

The Community Response to Medicaid Work and Community Engagement Requirements: Lessons from New Hampshire

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Executive Summary

As early as January 2014, states took advantage of the federal government's offer in the Affordable Care Act to provide substantial support to expand Medicaid health coverage to the newly eligible low income adult population.¹ Some states also considered seeking new restrictions on eligibility, including work requirements, with a focus on adults in the expansion population. New Hampshire was one of few states that passed legislation to require work and community engagement activities as a condition of eligibility for its Medicaid expansion population. Because such requirements are not otherwise allowed under federal rules, the NH Department of Health and Human Services (NH DHHS) applied for and received waiver approval from the Centers for Medicaid and Medicare Services (CMS) to implement Work and Community Engagement Requirements ("WACER").² In March 2019, when the WACER went into effect, NH Medicaid covered 50,411 beneficiaries in the Medicaid expansion program, making up almost 30% of the total Medicaid-covered population.³

Although WACER created an individual compliance obligation for each beneficiary in the Medicaid expansion population, it was foreseeable that the WACER program's impacts would extend to the community organizations that supported these beneficiaries. This project used New Hampshire as a case study to test the hypothesis that community organizations would be impacted by WACER for several reasons, including: 1) the organizations serve Medicaid beneficiaries who are enrolled in or eligible for health coverage through Medicaid expansion and/or 2) the organizations serve as resources for beneficiaries to understand benefits and health insurance coverage, including NH Medicaid. The project hypothesized that community organizations would need to respond to WACER through program, policy, and infrastructure changes. The project explored a range of questions, including:

- What was the impact of the implementation of New Hampshire's WACER on the operations and infrastructure of community organizations?
- What were the expectations of "effort" by providers and community organizations to engage beneficiaries in the requirements?

To assess community organization impact and response, this project reviewed the history of the WACER program and the involvement of the community organizations in the roll-out, and collected information from community organizations through stakeholder roundtables, qualitative interviews, and a survey.

The NH Work and Community Engagement Requirement (WACER) Program in Context

The impact of the NH WACER program must be examined in the context of the many contemporaneous changes to the Medicaid program. During the WACER roll out, other

changes impacting the New Hampshire Medicaid expansion program population and community organizations included:

- Legislative changes to the Medicaid expansion program and debates about its reauthorization;
- Termination of the Premium Assistance Program (PAP) waiver that was the original design of the Medicaid expansion program;
- Transition of the Medicaid expansion population from PAP to the new Granite Advantage program, with coverage through Managed Care Organizations (MCOs);
- Re-procurement process for Medicaid MCOs; and
- Legislative debates and changes to the WACER and its requirements.

These concurrent changes to the Medicaid expansion program caused confusion and disruption for both community organizations and their beneficiaries.

The Impact of WACER Implementation on Community Organizations

Community organizations identified a range of ways the WACER program impacted their ability to serve clients and burdened their staff and resources.

The community organizations articulated their key concerns, including:

- “The confusion about the requirements among the population we serve” was the top concern for half and was among the top 3 concerns for 17 of 18 of the respondents.
- “The amount of uncompensated care” that could result was the top concern for 7 and was among the top 3 concerns for 13 of 18 respondents.
- “The staff work involved in supporting beneficiaries, patients, family members, etc. in understanding the WACER” was among the top 3 choices for 12 of 18 respondents.

The community organizations explained that the WACER was difficult for them to track, prepare for and explain. Despite consistent efforts by DHHS to engage organizations, these difficulties were compounded by beneficiaries’ confusion and by other simultaneous changes to the Medicaid program impacting the same population.

Concerns for Beneficiaries

Awareness of WACER

Community organizations were concerned that the impacted populations were not receiving information about the WACER, given the transient (and sometimes homeless) nature of the population. In many instances, information was not reaching the beneficiaries; or, if notices reached them, beneficiaries did not fully understand the information about the requirements and how to comply. Given other changes to the Medicaid programs (e.g., moving from PAP coverage to MCO coverage), beneficiaries were sent multiple communications, and there was

confusion about what all the changes meant. The information and forms published by NH DHHS were complex and in English, so many beneficiaries may not have realized the importance of the information.

Understanding of Requirements

The WACER compliance requirements were complicated, and community organizations were concerned beneficiaries lacked sufficient explanatory information, tools, or trained assisters to be able to understand the compliance and documentation requirements. The exemptions and “good cause” exceptions for the WACER were not clearly defined. Many required supporting documentation, such as professional certifications, that were difficult for beneficiaries to understand, obtain, and submit.

Ability to Comply

In addition to understanding the WACER program, there was concern among the community organizations that many beneficiaries would have difficulty meeting the requirements. The targeted population often held seasonal and atypical work schedules, making it impossible to meet the hour requirement consistently. During implementation, it remained unclear if self-employment hours would count toward WACER. In addition, even for those who met the hour requirements, there were concerns about their ability to correctly document hours worked.

Consequences for Non-Compliance Were Not Clear

Community organizations knew beneficiaries did not fully comprehend that failure to meet the WACER (or verify an exemption) would result in a loss of Medicaid health benefits and require an administrative process to re-apply. Community organization interviewees said that many beneficiaries were “really surprised to find out about this” and it caused “panic” when the consequences were explained.

Burden on Community Organizations Who Support Beneficiaries

Investment in Staff Time Required for WACER Preparation

Many changes were happening in the Medicaid program simultaneously, and community organizations dedicated significant time to understanding those changes and educating their staff members about the implications. Preparation included reviewing materials published by NH DHHS and others; attending legislative hearings about the WACER provisions during several legislative sessions; and participating in administrative hearings, public hearings, public information sessions, and educational programs to learn about the details and provide feedback. As with the beneficiaries, however, community organizations expressed concerns that even after the March 1, 2019 implementation date, numerous questions about the WACER program remained unanswered.

Without additional funding, community organizations also invested time and resources to identify, reach out to and assist beneficiaries. Organizations hosted a variety of sessions for

their beneficiaries. The community organizations translated materials into additional languages and created their own educational resources for clients. These supplemental educational and support activities were not compensated.

Investment in Technology and Resources

In order to better assist beneficiaries with the WACER, community organizations:

- Identified a variety of necessary modifications to information technology systems;
- Invested resources in processes to identify the population for outreach, because community organizations did not have information about who was subject to the WACER;
- Developed prompts in intake processes and medical records to trigger compliance checks to support beneficiaries in meeting WACER;
- Invested in processes to assist staff in managing the required NH DHHS forms, including attestation for exemptions and exceptions; and
- Supported beneficiaries in using the online tools for documentation, reporting, and compliance.

Certification and Documentation Support

Many of the WACER exemptions and exceptions required certification by professional health care providers. Providers had to understand the certification processes and forms in order to support their patients and others seeking certification. Community organizations who provided professional medical services confronted issues raised by staff regarding the professional ethical conflict associated with confirming a medical or mental health frailty diagnosis when such a diagnosis was required for eligibility, but was also a prerequisite to the provider's ability to receive compensation for services.

Risk of Financial Loss

The substantial risk of coverage loss for noncompliance was concerning for the community organizations that provide clinical services. The population was at risk yet might not be eligible for coverage. The unique concept of a “curing” period during which someone may not be disenrolled from Medicaid, but held in suspension status, created uncertainty about whether services rendered could be paid for, as well. One community health care provider expressed concern about significant loss of revenue if their coverage loss estimates were realized.

Status of NH WACER – Program Suspension

New Hampshire's approved WACER was temporarily suspended by the NH DHHS commissioner on July 8, 2019 because, despite extensive efforts, NH DHHS had no information on the compliance status of over 17,000 beneficiaries. More specifically, the Commissioner stated:

“...there needs to be a continuing effort by the department, its managed care organizations who serve this population and other providers in order to educate the beneficiaries and implement the program in order that it does not result in the unintended loss of coverage for thousands of beneficiaries.”⁴

The suspension was authorized by newly adopted legislation (N.H. Senate Bill 290), signed by the Governor on July 8, 2019. On July 29, 2019, a decision of the Federal District Court for the District of Columbia, by Judge Boasberg, in *Philbrick v. Azar*, vacated CMS’s approval of the WACER. The WACER was thereafter suspended indefinitely. Following an appeal in *Philbrick v. Azar*, the District of Columbia Circuit Court of Appeals affirmed the decision on May 20, 2020.

The COVID-19 public health emergency declared in March 2020 has changed the landscape around employment. With COVID-19 Affected Unemployment Rates at over 20% in many communities across New Hampshire, any work requirement would result in significant coverage losses. As the U.S. Court of Appeals for the District of Columbia found in affirming the illegality of Arkansas’s work requirement waiver, the HHS Secretary has failed to address how a work and community engagement requirement would promote the objective of Medicaid when causing the loss of coverage for people who are poor. *See Gresham v. Azar*.⁵

Summary

In summary, the preparation and implementation process for New Hampshire’s approved WACER program was costly and confusing for community organizations. The process was exacerbated by the WACER’s uncertain future, and simultaneous changes to the Medicaid program that also impacted beneficiaries and community organizations. Community organizations realized many uncompensated costs associated with the WACER implementation. Many additional costs and impacts were not fully realized due to the suspension of the program.

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Introduction

Background

In January 2018, the Centers for Medicaid and Medicare Services (CMS) announced a new policy supporting state imposition of work and community engagement requirements on Medicaid beneficiaries as a condition of Medicaid eligibility.⁶ According to the policy, states would be able to obtain approval for work and community engagement requirements for adults who were not elderly, pregnant, or qualified for Medicaid on the basis of a disability through demonstration projects authorized under section 1115(a) of the Social Security Act.⁷ New Hampshire, along with several other states, applied for a section 1115 demonstration waiver in 2018 and was granted the authority to implement a work and community engagement requirement as an eligibility condition for its Medicaid expansion population. The New Hampshire work and community engagement requirements (“WACER”) were ultimately effective beginning on March 1, 2019.

Project Overview

Although WACER created an individual compliance obligation for each beneficiary in the Medicaid expansion population, it was foreseeable that the program’s impacts would extend to the community organizations that supported these beneficiaries. At the time CMS approved New Hampshire’s WACER, relatively little was known about the impact that implementation of the requirement would have on community organizations working with Medicaid enrollees, particularly as these organizations tried to meet Medicaid beneficiaries’ needs without funding to implement new programs to support the WACER program. Although community organization response to WACER and support of beneficiary compliance was a critical part of the implementation of the program, the efforts of these organizations are not typically included in the metrics that measure the program implications. For example, the costs borne by these organizations are not included in the CMS required cost-effectiveness studies. Accordingly, this study sought to identify, document, describe, and quantify programmatic and financial investments made by community partners to support Medicaid beneficiaries in meeting WACER.

The project hypothesized that community organizations would need to prepare for the WACER through program, policy, and infrastructure changes to support the complex compliance needs of their Medicaid beneficiaries. More specifically, community organizations would prepare by:

- (1) Understanding program requirements and fielding questions from beneficiaries;
- (2) Preparing documentation to support eligibility determinations;
- (3) Linking beneficiaries to employment services or other qualifying activities;
- (4) Assisting with documentation and professional certifications for exemptions and exceptions;
- (5) Assisting with documentation of qualifying activities; and
- (6) Tracking eligibility status.

In order to determine the full impact of the WACER on community organizations, this project reviewed the WACER roll-out process and the necessary involvement of community organizations in it, and collected information from community organizations about their experience through stakeholder roundtables, qualitative interviews, and a survey.

The NH WACER

Medicaid Expansion in New Hampshire

The adoption and implementation of the WACER in New Hampshire is inextricably linked to the State's Medicaid expansion story. New Hampshire imposed the WACER on its Medicaid expansion population alongside an elimination of 90-day retroactive eligibility by amending the same Section 1115 demonstration waiver that authorized Medicaid expansion.

Community organizations were intensely involved and unified around New Hampshire's Medicaid expansion; therefore, the authorization and reauthorization process provides important context for the WACER and its impact.

In 2014, the New Hampshire Legislature voted to expand Medicaid to adults ages 19–64 with incomes between 0–133% of the federal poverty level (“new adult group”).⁸ The legislation established the “New Hampshire Health Protection Program” (NHHPP) and required the Commissioner of NH DHHS to seek a section 1115 demonstration waiver establishing a mandatory “Premium Assistance Program” (PAP) for the newly eligible adults to access health insurance on the marketplace exchange.⁹ Until the waiver was submitted and approved by CMS, beneficiaries in the new adult group were enrolled in Medicaid Managed Care or “Bridge” plans.¹⁰

Medicaid expansion coverage for the new adult group through the NHHPP began effective August 2014.¹¹ In November 2014, NH submitted the NHHPP PAP demonstration waiver application to CMS seeking approval to implement a mandatory PAP, through which the State would purchase for enrollees qualified health plans meeting Medicaid requirements from insurance carriers offering individual coverage on the federally facilitated New Hampshire Insurance Marketplace Exchange.¹² Members of the new adult group who were medically frail or could otherwise opt out of the PAP would be covered through traditional Medicaid, by one of the state's Medicaid Managed Care Organizations (MCO).¹³

CMS approved New Hampshire's demonstration waiver on March 4, 2015. The NHHPP PAP program began on January 1, 2016.¹⁴ While CMS approved NHHPP to run through December 31, 2018,¹⁵ the authorizing legislation provided that the demonstration would sunset on December 31, 2016 unless the New Hampshire Legislature authorized its continuation.¹⁶

The History of the WACER: Legislation Changes and CMS Approval

2016

The development, approval, and implementation of the WACER program in New Hampshire occurred through a series of legislative efforts, waiver amendments, and new waiver applications that proposed many changes to the Medicaid program. (A complete NH WACER

timeline is set included as an Appendix.) The changes to the Medicaid expansion program caused confusion amongst community organizations and beneficiaries alike. In March 2016, New Hampshire passed legislation to reauthorize NHHPP through December 31, 2018. The reauthorization legislation included that NH DHHS seek a waiver for WACERs as a condition of eligibility for Medicaid expansion.¹⁷ In August 2016, NH DHHS requested that CMS amend the NHHPP 1115 demonstration waiver to, in part, condition certain participants' coverage on their compliance with WACERs.¹⁸ CMS denied DHHS's request for the WACER and several other amendments in November 2016, reasoning that they "could undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program."¹⁹

2017

In June 2017, the New Hampshire General Court enacted a budget bill statute (HB 517), which included a provision requiring NH DHHS to again seek a waiver or amendment from CMS to establish a new WACER as a condition of NHHPP PAP eligibility.²⁰ Section 219 required 20 hours a week of work upon eligibility, 25 hours a week upon 12 months of eligibility, and 30 hours a week upon 24 months of eligibility, or coverage would terminate. In October 2017, NH DHHS submitted the waiver amendment to CMS requesting approval of the WACER. In the waiver application, DHHS described the make-up of the PAP population this way:

As of August 1, 2017, the New Hampshire Health Protection Program provided coverage to 51,924 Granite Staters – 41,392 of whom were enrolled in the Premium Assistance Program and receiving coverage through four commercial insurance carriers offering Qualified Health Plans (QHPs) in New Hampshire's federally facilitated Marketplace. Another 7,093 members – those that are medically frail or may otherwise opt-out of the Premium Assistance Program – were served by the state's two Medicaid managed care organizations (MCOs), WellSense Health Plan and NH Healthy Families. The remaining 3,439 participants were in fee-for-service during their plan selection window.²¹

2018

In January 2018, CMS announced a major shift in policy by supporting state imposition of work requirements on Medicaid beneficiaries as a condition of Medicaid eligibility,²² and approving Kentucky's 1115(a) demonstration waiver with an 80 hour a month work requirement for adult Medicaid beneficiaries. During the winter months of 2018, NH's General Court was also debating the reauthorization of the NHHPP with a new and amended WACER (SB 313). Recognizing the shift in CMS policy, NH DHHS began to prepare for the possibility of implementing a WACER based on its 2017 application to CMS. On May 7, 2018, CMS approved New Hampshire's demonstration waiver application, making WACER a condition of NHHPP eligibility.²³ However, this approval was complicated. Because the WACER was based on prior

legislation, it could not go into effect until January 1, 2019. With the NHHPP waiver set to expire on December 31, 2018, there was uncertainty about the impact the approval may have on the actual implementation of WACER.

Shortly after CMS approved New Hampshire's waiver amendment, the NH General Court statutorily amended coverage for the Medicaid expansion population by ending the NHHPP and PAP, and creating a new program called the New Hampshire Granite Advantage Health Care Program ("Granite Advantage"). The change included shifting coverage for the expansion population to Medicaid MCOs, a revised WACER, an asset test and a citizenship requirement for eligibility, the elimination of 90-day retroactive eligibility, as well as other modifications, all to be effective January 1, 2019.²⁴

On May 8, 2018, consistent with SB 313, NH DHHS issued a notice to amend its demonstration waiver to discontinue the NHHPP PAP program and begin the Granite Advantage Program. The amended demonstration waiver application was filed with CMS in July 2018.²⁵ On November 30, 2018, CMS approved NH DHHS's July 1115 waiver amendment application (but not the asset test or citizenship requirement).²⁶

The overlapping regulatory and programmatic changes to the Medicaid program and WACER resulted in numerous and varied mandatory notices and public hearings, causing substantial confusion amongst beneficiaries and community organizations.

2019

New Hampshire's approved WACER, effective originally on January 1, 2019, then continued to March 1, 2019, impacted the entire Medicaid expansion population (ages 19-64 with incomes up to and including 133 percent of the federal poverty level).²⁷ The WACER required beneficiaries to undertake qualifying work and community engagement activities for 100 hours per month to remain eligible for health insurance coverage.²⁸ New Hampshire's WACER imposed the greatest number of hours compared to other states, with most states requiring 80 hours/month as opposed to 100.²⁹ The WACER included exemptions and temporary "good cause" exceptions, and a unique system that allowed beneficiaries to "cure" if they failed to meet the required hours in a month.

The WACER began March 1, 2019, with a 75-day waiting period for currently enrolled beneficiaries, making June 2019 the first month in which Granite Advantage beneficiaries had to engage in 100 hours of qualifying activities to maintain eligibility.³⁰

Details of the 2019 WACER

Community organizations were navigating the many changes to the Medicaid expansion program while trying to help beneficiaries understand and prepare for the new WACER.

The NH WACER required 100 hours a month of qualifying activity, unless a beneficiary met the criteria for an exemption. In addition to the exemptions, a beneficiary could meet a "good

cause” exception despite otherwise being subject to the requirements. The WACER also included a mechanism that would allow a beneficiary who did not meet the required hours for a month to “cure” non-compliance. Each of these components of the WACER is described below.

Qualifying Activities

Only certain “qualifying activities,” such as employment, education, job search, substance use disorder treatment (with limits), and community service endeavors could be used to satisfy the 100 hours a month required for the WACER. The list of qualifying activities included, but was not limited to, the following:

- Unsubsidized employment (including by nonprofit organizations);
- Subsidized private or public sector employment (including by nonprofit organizations);³¹
- Job skills training related to employment (including on-the-job training);
- Enrollment at an accredited college or university (including a community college) that is counted on a credit hour basis;³²
- Job search and readiness assistance, including but not limited to job training or job search activities that are required in order to receive unemployment benefits; and other job training related services, such as job training workshops and time spent with employment counselors, offered by the State of New Hampshire Employment Security Agency;³³
- Vocational educational training not to exceed 12 months;
- Education directly related to employment, in the case of a beneficiary who has not received a high school diploma or certificate of high school equivalency;
- Attendance at a secondary school or in a course of study leading to a certificate of high school equivalency, in the case of a beneficiary who has not received a high school diploma or certificate of high school equivalency;
- Participation in substance use disorder treatment (however, participation with an identified agency or organization qualified for up to only 40 hours per month);
- Community service and public service;
- Caregiving services for a non-dependent relative or other person with a disabling health, mental health, or developmental condition; or
- Participation in and compliance with Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements.³⁴

Exemptions

Certain beneficiaries were exempt and did not have to complete qualifying activities to maintain eligibility for health insurance.³⁵ Exemptions existed for beneficiaries who were:

- Temporarily unable to participate due to illness or incapacity as documented by a licensed provider (*licensed medical professional certification required*);
- Participating in a state-certified drug court program (*court order required*);
- A parent or caretaker where care of a dependent is considered necessary by a licensed provider (*licensed medical professional certification required*);
- A custodial parent or caretaker of a dependent child under 6 years of age (only applies to one parent or caretaker in case of a 2-parent household);
- A parent or caretaker of a dependent child of any age with a disability (*licensed medical professional certification required*);
- Pregnant or 60 days or less post-partum (*due date required*);
- Demonstrated medically frail (*licensed medical professional certification required*);
- Beneficiaries with a disability as defined by the ADA, Section 504, or Section 1557, who were unable to comply with the requirements due to disability-related reasons (*licensed medical professional certification required*);
- Residing with an immediate family member who has a disability as defined by the ADA, Section 504, or Section 1557, who are unable to meet the requirement for reasons related to the disability of that family member (*licensed medical professional certification required*);
- Experiencing a hospitalization or serious illness (*licensed medical professional certification required*);
- Residing with an immediate family member who was experiencing a hospitalization or serious illness (*licensed medical professional certification required*);
- Exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; or
- Enrolled in New Hampshire’s voluntary Health Insurance Premium Program (HIPP).³⁶

NH DHHS hoped to determine a beneficiary’s WACER status based on information from NH’s eligibility system and to inform the beneficiaries if they were: 1) “**exempt**”; 2) “**deemed to satisfy**” the WACER based on information already available to NH DHHS; or 3) “**mandatory**,” meaning the beneficiary needed to demonstrate compliance or an exemption. Existing beneficiaries subject to the WACER were sent letters from NH DHHS in the spring of 2019 accordingly. For those in the “mandatory” category, securing or confirming an exemption required documentation or, in many cases, a certification from a provider.

Noncompliance, Good Cause Exceptions, and the Opportunity to Cure

Non-exempt beneficiaries were able to document their compliance by verifying information and/or self-attesting to compliance.³⁷ The deadline for submitting hours of activity to NH DHHS was the 7th day of the month following the one in which the activities were completed.³⁸ Beneficiaries who completed more than 100 hours of qualifying activities in a month were not permitted to carry over hours to the next month.³⁹

The failure of a non-exempt beneficiary to complete 100 hours of qualifying activities in a month constituted noncompliance. By the 10th day of the month following the month of the deficiency, the state was required to send notice to the noncompliant beneficiary. The notice would explain that the beneficiary's Medicaid eligibility would be suspended effective the first day of the month after the month in which the notice was sent, unless, before the suspension took effect, the beneficiary was able to "cure" the deficiency.⁴⁰

To cure, a beneficiary needed to demonstrate: i) good cause for the deficient hours; ii) qualification for an exemption; iii) completion of the deficient hours for the month that resulted in noncompliance; or iv) some combination thereof for the month in which the deficit occurred.⁴¹ Circumstances constituting "good cause" included, but were not limited to:

- The beneficiary has a disability protected by the ADA, section 504, or section 1557, and was unable to meet the requirement for reasons related to that disability, but was not exempted from community engagement requirements;
- The beneficiary resides with an immediate family member who has a disability protected by the ADA, section 504, or section 1557, and was unable to meet the requirement for reasons related to the disability of that family member, but was not exempted from community engagement requirements;
- The beneficiary experiences a hospitalization or serious illness, but was not exempted from community engagement requirements;
- The beneficiary resides with an immediate family member who experienced a hospitalization or serious illness, but the beneficiary was not exempted from community engagement requirements;
- The beneficiary experiences the birth, or death, of a family member residing with the beneficiary;
- The beneficiary experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirements;
- The beneficiary has a family emergency or other life-changing event (e.g., divorce or domestic violence);
- The beneficiary is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the Commissioner of New Hampshire Department of Health and Human Services on a monthly basis, is unable to secure necessary child care to enable the beneficiary to participate in qualifying activities for the required number of hours because of inability to pay (including with the help of any available child care subsidies) or inability to locate a suitable child care provider due to provider capacity, distance, or another factor; or
- Other circumstances constituting good cause, as determined by the state.⁴²

All the "good cause" exceptions involving disability, hospitalization, or illness required both self-attestation and certification by a licensed medical professional; in some cases, verifying medical records was also required.

NH DHHS offered examples to illustrate how to cure deficient hours, such as:

A member completed 50 hours of qualifying activities for the month of June resulting in a 50-hour deficiency. To avoid suspension on August 1, the member would have to complete at least 50 hours of qualifying activities in July. Completing 100 hours in July would cure the June deficiency and satisfy the requirement for July. Completing 50 hours in July, however, would be enough to cure only June's deficiency. The member would still be noncompliant for July. Therefore, the member would receive notification of July's deficiency and would have an opportunity to cure in August. Failure to do so would result in suspension on September 1.⁴³

A member had two consecutive non-compliant months, resulting in suspension. In this scenario, the member completed 30 hours of qualifying activities in June and 60 hours in July, resulting in an August 1 suspension. The member's eligibility would be reinstated when the member completed 100 of qualifying activities in one month or when the member completed the lesser number of missing hours required from the two consecutive non-compliant months. Here that would be 40 hours. If the member completed only 40 hours, then the member would have to cure the missing 60 hours in the month following reinstatement to maintain coverage.⁴⁴

Implementation of the 2019 WACER Program

Following CMS approval, NH DHHS began implementation of the WACER. The many implementation activities included rulemaking, amending contracts for the MCOs, hosting public information sessions, sending various notification letters to beneficiaries, distributing forms and documentation requirements, developing web-based resources, and engaging multiple stakeholders, including community organizations, in the process.

Rulemaking

The rulemaking process provided a public forum for discussing concerns about the WACER. Because the rules were being developed as the program implementation was happening, many community organizations felt that they did not have clear directions for the WACER up to and after the effective date.

After CMS approval of the waiver in November 2018, NH DHHS filed notice of interim rulemaking in December 2018.⁴⁵ The New Hampshire Joint Legislative Committee on Administrative Rules (JLCAR) took up the rule at its December 20, 2018 meeting. Stakeholders, including community organizations, participated in the rulemaking process and expressed concerns. JLCAR objected to the proposed rules as contrary to legislative intent, in violation of the U.S. Constitution, and contrary to the public interest.⁴⁶ On January 9, 2019, NH DHHS responded JLCAR's objections and made substantive changes to the Granite Advantage proposed interim rule.⁴⁷ At its January meeting, JLCAR voted to postpone

action on the interim rule until the next meeting.⁴⁸ On February 15, 2019 (two weeks before the planned March 1 start date of the WACER), JLCAR approved the interim rule.⁴⁹ While the interim rule was going through the approval process, NH DHHS also filed a notice of rulemaking for the final rule, which JLCAR approved in May 2019, two months after the WACER had taken effect.⁵⁰ The approved Granite Advantage Health Care Program rule included key definitions; clarified the criteria for various qualifying activities, exemptions, and good cause exceptions; and identified the processes for and documentation necessary for compliance. It also described how NH DHHS would credit a finding of ‘good cause’ relief from the monthly hours requirement.

Forms

To support the documentation of exemption and exception requests and reporting compliance, NH DHHS drafted and revised the following forms, which were made available at public hearings, on-line, and eventually via the NH EASY website. The forms were all new and drafted to reflect NH’s unique WACER requirements, as interpreted by regulators during the brief implementation window between legislative and CMS approval and the WACER effective date.⁵¹

- **Medical Frailty Request:** Required that a licensed medical professional qualified to assess the beneficiary certify that the beneficiary was medically frail.
- **Release of Medical Information:** Authorized a licensed medical professional to release a beneficiary’s protected health information related to medical frailty to NH DHHS.
- **Exemption Request:** Used to request an exemption. Certain exemptions could be self-attested to and others required certification by a licensed medical professional.
- **Reporting Monthly Participation in Qualifying Community Engagement Activities:** Permitted reporting of job search and readiness activities; community service, volunteering, or public service; caregiver services; participation in outpatient substance use disorder services; and work or self-employment hours beyond what DHHS automatically credited the beneficiary based on its record keeping.
- **Reporting Education Participation in Qualifying Community Engagement Activities:** Permitted reporting of job skills training related to employment, enrollment at an accredited college or university, vocational educational training, education directly related to employment, and high school or equivalent enrollment.
- **Good Cause:** Used to request that NH DHHS excuse the beneficiary’s failure to satisfy WACER for one month based on the reason identified.

NH EASY Website

The NH EASY website was designed to help beneficiaries learn about and comply with the WACER. The website included educational videos about Granite Advantage, links to forms, a pre-screening tool, resources to assist beneficiaries in finding qualifying activities, and a

system for tracking hours.⁵² The information technology and tracking systems were developed with a vendor contract, which was amended for over \$50 million in upgrades in April 2018, including changes to accommodate WACER compliance.⁵³

Notice to Beneficiaries

The start date for WACER was adjusted from January 2019 to March 1, 2019.⁵⁴ All enrolled beneficiaries were given 75 calendar days from that date before they were required to comply.⁵⁵ This meant that June 2019 was the first month any beneficiary had to complete 100 hours of qualifying activities.⁵⁶

In the months leading up to the start date, NH DHHS sent various notification letters to beneficiaries. In February 2019, NH DHHS notified beneficiaries of their “Community Engagement status,” which fell into one of four categories: mandatory to participate, mandatory to participate and previously reported as medically frail, mandatory to participate but subject to another work requirement, and exempt from participation.⁵⁷ In April and June of 2019, after the start date, NH DHHS sent reminder letters to medically frail Granite Advantage members who had not yet submitted a medical frailty form.⁵⁸ In May 2019, NH DHHS reminded non-exempt beneficiaries that they would have to complete qualifying activities in June.⁵⁹ Providers were not notified of the status of any of their patients.

NH DHHS Outreach to Organizations and Beneficiaries

In addition to the letters to beneficiaries, NH DHHS also held public information sessions. NH DHHS held workshop sessions at the regional DHHS District Offices, where beneficiaries met with DHHS representatives to receive information and assistance. NH DHHS also met with stakeholder groups, including the community health centers, hospitals, provider organizations, community mental health centers, and refugee and immigrant assistance organizations to discuss the program and provide a forum for discussion. NH DHHS held training sessions on-site upon request by health centers and other provider offices to assist in using the NH EASY system for documentation and reporting.

Medicaid Managed Care Organization Re-procurement

While the Medicaid expansion population shifted from the NHHPP PAP to MCO coverage in the Granite Advantage program on January 1, 2019, the MCO contracts did not include any provisions regarding WACER compliance at that time. This left DHHS and community organizations without targeted help from the MCOs in WACER implementation efforts.

Further compounding the complexity of the NH WACER’s implementation context, in August 2018, before CMS approved the Granite Advantage WACER waiver, NH DHHS issued a notice of Requests for Proposals (RFP) for its Medicaid Care Management organizations. The RFP included requirements for the MCOs to support beneficiaries with WACER compliance, but not until the RFP process was complete and contracts implemented, which did not happen

until September 1, 2019. The RFP process resulted in more uncertainty about how the beneficiaries would be supported and put more pressure on community organizations to fill the gap.

NH WACER Suspension and Legal Challenge

While NH DHHS was implementing WACER, the state legislature was working on SB 290, a bill to amend the WACER. The Governor signed SB 290 on July 8, 2019.⁶⁰ As enacted, the legislation modified the WACER by making changes to the lists of the qualifying activities and exemptions. Notably, SB 290 also included provisions calling for the termination of the WACER under certain circumstances, including 500 or more beneficiaries losing eligibility or providers reporting increased uncompensated care,⁶¹ although these provisions were not part of the adopted legislation.

The same day SB 290 became law, the NH DHHS Commissioner issued a letter temporarily suspending the WACER.⁶² The Commissioner explained that suspension was necessary to give NH DHHS time to: 1) make software updates necessary to implement SB 290's changes to WACER and to amend the administrative rules; and 2) communicate effectively with Granite Advantage beneficiaries about the program, because despite its efforts, NH DHHS had no information on the compliance status of approximately 17,000 beneficiaries who were expected to engage in 100 hours of qualifying activities for the month of June.⁶³ The temporary suspension was scheduled to remain in effect until September 30, 2019.⁶⁴

Before the temporary suspension could expire, however, a federal district court vacated New Hampshire's WACER. On March 20, 2019, four New Hampshire beneficiaries had filed suit against the US DHHS Secretary for approving New Hampshire's WACER. *See Philbrick v. Azar*.⁶⁵ The beneficiaries challenged the Secretary's approval on several legal grounds, including alleging the approval was "arbitrary and capricious because it did not adequately consider the effects of the demonstration project on Medicaid coverage."⁶⁶ On July 29, 2019, Judge Boasberg of the Federal District Court for the District of Columbia issued a decision that vacated the WACER. The court noted that one of Medicaid's core objectives is to "furnish medical assistance to persons who cannot afford it"⁶⁷ and the Secretary failed to consider potential coverage losses when approving the New Hampshire's waiver.

Due to the *Philbrick v. Azar* decision, efforts by the community organizations to understand the complicated new WACER, prepare for implementation, and translate compliance needs to beneficiaries were suspended.

Future of Work Requirements

On October 25, 2019, the federal government and New Hampshire appealed Judge Boasberg's decision.⁶⁸ Also on appeal at that time were similar decisions overturning the work requirement approvals in Arkansas and Kentucky. Before the Court of Appeals for the

D.C. Circuit issued a decision, Kentucky's new Governor terminated that state's demonstration and Kentucky moved to dismiss its appeal. In February 2020, the appellate court affirmed the decision of the lower court in *Gresham v. Azar*, setting aside the approval of Arkansas's work requirement as arbitrary and capricious because it did not take coverage loss into consideration.⁶⁹ The D.C. Circuit Court of Appeals also affirmed *Philbrick v. Azar* in an unpublished, summary opinion dated May 20, 2020. The appellate court noted that its decision on New Hampshire's work requirement was controlled by its earlier decision in *Gresham v. Azar*.⁷⁰

On January 30, 2020, CMS released new guidance, called the "Healthy Adult Opportunity,"⁷¹ encouraging states to block grant or cap Medicaid programs through Section 1115(a)(2) waivers, offering flexibility in return to include limits on benefits, such as work requirements.

Given the intervening COVID-19 emergency, states have been focusing on Section 1135 emergency waivers and the expansion and retention of Medicaid coverage. The exponential rates of unemployment in New Hampshire and across the country caused by the COVID-19 crisis have significantly changed the landscape around employment. With COVID-19 Affected Unemployment Rates at over 20% in many communities across New Hampshire, any work requirement would again burden community organizations on the front lines of the public health pandemic and would likely result in significant coverage losses at a time when coverage is critical to the health and sustainability of New Hampshire communities.⁷²

Assessing the Impact of the NH WACER on Community Organizations

Project Methodology

This project assessed the impact on community organizations in three ways: stakeholder roundtables, qualitative interviews, and a survey.

Stakeholder roundtables reviewed major regulatory considerations for New Hampshire's WACER and provided forums for discussion. Each roundtable identified areas of interest and concern for the community organizations. The issues identified during the roundtable discussions were further explored during the qualitative interviews.

Two rounds of qualitative interviews were conducted with key stakeholders, selected from roundtable attendees and organizations that expressed the most potential impact from the WACER. Qualitative interview guides were developed and used for each round of interviews. Interviews were recorded and transcribed. Thematic analysis of the transcripts was conducted by the UNH Survey Center. Round one interviews were completed in March and April 2019; round two interviews were in October 2019. The second round of interviews were conducted because the administrative suspension of the WACER, the legal challenge, and the court decision overturning the WACER shifted the landscape significantly from the time of the initial qualitative interviews.

The final phase of the study was a survey to community organizations. Survey content was informed by the qualitative interview responses. The survey asked respondents about their understanding of the WACER and its suspension and how they learned about it, activities and processes taken by the organization to prepare for the WACER, participation in implementation activities by NH DHHS and Department of Employment Security to support beneficiaries, and other areas of interest and impact on the organizations. The survey was completed in September and October 2019.

Community organizations included those likely to be impacted, such as Goodwill, Easter Seals, Aging and Disability Resource Centers, community health centers, acute and critical access hospitals, family planning providers, community mental health centers, advocacy organizations, legal aid, day care centers, and other community organizations who served Medicaid beneficiaries and/or were in a position to provide or be asked to provide awareness to Medicaid beneficiaries about the WACER.

Community Roundtable Discussions

May 31, 2018

An initial stakeholder roundtable discussion of the NH WACER was held at the end of May 2018.⁷³ At this point, CMS had just approved NH's WACER, albeit a slightly different version from the one set forth in pending legislation (SB 313). The approval required a renewed and amended section 1115 waiver and Medicaid state plan to be effective.

Forty-seven participants attended the roundtable, including representatives from AARP, Goodwill Northern New England, FedCap, NH DHHS, philanthropic organizations, advocacy organizations, and hospitals and healthcare providers organizations. The goals of the roundtable were to outline the regulatory and procedural steps necessary to implement the Granite Advantage Program, summarize highlights of the WACER, and identify lessons learned and areas of interest from stakeholders involved in enrollment and employment supports. A question and answer document with background information about WACER was distributed.⁷⁴

Stakeholders included community organizations who were integrally involved in the Medicaid expansion authorization and were tracking the development of the WACER closely, as well as those who did not know about the WACER. Therefore, concerns were far-reaching and included:

- The lack of information available about the WACER;
- Confusion about the regulatory status of the CMS approval and impact of pending legislation;
- A misunderstanding of who the WACER applied to and the consequences of failing to meet the requirements;
- The need for specificity in definitions of qualifying activities, exemptions, and exceptions; for example, stakeholders voiced concerns about which caregiving activities would permit an exemption or exception and for what period of time, and whether treatment for SUD would qualify as an activity;
- A concern for how beneficiaries would be notified;
- The impact the WACER would have on enrollment and access to services;
- The potential for coverage losses and how that might increase uncompensated care;
- Uncertainty in how documentation processes for qualifying activities would be put into place; and
- How the complexity of the program would be explained to beneficiaries, especially to those beneficiaries for whom English is not their native language.

January 23, 2019

A second roundtable was held on January 23, 2019, after the amended 1115 waiver seeking approval of the Granite Advantage Program and the updated WACER was approved, and while DHHS was engaged in developing administrative rules for implementation. This session included twenty-seven participants, including representatives from the community mental health system, New Hampshire Legal Assistance, New Futures (a NH-based advocacy organization), Easter Seals, Granite United Way, Bi State Primary Care Association, NH Employment Security, and Planned Parenthood of Northern New England. The NH DHHS Medicaid Director also attended and presented. The roundtable session included a regulatory update on WACER in New Hampshire and other states, a status update from NH DHHS on the implementation process (with a focus on the curing component of the WACER program), and an opportunity for discussion.

Stakeholders asked numerous questions and posed concerns, including how:

- Providers would be able to identify patients as Medicaid beneficiaries that were in the Granite Advantage Program and subject to the WACER;
- Community organizations could determine whether clients were exempt or might need help meeting an exemption or qualifying activity;
- To define the exemptions and what certification or documentation was required;
- To track qualifying activities and “curing” hours and what mechanisms DHHS would use for such tracking;
- Providers would bill for services provided to patients whose coverage was suspended;
- Complicated forms could be clarified and simplified;
- Beneficiaries could be assisted in securing appropriate paperwork and certifications;
- The MCOs could support beneficiaries in understanding and meeting the requirements for WACER; and
- Materials that explained the program, especially qualifying activities and eligibility for exemptions and exceptions, would be made available in understandable formats and in multiple languages.

April 17, 2019

The third roundtable was held in April 2019, after the WACER’s effective date on March 1, yet before any beneficiary could be terminated for non-compliance. Thirty-five participants attended, including representatives from the community mental health system, New Hampshire Legal Assistance, New Futures, Easter Seals, Bi State Primary Care Association, the Medicaid MCOs, and NH DHHS.

The April roundtable included a procedural and legal update on the work requirement, including the status of SB 290, the bill that would amend the work and community engagement requirement, and the status of the *Philbrick v. Azar* lawsuit.

During the roundtable, NH DHHS described its outreach activities to date and its plans going forward. Plans included:

- District Office workshop sessions;
- Meetings with stakeholder groups;
- Training sessions at provider sites on reporting hours and curing; and
- The digital outreach and communication campaign.

NH DHHS provided a demonstration of NH EASY and the new system to manage WACER Forms, qualifying activity reporting, and enrollment information. The upgraded system was not yet ready for “go live,” but the demonstration allowed the stakeholders to provide input and feedback on the electronic process.

NH DHHS also introduced representatives from the three MCOs in NH. The MCO procurement process had recently ended, which resulted in two incumbent MCOs remaining in NH and one new MCO entering the state. According to the new contracts beginning on September 1, 2019, the MCOs would be required to help with outreach and compliance for members subject to WACER.

Stakeholders expressed concern about the lack of preparedness of providers and lack of engagement by beneficiaries. They also asked numerous questions about the WACER and the logistics associated with managing beneficiaries, including:

- How the opportunity to “cure” would work, and how hours would be counted;
- How beneficiaries could secure appropriate professional certification for exemptions;
- How to access the NH EASY monitoring system with or on behalf of a client;
- How many beneficiaries had been notified of their WACER status and how many had responded;
- How many beneficiaries were currently non-compliant and at risk for suspension;
- Who had access to information through the NH EASY documentation system;
- If and how MCOs could indicate an enrollee was part of the Granite Advantage Program, such that providers could identify which members had WACER obligations;
- The implications of provisions in the pending legislation (SB 290) modifying or “fixing” WACER requirements; and
- The impact of the pending lawsuit on implementation activities.

Qualitative Interviews with Community Organizations

Two rounds of qualitative interviews were conducted. The first phase was in spring 2019, as the WACER began. These interviews focused on identifying the activities that the community organizations were undertaking to support the population as beneficiaries were being notified of the obligation to comply with the WACER. The questionnaire included questions to better understand what resources community organizations were using to prepare for the

WACER, what operational changes they were making, what needs they were responding to in the community, what processes they were putting in place to address the needs, and any other issues they had related to the WACER implementation.

Selected interviewees were also interviewed in the second phase during the fall of 2019, after the WACER court challenge vacated the requirement. These interviews focused on the reaction to the suspension and vacating of the WACER and the phase of regulatory uncertainty. The interviews also asked about how the organizations managed their work and the beneficiaries' needs during the time between the implementation of the WACER and the court ruling.

A total of 9 qualitative interviews were completed. Interviewees included representatives from community health centers, community mental health centers, hospitals, professional associations, advocacy organizations, and other community organizations.

The qualitative interviews identified several common areas of impact for community providers:

- Concerns for and about beneficiaries;
- Concerns about the burdens on the community organizations in supporting beneficiaries with WACER compliance; and
- Concerns about the potential loss of insurance coverage and uncompensated care due to the WACER.

Concerns for the Beneficiaries

Lack of Awareness of WACER

An immediate issue raised by interviewees was the availability and accessibility of the information Medicaid beneficiaries would need to fully comprehend and comply with the new requirements. Community organizations were concerned that beneficiaries were not receiving information about the WACER at all, given the transient (and sometimes homeless) nature of the population. A few interviewees expressed some frustration with the process for outreach by NH DHHS; one stakeholder described a NH DHHS demonstration as “helpful,” but that they still “walked away with more questions than answers.”

One interviewee said the relevant forms were “confusing, even to well-educated people like clinicians.” Interviewees were concerned that beneficiaries would struggle to understand the requirements given the length and complexity of notices and other information provided by the State. Materials were made available primarily in English, which was a barrier to many beneficiaries. The simultaneous changes to the Medicaid program complicated the situation for everyone (e.g., moving from PAP coverage to MCO coverage), and beneficiaries were sent multiple communications. Beneficiaries were confused about what all the changes meant.

Difficulty Understanding the WACER

Given the complexity of the WACER, interviewees expressed concerns about the beneficiaries' ability to understand several specific aspects of the program. Among the anticipated difficulties for beneficiaries was understanding which qualifying activities could be counted, the precise criteria for an "exemption," and how to collect materials to document compliance in either circumstance.

The exemption definition, requirements, and compliance process were confusing and cumbersome. One stakeholder contended that supporters of these new requirements consistently argued that "no one who could not work would lose coverage" because they would be exempt as "medically frail." However, many interviewees noted that in practice, meeting an exemption was much more complicated because:

- Beneficiaries received inconsistent and unclear information about whether they were or were not exempt, even if they had self-attested as "medically frail" in the NHHPP.
- One stakeholder mentioned hearing that patients received unclear or inconsistent explanations of the exemption categories from NH DHHS.
- Providers did not know whether their patients had been determined to be exempt based on information available to NH DHHS. Providers felt frustrated that they had no way to proactively reach out or help patients who might be exempt, because providers did not receive notice about which patients were subject to WACER.
- Providers reported that not knowing or being able to determine the patients' requirements and/or exemption status had a detrimental effect on the patient interaction. This was especially true given how many exemptions required professional certification.

The concept of "medical frailty" as a valid reason for exemption from the WACER seemed particularly ambiguous and problematic. As one interviewee noted, there were two categories of exempt beneficiaries: those who are verifiably exempt based on existing documentation, such as having a minor under the age of six in the household, and those who claimed frailty that needed to be certified by a licensed provider. For the latter, there was significant confusion about what the status of "frailty" entailed, as that was a subjective assessment. Some wondered if those with chronic but non-physical conditions, such as substance abuse or mental health problems, qualified and, if so, for how long. Others noted the ambiguity of what constituted a "serious illness" that would qualify a patient as frail.

Community organizations also voiced concern about how beneficiaries would access appointments in time for the required professional certification for exemptions and "good cause" exceptions.

Others noted the definition of the various categories were stigmatizing as well, requiring a provider to confirm certain diagnosis or conditions simply to secure health insurance

coverage for a patient. Stakeholders indicated that some providers refused to perform exemption reviews for this reason.

The Ability to Meet and/or Document Compliance with the WACER

Stakeholders noted that the population impacted by the WACER have difficult lives with myriad stresses that may practically or mentally hinder their ability to comply with documenting compliance with the WACER. Some hold multiple jobs or care for young children. Others may lack access to technology or not be fully literate in its use. As one stakeholder interviewee put it, the WACER does not adequately account for the “complexity of people’s lives that they’re trying to fit into those forms and boxes.”

Many Medicaid beneficiaries work, and stakeholders were concerned that those who work might assume they complied with WACER and not understand the requirement to verify work hours. Stakeholders also noted that in their experience, many beneficiaries have atypical or irregular employment arrangements. Some experience wide variations in their hours of employment in any given time period, were paid “under the table,” or work for themselves, and these working conditions make WACER compliance near to impossible.

During the implementation phase, many were confused about whether self-employment hours could be counted as “qualifying” towards the WACER. In fact, NH DHHS interpreted NH’s authorizing legislation as prohibiting self-employment hours. When NH DHHS finally confirmed self-employment as a qualifying activity, the pathway for a beneficiary to confirm self-employment hours worked was complicated and based on a calculation of self-employed revenue.

Stakeholders were generally concerned that beneficiaries who met the WACER requirements would not understand the necessary compliance steps to confirm the hours or would not take those steps.

The Substantial Consequence to Lack of Compliance

Stakeholders noted that beneficiaries faced many obstacles to WACER compliance, including:

- Lack of knowledge about the WACER and the need for compliance;
- Failure to receive notice of the specific requirements;
- Misunderstanding the notices or required compliance steps;
- Lack of centralized access to trained assisters who could help with navigating compliance;
- Misunderstanding the basis for an exemption;
- Inability to access a medical professional to certify an exemption;
- Confusion about how to track qualifying activities; and
- Inability to access the system to find forms and records.

Stakeholders were concerned that these obstacles would cause the loss of Medicaid coverage for many beneficiaries, yet were certain most beneficiaries did not realize their coverage was at risk.

When beneficiaries were ultimately alerted to the potential loss of Medicaid coverage due to the WACER, the typical reaction among beneficiaries was described as “panic.” Beneficiaries were “really surprised to find out about this.” One stakeholder explained that many of those who would have lost coverage were likely not aware of the risk and would not have learned of their coverage loss until they sought out medical care.

If beneficiaries were terminated due to the WACER, they would be forced to reapply, causing additional administrative work for NH DHHS, stakeholders, and beneficiaries. Termination would also likely result in significant cost to the beneficiaries and unknowing providers due to the gap in coverage.

Interviewees indicated that the lack of awareness of requirements among beneficiaries and limited capacity of NH DHHS and community organizations to support beneficiaries meant that significant numbers of Medicaid beneficiaries would lose their coverage due to these requirements. One stakeholder alleged that proponents of the work requirement made it seem as though the requirements would be easy to meet when, in reality, compliance was difficult, if not unattainable, for many reasons. Stakeholders believed the number of people who would be displaced if the WACER were implemented would be considerably higher than originally estimated.

Community Organizations Invest Time and Resources to Support Beneficiaries with WACER Requirements

Investment in Staff Time Required for WACER Preparation

While NH DHHS facilitated a range of educational sessions on the WACER, stakeholders expressed alarm at the number of questions from community organizations that remained unanswered even after the WACER’s effective date. The implementation timeline was short, and despite best efforts, the many complications, changes, and unanswered questions caused uncertainty and confusion.

Some stakeholders were caught off guard when the WACER was approved in May 2018, because CMS had previously denied NH’s application for a work requirement. To complicate matters, during the WACER planning and implementation period, the legislature was still debating Medicaid expansion reauthorization, the Medicaid expansion population was moving from NHHPP PAP to the Granite Advantage Program and into managed care, and the managed care program was in re-procurement, meaning that there would be new MCOs with different contract terms.

Community organizations did not have time to consider all the implications of these simultaneous changes to the Medicaid expansion program. Stakeholders expressed concern

that there was too much change going on for providers or beneficiaries to make sense of and for which they could appropriately prepare. Beneficiaries were receiving notices about transitioning to managed care, about new MCOs, and about the WACER over the course of a few months.

In order to stay abreast of all the changes, community organizations undertook a wide range of activities, including reviewing materials published by DHHS and others; attending legislative hearings about the WACER provisions during several legislative sessions; and participating in public hearings on the waivers, administrative rules hearings, public information sessions, and other educational events hosted by stakeholders to learn about the WACER and provide feedback.

The WACER's regulatory uncertainty itself caused confusion. As noted, the implementation date was delayed several times. The Commissioner's temporary suspension of the WACER to September 2019 brought about a sense of relief for community organizations. However, the delay also caused confusion about next steps. While one interviewee mentioned that some providers assumed the legal challenges would delay the WACER, most community organizations felt compelled to prepare for WACER to the best of their ability. Interviewees explained that their organizations could not stop preparing based on a hope the WACER would be suspended; as one said, "every health center wanted to be ready." Therefore, preparation activities were happening in earnest across community organizations, despite the uncertainty in the environment.

Investment in Technology and Resources

Interviewees, particularly service providers, felt that they lacked specific information about which of their patients was subject to WACER; this information would have allowed them to be more proactive and better prepared to support beneficiaries.

Identifying the beneficiaries who were going to need assistance with the WACER was a difficult, if not impossible, task. One provider interviewee reported devoting hundreds of hours of employee time to categorizing the benefit status of their Medicaid patients (estimated at almost 5,000 individuals) because patient status was not provided by the NH DHHS. Such categorization required staff to review patient records and diagnoses to determine who might be in the Granite Advantage program, what their WACER compliance might be and whether they might be "exempt."

Interviewees reported reviewing enrollment databases and hundreds of medical records to potentially identify and reach out to Granite Advantage members to provide information about the WACER and offer support. These manual review processes were time-consuming and incomplete. Despite these challenges, interviewees expressed a sense of duty to help notify beneficiaries of the WACER and to help explain the requirements. In the view of one interviewee, it was "critically important for this population [Medicaid beneficiaries] to really

have someone who can help them navigate all of these new changes and responsibilities in order to keep their benefits.”

Interviewees felt there was a need for additional clarity for beneficiaries about the notices and forms provided by DHHS. Interviewees explained that their organizations invested substantial time and effort trying to educate patients about the WACER and supporting compliance. For example, community organizations reworded and republished WACER materials and notices into easier-to-understand language.

One health care provider explained that a large proportion of their clients are non-Anglophones, making it difficult or impossible for them to understand the letters and notices sent by NH DHHS despite information about free language assistance services included in the notices. Multiple languages are spoken throughout NH, particularly in urban areas. Community organizations invested significant time and effort helping clients understand these materials by using bilingual employees, external interpreters, or translation software, all at additional expense. Community organizations scheduled regular follow-up meetings with patients about WACER documentation and helped provide supports for employment services like résumé-building and application submission.

All the review, education, and support activities required existing staff to perform additional duties and/or required the hiring of additional staff. This staff investment was not resourced externally, and community organizations had to absorb the costs for this work. As one interviewee pointed out, NH DHHS did not provide additional resources to community organizations for additional staff or time for these purposes, “...but it’s got to get done” despite the burden on staff. Interviewees noted that the work was spread across a range of people, including administrative staff, community health workers, case managers, and interpreters. Another interviewee mentioned the possibility that if the rules were implemented fully, their organization would be forced to hire dedicated staff to help people navigate the new system, and another mentioned that they would need to continue retraining numerous staff members.

Personnel costs were not the only WACER-related investment for community organizations. Interviewees explained they would need to:

- Modify their information technology (IT) infrastructures to more readily produce information for reporting,
- Continue to develop informational materials for beneficiaries and disseminate messages through websites, social media, and other messages, and
- Invest in modifications to electronic health records or administrative IT systems to create and accommodate forms for attestation or compliance, as well as how to track an individual’s health coverage suspension or termination status and associated billing changes.

Most community organizations had spent dollars to prepare and were budgeting for the future implementation phase of the WACER.

Supporting Beneficiaries in Certification and Documentation Process

Stakeholders noted that the WACER exemption and “good cause” exception categories were complicated. The wide range of possibly valid reasons for an exemption complicated the task of discerning patients who were or were not exempt. For instance, a beneficiary who was a caregiver might qualify depending on the type of care they were providing and to whom. One interviewee noted that their employees felt a “lack of clarity or any sort of predictability about whether someone will be exempt or not.” Another felt that it might be necessary to have attorneys do a full, comprehensive view of the applicable regulatory text to be confident in knowing when exemptions applied to a specific beneficiary.

Most exemptions also required professional certifications. Therefore, a social service organization might provide supports to a beneficiary but not be qualified to certify the patient’s illness or need for hospitalization, or the disability of the patient’s dependent. The exemption forms were complicated and required supporting paperwork and certifications; therefore, some stakeholders were going above and beyond to aid beneficiaries by logging on with clients to NH DHHS portals in order to fill out forms. According to one interviewee, this raised concerns about compliance with HIPAA and whether providers should be able to access this level of personal information.

Finding a professional to certify an exemption presented numerous complicating issues. Community organizations expressed concern about the ethical quandary for medical professionals, who might need to reconcile diagnosing patients as “medically frail” while working with them on treatment plans that may appear to contradict a designation of frail. One interviewee described this as a threat to the patient-provider relationship and “not a good position for the healthcare provider.” One stakeholder described a case where the patient’s physician cited organizational policy to *not* certify frailty. In another case, a physician refused to declare the patient “medically frail” based on his ability to walk. One patient’s process to certify medical frailty took approximately four months, required significant patient and medical professional involvement, and created a risk of non-compliance for the patient.

Loss of revenue

An important concern to health care providers was the potential of lost revenue from patient care provided to beneficiaries who lost coverage because they did not meet the WACER. As one interviewee put it, “if people lose their benefits and we continue to provide care, then we don’t get paid and ultimately the program isn’t sustainable.” Another mentioned that continuing treatment for those who lose Medicaid coverage would result in fewer available dollars for non-Medicaid patients. One interviewee expressed concern that some sub-populations of Medicaid beneficiaries, such as those with substance use disorders, would be

particularly unable or unwilling to consistently provide paperwork verifying their fulfillment of the WACER, including being in a treatment program.

One interviewee estimated significant lost revenue in uncompensated care based on the population estimated to lose coverage if the requirements were to be implemented. This amount did not include those who simply decided not to access care out of fear they might not comply with the requirements. Another expressed concern that the government would retroactively recoup Medicaid funds from providers if the patient was later found to have not been in compliance with the WACER at the time of service.

The WACER's "suspended" designation for people who were not meeting the requirements but not yet disenrolled from Medicaid caused significant uncertainty to stakeholders. One interviewee noted that other states with work requirements simply terminated beneficiaries who failed to comply. However, in New Hampshire, those who were noncompliant with the WACER went into "suspended" status, and beneficiaries had an ability to "cure."

Although well-intended, the ambiguity of the "suspended" status presented unique difficulties. First, the status of any beneficiary was difficult to verify. One provider noted that there is a lag in their knowledge of a patient's eligibility for Medicaid that would delay alerting them for up to forty-five days after a patient fails to comply with requirements. Second, certain organizations, such as Federally Qualified Health Centers, are supported by grants and resources that in some cases may not be used to supplant Medicaid, making it decidedly unclear how to help "suspended" Medicaid beneficiaries who technically remain recipients of Medicaid support but lack access to Medicaid benefits. One interviewee reported receiving an advisory opinion from the federal government that health centers may use grants to pay for "suspended" individuals, but the interviewee had no formal legal notice to reassure them.

Stakeholders reported hearing a considerable amount of concern and generalized fear among beneficiaries about the WACER. Interviewees noted that the number of enrollees in the Granite Advantage program had declined during the first few months of 2019, but believed the decline was not due to an improving economy. Instead, stakeholders speculated, based on anecdotal evidence, that people were hesitant to enroll in health insurance coverage of any kind, or even access services, out of fear of the WACER. Another interviewee reported having heard that potential beneficiaries have conflated the WACER with proposed changes to the "public charge" rule announced in August 2019,⁷⁵ while another said the beneficiaries lack an understanding of the legal aspect of these developments and the state has not provided them with clear answers.

Survey of Community Stakeholders

A survey of community providers was conducted in the fall of 2019. The survey addressed major areas identified in the qualitative interviews: understanding of the work requirement; sources of information for learning about the work requirement; activities to prepare and

support members for the WACER; training of staff for the WACER; assistance with enrollment, documentation, frailty, exemption, and exception; and other impacts. The survey also inquired about the interviewee's knowledge of the temporary suspension and the legal challenge to the WACER.

The survey link was distributed in several ways. Several community provider organizations distributed the invitation and link to the survey via email to their members, including:

- Bi-State Primary Care
- NH Behavioral Health Association
- NH Hospital Association
- NH Medical Society

Invitations to participate in the survey were sent directly to the Aging and Disability Resource Centers, Easter Seals, Granite United Way, NH Legal Assistance, and Planned Parenthood. The survey invitation included a request for the recipient to distribute the survey to other relevant organizations and people.

A total of 18 respondents completed the survey. The respondents represented a broad mix of organizations; almost 70% were from community health centers or community mental health centers. Most commonly, the person responding to the survey was an administrator. Respondents indicated that they served members from all counties in NH.

Knowledge of and Readiness for the WACER

Overall, respondents to the survey felt that they generally understood the WACER program. Most (over 83%) responded that they completely or mostly understood the WACER, and the remainder understood "only a little." The survey asked respondents if there were specific parameters of the WACER that they did *not* understand. Respondents indicated they understood the population to whom the WACER applied but, mirroring the areas of confusion described in the qualitative interviews, stakeholders most commonly did not understand the WACER documentation requirements for work hours, community engagement hours, exemptions, and exceptions.

Table 1. Reported Knowledge Gaps for Selected Aspects of the NH WACER Program

	Count
Population to whom the requirement applied	1
What counts for work hours	2
What counts for community engagement hours	3
How to document work hours	5
How to document community engagement hours	4
What qualified for an exemption	2
Who qualified for an exemption	3
How to document an exemption	4
Who qualified for a “good cause” exception	4
How to document a “good cause” exception	5

Although there were a lot of changes to the WACER over the course of its implementation, most respondents reported that they were aware of the milestone events in WACER:

- 94% were aware of the March 1, 2019 effective date
- 100% were aware that the WACER was suspended from June 1 to September 1, 2019
- 89% were aware that a Federal Court decided to prohibit the WACER in July 2019

The survey also asked about what sources of information the community providers used to learn about the WACER and its regulatory milestones. Press coverage was commonly cited as a source of information for all events. Community organizations often relied upon their professional associations for information, as well as NH DHHS website posts, notices sent directly to provider and advocacy organizations, and community information sessions.

Table 2. Awareness of Selected Milestones of the NH WACER Program

	WACER Effective date of March 1	Suspension of WACER from June-September	Court Decision in July
NH DHHS notice to your organization	7	4	4
NH DHHS public notice	11	7	4
Press coverage	10	13	11
NH Legislative hearing	3	1	0
Society or association (e.g., hospital association, Medical Society, etc.) newsletters	7	7	7
Information sessions hosted by NH DHHS	12	1	0
Information sessions hosted by another organization - Please specify:	0	1	1
Other - Please specify:	0	1	2

Preparing for the WACER

During the spring and summer of 2019, the majority of survey respondents indicated that their organizations were prepared to support the beneficiaries they served in WACER compliance. Over 66% were completely or mostly ready, 28% were not ready at all, and almost 6% were not sure. Community organizations undertook a wide variety of activities in preparation for the WACER. Similar to what was reported in the qualitative interviews, the most common activities reported by the community organizations focused on internal training (for themselves and their staff); providing group and individual outreach and education to beneficiaries and their families; and developing, translating, and messaging print and social media materials for beneficiaries and family members.

Table 3. Reported Activities Completed to Prepare for NH WACER

	Count
Educating yourself about the WCE	16
Training your organization’s staff	14
Modifying your information technology systems	2
Developing or providing educational sessions for beneficiaries, patients, family members, etc.; OR Individual correspondence to beneficiaries, patients, family members, etc.; OR Individual in-person outreach to beneficiaries, patients, family members, etc.	17
Development of print materials for patients, family members, etc.; OR Translation of materials from DHHS into additional languages; OR Development of messaging for social media communication;	16

Providing training to staff was a common activity among survey respondents. Given the complexity of the program, the trainings included a range of topics, such as: who was subject to WACER, the exemption process, what work and community engagement activities counted toward the requirement and how to count and document work and community engagement hours, and resources to find more information.

Table 4. Training Topics to Prepare for NH WACER

	Count
Who is subject to the requirement	12
What types of activities meet the work and community engagement requirement	9
How to calculate work and community engagement hours	6
How to document work and community engagement activities	8
The exemption process	11
The “good cause” exception process	8
How to find answers to questions	9

WACER Implementation and Beneficiary Assistance Activities

Although the WACER implementation was suspended just prior to any beneficiary having to document hours in order to maintain coverage, community organizations prepared themselves and supported beneficiaries in many ways as the program began. Given the early nature of the program, most of the activities reported by survey respondents focused on enrollment of people who were subject to WACER, assisting people with information to understand the program and the milestone events in implementation, and assisting in documentation. More specifically:

- 86% indicated enrolling people subject to WACER during the March-July 2019 timeframe (when the requirement was active)
- 94% assisted individuals by providing them with information for WACER
- 62% assisted individuals with documenting a medical frailty exemption for WACER
- 37% assisted individuals with documenting a good cause exemption for WACER
- 62% assisted individuals with understanding the continuance of WACER in July 2019
- 37% assisted individuals with understanding the result of the court order in August 2019

Community organizations were following the WACER developments closely, preparing their organizations for the WACER, and trying to support their patients and clients. Because of their knowledge of the WACER, survey respondents were asked to identify their top concerns with the WACER. The top 3 responses in the survey mirrored the primary issues identified in the qualitative interviews:

- “The confusion about the requirements among the population we serve” was the top concern for half and was among the top 3 concerns for 17 of 18 of the respondents.
- “The amount of uncompensated care” was the top concern for 7 and was among the top 3 concerns for 13 of 18 respondents.
- “The staff work involved in supporting beneficiaries, patients, family members, etc. in understanding the WACER” was among the top 3 choices for 12 of 18 respondents.

Quantifying the Impact

While the direct estimation of costs incurred is limited, the community organizations reported using a significant amount of resources to prepare their organizations and beneficiaries for the WACER, through a wide range of tracking, educational, outreach, and implementation activities.

The survey included several questions that sought to better quantify the impact of the WACER program on community organizations. The few number of responses to these questions limit the utility of the information collected around quantitative financial impact. However, community providers were clear in their interviews that they did not receive direct funding for the significant activities they undertook to prepare themselves and their beneficiaries for the

WACER. Supporting beneficiaries was a critical need and, therefore, the community organizations expended their own resources to prepare.

The survey asked the respondents to estimate staff hours and money spent on the activities. Few respondents provided estimates for the number of staff hours or dollars spent on these activities. Among those who did, there were over 5,000 hours spent on WACER activities. Across the educational, training, and systems modifications, respondents estimated over \$100,000 in associated costs. Between all the activities related to WACER, respondents to the survey estimated directly assisting over 1,000 members with WACER compliance through enrollment assistance, information, educational activities, and support in completing forms or other documentation.

Known Implementation Expenses

In addition to the direct and indirect costs incurred by community organizations related to WACER implementation, DHHS incurred actual and anticipated administrative costs. Some of these costs to NH DHHS have been estimated and reported.

United States Government Accountability Office Audit

From August 2018 to September 2019, the United States Government Accountability Office (GAO) conducted a performance audit regarding the administrative costs of Section 1115 demonstrations with work requirements.⁷⁶ The GAO reviewed demonstrations in five states, including New Hampshire.⁷⁷ The GAO reviewed estimates of the federal and non-federal administrative costs over the course of the demonstration approval periods.⁷⁸ The GAO also received information on the actual expenditures the state had incurred, broken down by administrative activities, such as implementation and operation of IT systems, beneficiary outreach, and staff training.⁷⁹ The GAO interviewed Medicaid officials in each state to ask them about expected costs and actions they planned to take with regard to administrative activities.⁸⁰

New Hampshire estimated \$6.1 million to the GAO for their implementation activities.⁸¹ This estimate includes \$4.5 million for IT system and other contracts, and \$1.6 million for evaluation activities from 2019 to 2025.⁸² New Hampshire also planned to spend \$200,000 to \$300,000 in non-Medicaid funds for six case management positions for workforce development.⁸³

The GAO noted that estimates primarily reflected up-front costs and did not include all expected Medicaid costs.⁸⁴ In other words, New Hampshire did not estimate the ongoing expected costs to maintain the WACER. For example, although most of the selected states planned to use Managed Care Organizations (MCOs) or other health plans to help administer work requirements, New Hampshire did not estimate the anticipated costs to the MCOs to help administer work requirements.⁸⁵ New Hampshire also reported that they believed the

work requirement would increase certain non-Medicaid costs – costs that are not funded by federal Medicaid, but instead agencies, stakeholders, or individuals.⁸⁶

New Hampshire expected to receive a 90% federal match rate for most of the costs and leverage other federally funded programs to assist with work requirements.⁸⁷ New Hampshire used TANF funds and increased capitation payments for MCOs (see below) to help administer the work requirement. In total, from October 2017 through 2018, New Hampshire reportedly spent more than \$4.4 million in administrative expenditures to implement the WACER.⁸⁸ The GAO noted that “New Hampshire did not include expenditures they could not separately identify, such as certain beneficiary outreach expenditures.”⁸⁹

Table 3: Selected States’ Estimates of Administrative Costs and of Initial Expenditures for Implementing Medicaid Work Requirements

State	Estimated costs (dollars in millions)	Description of estimates of administrative costs and of initial expenditures
Kentucky	271.6	<ul style="list-style-type: none"> Estimate includes \$220.9 million in information technology (IT) costs for the Medicaid demonstration as a whole, including work requirements, for fiscal years 2019 and 2020, and \$50.7 million in payments for managed care organizations’ cost to administer work and other beneficiary requirements for the period of July 2018 through June 2020. Estimate does not include expected costs for evaluating work requirements. <p>Expenditures from application date (August 2016) through 2018: more than \$99.5 million.^a</p>
Wisconsin	69.4	<ul style="list-style-type: none"> Estimate includes \$57.3 million for beneficiary outreach, evaluation, and other services from July 2019 through June 2021, and \$12.1 million in fiscal year 2019 for IT systems changes for the Medicaid demonstration as a whole. <p>Expenditures from application date (January 2018) through 2018: None.^b</p>
Indiana	35.1	<ul style="list-style-type: none"> Estimate includes \$14.4 million for IT systems for fiscal years 2018 through 2021, and \$20.7 million for managed care organizations’ activities in 2019. Estimate does not include expected costs for evaluation. <p>Expenditures from application date (July 2017) through 2018: more than \$800,000.^c</p>
Arkansas	26.1	<ul style="list-style-type: none"> Estimate includes contracts in place from July 2017 through June 2019 for IT systems, beneficiary outreach, and other activities, such as data analysis. Estimate does not include expected costs for beneficiary notices and increased payments to qualified health plans. <p>Expenditures from application date (June 2017) through 2018: more than \$24.1 million.^d</p>
New Hampshire	6.1	<ul style="list-style-type: none"> Estimate includes \$4.5 million for IT system and other contracts in place from July 2018 through June 2019, and \$1.6 million for evaluation activities from 2019 through 2025. Estimate does not include all expected costs, such as increased payments to managed care organizations. <p>Expenditures from application date (October 2017) through 2018: more than \$4.4 million.^e</p>

Costs Reported by DHHS to Legislature During 2018- 2019

In New Hampshire, DHHS undertook considerable unbudgeted efforts to educate Granite Advantage members, providers, and other stakeholders regarding the WACER.⁹⁰ Beginning in the summer of 2018, DHHS held 11 public information sessions, ran radio advertisements for 8 weeks over 98 radio stations, ran advertisements over social media, made over 50,000 calls to members (where less than 10% of the calls were answered), held counseling sessions in each of the department’s 11 district offices, and sent four separates letters/notices to beneficiaries.⁹¹ During the summer of 2019, DHHS engaged in a door-to-door campaign where staff visited over 1,500 members’ homes. Staff made in-person contact in only 12% of the visits.⁹² These outreach expenses were not included in the GAO report.

After the WACER was suspended, the Commissioner of the NH DHHS informed legislators in two separate letters about estimated costs associated with the WACER implementation.

In a letter to Senator Bradley, Chair of the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, the Commissioner stated that DHHS had expended \$187,378.11 on “outreach activities” as of August 26, 2019.⁹³ These costs included outbound calling, sending out letters, and door-to-door activities.⁹⁴

Then-Commissioner Meyers was later asked to provide additional information on costs. In a letter to Senator Dan Feltes, Senator Cindy Rosenwald, and Representative Mary Jane Wallner dated October 24, 2019, the Commissioner informed them that “in addition to” the previously reported “outreach” costs, “there was a total of \$438,000 in general funds expended as the state match for changes to the New Heights Eligibility System.”⁹⁵ The Commissioner expected CMS to contribute \$3,944,997.11 as the federal match for the changes. The Commissioner noted that there was also an initial expenditure of \$32,307 in general funds for the CMS required program evaluation design (with a federal 50% match), and costs for additional mailings in February and March 2019 totaling \$56,430.⁹⁶ The Commissioner also informed the Senators that DHHS had expended \$391,219.88 of the TANF funds as beneficiary supports for the work requirement.⁹⁷

In total, the Commissioner reported spending approximately \$243,808.11 in additional outreach costs. Other states reported similarly engaging in robust educational campaigns to inform beneficiaries of work requirements, including letters, emails, text messages, social media posts and phone calls, along with direct outreach by health care providers, community groups and payers.⁹⁸ The GOA report coupled with New Hampshire’s own experience highlight just how much a state must invest in administrative, education and outreach costs and resources to implement the WACER.

MCO Assistance with Work Requirement Implementation

New Hampshire intended to use MCOs or other health plans to help administer the WACER and increase capitation payments for MCOs to help administer the new requirements, but the effort came too late, as the new MCO contracts did not go into effect until after the WACER was suspended.⁹⁹ New Hampshire did not report these costs to the GAO.

The new MCO contracts, effective September 1, 2019, specified the MCOs role in implementing the work and community engagement requirements.¹⁰⁰ Under section 4.3.2 of the contract, “[t]he MCO shall support the implementation and ongoing operations of the work and community engagement eligibility requirements for certain Granite Advantage Members.”¹⁰¹ This included general outreach and member education activities, identification of exempt or potentially exempt members, and status tracking and targeted outreach.¹⁰²

The contracts also provide specific guidance on how an MCO should:

- Inquire into the client’s awareness of the community engagement requirement, and then into whether they are aware of any exemptions;
- Explain how to satisfy the community engagement requirements, including the reporting requirements if reporting is necessary for the member;
- Participate and support “outreach and education initiatives related to work and community engagement requirements”;
- Provide the member assistance with “DHHS processes for reporting compliance, obtaining good cause or other exemptions,” and in the event the member contacts the MCO seeking to report his/her compliance, the MCO needs to help the member navigate the DHHS processes;
- Provide information on options for the member to satisfy the work requirement;
- Screen the member for all other bases of Medicaid eligibility;
- Analyze claims to assess member exemptions and notify DHHS of any Granite Advantage Members that the MCO identifies as potentially exempt; and
- Perform targeted outreach to members “identified by DHHS as ‘mandatory, non-compliant’” to ensure that the member’s coverage is not suspended or terminated.¹⁰³

The costs or potential success of these MCO implementation efforts were not clear, nor did the efforts materialize during the implementation of the WACER, leaving the burden of assisting beneficiaries on community organizations.

Summary

Community organizations incurred costs associated with educating their own staff and assisting clients with the WACER. These organizations were impacted not only by the time and resources it took to prepare, but also the potential disruption to coverage and care the WACER caused. In addition, community organizations and beneficiaries were confused by the many simultaneous changes to the Medicaid expansion program, resulting in fear and uncertainty about its impact.

Despite the significant efforts and resources devoted by NH DHHS to notify beneficiaries and explain the WACER to them, NH DHHS had no information on the compliance status of approximately 17,000 beneficiaries as of July 8, 2019.¹⁰⁴ In other words, of the 24,766 Granite Advantage beneficiaries who were subject to the requirement in June, 17,000 (roughly two-thirds) were out of compliance.¹⁰⁵ If the program had not been suspended in July, and the beneficiaries had still not reported compliance, these 17,000 individuals would be at risk of suspension from the program. This experience in New Hampshire is very similar to what occurred in Arkansas¹⁰⁶ and Kentucky when their work and community engagement requirements were in effect.¹⁰⁷

The impact of the WACER was evidenced by the large numbers of beneficiaries on track to lose coverage as of the effective date in New Hampshire, the costs to DHHS of implementing the WACER, and its impact on community organizations. Ultimately, “lack of coverage is associated with delays in seeking needed care, higher rates of chronic illness, and overall increased morbidity and mortality, as well as other negative consequences, such as higher medical debt.”¹⁰⁸ The impact on New Hampshire’s community organizations leading up to the implementation date alone were substantial, yet never predicted or fully assessed in the planning for and implementation of the WACER.

About the Authors

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Appendix: NH WACER Timeline

The New Hampshire Work and Community Engagement Requirements (the “WACER”) were adopted, approved, and modified over a period of years as part of New Hampshire’s Medicaid expansion program. To illustrate the complex regulatory history of the WACER and the corresponding impact on community providers, a reverse chronological timeline of the WACER, and the contemporaneous changes to the Medicaid expansion program are highlighted below:

- **May 20, 2020:** The U.S. Court of Appeals for the DC Circuit issues a summary decision in *Philbrick v. Azar* affirming the lower court’s decision setting aside the approval of New Hampshire’s work requirement. ([Philbrick v. Azar](#))
- **February 14, 2020:** The U.S. Court of Appeals for the DC Circuit issues a decision in *Gresham v. Azar* affirming the lower court ruling that set aside the approval of Arkansas’s work requirement. ([Gresham v. Azar](#))
- **December 16, 2019:** The administration of Kentucky’s newly sworn in Governor, Andy Beshear, notifies CMS that Kentucky is terminating its section 1115 demonstration project creating a work requirement and is no longer challenging the federal district court ruling setting aside its work requirement. ([Kentucky letter to CMS](#))
- **October 25, 2019:** New Hampshire and US DHHS appeal the decision in *Philbrick v. Azar* to the U.S. Court of Appeals for the DC Circuit. ([Philbrick v. Azar Docket Sheet](#))
- **October 11, 2019:** The U.S. Court of Appeals for the DC Circuit hears oral argument in *Stewart v. Azar* and *Gresham v. Azar*, the Kentucky and Arkansas cases on their Medicaid Section 1115 waiver experiments to establish work requirements. ([Oral Argument Recording](#))
- **September 1, 2019:** NH’s new Medicaid Managed Care Organization (MCO) contracts begin with AmeriHealth Caritas NH, NH Healthy Families, and Well Sense Health Plan. ([MCO Contracts](#))
- **August 8, 2019:** NH DHHS sends Granite Advantage members a letter notifying them that they no longer must comply with the work requirement due to the Federal District Court for the District of Columbia’s decision in *Philbrick v. Azar*. ([DHHS Granite Advantage Notification Letter](#))
- **July 29, 2019:** The Federal District Court for the District of Columbia grants summary judgment to the plaintiffs in *Philbrick v. Azar* and vacates the Secretary of HHS’s approval of NH’s work requirement. ([Philbrick v. Azar, 397 F.Supp.3d 11](#))
- **July 23, 2019:** Oral argument on pending motions in *Philbrick v. Azar*, which challenges the U.S. Department of Health and Human Services’ (“HHS”) approval of NH’s Granite Advantage 1115 Demonstration Waiver. ([Philbrick v. Azar Docket Sheet](#))
- **July 11, 2019:** DHHS sends a letter notifying Granite Advantage members that the work/community engagement requirement is temporarily suspended. ([DHHS WACER Temporary Suspension Letter](#))

- **July 8, 2019:** The Commissioner of NH DHHS, Jeffrey Meyers, notifies the Governor, Senate President, and Speaker of the House by letter that the work/community engagement requirement will be suspended from June 1, 2019 to September 30, 2019. ([Commissioner's Letter Temporarily Suspending WACER](#))
- **July 8, 2019:** Senate Bill 290, which amends the work/community requirement, is signed by the Governor. ([Final Version of Senate Bill 290](#) and [Bill Docket](#))
- **June 17, 2019:** NH DHHS sends a second reminder letter the week of June 17th to medically frail Granite Advantage members who have not yet submitted their medical frailty form. The letter explains that a medically frailty form is required to be exempt from the work/community engagement requirement. ([Reminder letter to those with employment hours](#) and [Reminder letter to those without employment hours](#))
- **June 1, 2019:** This begins the first month that non-exempt beneficiaries must comply with the work/community engagement requirement.
- **May 29, 2019:** DHHS submits the Granite Advantage Draft Demonstration Evaluation Design Document to the Centers for Medicare and Medicaid Services (CMS) as required by their Special Terms and Conditions # 39. ([NH Draft Evaluation Design Document](#))
- **May 17, 2019:** The Joint Legislative Committee on Administrative Rules (JLCAR) votes to approve the final Granite Advantage Health Care Program rule, He-W 837. ([JLCAR 5/17/19 meeting minutes #14](#))
- **May 13, 2019:** NH DHHS sends a letter to Granite Advantage members who are not exempt from the work/community engagement requirement reminding them that beginning in June 2019 they will need to complete 100 hours a month of qualifying activities. ([Reminder letter to those with employment hours](#) and [Reminder letter to those without employment hours](#))
- **April 29, 2019:** Date by which NH DHHS must submit a Monitoring Protocol to CMS according to the NH Granite Advantage Health Care Program 1115 demonstration waiver special terms and conditions. ([CMS November Special Terms and Conditions, 29](#))
- **April 25, 2019:** The U.S District Court for the District of Columbia grants NH DHHS's Motion to Intervene in *Philbrick v. Azar*, which challenges HHS's approval of NH's Granite Advantage 1115 Demonstration Waiver. ([Philbrick v. Azar Docket Sheet](#))
- **April 17, 2019:** The Governor and Executive Council vote to authorize amendments to NH DHHS's agreements with the three MCOs – NH Health Families, Well Sense Health Plan, and AmeriHealth Caritas NH to change the program start date and price. ([Governor and Executive Council 4/17/19 minutes, #9](#))
- **April 2, 2019:** NH DHHS sends reminder letters to medically frail Granite Advantage beneficiaries who have not yet submitted their medical frailty form. The letter reminds them that submission of the form is necessary to be exempt from the work/community engagement requirement. ([Reminder letter to medically frail members](#))
- **March 27, 2019:** The Governor and Executive Council vote to authorize NH DHHS's request to enter into agreements with three MCOs – NH Healthy Families, Well Sense

Health Plan, and AmeriHealth Caritas NH – to provide health care services to Medicaid participants through NH Medicaid Care Management. ([Governor and Executive Council 3/27/19 minutes, # A](#))

- **March 27, 2019:** The Federal District Court for the District of Columbia issues a decision in *Gresham v. Azar* setting aside Arkansas’s work and community engagement requirement ([Gresham v. Azar](#)) and in *Stewart v. Azar* setting aside Kentucky’s work and community engagement requirement for a second time ([Stewart v. Azar](#)).
- **March 20, 2019:** The National Health Law Program, joined by New Hampshire Legal Assistance and the National Center for Law and Economic Justice, file a complaint, captioned *Philbrick v. Azar*, in the Federal District Court for the District of Columbia challenging the U.S. Department of Health and Human Services’ approval of NH’s Granite Advantage 1115 Demonstration Waiver. ([Philbrick v. Azar Complaint](#))
- **March 5, 2019:** NH DHHS holds a public hearing on the NH Granite Advantage Health Care Program Rule, He-W 837. ([Rescheduling of Rulemaking Hearing](#))
- **March 1, 2019:** Work/community engagement requirement takes effect in NH.
- **February 28, 2019:** Date by which DHHS must submit its Granite Advantage Health Care Program Implementation Plan to CMS. ([CMS November Special Terms and Conditions, 24\(v\), 28](#))
- **February 26, 2019:** NH DHHS mails notices indicating members’ community engagement status, including information about what members need to do to meet the work/community engagement requirement beginning June 1, 2019 and how to request an exemption. ([Letter to mandatory to participate members](#), [Letter to mandatory to participate and previously reported as medically frail members](#), [Letter to participate but subject to another work requirement members](#), [Letter to exempt from participating members](#))
- **February 20, 2019:** The Governor and Executive Council vote to table NH DHHS’s request to enter into agreements with three MCOs to provide health care services to Medicaid participants through NH Medicaid Care Management. ([Governor and Executive Council 2/20/19 minutes, #A](#))
- **February 15, 2019:** JLCAR votes to approve the interim Granite Advantage Health Program Rule, INT 2018-26, and recommends that the Director of the Office of Legislative Services accept changes. ([JLCAR 2/15/19 minutes, #4](#))
- **February 5, 2019:** NH DHHS sends notification to Granite Advantage Health Care Program members that the work/community engagement start day has changed from January 1, 2019 to March 1, 2019. ([Letter to members](#))
- **January 18, 2019:** JLCAR postpones review of the revised interim Granite Advantage Health Care Program Rule, INT 2018-26. ([JLCAR 1/18/19 Agenda, #11\(a\)](#))
- **January 16, 2019:** Commissioner Meyers sends notification to CMS that NH’s work/community engagement requirement will begin on March 1, 2019. ([Letter from Comm’r Meyers to CMS](#))

- **January 9, 2019:** NH DHHS submits a revised proposed interim Granite Advantage Health Care Program Rule, INT 2018-26, to JLCAR. ([Comm'r Meyers letter to JLCAR and revised proposed interim rule](#))
- **January 7, 2019:** DHHS continues the public forums on the Granite Advantage Health Care Program begun in Conway on December 5, 2018. Forums are scheduled throughout January in Concord, Colebrook, Laconia, Littleton, Claremont, Portsmouth, and Keene. ([Jan. Public Forum Schedule at 34](#))
- **January 1, 2019:** Pursuant to statutory language creating the NH Granite Advantage Health Care Program, this is the latest date the NH DHHS Commissioner may submit a plan for the implementation of a fully automated verification system to assess all work/community engagement activities by July 1, 2020. ([Senate Bill 313, RSA 126-AA:2 IV\(c\)](#))
- **January 1, 2019:** Granite Advantage Health Care Program begins. The New Hampshire Health Protection Program (NHHPP) terminates and all participants transition to coverage from one of the state's Medicaid Care Management Plans. ([DHHS Notice](#))
- **December 31, 2018:** The NHHPP Premium Assistance section 1115 demonstration, a PAP program, sunsets. ([NHHPP Special Terms and Conditions](#))
- **December 28, 2018:** Commissioner Meyers sends a letter to the Governor, Senate President and Speaker of the House providing notice that there are differences between RSA 126-AA:2, IV, the statute authorizing the Granite Advantage Health Care Program, and the section 1115 demonstration waiver approved by CMS. ([Comm'r Meyers letter to Gov. Sununu, Sen. Pres. Soucy, and Speaker Shurtleff](#))
- **December 24, 2018:** DHHS submits the amended interim Granite Workforce Pilot Program rule to JLCAR and, following confirmation by the Office of Legislative Services that the rule had been amended as conditionally approved, the interim rule is approved. ([1/18/19 JLCAR Agenda](#)).
- **December 20, 2018:** JLCAR reviews two proposed interim rules related to the Granite Advantage Health Care Program JLCAR. JLCAR objects to the NH Granite Advantage Health Care Program rule and conditionally approves the Granite Workforce Pilot Program rule. ([12/20/18 JLCAR Agenda, 13\(b\) & \(c\)](#))
- **December 6, 2018:** NH accepts the CMS Special Terms and Conditions for the Granite Advantage Health Care Program 1115 Demonstration Waiver. ([Comm'r Meyers letter to CMS](#))
- **December 5, 2018:** DHHS holds a public forum in Conway to introduce the Granite Advantage Health Care Program. ([Granite Advantage Public Forums Presentation](#))
- **December 1, 2018:** Deadline set by SB 313 for CMS approval of the Granite Advantage Health Care program 1115 demonstration waiver extension application and the Alternative Benefit Plan state plan amendment. If CMS does not approve all waivers necessary for the program by this date, the program will be terminated. ([SB 313, RSA 126-AA:2\(d\)](#))

- **November 30, 2018:** CMS approves NH's Granite Advantage Health Care Program 1115 Demonstration Waiver, including the work/community engagement requirement and the elimination of the 90-day retroactive coverage permission. The citizenship requirement and asset tests are not approved. ([CMS Approval Letter](#) and [Special Terms and Conditions](#))
- **August 30, 2018:** NH DHHS issues a Request for Proposals for Medicaid Care Management Services for July 1, 2019 through June 30, 2024. ([DHHS MCM Services RFP](#))
- **August 7, 2018:** Approximate deadline by which NH DHHS must submit to CMS an eligibility and enrollment monitoring plan pursuant to the NHHPP Waiver STCs. ([CMS May 2018 STC #48q](#))
- **July 23, 2018:** Governor Sununu submits NH's waiver application to CMS to amend the current NHHPP demonstration waiver to create the Granite Advantage Health Care Program and to extend the State's demonstration. ([Letter from Gov. Sununu to Secretary Azar](#) and [Granite Advantage 1115 Waiver Amendment and Extension Application](#))
- **June 30, 2018:** Deadline set by SB 313 for NH DHHS to submit to CMS its 1115(a) Waiver Extension Application and its Title XIX State Plan Amendment. ([SB 313, RSA § 126-AA:2, I\(d\)](#))
- **June 28, 2018:** Effective date of the statute creating the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program. ([RSA 126-AA:4](#))
- **June 29, 2018:** Deadline for submission of written public comments to NH DHHS on the Granite Advantage Health Care Program 1115 waiver demonstration extension application, including a work/community engagement requirement. ([Public Notice](#) and [Updated Public Notice](#))
- **June 7, 2018:** Deadline for submission of written public comment to NH DHHS on the Title XIX State Plan Amendment to update the Medicaid Alternative Benefit Plan that will be provided to the Medicaid new adult group. ([Public Notice](#))
- **June 5, 2018:** DHHS hosts a public hearing on the Granite Advantage Health Care Program in Concord, NH. ([Updated Public Notice](#))
- **May 24, 2018:** DHHS hosts a public hearing on the Granite Advantage Health Care Program in Nashua, NH. ([Updated Public Notice](#))
- **May 14, 2018:** DHHS hosts a public hearing on the Granite Advantage Health Care Program in Concord, NH and presents at MCAC Meeting, where public comment is also accepted. ([Updated Public Notice](#))
- **May 10, 2018:** The Senate concurs with House amendments to SB 313, effectively continuing Medicaid expansion, but extending coverage for the new adult group. The statute terminates the NHHPP, effective upon expiration of the PAP waiver, and creates the Granite Advantage Health Care Program. The Granite Advantage Health Care Program will begin on January 1, 2019 if CMS approves the 1115 demonstration waiver and will include a work/community engagement requirement. The bill includes an asset test and a citizenship requirement. ([Version adopted by both parties as of 5.10.18](#), and [Enrolled Bill Amendment dated 5.25.18](#))

- **May 8, 2018:** NH DHHS issues a notice to amend its Title XIX State Plan to update the Medicaid Alternative Benefit Plan that will be provided to the Medicaid new adult group reflecting legislative changes. ([State Plan Amendment Notice](#))
- **May 8, 2018:** NH DHHS issues a notice to amend its waiver in order to discontinue the NHHPP and implement the Granite Advantage Health Care Program, providing Medicaid coverage to the expansion population through managed care with a work/community engagement requirement. ([Public Notice](#))
- **May 7, 2018:** CMS approves NH's waiver including the work/community engagement requirement and makes approval of the elimination of retroactive coverage contingent upon future data submission and a determination by CMS. Implementation may begin no sooner than January 1, 2019. ([CMS Work/Community Engagement Approval Letter](#) and [Special Terms and Conditions for Work/Community Engagement Requirement](#))
- **May 2, 2018:** The Executive Council authorizes NH DHHS to engage in enhancements to the New HEIGHTS system in order to facilitate the Granite Advantage program enrollment and verification including for the work/community engagement requirement including a contract renewal increasing the price limitation by \$17 million and a contract amendment to implement enhancements including the work requirement by \$33,54,971 through June 30, 2020. ([5/2/18 Executive Council Consent Calendar #43](#))
- **April 9, 2018:** The Commissioners for the Departments of Information Technology and Health and Human Services send to the Governor a contract renewal request for continued maintenance of the New HEIGHTs system and a contract amendment to implement necessary enhancements to the New HEIGHTs system. ([4/9/18 Letter](#); [5/2/18 Executive Council Consent Calendar #43](#))
- **January 12, 2018:** CMS approves Kentucky's 1115(a) demonstration project waiver with an 80 hour per month work/community engagement requirement for adult beneficiaries ages 19 to 64, with exemptions for various groups. Kentucky is the first state to receive approval for a work/community engagement requirement. ([Kentucky Approval Letter from CMS](#))
- **January 11, 2018:** In a letter to state Medicaid Directors, CMS announces a new policy that supports 1115(a) demonstration projects where participation in work/community engagement is a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries. ([CMS Letter to State Medicaid Directors, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries](#))
- **October 24, 2017:** NH submits an application to CMS to amend the NHHPP demonstration to promote work/community engagement opportunities for the NH Health Protection population. ([NH Work/Community Engagement application](#))
- **September 29, 2017:** Deadline for submission of written public comments to NH DHHS on the NHHPP Premium Assistance Demonstration waiver application. ([NH Work/Community Engagement application](#))

- **September 21, 2017:** NH DHHS hosts a public hearing on the NHHPP Premium Assistance Demonstration waiver application in Concord. ([NH Work/Community Engagement application](#))
- **September 14, 2017:** NH DHHS hosts a public hearing on the NHHPP Premium Assistance Demonstration waiver application in Manchester. ([NH Work/Community Engagement application](#))
- **August 30, 2017:** DHHS releases a draft amendment to the PAP including a work/community engagement requirement. At that time, 51,924 individuals were covered as part of the NHHPP, including 41,392 in QHPs and 7,093 in managed care plans as medically frail or opt-outs. ([DRAFT NHHPP Premium Assistance Project Demonstration Waiver](#))
- **June 28, 2017:** The Governor signs HB517 into law as the trailer bill to the biennial budget for SFY 19-SFY20. HB 517 includes a provision that requires NH DHHS to seek a waiver or state plan amendment from CMS in order to establish certain work/community engagement requirements as conditions of eligibility in the NHHPP. ([HB 517 Docket](#) and [RSA § 126-A:5, XXX\(a\)\(1\) Commissioner of Health and Human Services](#))
- **January 20, 2017:** Donald J. Trump becomes President.
- **January 5, 2017:** Christopher T. Sununu becomes Governor of NH.
- **November 1, 2016:** CMS approves other parts of the amendment submitted on August 10, 2016 but does not approve the work/community engagement requirement and citizenship documentation requirement. ([November 1, 2016 Letter](#)).
- **August 10, 2016:** NH DHHS seeks an amendment from CMS to the NHHPP Section 1115(a) Demonstration Waiver that, for newly eligible adults, includes a work/community engagement requirement of 30 hours per week and a citizenship documentation requirement. ([1115\(a\) Demonstration Amendment Application](#))
- **April 5, 2016:** The NH Legislature reauthorizes the NHHPP through December 2018 (HB 1696) with 100% federal funding continuing through December 31, 2016. HB 1696 includes a work and community engagement requirement for the first time. At this time CMS has never approved a work/community engagement requirement. ([Version adopted by both bodies as of 3.31.16](#);, and [Enrolled Bill Amendment as of 4.4.16](#))
- **January 1, 2016:** The new adult group transitions to the NHHPP PAP. Newly eligible adults enroll in approved qualified health plans offered by health insurance carriers offering coverage on NH's Insurance Marketplace Exchange. ([NHHPP Special Terms and Conditions](#))
- **March 4, 2015:** CMS approves NH's mandatory individual Premium Assistance Program requiring the new adult group to enroll in Qualified Health Plans through New Hampshire's Marketplace Exchange, with contingent approval granted through December 31, 2018. ([1115\(a\) Demonstration Approval Letter](#) and [NHHPP Special Terms and Conditions](#))
- **November 20, 2014:** NH submits to CMS its 1115(a) Demonstration Waiver for the qualified health plan Premium Assistance Program under the NHHPP. ([1115\(a\) Waiver Application](#))

- **August 15, 2014:** Coverage becomes effective for the newly eligible adult group ages 19-64 (new adult group) with incomes between 0-138% of the Federal Poverty Level enrolling in the managed care “bridge” Alternative Benefit Plans offered by 3 MCOs. The ABPs include individual cost-sharing responsibilities and a substance use disorder benefit. ([Profile of Managed Care in NH](#))
- **July 1, 2014:** NH’s NHHPP goes into effect. ([Profile of Managed Care in NH](#)))
- **March 27, 2014:** Governor Maggie Hassan signs SB 413 into law, which establishing the NHHPP to expand health coverage in NH for adults with incomes up to 133% of the Federal Poverty Level. The NHHPP includes 1) a mandatory Health Insurance Premium Payment Program for individuals with access to cost-effective employer-sponsored insurance, 2) a bridge program to cover the new adult group in Medicaid managed care plans through December 31, 2015, and 3) a mandatory individual qualified health plan premium assistance program beginning on January 1, 2016. Until January 1, 2017, the cost of benefits would be paid with 100% federal funds. The legislation requires DHHS to file a premium assistance program waiver and gain CMS approval by March 31, 2015. ([Version adopted by the General Court as of 3.25.14](#) and [enrolled bill amendment on 3.26.14](#))
- **July-September 2013:** The Commission to Study Expansion of Medicaid meets and ultimately recommends expanding Medicaid based on a public-private premium assistant program like Arkansas. E.g., NHID Presentation - https://www.nh.gov/insurance/consumers/documents/nhid-medexpres_07.30.13.pdf
- **January - June 2013:** NH General Court fails to pass legislation authorizing the expansion of Medicaid consistent with the Affordable Care Act opportunity to fund such expansion beginning January 1, 2014. As part of New Hampshire’s 2014–2015 state budget, a bipartisan committee called the Commission to Study Expansion of Medicaid Eligibility is formed. [2014-2015 NH budget bill](#)

¹ The federal government provided 100% federal financing for those up to 138% FPL made newly eligible for Medicaid under the Affordable Care Act's Medicaid expansion offer. The federal match rate (FMAP) fell to 95% in 2017, 94% in 2018, 93% in 2019, and then 90 percent in 2020 and beyond. The newly eligible low income adult population will be referred to herein as the "Medicaid expansion population."

² See Section 1115 of the Social Security Act, 42 U.S.C. § 1315.

³ New Hampshire Medicaid Enrollment Demographic Trends and Geography for March 2019, <https://www.dhhs.nh.gov/ombp/medicaid/documents/medicaid-enrollment-04022019.pdf>.

⁴ Letter from Commissioner Jeffrey Meyers to Governor Sununu, et al, (July 8, 2019). The suspension was authorized by Senate Bill 290 (2019), which was codified at RSA 126-AA:2, X.

⁵ *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020); <https://law.justia.com/cases/federal/appellate-courts/cadc/19-5094/19-5094-2020-02-14.html>

⁶ Letter from Brian Neale to State Medicaid Directors (Jan. 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

⁷ *Id.*

⁸ SB 413-FN-A (adopted March 26, 2014), codified at RSA 126-A:5, XXII-XXVI, https://gencourt.state.nh.us/legislation/2014/SB0413_HOTP.html. Although the Patient Protection and Affordable Care Act ("ACA") expands coverage to 133% of the federal poverty level, the ACA also establishes a 5 percent disregard for program eligibility, which extends coverage to those persons up to 138% of the federal poverty level. To be consistent with the presentations and publications from NH DHHS, the 133% figure is used throughout this paper.

⁹ *Id.*

¹⁰ Managed Care in New Hampshire, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/new-hampshire-mcp.pdf>.

¹¹ *Id.*

¹² New Hampshire 1115(a) Demonstration Waiver for Premium Assistance at 1 (Nov. 20, 2014), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-pending-app-11202014.pdf>; see also <https://www.macpac.gov/wp-content/uploads/2015/07/New-Hampshire-Medicaid-Expansion-Waiver.pdf>.

¹³ New Hampshire 1115(a) Demonstration Waiver for Premium Assistance at 18–19 (Nov. 20, 2014).

¹⁴ Letter from Andrew Slavitt to Commissioner Nicholas Toumpas (Mar. 4, 2015), https://www.dhhs.nh.gov/pap-1115-waiver/documents/pa_approvalletter.pdf.

¹⁵ *Id.*

¹⁶ RSA 126-A:5, XXIII-XXV (2014).

¹⁷ HB 1696 (2016), codified at RSA 126-A:5, XXX (2016), https://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2016&v=SP&id=795.

¹⁸ Section 1115 Demonstration Waiver Amendment – NHHPP (Aug. 10, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-state-application-081016.pdf>.

¹⁹ Letter from Vikki Wachino to Jeffrey Meyers Commissioner (Nov. 1, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf>.

²⁰ HB 517, Chapter 156, Laws of 2017, Section 219 (June 2017), codified at RSA 126-A:5, XXX(a), https://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=744&txtFormat=pdf&v=current. New Hampshire's bicameral state legislature is called the General Court.

²¹ Letter from Governor Sununu to Acting Secretary Eric Hargan and attached Section 1115 Demonstration Amendment, New Hampshire Health Protection Program Premium Assistance (Oct. 24, 2017);

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa3.pdf>.

²² Letter from Brian Neale to State Medicaid Directors (Jan. 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

²³ Letter from CMS to Henry Lipman (May 7, 2018), <https://www.dhhs.nh.gov/pap-1115-waiver/documents/cms-approval-letter-05072018.pdf> and CMS Special Terms and Conditions for NHHPP Premium Assistance Program Section 1115(a) Demonstration Waiver <https://www.dhhs.nh.gov/pap-1115-waiver/documents/nh-pap-stcs-05072018.pdf>.

²⁴ SB 313-FN (May 2018), codified at RSA 126-AA (2018).

²⁵ Letter from Gov. Christopher Sununu to Hon. Alex Azar (Jul. 23, 2018), <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-governor-letter.pdf>, and Granite Advantage 1115 Waiver Amendment and Extension Application, <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-waiver-app-072318.pdf>.

²⁶ Letter from CMS to Henry Lipman (Nov. 30, 2018), <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-approval-letter-11302018.pdf> and New Hampshire Granite Advantage Health Care Program Special Terms and Conditions (hereinafter CMS Nov. 2018 STCs), <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-stc-11292018.pdf>.

²⁷ CMS Nov. 2018 STCs at 3, 10, 12-13.

²⁸ *Id.* at 3, 11-12.

²⁹ Henry J. Kaiser Family Foundation Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>.

³⁰ Comm'r Jeffrey Meyers letter to Christopher Traylor (Jan. 16, 2019), <https://www.dhhs.nh.gov/ombp/medicaid/documents/cmcs-traylor-wce-notice.pdf>.

³¹ During the rulemaking process, community providers raised concerns about whether “self-employment” was a “qualifying activity,” and if so, how the hours would be counted. This issue, while slowly clarified to allow recognition of such hours, remained controversial up through the implementation period.

³² Many community providers questioned how education hours would be counted or recorded during the rulemaking and public hearing process.

³³ Granite Workforce was a pilot work program offered through NH Employment Security and NH DHHS as part of the WACER program. <https://www.nhes.nh.gov/services/granite-workforce/index.htm>

³⁴ CMS Nov. 2018 STCs at 11.

³⁵ *Id.* at 10-11.

³⁶ *Id.*

³⁷ *Id.* at 11.

³⁸ NH DHHS letter to beneficiaries (May 8, 2019);

<https://www.dhhs.nh.gov/medicaid/granite/documents/reminder-letter-with-employment-hours.pdf>.

³⁹ CMS Nov. 2018 STCs at 12.

⁴⁰ *Id.* at 13-14.

⁴¹ *Id.*

⁴² *Id.* at 12-13.

⁴³ NH DHHS presentation at 5 (Jan. 23, 2019).

⁴⁴ *Id.* at 6-7.

⁴⁵ N.H. Proposed Interim Rule, He-W 837.

⁴⁶ JLCAR Meeting Minutes, #17 (Dec. 20, 2018), <https://www.gencourt.state.nh.us/rules/jlcar/minutes/AM12-20-18.pdf>.

⁴⁷ Letter from Jeffrey A. Meyers to Honorable William A. Hatch et al. (Jan. 9, 2019), <https://www.dhhs.nh.gov/oos/arj/documents/hew837.pdf>.

⁴⁸ JLCAR Meeting Minutes, #12 (Jan. 18, 2019), <https://www.gencourt.state.nh.us/rules/jlcar/minutes/AM1-18-19.pdf>.

- ⁴⁹ JLCAR Meeting Minutes, #4 (Feb. 15, 2019), <https://www.gencourt.state.nh.us/rules/jlcar/minutes/AM2-15-19.pdf>.
- ⁵⁰ N.H. Admin. Rule, He-W 837; JLCAR Meeting Minutes, #14 (May 17, 2019), <https://www.gencourt.state.nh.us/rules/jlcar/minutes/AM5-17-19.pdf>.
- ⁵¹ The Granite Advantage Forms are available online at <https://nheasy.nh.gov/#/granite-advantage/resources/notices>.
- ⁵² <https://nheasy.nh.gov/#/granite-advantage>.
- ⁵³ Governor and Executive Council Agenda, #43 (May 2, 2018), http://sos.nh.gov/nhsos_content.aspx?id=8589976832.
- ⁵⁴ Letter from Comm’r Jeffrey Meyers to Christopher Traylor (January 16, 2019), <https://www.dhhs.nh.gov/ombp/medicaid/documents/cmcs-traylor-wce-notice.pdf>.
- ⁵⁵ CMS Nov. 2018 STCs at 15.
- ⁵⁶ Any beneficiary who enrolled in Medicaid after March 1, 2019 would be required to begin tracking hours in the first full month following 75 calendar days from the date of eligibility.
- ⁵⁷ NH DHHS Granite Advantage Health Care Program, February 26, 2019, <https://www.dhhs.nh.gov/medicaid/granite/index.htm>.
- ⁵⁸ NH DHHS Granite Advantage Health Care Program, April 2, 2019 and June 19, 2019, <https://www.dhhs.nh.gov/medicaid/granite/index.htm>.
- ⁵⁹ NH DHHS Granite Advantage Health Care Program, May 14, 2019, <https://www.dhhs.nh.gov/medicaid/granite/index.htm>.
- ⁶⁰ SB 290 (2019), codified at RSA 126-AA (2019).
- ⁶¹ “RSA 126-AA, X. The work and community engagement requirement shall be immediately eliminated as a condition for eligibility for the program under any the following circumstances:
- (a) Five hundred or more beneficiaries have their Medicaid eligibility suspended and/or are disenrolled from the program as a result of noncompliance with the work and community engagement requirement.
 - (b) Providers experience and report to the commission an increase in uncompensated care as a result of beneficiaries being suspended or disenrolled due to non-compliance with the work and community engagement requirement.
 - (c) If the commissioner reports to the commission, established under RSA 126-AA:4, by July 1, 2019 a projection that the number of beneficiaries suspended or disenrolled as a result of noncompliance with the requirement exceeds 500, then the commission shall, by majority vote, require the commissioner to notify CMS that the work and community engagement requirement shall be immediately eliminated.”
- ⁶² Letter from Commissioner Jeffrey Meyers letter to Gov. Sununu, Hon. Donna Soucy, and Hon. Steve Shurtleff (July 8, 2019) <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf>.
- ⁶³ *Id.*
- ⁶⁴ *Id.*
- ⁶⁵ 397 F.Supp.3d 11.
- ⁶⁶ *Id.* at 22.
- ⁶⁷ *Id.*
- ⁶⁸ *Philbrick* Docket Entries, <https://www.courtlistener.com/docket/14756647/philbrick-v-azar-ii/>.
- ⁶⁹ *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020).
- ⁷⁰ National Health Law Program, “Appeals Court Again Rejects Administration’s Medicaid Barriers,” <https://healthlaw.org/news/appeals-court-again-rejects-administrations-medicaid-barriers/>.
- ⁷¹ CMS Health Adult Opportunity Fact Sheet, January 30, 2020, <https://www.cms.gov/newsroom/fact-sheets/healthy-adult-opportunity-fact-sheet>
- ⁷² NH DES, Weekly New Unemployment Claims, April 23, 2020, <https://www.nhes.nh.gov/media/press/2020/documents/new-claims-release-042320.pdf>
- ⁷³ Note that this roundtable preceded the project funding from the Robert Wood Johnson Foundation. This roundtable helped shape the project and is summarized here for context. The May 2018 roundtable was supported by funding from the Endowment for Health.

- ⁷⁴ Hodder, L., Wyman, A., Institute for Health Policy and Practice, “Work Requirement Roundtable Q&A,” <https://chhs.unh.edu/sites/default/files/work-requirement-roundtable-questions-and-answers-060618-unh.pdf>
- ⁷⁵ Kaiser Family Foundation, Changes to “Public Charge” Inadmissibility Rule: Implications for Health and Health Coverage, August 12, 2019, <https://www.kff.org/disparities-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>.
- ⁷⁶ United States Government Accountability Office (GAO), Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements, GAO-20-149 (Washington, D.C.: Oct. 1, 2019), <https://www.gao.gov/assets/710/701885.pdf>.
- ⁷⁷ *Id.* at 4.
- ⁷⁸ *Id.*
- ⁷⁹ *Id.*
- ⁸⁰ *Id.* at 5.
- ⁸¹ *Id.* at 20.
- ⁸² *Id.*
- ⁸³ *Id.* at 23.
- ⁸⁴ *Id.* at 19.
- ⁸⁵ *Id.* at 22.
- ⁸⁶ *Id.*
- ⁸⁷ *Id.* at 23. In general, CMS provides a 50% matching rate for state Medicaid administrative costs. CMS provides higher rates for certain administrative costs, such as those related to IT systems. *Id.* at 11. “For example, expenditures to design, develop, and install Medicaid eligibility and enrollment systems are matched at 90 percent.” *Id.* at 23. In a similar fashion, the Federal government pays at least 90 percent of capitation payments to MCOs who are providing coverage to newly eligible members under the ACA. *Id.* at 24.
- ⁸⁸ *Id.* at 20.
- ⁸⁹ *Id.* at 21 fn 6.
- ⁹⁰ June 2019 Community Engagement Report at <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>.
- ⁹¹ June 2019 Community Engagement Report at <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>; Letter from Commissioner Jeffrey Meyers letter to Gov. Sununu, Hon. Donna Soucy, and Hon. Steve Shurtleff (July 8, 2019) <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf>.
- ⁹² June 2019 Community Engagement Report at <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>.
- ⁹³ Letter from Commissioner Jeffrey Meyers to Senator Jeb Bradley, Re: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, (Sept. 3, 2019).
- ⁹⁴ *Id.*
- ⁹⁵ Letter from Commissioner Jeffrey Meyers to Senator Dan Feltes, et al, Re: Costs to Implement the Community Engagement Requirement for Granite Advantage, (Oct. 24, 2019).
- ⁹⁶ *Id.*
- ⁹⁷ *Id.*
- ⁹⁸ In its disclosures to the GAO, Arkansas estimated \$2.9 million in costs from July 2018 to June 2019 to conduct education and outreach with similarly ineffective results. GAO Medicaid Demonstrations at 22.
- ⁹⁹ *Id.*
- ¹⁰⁰ NH Medicaid Care Management Services Contracts with AmeriHealth Caritas New Hampshire, Boston Medical center Health Plan, and Granite State Health Plan (April 2019).
- ¹⁰¹ *Id.* at § 4.3.2.
- ¹⁰² *Id.*
- ¹⁰³ *Id.*
- ¹⁰⁴ Letter from Commissioner Jeffrey Meyers letter to Gov. Sununu, Hon. Donna Soucy, and Hon. Steve Shurtleff (July 8, 2019) <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf>.
- ¹⁰⁵ June 2019 Community Engagement Report at <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>.

¹⁰⁶ Note that Arkansas is the only state where a work and community engagement actually went into effect.

¹⁰⁷ In June of 2018, Arkansas launched Arkansas Works, Arkansas's equivalent to the Granite Advantage program. Like New Hampshire, beneficiaries in Arkansas could file for an exemption or perform a range of activities to fulfill their work requirement. And, like New Hampshire, Arkansas engaged in significant outreach efforts to inform its beneficiaries of the new requirement. Despite Arkansas state outreach, 4,300 Medicaid beneficiaries were disenrolled in the first month enrollees could face the consequence. By December 2018, disenrollment from Arkansas's Medicaid program had grown to 18,164, an estimated one in four of the enrollees subject to work requirements. These experiences in Arkansas and New Hampshire are not unique. In Kentucky's application to US DHHS, it estimated that its project would cause more than 95,000 people (*Amici* contended that the real number was between 175,000 and 297,500) to lose coverage by the fifth year of the program. In Indiana's lawsuit, the plaintiffs argued that work requirements could cause 24,000 people in Indiana to lose coverage. Urban Institute, [Lessons from Launching Medicaid Work Requirements in Arkansas, Oct. 2019 \(rev. Nov. 5, 2019\)](#).

¹⁰⁸ *Id.* at 24-25.