed target population for New Hampshire's work requirement are people who aren't working and who don't qualify for an exemption, large numbers of people who should remain eligible, because they are working or should be exempt will likely lose coverage. That's because an increase in red tape will cause many working people, and people who should qualify for an exemption, will lose coverage. Kaiser Family Foundation researchers recently estimated that nationwide work requirements would cause disenrollment ranging from 1.4 million to 4 million people among the 23.5 million adults who are under 65 and not receiving SSI based on disability. Most of those losing coverage would be people who are already working or engaged in work-related activities or should be exempt.[7] Moreover, many people who should qualify for an exemption may not get one. Evidence from SNAP and TANF shows the difficulty of screening for exemptions from work requirements. A 2016 investigation by the USDA Office of the Inspector General found that some states were failing to administer the SNAP work requirements effectively and accurately.

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[5] 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.

[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, 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] Rachel Garfield, Robin Rudowitz, and MaryBeth Musumeci, "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses," Kaiser Family Foundation, June 27, 2018, https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/.

The report highlighted examples of states improperly terminating SNAP benefits for individuals who qualified for exemptions. Similarly, families sanctioned due to noncompliance with TANF requirements were more likely than other families receiving TANF to have barriers that kept them from working, including having a child with a chronic illness or disability.[8]

Most of Those Losing Coverage Will Become Uninsured

Supporters of restrictive eligibility policies claim that work requirements will potentially lead to employer coverage, but a large share of New Hampshire residents whose coverage is terminated because they don't meet the state's work requirement will become uninsured. There's little evidence that work requirements will meaningfully increase employment, and even less to support New Hampshire's claim that work requirements will cause large numbers of enrollees to gain good jobs with health insurance, especially since the state isn't providing new resources to address the barriers to employment such as a lack of access to childcare, job training and transportation.

Moreover, even if some New Hampshire enrollees do find jobs due to work requirements, these will probably be mostly low-wage jobs. Such jobs are unlikely to boost enrollees' incomes over the poverty line, so they wouldn't qualify for subsidized individual market coverage, and the large majority of low-wage jobs do not offer affordable health coverage. According to Labor Department data, among workers with earnings in the bottom quartile of the wage distribution, only 37 percent are offered health coverage, and less than a quarter actually obtain coverage, presumably in large part because required employee premium contributions are often higher than low-wage workers can afford.[9] Similarly, only 37 percent of full-time workers with family incomes below the poverty line (and only 13 percent of such part-time workers) are even offered health coverage.[10]

Coverage Loss Means New Hampshire's Proposed Waiver Is Contrary to the Objectives of Medicaid — and Would Not Improve New Hampshire Beneficiaries' Health

The significant coverage loss and increase in the number of uninsured people that would result from New Hampshire's waiver can't be justified. While HHS has claimed that "work [will] promote health and well-being"[11] as a rationale for approving policies that take health coverage away from those who don't meet work requirements in Medicaid, this argument does not demonstrate that New Hampshire's waiver is consistent with the primary objective of Medicaid, which is to provide

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[8] Hannah Katch, Jennifer Wagner, and Aviva Aron-Dine, "Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes," Center on Budget and Policy Priorities, Updated August 13, 2018, https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce.

[9] Bureau of Labor Statistics, Healthcare benefits: Access, participation, and take-up rates, https://www.bls.gov/ncs/ebs/benefits/2017/ownership/civilian/table09a.htm.

[10] Michelle Long *et al.,* "Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014," Kaiser Family Foundation, March 21, 2016, https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/.

[11] CMS letter to state Medicaid directors (18-002), January 11, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

access to health coverage for those eligible. While we accept that improving health and well-being are objectives of the Medicaid program along with providing coverage, these are outcomes of having coverage and don't result when coverage is taken away from people who don't work.

HHS cannot show that allowing states to take coverage away from people who don't work would promote health and well-being. The evidence HHS cites on how work affects health is murky, since all studies in this area are plagued by bidirectional causation: regardless of whether work improves health, it's clear that people in better health are more able to work. As noted in a recent comprehensive review of the literature conducted by the Kaiser Family Foundation, "There is strong evidence of an association between unemployment and poorer health outcomes, but authors caution against using these findings to infer that the opposite relationship (work causing improved health) exists."[12] For example, the author of one study cited by HHS clearly states that his work did not demonstrate a causal relationship between work and health, stating, "Importantly, these findings do not necessarily imply that income has a *causal* effect on life expectancy… we caution that this correlational analysis does not uncover causal mechanisms."[13]

Moreover, increasing employment in low-paying jobs that do not offer employer sponsored coverage — which is likely the best-case outcome for a policy such as this one — may be bad for enrollees' health. Kaiser Family Foundation researchers note, "Studies on work and health have found that the quality and stability of work is a key factor in the work-health relationship: research finds that low-quality, unstable, or poorly-paid jobs lead to or are associated with adverse effects on health."[14]

On the other hand, the evidence on how health coverage has a positive benefit for health is clear. A large and growing body of research on the ACA's Medicaid expansion finds that coverage gains are generating large gains in access to care and financial security.[15] And a new survey of Ohio enrollees who gained coverage under Medicaid expansion confirms earlier research in Ohio and Michigan finding that having Medicaid makes it easier for workers to work and for unemployed

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[12] Larisa Antonisse and Rachel Garfield, "The Relationship Between Work and Health: Findings from a Literature Review," Kaiser Family Foundation, August 2018, https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

[13] Raj Chetty *et al.,* "The Association Between Income and Life Expectancy in the United States, 2001-2014: Executive Summary," April 2016, http://www.equality-of-opportunity.org/assets/documents/healthineq_summary.pdf; *see also* Raj Chetty *et al.,* "The Association Between Income and Life Expectancy in the United States, 2001-2014," Journal of the American Medical Association, May 13, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4866586/.

[14] *Ibid.*

[15] See Benjamin D. Sommers et al., "Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults," Health Affairs, June 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0293; Antonisse et al., *op. cit.*, Olena Mazurenko et al., "The Effects of Medicaid Expansion Under the ACA: A Systematic Review," Health Affairs, June 2018, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1491, Hefei Wen, Benjamin Druss, and Janet Cummings, "Effect of Medicaid Expansions on Health Insurance Coverage and Access to Care Among Low-Income Adults with Behavioral Health Conditions," Health Services Research, December 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693853/.

enrollees to look for a job.[16] Since Medicaid requires much lower enrollee cost- sharing than most employer plans, it likely offers better access to care and more financial protection to low-income parents than most employer plans.[17] In addition, evidence on earlier Medicaid expansions to low-income adults, as well as emerging evidence on the more recent ACA expansion, finds that coverage gains have led to improved mental and physical health outcomes.[18]

Overall, as shown above, New Hampshire's waiver would cause many poor adults to lose coverage, which would have unambiguous negative effects on their health. The waiver would have at best very small effects on work, which would have ambiguous effects on health. It's therefore clear that the overall impact on health would be negative, and it's certain that there would be no large positive benefit on health to be weighed against the coverage loss the waiver would cause. Thus New Hampshire's proposal does not promote the objectives of Medicaid and approving it would not be a proper exercise of your authority under section 1115.

Retroactive Coverage is Crucial for Beneficiaries and Providers and Shouldn't be Waived

New Hampshire's proposal would remove conditions around its existing retroactive coverage waiver, which would allow the state to waive the statutory provision requiring that Medicaid reimburse medical costs incurred by Medicaid beneficiaries for up to three months before they apply if they were eligible during the retroactive period.

Retroactive coverage, which has been a feature of Medicaid since 1972, helps prevent medical bankruptcy and provides financial security to vulnerable beneficiaries 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. Data from Indiana show how important retroactive coverage is for low-income parents in the state who incurred costs prior to enrollment. Medicaid

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[16] "2018 Ohio Medicaid Group VIII Assessment, Executive Summary," Ohio Department of Medicaid, August 2018, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Executive-Summary.pdf; see also Kara Gavin, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan Health Lab, June 27, 2017, http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches.

[17] Benjamin D. Sommers et al., "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," JAMA Internal Medicine, August 8, 2016, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420.

[18] See Aparna Soni et al., "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses," American Journal of Public Health, February 2018 and Andrew P. Loehrer, et al., "Association of the Affordable Care Act Medicaid Expansion with Access to and Quality of Care for Surgical Conditions," JAMA Surgery, March 21, 2018, https://jamanetwork.com/journals/jamasurgery/article-abstract/2670459; Benjamin D. Sommers, Sharon K. Long, and Katherine Baicker, "Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study," Annals of Internal Medicine, May 2014, http://annals.org/aim/article-abstract/1867050/changes-mortality-after-massachusetts-health-care-reform-quasi-experimental-study; Benjamin D. Sommers, Katherine Baicker, and Arnold Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," New England Journal of Medicine, September 2012, https://www.nejm.org/doi/full/10.1056/nejmsa1202099.

paid $1,561 on average on behalf of parents who incurred medical costs prior to enrolling in Medicaid.[19]

The state's proposal claims that eliminating retroactive coverage would encourage beneficiaries to obtain and maintain health coverage, even when they are healthy, as well as increase continuity of care by reducing gaps in coverage when beneficiaries move in and out of Medicaid or sign up for Medicaid only when sick. Regardless of whether these are appropriate objectives for a waiver, eliminating retroactive coverage would not facilitate early enrollment or increase continuity of care without significant outreach and education about Medicaid eligibility. It would instead lead to increased financial insecurity and instability for low-income families and higher uncompensated care costs for Medicaid providers. It is also worth noting that all the other major features of New Hampshire's waiver would, as discussed in this letter, lead to more interruptions and gaps in coverage and disruption in access to care; to the extent CMS believes continuity of coverage is an important objective of the Medicaid program, this should have been an additional reason to reject work requirements, asset tests and additional citizenship and residency documentation requirements.

As the court recognized in vacating approval of Kentucky's waiver, the primary objective of Medicaid is to provide affordable coverage, including when an individual moves in and out of the program, or is sick and otherwise eligible for Medicaid. Taking months of coverage away from people and exposing them to financial harm does not promote the objectives of Medicaid. While New Hampshire's retroactive coverage waiver request would only apply to Medicaid expansion adults, including low-income parents, the financial insecurity that would result from it wouldn't just affect these adults — it would also affect their children. Without retroactive coverage, parents may go without needed medical care and incur significant medical debt for care they receive prior to the effective date of enrollment. Research shows that children's development can be negatively affected by issues resulting from poverty, such as toxic stress.[20]

In addition to helping individuals get the care they need, retroactive coverage ensures the financial stability of hospitals and other safety net providers as it allows them to be reimbursed for care they have provided during the three-month period that would otherwise have gone as uncompensated care, helping them meet their daily operating costs and maintain quality of care. Under waivers that eliminate retroactive coverage, a hospital would no longer get paid for, say, providing an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident, increasing the hospital's uncompensated care costs.

In its comments submitted during the state comment period, the New Hampshire Hospital Association expressed concern over the state's proposal to eliminate retroactive coverage. Specifically, it stated that this "policy change could result in fewer services covered and ultimately

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[19] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at 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.

[20] American Academy of Pediatrics: Council on Community Pediatrics, "Poverty and Child Health in the United States," *Pediatrics,* April 4, 2016, http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf.

increased uncompensated care for hospitals," and that "it is counterintuitive to remove this important coverage policy."[21]

Federal Law Doesn't Allow the Asset Test New Hampshire is Proposing

The proposal would impose a $25,000 asset test on beneficiaries even though the ACA explicitly prohibits HHS from granting waivers to allow them.[22] The ACA eliminated asset tests and made other changes to Medicaid rules for most beneficiaries to align eligibility for Medicaid, the Children's Health Insurance Program, and subsidized marketplace coverage for children and adults in order to create a system where people can easily transition between insurance affordability programs as their incomes and circumstances change. Allowing an asset test in Medicaid would undermine this system, and states cannot vary from the ACA's rules.

Additional Citizenship and Residency Documentation Requirements Will Create Barriers to Coverage

New Hampshire's proposed citizenship documentation requirement is not allowable under federal rules, would be costly to the state and federal government and adds red tape that will result in eligible people being delayed or deterred from obtaining benefits. Specifically, the state's proposal would require expansion adults to verify that they are United States citizens by providing two forms of identification, and verify that they are residents of New Hampshire by providing a New Hampshire driver's license or a non-driver's picture identification card. By implication, qualified immigrants who are eligible for Medicaid could not enroll, because they couldn't prove they are citizens. It isn't clear that the state actually intends to bar otherwise eligible legal immigrants from the program but that would be the consequence of requiring documentation of *citizenship* from all applicants.

The requirements that New Hampshire is attempting to impose are not only unnecessary and would create a significant barrier to keeping people uninsured — they would also violate the Medicaid statute. The key provisions governing proof of immigration status and citizenship are in parts of the Social Security Act that cannot be waived. Section 1137 governs verification of immigration status and section 1903(x) is the core provision governing verification of citizenship. Neither of these provisions can be waived under section 1115 which only allows waivers of provisions in section 1902.

The state hasn't provided any justification for this proposal, which is not surprising given there isn't any evidence that current procedures aren't sufficient to guarantee that only eligible citizens and qualified immigrants are participating in New Hampshire's Medicaid program. The requirements New Hampshire is proposing would be unnecessarily burdensome for consumers and for the state. Many eligible people would likely be unable to provide the documents because they aren't readily available and obtaining them would

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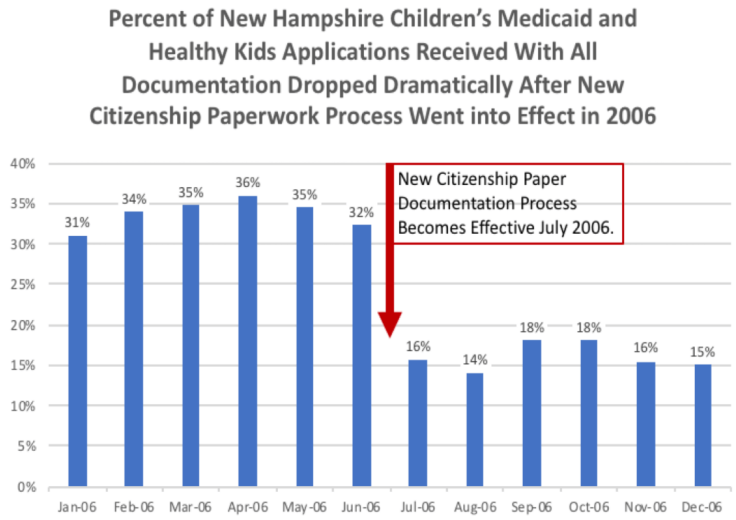
[21] New Hampshire Hospital Association, Letter to the New Hampshire Department of Health and Human Services," June 29, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa4.pdf.

[22] Social Security Act, Title XIX, Section 1902(e)(14)(F)

take time and money, which in turn would result in delays or outright denials of coverage as New Hampshire experienced in 2006 after implementing the burdensome paper-based citizenship documentation requirement under the Deficit Reduction Act of 2005.

During this time, New Hampshire Healthy Kids (NHHK), processed child applications for the state's Children's Health Insurance Program (CHIP) and Medicaid. Prior to implementing the burdensome paper-based citizenship documentation requirement, 34 percent of applications received monthly by NHHK included all of the documents needed to verify eligibility. During the first six-months of implementing the new burdensome citizenship documentation requirement, only 16 percent of applications received by NHHK had all documents needed to verify eligibility.[23]



Adding the requirements New Hampshire proposes is unnecessary. Existing Medicaid regulations require verification of citizenship and noncitizen status for Medicaid enrollees. In fact, state and federal governments have spent millions of dollars establishing systems that electronically verify citizenship or eligible immigration status accurately and efficiently through 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. Applicants must provide their names, dates of birth, and Social Security or relevant immigration numbers, which are then matched against information held by these agencies. The majority of people have their status verified quickly, accurately, and securely using these processes. Some people can't instantly be verified and they must provide additional information or documents to prove their status. In cases where individuals must provide documentation to prove their citizenship many do not have to provide two forms of proof—as would be the requirement under this policy— several forms of proof are sufficient by themselves to prove citizenship under law including U.S. issued passports, certificates of U.S. citizenship and certificates of naturalization.[24]

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[23] Tricia Brooks, Why is NH Proposing to Replace Proven Electronic Citizenship Verification with Burdensome Medicaid Paperwork Requirements?, Georgetown University Health Policy Institute Center for Children and Families, June 28, 2018. https://ccf.georgetown.edu/2018/06/28/why-is-nh-proposing-to-replace-proven-electronic-citizenship-verification-with-burdensome-medicaid-paperwork-requirements/

[24] Sec. 1903(x)(1) of the Social Security Act.

The new documentation requirements included in New Hampshire's proposal would cause massive delays in coverage for many Medicaid beneficiaries. The current process that verifies citizenship or immigration status through data matches allows most people to have their circumstances verified quickly and accurately. The quick decision helps ensure that the state sends people who aren't eligible for Medicaid to the Marketplace without significant delay.

Moreover, New Hampshire's proposal seeks to impose a restrictive and burdensome residency requirement that would only accept New Hampshire driver's license or a non-driver's picture identification card as evidence of state residency. Similar to the experience with burdensome and restrictive citizenship documentation, this requirement will result in eligible consumers unable to meet the requirement and as result will get delayed coverage or miss out in coverage altogether. Similar to the citizenship proposal, the state provides no evidence that suggests that the current procedure is resulting in ineligible people being enrolled.

Conclusion

To approve a state proposal for a demonstration project under section 1115 of the Social Security Act HHS must find that the state's proposal is in fact experimental in nature and that it would promote the objectives of Medicaid. The recent court decision in *Stewart v. Azar* confirmed that providing affordable coverage is a primary objective of the Medicaid program. Our comments show that New Hampshire's proposal is not a proper experiment and that it would lead large numbers of low-income residents in New Hampshire to become uninsured or have poorer access to health care services. For all these reasons you should not approve it.

Our comments include citations to supporting research and documents for the benefit of CMS in reviewing our comments. We direct CMS to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).

CC: Seema Verma, Tim Hill, Judith Cash

Asian & Pacific Islander American Health Forum
Autistic Self Advocacy Network
Center on Budget and Policy Priorities
Children's Defense Fund
Community Catalyst
Epilepsy Foundation
First Focus
Georgetown University Center for Children and Families
National Association of Community Health Centers

National Center for Law and Economic Justice
National Health Care for the Homeless Council
National Multiple Sclerosis Society
New Hampshire Chapter of the American Academy of Pediatrics
UnidosUS