UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SAMUEL PHILBRICK, *et al.*, Plaintiffs, v. ALEX M. AZAR II, *et al.*, Defendants.	Civil Action No. 1:19-cv-00773 (JEB)

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BRIEF FOR DEANS, CHAIRS AND SCHOLARS AS *AMICI CURIAE*
IN SUPPORT OF PLAINTIFFS

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CORPORATE DISCLOSURE STATEMENT

Amici are individuals and as such do not have a parent company and no publicly held company has a 10% or greater ownership interest in any *amici*.

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INTEREST OF *AMICI CURIAE*

Pursuant to Local Civil Rule 7(o), *amici* have sought leave for filing the instant brief. *Amici* are researchers and academics who are experts in the fields of health law, health policy, health services research, and national health reform. They seek to inform the Court about the history of Section 1115 of the Social Security Act, the essential elements of Medicaid demonstration evaluation, the validity of the assumptions on which Defendants' actions rest, and the likely effects of permitting Defendants' actions to continue to take effect in New Hampshire. Given the scope of Defendants' actions, that they authorized similar activities in Arkansas and Kentucky, which this Court found required *vacatur,* and that they have authorized or will authorize similar activities in other States, *amici* believe this case provides an appropriate vehicle for the Court to find that Defendants' actions are contrary to federal law.

No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party or any other person contributed money that was intended to fund preparing or submitting the brief.

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STATEMENT

This Court has once again been asked to evaluate whether the Secretary of the U.S. Department of Health and Human Services ("HHS") has acted arbitrarily, capriciously, and contrary to law when he approved the imposition of work requirements on another state Medicaid program; this time in New Hampshire (or the "State"). Fortunately, the Secretary's approval of New Hampshire's Social Security Act ("SSA") § 1115 demonstration project waiver (*see* 42 U.S.C. § 1315) does not materially differ from the waivers this Court enjoined in Kentucky and Arkansas. As before, the waiver only serves to impose an untested and unsupported premise that requiring Medicaid beneficiaries to work will increase their health outcomes, punishing those who cannot meet such requirements with the complete loss of health care coverage. Imposing this requirement is contrary to Medicaid's purpose of providing medical assistance to people whose income and resources are insufficient to pay for the cost of necessary care, and is therefore arbitrary, capricious, an abuse of discretion, and contrary to law.

Following the enactment of the Patient Protection and Affordable Care Act of 2010 (the "ACA"), Pub. L. No. 111-148, New Hampshire extended Medicaid coverage to the entire nonelderly population with income below 133 percent of the poverty level. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (extending Medicaid coverage effective January 1, 2014 to the "expansion population"). As a result, the State has provided medical assistance to over an additional 50,000 beneficiaries in any given month since July 2014. NEW HAMPSHIRE DEP'T OF HEALTH & HUMAN SERVS., *New Hampshire Medicaid Enrollment Demographic Trends and Geography* at 2 (Feb. 4, 2019).

After implementing the expansion, New Hampshire obtained the Secretary's approval to provide medical assistance to the expansion population through enrollment in Marketplace

qualified health plans in lieu of the traditional Medicaid managed care market. Later, in 2018, the Secretary approved the State's proposal to amend this demonstration to create the "Granite Advantage Health Care Program" ("Granite Advantage"), which permitted the State to institute work and "community engagement" requirements, as well as other eligibility restrictions, on the expansion population. *See* AR 1-56.

Granite Advantage constitutes arguably the harshest work experiment approved to date. This "experiment" requires an unprecedented twenty-five hours per week of work without a minimal effort to ensure that its impact is objectively measured. It also targets beneficiaries through the age of sixty-four despite evidence showing that, by age fifty, seventy percent of the low-income adult population is in fair to poor health or have a chronic condition, compared to fifty percent of non-poor adults. Sara Rosenbaum et al., *Medicaid Work Demonstrations: What is at Stake for Older Adults?* THE COMMONWEALTH FUND (Mar. 19, 2018). This concern was repeated throughout the record, particularly addressing serious health conditions. *See* AR 1483-1485 (Disability Rights Center), AR 1486-1493 (American Cancer Society Action Network), AR 1952-1953 (Cystic Fibrosis Foundation), AR 2219-2222, 2227-2228 (New Hampshire Public Health Association), AR 1479-1482 (American College of Obstetricians and Gynecologists), AR 1454-1457 (New Hampshire Community Behavioral Health Association), AR 2130-2133 (American Diabetes Association), and AR 2229-2236 (Bi-State Primary Care Association).[1]

Despite such stringent requirements, the State is not obligated to provide either job training or work supports. A fact complicated by New Hampshire's extremely low

[1] In addition to not providing reasonable explanation for imposing the requirements, the HHS Secretary also insisted upon more stringent reporting requirements, limiting the number of times beneficiaries are able to "cure" their inability to reach 100 hours in a given month starting in May 2020, resulting in longer "lockout periods" for certain beneficiaries. AR 28.

unemployment rates (2.6 percent), even amongst older adults (1.8 percent). *See* U.S. DEPT. OF LABOR, Bureau of Labor Statistics, *Table - Employment status of the civilian noninstitutional population by sex, race, Hispanic or Latino ethnicity, and detailed age, 2018 annual average:* New Hampshire Data (2018). Regardless, the Secretary is silent as to how unemployed beneficiaries should meet the monthly 100-hour requirement or if there are any jobs available.

Similarly, the Secretary also waived New Hampshire's retroactive eligibility obligations with virtually no justification and in the face of overwhelming public comments in opposition to the waiver on the ground of its potential to expose people with sudden-onset health problems to enormous levels of debt. AR 15.

The Secretary's approval followed the same bizarre logic found in the January 2018 State Medical Director Letter (the "SMDL") and other State approval letters considered by this Court: the purpose of depriving Medicaid beneficiaries of medical assistance is to improve their health. Defendants assert, without explanation or evidence, that Medicaid work requirements "are designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness and increased financial independence for beneficiaries." AR 4. These demonstrations supposedly let States test this hypothesis.

However, even if promoting financial independence were a purpose of Medicaid, which it is not, Defendants cite no authority to support the assertion that paid part-time work raises income or access to employer-sponsored insurance. Indeed, only twenty-one percent of all part-time workers are offered job-based medical benefits. U.S. DEPT. OF LABOR, Bureau of Labor Statistics, *Employee Benefits in the United States:* Table A at 2 (Mar. 2018). This figure undoubtedly is even lower for low-wage part-time workers, who are less than half as likely as the

general working population to be offered employee medical benefits even when they work full-time. *See* Matthew Rae et al., *Long-Term Trends in Employer-Based Coverage*, Peterson-Kaiser Health System Tracker (Jan. 30, 2019) (14.5 percent of the non-elderly poor are enrolled in employer-sponsored coverage.); Emily Johnston et al., *New Hampshire Residents Who Lose Medicaid Under Work Requirements Will Likely Face Limited Employer-Sponsored Insurance Options*, URBAN INSTITUTE (May 13, 2019) (5.9 percent of New Hampshire part-time employees eligible for employer-sponsored insurance). Further, if the purpose of the demonstration is to increase financial independence, the Secretary curiously never explained how allowing volunteer work, as an alternative to paid work, would fulfill this goal.

This again confirms that the Secretary failed to fulfill his legal responsibility to examine "'the impact of the state's project' on the individuals whom Medicaid was enacted to protect.'" *Stewart v. Azar*, 313 F.Supp.3d 237, 265 (D.D.C. 2018) (internal citation omitted). As before, the record before the Secretary does not support his approval of the demonstration. For instance, the Secretary ignored ample evidence in the record that the waiver will likely cause a Medicaid disenrollment spiral similar to the one that occurred in Supplemental Nutrition Assistance Program ("SNAP"). Following the imposition of work requirements in SNAP, several States saw participant rates decline from fifty percent to eighty five percent within a year. A similar, precipitous drop will likely occur in New Hampshire by the time the demonstration ends in 2023.

This is not what Congress envisioned when it permitted experimentation to test improvements in the major SSA programs, under § 1115, by waiving certain requirements for demonstration projects that "promote[] the objectives of the program," and by expending funds in ways not ordinarily permissible under federal law. That is, Defendants' approval of Granite

Advantage is not a valid experiment, but an assault on Medicaid utterly lacking the necessary indicia of experimentation to justify invoking waiver authority.

The Secretary's approval also ignored the evaluation criteria imposed by § 1115 and guidance issued by the Centers for Medicare and Medicaid Services ("CMS"). For instance, the State offered no hypotheses regarding how its new restrictions would promote Medicaid objectives. *See* AR 4402-4403 (listing *pro forma* "Evaluation Hypotheses under Consideration"). However, § 1115 requires the Secretary to condition his approval on an approved independent evaluation plan to produce timely baseline data before implementing a demonstration. Similarly, despite CMS' evaluation guidance policies, the Secretary approved the waiver without requiring the State to conduct ongoing beneficiary surveys to elicit objective evidence about the consequences of exclusion. *See* CMS, *Evaluation Design Guidance for Section 1115 Eligibility and Coverage Demonstrations* (Mar. 2019). Almost five months later, and on the eve of full implementation, there still is no evaluation in place.

HHS's approval may pay lip service to § 1115's experimental purposes, but it clearly is an extension of the Administration's intent to roll back eligibility for the expansion population, which Defendants deem to be "a clear departure from the core, historical mission of" the Medicaid program. *See* U.S. DEPT. OF HEALTH & HUMAN SERVS, *"Dear Governor" letter from Thomas E. Price, Secretary of HHS and Seema Verma, CMS Administrator*. If implemented, the Administration will meet this goal as Granite Advantage will result in thousands of low-income individuals losing coverage under untested conditions designed to drive people off Medicaid – a purpose directly counter to the Medicaid Act. To accomplish this aim, CMS ignored the public comment record, ignored health risks, and disregarded its own guidelines governing experiments

aimed at limiting eligibility. Defendant's approval of Granite Advantage is therefore arbitrary and capricious, an abuse of discretion and contrary to law.

ARGUMENT

I. The Purpose of § 1115 Medicaid Demonstrations is to Improve the Program, Not to Remove Thousands of Eligible People.

Section 1902 of the SSA sets forth Medicaid eligibility criteria and detailed operational requirements. *See* 42 U.S.C. § 1396a. While states have the option to expand eligibility and improve coverage and delivery, they have never been able to impose eligibility or coverage restrictions not authorized by law. *See T.H. v. Jones*, 425 F.Supp. 873, 877 (D. Utah 1975), *aff'd sub nom. Jones v. H.*, 425 U.S. 986 (1976) (invalidating Utah's parental consent requirements for Medicaid family planning services); *Comacho v. Tex.Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005) ("Texas cannot add additional requirements for Medicaid eligibility."); Congressional Research Service, R44802, JUDICIAL REVIEW OF MEDICAID WORK REQUIREMENTS UNDER SECTION 1115 DEMONSTRATIONS at 3, n. 17 (Mar. 28, 2017). Moreover, § 1115 authorizes the Secretary to add flexibility by waiving State compliance with § 1902 requirements "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of…[Medicaid]." 42 U.S.C. § 1315(a)(1). This provision, by both its terms and history, allows the Secretary to test program innovations, not to introduce restrictions that defeat the purpose of Medicaid.

A. Congress Enacted § 1115 to Permit States to Test New Approaches to Expand Access, Provide Better Services and Strengthen Social Programs.

In 1962, the Kennedy Administration asked Congress to enact legislation authorizing "[d]emonstration projects that states could undertake without having to meet all the conditions of the federal [Social Security] act." Public Welfare Amendments of 1962, Pub. L. No. 87-543 §

122, 76 Stat. 172, 192; *see also* S. Rep. No. 1589 at 1 (1962), *reprinted in* 1962 U.S.C.C.A.N. 1947. The President identified "needed improvements" in safety net programs including liberalization of eligibility requirements and benefit rules. *See* SOCIAL SECURITY ADMINISTRATION, *SOCIAL SECURITY HISTORY: KENNEDY'S STATEMENTS ON SOCIAL SECURITY* (Feb. 20, 1961). President Kennedy viewed this additional authority, which later extended to Medicaid, as a way to help, not penalize, the poor: "[c]ommunities which have – for whatever motives – attempted to save money through ruthless and arbitrary cutbacks in their welfare rolls have found their efforts to little avail. The root problems remained . . . ." *President's Special Message to the Congress on Public Welfare Programs* (Feb. 1, 1962).

Explaining that demonstration authority would enable states "to improve the techniques of administering assistance and the related rehabilitative service under the assistance titles," the Senate envisioned demonstrations of limited scope and limited geographic impact, and disfavored duplication of demonstration projects. S. Rep. No. 1589 at 1943, 1961. Furthermore, "[a]t the committee hearing, no witness suggested – nor did the Finance Committee ever intimate – that section 1115 was to be used to reduce benefits by varying eligibility criteria . . . . In short . . . Congress and the Administration intended this section to be a narrow, technical, and beneficent research option." Lucy A. Williams, *The Abuse of Section 1115 Waivers: Welfare Reform in Search of a Standard*, 12 YALE L. & POL'Y REV. 1, 12, 13 (1994). In fact, in 1967, Department policy guidelines reaffirmed that demonstrations ought to strengthen programs by "provid[ing] assistance to needy individuals *who would not otherwise be eligible*; increas[ing] the level of payments; provid[ing] social services not presently available…; [and] experiment[ing] with new patterns and types of medical care…." U.S. DEPT. OF HEALTH, EDUC. & WELFARE, *HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION*, H.T. No. 109, pt. IV, § 8432

(Feb. 17, 1967) (emphasis added) (*cited in* Williams, *supra*, at 14, n. 29); *see also* S. Rep. No. 744 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 2863.

Clearly, when the Secretary acts under § 1115, he has authority to permit experiments that test methods to promote the objectives of the Medicaid program, not to terminate medical assistance to eligible individuals.

B. Since 1965 Congress Has Added Protections to Ensure Demonstrations Promote Medicaid's Purpose.

Since Medicaid's enactment, Congress has taken additional steps to ensure § 1115 promotes the statute's purpose. In 1982, Congress added SSA § 1916 to restrict § 1115 waivers that compel beneficiary participation in premium or cost-sharing demonstrations. *See* Tax Equity and Fiscal Responsibility Act, Pub. L. No. 97-248 § 131(b), 96 Stat. 367 (1982) (codified at 42 U.S.C. § 1396o(f)). When Congress enacted the ACA, it further amended § 1115 to require the Secretary to permit public notice and comment at both the state and federal level prior to approving demonstrations and to ensure that demonstrations comply with the Medicaid provisions of the SSA. Pub. L. 111-148, § 2601(b)(2), § 10201(i), 124 Stat. 119, 922 (2010) (codified at 42 U.S.C. § 1315(d)(2)). In 2012, CMS promulgated regulations to require that demonstrations serve a legitimate experimental purpose. 42 C.F.R. §§ 431.400-431.428. States must submit for CMS approval detailed evaluation designs of demonstrations' "key programmatic features," including testable hypotheses, valid designs, reliable collection methods and approaches to minimize burdens on beneficiaries. *Id*. at § 431.424.

The text and history of § 1115 clearly show that demonstration authority is not a blank check to circumvent Medicaid eligibility and coverage protections. As the U.S. Court of Appeals for the Ninth Circuit warned: "we doubt that Congress would enact such comprehensive [*Social Security Act*] regulations, frame them in mandatory language, require the Secretary to

enforce them, and then enact a statute [Section 1115] allowing states to evade these requirements with little or no federal agency review." *Beno v. Shalala*, 30 F.3d 1057, 1068-69 (9th Cir. 1994); *see also Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011). As a result, the administrative record must show that the Secretary's approval of States' proposals that leave eligible individuals without medical assistance was the result of reasoned decision-making, weighing potential harm against expected benefits, and not mere rubber stamping.

In direct contravention of this requirement, Defendants approved Granite Advantage without a record that weighed such harm and benefits. In fact, despite numerous comments regarding the hardship the waiver would impose, the Secretary approved Granite Advantage without even a plan to evaluate the ensuing harm. Indeed, Defendants' approval says nothing about evaluation other than noting that "[u]pon approval of this amendment and extension, the State will work with CMS to develop an evaluation design plan consistent with the STCs and CMS policy." AR 4403. No evaluation of this complete departure from the original demonstration has been launched or approved.

C. Because § 1115 Cannot be a Pretext to Restrict Medicaid Eligibility or Coverage, the Approval of Granite Advantage was Arbitrary, Capricious and Contrary to Law.

The Secretary approved Granite Advantage notwithstanding overwhelming evidence in the record of the harm it will cause and no evidence that supports the claim that the demonstration will produce health gains. Rather than waiving conditions, the Secretary adds conditions of eligibility that frustrate Medicaid's core objective to provide medical assistance to all eligible individuals. *See* 42 U.S.C. §§ 1396a(a)(8), (10). The Secretary's approval only erects barriers to medical assistance and pushes people out of the program. This demonstration is not a valid exercise of the Secretary's waiver authority.

1. CMS' New § 1115 Policy Contradicts Consistent Agency Views that Work Requirements Have No Place in Medicaid and that Demonstrations Must Test Program Improvement Innovations.

The January 2018 SMDL admits that requiring work or community engagement as an eligibility condition "is a shift from prior agency policy regarding work and other community engagement as a condition of Medicaid eligibility or coverage." AR 59. Yet, the agency glossed over this drastic policy change stating that "it is anchored in historic CMS principles that emphasize work to promote health and well-being." *Id*. There are, however, no "historic CMS principles."

Until very recently, CMS has opposed work requirements consistently, including in New Hampshire. In 2015, CMS' Deputy Administrator and Director for the Center for Medicaid and CHIP Services told Congress that "the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work or receive job training because that is not an objective of [Medicaid]." Vikki Wachino, *Hearing on "Medicaid at 50," Responses to Additional Questions for the Record*, U.S. House of Rep. Energy and Commerce Health Subcommittee (July 8, 2015) at 37. Moreover, in 2016, CMS denied past Arizona and, tellingly here, New Hampshire proposals because work requirements "undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program." AR 99 (CMS letter denying work requirements in New Hampshire) and 152 (CMS letter denying work requirements in Arizona). In short, "[t]he Secretary has no Section 1115 authority to allow a work requirement or work incentive." Sidney D. Watson, *Out of the Blackbox and into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y L. & ETHICS 213, 227 (Winter 2015).

Based on years of Congressional enactments, HHS has consistently viewed Medicaid eligibility as a matter entirely "decoupled" from programs whose express purpose is to promote work, such as Temporary Assistance for Needy Families ("TANF"), which statutorily ties benefits to work activities. *See* Letter from Olivia Golden, Assist. Secretary for Children and Families and Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration to State Medicaid Directors and TANF Administrators (June 5, 1998). As such, CMS' recent reversal deserves little deference: "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view.'" *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n. 30 (1987).

2. <u>Extensive Commentary in the Administrative Record Made Clear the Risks Created by Work Requirements and Coverage Restrictions</u>.

An experiment to reduce Medicaid coverage flies in the face of extensive research demonstrating the adverse effects of denying low income people access to health insurance. *See, e.g.*, KAISER FAMILY FOUNDATION, *Sicker and Poorer: The Consequences of Being Uninsured* (Apr. 2002). Yet CMS simply ignored or provided unresponsive answers to extensive public comments presenting well-supported research opposing its assumptions in the SMDL and the Granite Advantage approval. Repeated comments in the record underscore how the demonstration would harm beneficiaries, especially those already facing health problems, while doing little, in a State in which virtually everyone works, to increase incomes or access to employer insurance. *See, e.g*, AR 1952-1457, 1479-1493, 2130-2133, 2219-2222, 2227-2228. CMS responded, again without citing supporting evidence, that Medicaid work requirements "may help enable beneficiaries to enjoy the many personal benefits that come with improved health outcomes and increased financial independence." AR 10. CMS also invoked vague

notions of experimentation to justify the community engagement requirement while downplaying the fact that thousands stand to lose coverage, stating, again without any basis in the record, that demonstrations such as Granite Advantage are "designed to examine innovative ways to incentivize beneficiaries to engage in desired behaviors that improve outcomes and lower healthcare costs, as well as innovative ways to stretch limited state resources . . . . Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment." AR 11.

However, the record contains evidence-based opposition to CMS' new policy of requiring work as an eligibility condition, due to the catastrophic impact of work requirements seen in programs such as TANF. *See* AR 1949-1951, 1480, 2204-2218. The only experimental question CMS conceivably could be trying to answer, yet again, is whether subjecting New Hampshire beneficiaries to similar requirements to qualify for medical assistance would produce similar catastrophic results. To the many concerns raised in the record, CMS provided a cursory response that "these comments reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making." AR 12. Clearly, the agency approved uncritically Granite Advantage's "hypotheses" and sidestepped the essential purpose of Section 1115 demonstrations: to promote the objectives of Medicaid. *See* 42 U.S.C. §1315(a); *see also* AR 4402-4403 (listing *pro forma* "Evaluation Hypotheses under Consideration").

CMS was also warned repeatedly with extensive research showing the adverse impact of coverage lock-outs that could result from noncompliance with the community engagement requirement and the harms that could flow from eliminating retroactive eligibility. *See* AR

1486-1493, 2204-2222, 2240-2250, 2692-2727 (harms from coverage lock-outs) and AR 1479-1482, 1486-1493, 1952-1957, 2200-2250 (harms of waiving retroactive coverage). CMS' unresponsive answer was that "any loss of coverage as the result of noncompliance [with demonstration requirements] must be weighed against the benefits New Hampshire hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program." AR 11. CMS thus has based its approval on balancing certain coverage loss against theoretical "benefits" whose achievement is "hoped." CMS offers no explanation of how eliminating coverage for an eligibility group whose costs to the State of providing medical assistance qualify for a ninety-three percent federal contribution rate in 2019 (ninety percent in 2010 and thereafter (42 U.S.C. § 1396d(y)(1)(D), (E))) advances the goal of financial sustainability; nor does CMS weigh the consequences for the State economy flowing from a major loss of federal funds – an economic loss that one expert estimates would amount to between $114 million and $174 million in 2020 alone – between seven percent and eleven percent of the State's general funds budget. Sherry A. Glied, *How a Medicaid Work Requirement Could Affect New Hampshire's Economy*, THE COMMONWEALTH FUND (May 9, 2019).

CMS' cavalier approach to approving Granite Advantage is self-evident. CMS turned a blind eye to actual research findings, undertook actions contrary to compelling evidence against it, implemented a major policy change after the mandatory comment periods had concluded, and failed to weigh this demonstration's health risks. In sum, CMS did not meaningfully consider the relevant factors, failed to document a reasoned decision to approve the amendment, and offered implausible explanations of the health gains to be had by imposing work requirements or

depriving expansion beneficiaries of medical assistance. The record contains nothing to show that the agency actually considered critical public comments. "Stating that a factor was considered…is not a substitute for considering it." *Getty v. Federal Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) (rejecting as "conclusory" an agency statement that all relevant factors had been considered). This record is insufficient to justify approval of Granite Advantage.

3. <u>CMS Falsely Claims that Research Supports a "Positive Link" Between Work Requirements and Improved Health Outcomes, and Fails to Explain How Eliminating Coverage Fulfills Medicaid Program Objectives</u>.

The cornerstone of CMS' determination to approve Granite Advantage is that "both the community engagement requirement and the waiver of retroactive eligibility for beneficiaries in the new adult ["expansion"]…are intended to improve beneficiary health and wellness and increase financial independence." AR 6. Notably, in approving Granite Advantage, CMS has dispensed with past claims that there exists research that supports the claim that these "community engagement" demonstrations promote improved health or wellness. Contrary to 1115 waiver approvals for work requirements in Kentucky and Arkansas, the Granite Advantage approval documents do not contain a single reference to research that could support approval. *Cf*. Letter from Paul Mango, CMS Chief Principal Deputy Administrator and Chief of Staff to Carol H. Steckel, Commissioner, Kentucky Department for Medicaid Services (Nov. 20, 2018) at 16, n. 10 *and accompanying text* (approving 1115 waiver known as "Kentucky HEALTH" and making the unsupported claim that "other research also shows a positive link between community engagement and improved health outcomes"); *see also* Letter from Seema Verma, CMS Administrator to Asa Hutchinson, Arkansas Governor (Mar. 5, 2018) at 4 (approving 1115 waiver known as "Arkansas Works" and citing research for the incorrect proposition that

"Arkansas Works' community engagement requirement is designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness."). This time, the agency does not make the bald claim that there is research that justifies imposing work requirements on Medicaid beneficiaries. There is no pretense in the Secretary's approval that there is research that "correlates" requiring people to work and "improved health outcomes," much less that correlates with fulfillment of Medicaid's objectives.

Moreover, CMS ignored numerous studies that have found a positive economic impact of the Medicaid expansion, both for people able to return to work because of improved access to medical care and as a jobs-creating economic engine. *See* Angshuman Gooptu et al., *Medicaid Expansion Did Not Result in Significant Employment Changes or Job Reductions in 2014*, 35 HEALTH AFFAIRS 111 (2016); Bowen Garrett & Robert Kaestner, *Recent Evidence on the ACA and Employment: Has the ACA Been a Job Killer?* THE URBAN INSTITUTE AND THE ROBERT WOOD JOHNSON FOUNDATION (Aug. 2015); *and* Robert Kaestner et al., *Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply*, JOURNAL OF POLICY ANALYSIS AND MANAGEMENT 36(3): 608-642 (May 2017). Individual states have also found that Medicaid enabled greater work engagement from people previously unable to do so because of poor health. *See, e.g.*, OHIO DEPARTMENT OF MEDICAID, *OHIO MEDICAID GROUP VIII ASSESSMENT* at 4 (2016) (Ohio) *and* Renuka Tipirneni et al., *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, UNIVERSITY OF MICHIGAN (Jun. 2017) (Michigan).

Medicaid's positive impact on work underscores a fundamental truth about the poor: research shows that two-thirds are either working or looking for work, while the rest overwhelmingly cannot work because of their own poor health or that of a family member or are

caring for young children. In other words, CMS' authorized "experiment" to measure the impact of depriving thousands of Medicaid coverage in New Hampshire is a dangerous solution in search of a problem, launched with no formal evaluation in place. *See* Leighton Ku & Erin Brantley, *Medicaid Work Requirements: Who's at Risk?* HEALTH AFFAIRS BLOG (Apr. 2017).

4. Granite Advantage's Work and Community Engagement Requirement Lacks the Requisite Experimental Soundness for a Valid § 1115 Demonstration.

Consistent with applicable decisions, *see, e.g.*, *Newton-Nations*, 660 F.3d 370 (Medicaid) *and Beno*, 30 F.3d 1057 (Aid to Families with Dependent Children), the record must show the basic methodological soundness of the experiment. The demonstration must produce valuable information that could lead to program improvements, facilitate "true research data and serve interests beyond state fiscal concerns." *Recent Case: Ninth Circuit Holds Statutory Waivers for Welfare Experiments Subject to Judicial Review*, 108 HARV. L. REV. 1208, 1212 (1995). "[T]he Secretary must make at least some inquiry into the merits of the experiment-she must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration." *Beno*, 30 F.3d at 1069. Moreover, "[t]he Secretary's second obligation under *Beno* is to 'consider the impact of the state's project on the' persons the Medicaid Act 'was enacted to protect.'" *Newton-Nations*, 660 F.3d at 381. In the absence of a true experimental design, the risks are confusion, contamination of research findings, and additional hardship to people who depend on the program. Like all sound experimentation, the demonstration must yield new knowledge, be methodologically sound, and benefits should outweigh risks.

The work requirements of Granite Advantage do not even rise to the level of experiment. The State's demonstration, as amended, is simply an invitation to remove people from Medicaid because they cannot find enough work or navigate complex reporting or exemption rules. Its

retroactive eligibility provisions simply strip away coverage on the unproven theory that people will be incentivized to enroll earlier. *See id*.; s*ee also* AR 3, 5, 12-13.

CMS compounded the problem by not requiring submission of even a proposed evaluation design before allowing New Hampshire to launch requirements with the potential to eliminate or deny coverage for tens of thousands of beneficiaries. Its approval letter requires the State to perform an evaluation by an independent party and to submit an evaluation plan. *See* AR 5 ("CMS is requiring the state's evaluation design to include hypotheses on the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings), as well as the effects of the demonstration on health outcomes and the financial impact of the demonstration (for example, an assessment of medical debt and uncompensated care costs)."); *see also id*. at 39 (X. EVALUATION OF THE DEMONSTRATION, ¶39. DRAFT EVALUATION DESIGN) ("The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration."). Thus, CMS authorized the State to launch Granite Advantage effective January 1, 2019, as an experimental 1115 waiver without requiring the State to have a comprehensive evaluation in place. Seen in its proper context as a Section 1115 demonstration, Granite Advantage falls well short of requisite, quality experimental standards. *Generally*, *see* Gov't Accountability Office, GAO-18-220, MEDICAID DEMONSTRATIONS: EVALUATIONS YIELDED LIMITED RESULTS, UNDERSCORING NEED FOR CHANGES TO FEDERAL POLICIES AND PROCEDURES (Feb. 20, 2018) (citing CMS' poor record of § 1115 research oversight and failure to produce evaluation results). Indeed, the approval documents contain no sound evaluation hypotheses related to the effects of work requirements, beyond mere testing to see what happens when work requirements are unleashed in Medicaid.

5. **Defendants' Claim that Granite Advantage Will Enhance the Sustainability of the Safety Net is Baseless.**

Just as there is a complete lack of evidence to support a harsh work experiment design in relation to health and employability, there is no evidence to support CMS' assertion that the demonstration "will furnish medical assistance in a manner that improves the sustainability of the safety net." AR 6. This demonstration is aimed wholly at the expansion population whose Medicaid federal financial participation ("FFP") beginning in 2020 and continuing permanently stands at ninety percent of State costs. Granite Advantage will have no effect on the far costlier part of the State's "traditional" Medicaid program, which qualifies for only fifty percent FFP. Indeed, the experiment could have the opposite effect, costing the State well over $100 million in lost federal revenue in a single year and substantially more as the demonstration proceeds over time. *See* Glied, *supra* at 13.

CMS further asserts that "[t]he community engagement requirements may impact overall coverage levels if the individuals subject to the requirements choose not to comply with them. However, the demonstration as a whole is expected to provide a greater access to coverage for low-income individuals than would be available absent the demonstration." AR 6. There is no evidence to support either assertion – that people who fall out of the program will "choose" not to comply or that the demonstration will provide "greater access" to coverage "than would be available absent the demonstration." CMS fails to offer any grounds for these statements.

Likewise, CMS offers no evidence-based response to public comments regarding the threat of coverage losses. Indeed, in response to the comment that the demonstration would elevate the number of beneficiaries with threatened access to care, CMS stated that "[b]eneficiaries whose Medicaid enrollment is terminated can re-apply for coverage at any time, and prior non-compliance with the community engagement requirements will not be considered

as part of their new eligibility determination." AR 8. This of course suggests that the agency is prepared to launch a demonstration whose clear consequence will be to churn people, interrupt coverage and perhaps achieve some short-term money savings. CMS offers no explanation of how churning avoids health and access risks; indeed, the evidence points in the other direction – that is, that churning interrupts and delays care, since it takes months to get enrollment back and then months more to resume utilization. *See* Eric T. Roberts & Craig Evan Pollack, *Does Churning in Medicaid Affect Health Care Use?*

Furthermore, Defendants' approach lacks minimum guardrails expected of federally assisted experiments that could harm human subjects. CMS assumes, based on no evidence, that people repeatedly subject to sanctions and pushed off the program will understand that they can re-qualify. CMS' response to the risks noted by commenters is that "if monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, or if evaluation data for this demonstration indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan . . . [or] to withdraw waivers at any time it determines that continuing the waivers would no longer be in the public interest . . . ." AR 10. In other words, CMS is allowing an experiment to proceed on the promise it may reconsider if injury begins to be visible.

II. New Hampshire's Remarkable Achievements in Providing Medical Assistance to Uninsured Adults Make the Impact of Imposing Work Requirements, Coverage Lock-Outs, and Limited Retroactive Eligibility Even More Catastrophic.

A. Defendants Ignored Evidence Indicating the Work Requirements Will Be Profoundly Disruptive.

As it did in reviewing § 1115 demonstration applications from Kentucky and Arkansas, CMS failed to provide any estimates of the magnitude of insurance losses and failed to consider the harms such losses would cause, despite extensive evidence linking coverage to access to care.

Defendants did not question New Hampshire's ". . . estimates that enrollment in Granite Advantage will not change materially over the course of the five-year extension period, with enrollment remaining near current levels." AR 4386. This disregard ignores common sense and the extensive public commentary regarding impact and loss. *See supra* § I.C.2. It is all the more remarkable given readily available evidence regarding the impact of work requirements and other eligibility restrictions on Medicaid participation. Not only were losses readily apparent to Defendants given the events transpiring in Arkansas' demonstration, but in New Hampshire's own case, its previous extension of work requirements to the SNAP program in 2012 showed large and rapid enrollment losses among a similar population of low income adults. Leighton Ku & Erin Brantley, *New Hampshire's Medicaid Work Requirements Project Could Cause More Than 15,000 to Lose Coverage*, THE COMMONWEALTH FUND (May 9, 2019). Indeed, nationwide, SNAP work requirements, which parallel those under Medicaid, led more than 500,000 adults to lose benefits. Bolen et al., *More Than 500,000 Adults Will Lose SNAP Benefits in 2016 as Waivers Expire*, CENTER ON BUDGET AND POLICY PRIORITIES (Mar. 18, 2016).

Following the State's Medicaid expansion in late 2014, the percentage of New Hampshire adults 19 to 64 who were uninsured fell by half, from sixteen percent to eight percent. As a result, by 2017, 62,000 fewer New Hampshire adults were uninsured in 2017, primarily due to the State's Medicaid expansion. *See* KAISER FAMILY FOUNDATION, Health Insurance Coverage of Adults 19-64 (2017). However, recent analysis indicates that between 15,000 and 23,000 New Hampshire enrollees – between thirty percent and forty-five percent of the 51,000 targeted Medicaid expansion enrollees – could lose Medicaid coverage within a year if New Hampshire terminates those who fail to comply with the onerous requirements. Ku & Brantley, *supra* at 20.

Work requirements in New Hampshire are substantially harsher than those that had been proposed or implemented in Kentucky, Arkansas, or SNAP and can be expected to lead to larger coverage disruptions. These losses will unravel the State's substantial coverage gains while making health care unaffordable for thousands. *Id.* Furthermore, the loss of federal revenue and the multiplier effect on State employment rates overall will be significant, with an estimated loss of 2,500 jobs annually. Glied, *supra* at 13.

B. There is No Realistic Expectation that Those Leaving Medicaid for Work Will Find Alternative Sources of Health Insurance Following Loss of Medicaid Coverage.

In approving Granite Advantage, the Secretary believes, without explaining on what basis, that work requirements "promote[] beneficiary health and financial independence." *See* AR 4. Defendants' assertion rests on two assumptions: (1) part-time work at low wages offers employer health benefits and (2) threatening people with the loss of Medicaid will lead them to find the jobs with generous benefits. CMS cites no evidence to support its assertions. Indeed, as noted, in the very same approval, CMS permitted the State to abandon the subsidized employer insurance component of the original expansion waiver. All evidence points in the opposite direction: part-time, low wage jobs come without health benefits.

Extensive evidence from TANF work programs shows that jobs gained, if any, are low-wage jobs without employer health benefits. In an examination of eight pending state Medicaid work demonstration proposals, the MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION ("MACPAC") reported that: (1) only one third of people losing TANF benefits found jobs that included employer-sponsored coverage; (2) almost half of the jobs held by Medicaid beneficiaries were at small firms not required under the ACA to provide health insurance; and (3) 40 percent worked in the agriculture and service industries, known for their low employer-

sponsored insurance offer rates." MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, *Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF* (Oct. 2017); *see also* MaryBeth Musumeci & Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience*, KAISER FAMILY FOUNDATION (Aug. 2017). Employee health benefits for low wage workers are uncommon: an average of sixteen percent of poor adults had access to employer-sponsored insurance in the United States in 2016. *See* KAISER FAMILY FOUNDATION, *Health Insurance Coverage of the Total Population* (2016). There is no evidence to suggest that depriving people of Medicaid will lead to greater levels of employer-sponsored insurance. For the people who lose Medicaid because they fail to satisfy work and "community engagement" requirements, a return to persistently uninsured status will be the norm.

Unsurprisingly, in addressing "Arkansas Works," the recently vacated § 1115 waiver which would have required expansion beneficiaries to certify 80 hours monthly of "community engagement," MACPAC noted that "[w]ork and community engagement waivers represent a significant new policy direction for the Medicaid program," expressed its concern that, as with Granite Advantage, "there was not an approved evaluation design in place at the time of implementation," and "urge[d] HHS to pause disenrollments under the waiver." *See* Letter from Penny Thompson, MACPAC Chair, to Alex Azar II, Secretary of HHS (Nov. 8, 2018) at 2, 4.

III. Granite Advantage Will Produce a Major Spillover Impact, Affecting Access to Health Care Community-wide.

Granite Advantage's new requirements could lead to a large number of beneficiaries losing coverage, either permanently or with increasingly frequent breaks in coverage because of the additional reporting burdens. Indeed, one study projects that work requirements may literally double the Medicaid disenrollment rate over a two-year period, thereby significantly increasing the proportion of Medicaid beneficiaries who experience major gaps in coverage. Sara Collins et

al., *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky,* THE COMMONWEALTH FUND (2018).

With this insurance rollback will come important spillover effects that will go completely undocumented given the lack of an objective evaluation. A major examination of the community-wide effects of uninsured individuals found that communities with high levels of uninsured persons lack critical services even for insured people because these communities lack the market conditions essential to financing health care. *See America's Uninsured Crisis: Consequences for Health and Health Care,* INSTITUTE OF MEDICINE at 4 (2009). New Hampshire's Medicaid expansion produced major health system gains; over 41,000 people received mental health care, more than 23,000 received cardiovascular treatment, 11,000 were able to secure substance use disorder treatment, 1,300 received cancer treatment, and 6,100 received diabetes related care. NEW HAMPSHIRE FISCAL POLICY INSTITUTE, *Medicaid Expansion in New Hampshire and the State Senate's Proposed Changes* (Mar. 30, 2018).

With the loss of Medicaid, these access gains are threatened, since providers depend on insurance to finance care their patients need. New Hampshire's community health centers, which served one in four low-income residents (91,440 people) in 2017, offer insight into this spillover phenomenon. *See* U.S. DEPT. OF HEALTH & HUMAN SERVS., Health Resources and Services Administration, Bureau of Primary Healthcare, 2017 *Health Center Data: New Hampshire Data* (2018). Health centers are major Medicaid providers in the State and treat thousands of uninsured patients. With basic grant funding under Section 330 of the Public Health Service Act, 42 U.S.C. § 254b ("Section 330"), health centers make health care accessible and affordable to medically underserved urban and rural populations regardless of ability to pay. Section 330 grants represent less than twenty percent of health centers' operating budgets. *See*

Sara Rosenbaum et al., *Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained*, KAISER FAMILY FOUNDATION (Mar. 26, 2019). New Hampshire health centers, like those in other states, depend heavily on Medicaid to fund the care they provide. Indeed CMS in its approval letter required the State to notify people losing Medicaid that they could get free or low-cost coverage at health centers – a remarkable, if tacit admission by Defendants regarding the impact of work requirements on insurance coverage. *See* AR 33 (¶ 24.u). Should enrollment losses reach the levels projected by experts, such losses could translate into a 2,500-patient reduction in health centers' service capacity and close to 11,000 fewer patient visits. Sara Rosenbaum, Jessica Sharac, and Peter Shin, *What Could New Hampshire's Medicaid Work Experiment Mean for Community Health Centers?* GW HEALTH POLICY & MANAGEMENT MATTERS (May 9, 2019).

CONCLUSION

For the foregoing reasons, New Hampshire's Granite Advantage demonstration falls short of the applicable standard of review and short-changes Medicaid participants in the State, which justifies enjoining its further implementation. Moreover, Defendants' approval of the amendment should be vacated and remanded to the agency.

Respectfully submitted,

Dated: May 16, 2019

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Local Civil Rule 7(o). This brief consists of 24 pages of text, exclusive of the Table of Contents, Table of Authorities, Attorney identification and Certificate of Compliance, and contains 1 footnote containing 4 aggregate lines of text.

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CERTIFICATE OF SERVICE

I hereby certify that on May 16, 2019, I caused the foregoing document to be served on the parties' counsel of record electronically by means of the Court's CM/ECF system.

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