

Adult
Congenital
Heart 
Association



August 31, 2018

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

Re: Granite Advantage 1115 Waiver Amendment and Extension Application

Dear Secretary Azar:

Thank you for the opportunity to submit comments on New Hampshire's Granite Advantage 1115 Waiver Amendment and Extension Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. This waiver does not meet this standard and therefore, our organizations ask HHS to reject this proposal.

Waiving Retroactive Eligibility

New Hampshire is proposing to continue the policy of waiving the three-month retroactive eligibility in the Medicaid program. Continuing this policy will harm patients.

Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.ⁱ This proposal will harm patients and should not be extended.

Work and Community Engagement Requirements

New Hampshire is asking to extend their requirement that enrollees work or volunteer at least 100 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on all patients. Individuals will need to attest that they meet certain exemptions or have worked the required number of hours on a monthly basis. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.ⁱⁱ Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If enrollees do not meet this requirement, they have 30 days to meet the requirement or obtain a “good cause” exemption, or they will lose coverage. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

These problems are already apparent in Arkansas, another state currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. According to the state's own report on the second month of implementation, 5,426 individuals did not meet the reporting requirement for two consecutive months and are at risk of losing coverage on September 1, at which point they would be locked out of coverage until January 2019.ⁱⁱⁱ An additional 6,531 individuals did meet the reporting requirement for one month and also remain at risk for losing their coverage.^{iv} Our

organizations are concerned that implementing these requirements in New Hampshire will also lead patients to lose their coverage.

Our organizations are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from meeting these requirements. No exemption criteria can circumvent this problem and the serious risk to the coverage and health of the people we represent.

Administering these requirements will be expensive. Other states including Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.^v These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

These requirements do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.^{vi} A study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.^{vii} The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid make it easier to work or look for work (83.5 percent and 60 percent, respectively). The report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier.^{viii} This proposal should not be extended.

Citizenship and Residency Documentation Requirement

The waiver proposes to require enrollees to present paper forms of identification (two forms of identification or a state driver's license or ID card) rather than the electronic database that is currently being used when applying for coverage. The proposal states potential enrollees without the appropriate forms of identification will be denied coverage.^{ix} This proposal puts yet another paperwork requirement on Medicaid enrollees that could jeopardize their access to care. The waiver lacks details on what forms of ID, other than a driver's license or State ID card will be valid for proving citizenship and residency.

Even getting a Driver's License or State ID card can be challenging for the low-income population. Obtaining the underlying documents, like a birth certificate, can be expensive. Conditioning healthcare on the ability to obtain paperwork does not promote the goals of the Medicaid program. This proposal should be rejected.

Asset Test

The waiver requests the authority to consider an individual's assets when determining Medicaid eligibility. Enrollees having assets exceeding \$25,000 would be ineligible for the Medicaid program. Current Medicaid rules do not allow for asset tests when determining eligibility for the program. Holding resources against a person when they apply for Medicaid will not help people achieve upward economic mobility or better health or promote the goals of the Medicaid program. As such, this proposal should be rejected.

Other Eligibility Policy Changes

New Hampshire is proposing a new policy that would require enrollees to submit information regarding financial eligibility, residency, citizenship/immigration status and insurance coverage when enrolling and within 10 days of a change in any of these categories or risk losing coverage. This is another administrative burden for enrollees and will jeopardize enrollees access to needed care. For patients with serious and chronic illness, interruptions in care can further exacerbate illness or in some cases even result in death. This proposal should be rejected.

Incentivize Health Behaviors and Cost Effectiveness

The waiver proposes to add incentives to promote personal responsibility and improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. These incentives would be added through the Managed Care contracts and could include incentives to encourage the appropriate use of the emergency department and the reduction of polypharmacy. Incentives like those proposed here are have the ability to reduce patient access to care. Any proposal should require public comment and not be tucked into the Managed Care contract, where unintended consequences can be overlooked.

Our organizations represent patients who have complex medical needs and require treatment. For these patients, utilization of healthcare is not a choice, but a necessity and can be a matter of life or death.

Lack of Key Information

Our organizations are troubled that the waiver application lacks key information. The proposal does not predict the impact of the waiver on enrollment (with or without waiver baseline) or cost savings over five years. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. In order to meet these transparency requirements, New Hampshire should have included these projections and their impact on budget neutrality. This waiver is incomplete and should be rejected.

Our organizations believe everyone, including the patients we represent, should have access to quality and affordable healthcare. New Hampshire's Granite Advantage 1115 Waiver Amendment and Extension Application does not achieve that goal or advance the goals of the Medicaid program. We urge the Secretary to reject this waiver application. Thank you for the opportunity to provide comment.

Sincerely,

Adult Congenital Heart Association
American Heart Association
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services
March of Dimes

National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

ⁱ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

ⁱⁱ Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

ⁱⁱⁱ Joan Alker and Maggie Clark, "After Two Months Under New Work Requirements, Thousands of Arkansans May Lose Medicaid Without Even Realizing the Rules Changed," Georgetown University Health Policy Institute Center for Children and Families. August 15, 2018. Accessed at: <https://ccf.georgetown.edu/2018/08/15/after-two-months-under-new-work-requirements-thousands-of-arkansans-may-lose-medicaid-without-even-realizing-the-rules-changed/>.

^{iv} Arkansas Department of Health and Human Services, Arkansas Works Program, July 2018 Report. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/08/081418_AWReport_July.pdf.

^v Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, <https://www.rollcall.com/news/politics/medicaid-kentucky>.

^{vi} Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

^{vii} Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med*. Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

^{viii} The Ohio Department of Medicaid. 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment. August 2018. Accessed at: <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf>

^{ix} Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver: <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>