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Dear Mr. Lipman:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend New Hampshire's section 1115 demonstration, now entitled "New Hampshire Granite Advantage Health Care Program 1115 Demonstration" (Project Number 11-W-00298/1), under authority of section 1115(a) of the Social Security Act (the Act).

The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been waived as described in the demonstration. The approval is effective November 30, 2018 through December 31, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the waivers and special terms and conditions (STCs). The state will begin implementation of the community engagement requirement and the enrollment of eligible beneficiaries into Medicaid managed care no sooner than January 1, 2019, and only in compliance with the requirements outlined within the STCs.

**Objectives of the Medicaid Program**

The Secretary may approve a demonstration project under section 1115 if, in his judgment, the project is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include the appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This appropriations provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing medical assistance to pay for healthcare services, is to advance the health and

wellness needs of its beneficiaries and that it is appropriate for the state to structure its demonstration program in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care, and focus on interventions that drive better health outcomes and quality of life improvements, and may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants, including by encouraging beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But, in the long term, they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services furnished to beneficiaries, as healthier, more engaged beneficiaries tend to receive fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance, including medical assistance, from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.<sup>1</sup> By the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial

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<sup>1</sup> States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, non-elderly adult population (ACA expansion population or new adult group) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide coverage for more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

### **Extent and Scope of Demonstration**

In this extension package, changes have been made to the STCs and related authorities to align with New Hampshire State Legislature Senate Bill 313, requiring the state to request waivers under section 1115 needed to implement the Granite Advantage Health Care Program, which will serve beneficiaries through the state's Medicaid managed care delivery system rather than through the New Hampshire Health Protection Program (NHHPP) Premium Assistance program, which assisted beneficiaries in covering premiums to purchase qualified health plan coverage through the Health Insurance Exchange. Separately, on September 13, 2018, CMS approved New Hampshire's state plan amendment to effectuate mandatory enrollment of the new adult group population into Medicaid managed care. By transitioning all beneficiaries into a single Medicaid managed care delivery system, the state intends to streamline administration of beneficiary services and reduce administrative costs. Consistent with the STCs for this extension, the state must ensure the availability of adequate resources for implementation and monitoring of the demonstration. Approval of this demonstration extension does not imply approval of any particular state financing approach and the state must comply with all general financial requirements under Title XIX.

As required under state law, the demonstration application includes a request for a waiver of retroactive coverage for the new adult group. This waiver does not apply to individuals who would have been eligible at any point during the otherwise available three-month retroactive eligibility period as pregnant women (including during the 60-day post-partum period), infants under 1, or children under 19, parents or caretaker relatives, or as individuals eligible in aged, blind, or disabled eligibility groups (including those who are applying for a long-term care determination). With this waiver, the state will test whether eliminating retroactive coverage will encourage beneficiaries to enroll earlier, to maintain health insurance coverage even while healthy, and to obtain preventive health care. This feature of the demonstration is designed to encourage preventive care and reduce Medicaid costs, with the ultimate objective of improving beneficiary health. If eligible individuals wait until they are sick to enroll in Medicaid, they are less likely to obtain preventive health services during periods when they are not enrolled. In addition to evaluating the effect on receipt of preventive services and on health outcomes, the state will also evaluate whether the policy increases continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick. Similar waivers for retroactive eligibility have been included in this and other prior demonstration projects.

Consistent with the approval of the state's demonstration amendment approved on May 7, 2018, this extension allows New Hampshire, no sooner than January 1, 2019, to require all

beneficiaries in the new adult group, ages 19 through 64, with certain exemptions,<sup>2</sup> to participate in 100 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility. Under the community engagement program, the state will test whether coupling the requirements for certain beneficiaries to engage in community engagement activities with certain meaningful incentives to encourage compliance, as detailed below, will lead to improved health outcomes, including improved health and wellness, and greater independence, while better integrating fiscal sustainability and personal responsibility into the state's Medicaid program.

**Determination that the demonstration project is likely to assist in promoting Medicaid's objectives**

For reasons discussed below, the Secretary has determined that Granite Advantage Health Care Program is likely to assist in promoting the objectives of the Medicaid program.

**The demonstration promotes beneficiary health and financial independence.**

The New Hampshire Granite Advantage Health Care Program's community engagement requirements are designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness and increased financial independence for beneficiaries. Promoting beneficiary health and independence advances the objectives of the Medicaid program; indeed, in 2012, HHS specifically encouraged states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes."<sup>3</sup>

The community engagement provisions generally require adults in the new adult group to work, look for work, or engage in activities that enhance their employability, such as job training, education, or community service. The demonstration will thus help the state and CMS evaluate whether the community engagement requirement helps adults in this population transition from Medicaid to financial independence and commercial insurance, including the federally subsidized coverage that is available through the Exchanges.

Failure to comply with the community engagement requirements could result in suspension of Medicaid eligibility, and termination of Medicaid enrollment if the beneficiary is not in compliance with the requirements on his or her redetermination date. Beneficiaries whose Medicaid enrollment is terminated can re-apply for coverage at any time, and any prior noncompliance with the community engagement requirements will not be considered as part of their new eligibility determination. Although the state and CMS are testing the effectiveness of

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<sup>2</sup> If a New Hampshire Granite Advantage Health Care Program beneficiary meets one or more of the exemption criteria as described in the STCs, he or she is exempted from the community engagement requirements for the duration of his or her qualification for the exemption. Additionally, the STCs require that a non-exempt beneficiary have an opportunity to demonstrate that he or she had good cause for failing to meet the community engagement requirements for a month, and coverage and eligibility will not be suspended for failure to meet community engagement requirements for a month for which the beneficiary has established good cause for the failure.

<sup>3</sup> The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), *available at*: [https://www.in.gov/fssa/files/Lewin\\_IN%20HIP%202%200%20Interim%20Evaluation%20Report\\_FINAL.pdf](https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf)

an incentive structure that attaches penalties to failure to take certain measures, the program is designed to make compliance with requirements achievable.

Beneficiaries can comply with the community engagement requirements by participating in a number of activities, such as subsidized or unsubsidized employment; community service; job skills training; enrollment in an accredited college or university; and substance use disorder treatment. Beneficiaries whose circumstances could make it unreasonably difficult or impossible to participate in qualifying activities are exempt from the community engagement requirements. This includes beneficiaries who are temporarily unable to participate due to illness or incapacity as documented by a licensed provider; beneficiaries who are a parent or caretaker where care of a dependent is considered necessary by a licensed provider; beneficiaries who are pregnant or 60 days or less post-partum; beneficiaries who are identified as medically frail; and beneficiaries with a disability as defined by the ADA, Section 504, or Section 1557, who are unable to comply with the requirements due to disability-related reasons. Beneficiaries have 75 days after the start date of the community engagement requirements before they must begin to meet the requirements or qualify for an exemption. Beneficiaries who do not meet the monthly community engagement requirements have an opportunity to cure their noncompliance by demonstrating good cause for failing to meet the requirements; demonstrating that they qualify for an exemption; or making up the deficient hours for the month that resulted in noncompliance.

Moreover, New Hampshire has taken steps to include adequate beneficiary protections to ensure that the demonstration program requirements apply only to those beneficiaries who can reasonably be expected to meet them and to notify beneficiaries of their responsibilities under the demonstration. Any individual whose coverage is suspended or terminated for failure to meet the requirements will have the right to appeal the state's decision as with other types of eligibility terminations, consistent with all existing appeal and fair hearing protections. Furthermore, the incentives to meet the requirements, if effective, may result in individuals becoming ineligible because they have attained financial independence – a positive result for the individual. Individuals who become ineligible for Medicaid because their income has exceeded the upper limit for the new adult group may receive an offer of employer-sponsored insurance or may obtain subsidized commercial coverage through the Health Insurance Exchange, through which premium tax credits are available to help pay the plan premium for qualified individuals with income over 100 percent of the federal poverty level.

Similarly, the waiver of retroactive eligibility for the new adult group, subject to specified exceptions, is also designed to promote improved beneficiary health and wellness by encouraging continuity of coverage and care, including the receipt of preventive health services. It is designed to encourage beneficiaries to obtain and maintain health coverage, even when healthy, and is therefore intended to reduce gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick. If eligible individuals wait until they are sick to enroll in Medicaid, they are less likely to obtain preventive services during periods when they are not enrolled, potentially resulting in worse health outcomes. CMS is requiring the state's evaluation design to include hypotheses on the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings), as well as the effects of the demonstration on health outcomes and the

financial impact of the demonstration (for example, an assessment of medical debt and uncompensated care costs).

**The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.**

Approval of this demonstration will enable the state to continue coverage of the new adult group in the manner contemplated under state law. The state's current Medicaid expansion demonstration expires on December 31, 2018. As the state explained in its demonstration application, the Granite Advantage demonstration would extend New Hampshire's Medicaid expansion program with the objective of improving beneficiary health, while better integrating fiscal sustainability and personal responsibility into the state's Medicaid program. The state repeatedly articulated that its intention with this extension is "to continue to provide coverage for the Medicaid expansion population." Because the state is seeking to "sustain and improve its Medicaid expansion," state law requires that if CMS does not approve the waivers necessary for the program by December 1, 2018, the state's Health Commissioner must immediately notify all program participants that the Granite Advantage demonstration program will be terminated in accordance with the current waiver STCs. If CMS were to disapprove the Granite Advantage demonstration, we recognize that the state plans to end its current coverage of the new adult group that the Granite Advantage program was designed to cover, as the state has informed CMS that, under its interpretation of state law, it would be required to terminate coverage for its expansion population should CMS not approve this demonstration extension.

New Hampshire's stated goals for the extension of the Granite Advantage demonstration program align with the goals of the Medicaid program. As discussed above, both the community engagement requirement and the waiver of retroactive eligibility for beneficiaries in the new adult group, with specified exceptions, are intended to improve beneficiary health and wellness and increase financial independence. Promoting improved health and wellness ultimately helps to keep health care costs at more sustainable levels. Moreover, to the extent that the community engagement requirements help individuals achieve financial independence and transition into commercial coverage, the demonstration may reduce dependency on public assistance while still promoting Medicaid's purpose of helping states furnish medical assistance by allowing New Hampshire to stretch its limited Medicaid resources. Helping the state stretch its limited Medicaid resources will assist in ensuring the long-term fiscal sustainability of the program and preserving the health care safety net for those New Hampshire residents who need it most.

The community engagement requirements may impact overall coverage levels if the individuals subject to the requirements choose not to comply with them. However, the demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. It furthers the Medicaid program's objectives to allow states to experiment with innovative means of deploying their limited state resources in ways that may allow them to provide services beyond the legal minimum. Enhancing fiscal sustainability allows the state to provide services to Medicaid beneficiaries that it could not otherwise provide.

As described in the STCs, if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require

the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

### **Consideration of Public Comments**

Both New Hampshire and CMS received comments during the state and federal public comment periods. The state's public comment period began on May 8, 2018, and lasted through June 29, 2018. The state held three public hearings in May and June 2018. New Hampshire has no federally recognized tribes or Indian health programs, so tribal consultation was not required. New Hampshire reviewed and considered all public comments received during the public notice period. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all public comments received during the federal comment period, to determine whether the demonstration project as a whole is likely to assist in promoting the objectives of the Medicaid program, and whether the waiver authorities sought are necessary and appropriate to implement the demonstration.

#### *Comments on Community Engagement*

Many of the public comments received during the federal public comment period expressed concern that community engagement requirements would be burdensome on families and caretakers and create barriers to coverage. As CMS explained in the May 7, 2018 approval letter for the state's demonstration amendment, to mitigate some of those concerns, New Hampshire has exempted beneficiaries who are parents or caretakers where care of a dependent is considered necessary by a licensed provider; parents or caretakers of a dependent child under 6 years of age; and parents or caretakers of a dependent of any age with a disability residing with the parent or caretaker. To minimize the administrative burden of reporting, beneficiaries will be able to verify or document their compliance or exemption status via the internet, via telephone, by mail, in person, or through other commonly available electronic means as described in 42 CFR 435.907(a). CMS also intends to monitor state-reported data on how the new requirements are impacting enrollment.

Commenters specifically noted that the requirement that non-exempt beneficiaries participate in 100 hours of community engagement monthly is higher than other states with similar community engagement requirements approved to date, and may be correspondingly more difficult for beneficiaries to meet. Commenters also noted that beneficiaries whose income qualifies them for coverage in the new adult group can work unpredictable hours that vary from month to month, and often lack control over their work schedules and may involuntarily work part time. As mentioned above, to accommodate these beneficiaries irregular work schedules, the state provides beneficiaries who fail to participate in an allowable activity for 100 hours in one month with an opportunity to cure their non-compliance by making up their deficient hours in the next month, or by demonstrating good cause or qualification for an exemption, without losing coverage.

Some commenters expressed concern that, despite participating in an allowable activity or having an exempt status, beneficiaries will lose coverage due to the administrative burden of

reporting compliance with the community engagement requirements. New Hampshire's system for reporting and verifying compliance is designed to minimize burden on beneficiaries. First, the state will use existing data sources, where available, to record a beneficiary's monthly participation in qualifying activities or verify his or her exempted status. Second, beneficiaries will be able to verify this information via the internet, via telephone, by mail, in person, or through other commonly available electronic means as described in 42 CFR 435.907(a). Finally, in cases where the beneficiary has to report information to the state (that being when the state is unable to locate information in existing data systems), the beneficiary can document their compliance or exemption status via the internet, via telephone, by mail, in person, or through other commonly available electronic means as described in 42 CFR 435.907(a).

Other commenters were concerned about areas of high unemployment acting as a barrier to meeting the community engagement requirements. Through this demonstration, New Hampshire seeks to incentivize beneficiaries to obtain employment or undertake other community engagement activities by offering an array of qualifying activities, including training, education, caregiving, and community service to allow beneficiaries multiple ways to meet the requirements. Additionally, the state assures that it will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet.

Some comments expressed concern that beneficiaries with chronic or acute health conditions may not be able to meet the community engagement requirements and characterized the proposal to suspend eligibility for failure to participate in community engagement activities as having a "potentially detrimental impact on Medicaid beneficiaries' access to coverage and care." CMS acknowledged these concerns in the May 7, 2018, approval letter, and New Hampshire will exempt from the requirements those individuals who are medically frail, as well as those individuals whom a licensed professional has certified to be temporarily unable to participate in community engagement activities due to illness or incapacity. Additionally, New Hampshire will provide multiple ways for beneficiaries to reactivate their coverage or re-enroll in Medicaid, to appropriately support individuals who have experienced a suspension of eligibility or disenrollment in regaining access to the program's benefits and resources. As stated above, beneficiaries who do not meet the monthly community engagement requirements have an opportunity to cure their noncompliance by demonstrating good cause for failing to meet the requirement; demonstrating that they qualify for an exemption; or making up the deficient hours for the month that resulted in noncompliance. Beneficiaries whose Medicaid enrollment is terminated can re-apply for coverage at any time, and any prior noncompliance with the community engagement requirements will not be considered as part of their new eligibility determination.

Commenters also raised concerns about beneficiaries with disabilities and beneficiaries who may not be eligible for Medicaid on the basis of disability but who may still have issues gaining and maintaining employment or otherwise performing qualifying activities due to their medical or behavioral health conditions. To mitigate these concerns, New Hampshire has exempted

beneficiaries with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or Section 1557 of the Patient Protection and Affordable Care Act from the community engagement requirements, who are unable to comply with the requirements due to disability-related reasons. The state must provide reasonable modifications related to meeting community engagement requirements for beneficiaries with disabilities as defined under the ADA, Section 504, or Section 1557, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. Per the STCs, the state must also provide reasonable modifications for protections and procedures, including but not limited to assistance with demonstrating eligibility for an exemption from community engagement requirements on the basis of disability; appealing disenrollments; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications. The reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the otherwise-required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

Commenters also characterized the requirement to obtain provider documentation for exemptions/exceptions as excessively burdensome. Commenters had concerns about the process involved in getting documentation of exempted or excepted status from a provider. In particular, commenters were concerned that an individual might have his or her eligibility suspended or be disenrolled for failure to meet the community engagement requirements, but might need documentation from a provider so that he or she can demonstrate qualification for an exemption or exception to regain Medicaid eligibility. In this case, the individual would need coverage to be able to see the provider to obtain documentation. In order to reduce administrative burden, the state will not require beneficiaries to begin meeting the community engagement requirements until the first month after that date that is 75 days after the community engagement requirements are implemented by the state. After implementation, newly eligible beneficiaries will not be required to meet the community engagement requirements until the first month after the date that is 75 days after the beneficiary's eligibility determination. This 75-day period allows individuals who may require documentation for an exemption or exception to obtain the needed documentation before the community engagement requirements begin to apply. If an individual later fails to meet the community engagement requirements for a month, he or she will be notified and will have coverage during the following month to obtain provider documentation, if needed, before eligibility suspension. Individuals whose enrollment is terminated at eligibility redetermination because their eligibility was in a suspended status for failure to meet the community engagement requirements may reapply for Medicaid at any time, and their prior noncompliance with the community engagement requirements will not be considered in making their new eligibility determination. Furthermore, beneficiaries whose eligibility is suspended or terminated may use the mechanisms in place to appeal their suspension or termination and may demonstrate qualification for an exemption or exception through this process.

Some commenters noted that most Medicaid beneficiaries are already working. CMS acknowledges that many beneficiaries are already working or attending school; therefore, those activities are included as qualifying activities that meet the community engagement requirement and access to coverage should not be impacted for beneficiaries who are engaging in these activities for the required number of hours each month.

Other commenters expressed concerns that the administration of the demonstration, especially the community engagement requirement, would be burdensome and costly to state. Although such measures may have associated administrative costs, particularly at the initial stage, in the long term they may help enable beneficiaries to enjoy the many personal benefits that come with improved health outcomes and increased financial independence.

As described in the STCs, if monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, or if evaluation data for this demonstration indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers at any time it determines that continuing the waivers would no longer be in the public interest or promote the objectives of Medicaid.

#### *Comments on Coverage Loss*

Some commenters expressed concern that the Granite Advantage demonstration will lead to coverage losses. But the demonstration will provide coverage to individuals that the state is not required to cover. Any potential loss of coverage that may result from a demonstration is properly considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage for existing (but non-mandatory) populations, such as (in light of the Supreme Court's ruling in *NFIB v. Sebelius*) the ACA expansion population. As of October 2018, more than 51,000 individuals received medical assistance under the New Hampshire state plan as a result of New Hampshire's decision to participate in the ACA eligibility expansion. New Hampshire's ACA expansion population includes not only childless adults but also many parents of dependent children, who are not eligible for coverage under the New Hampshire state plan unless their household income is equal to or less than 67 percent of the federal poverty level. Under state law, however, if this demonstration were not approved, the State Commissioner of Health and Human Services would be required to report this to the State Legislature and Governor, who could then respond by seeking to scale back or even end coverage for the ACA expansion population, or other optional populations and services currently covered under the state plan. Thus, the ACA adult expansion could be eliminated if the state is unable to implement the demonstration project.

Moreover, conditioning eligibility for Medicaid coverage on compliance with certain measures is an important element of the state's efforts, through experimentation, to improve beneficiaries' health and independence and enhance programmatic sustainability. To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence. This may mean that

beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the incentives included in this demonstration are not designed to encourage this result; rather, they are intended to incorporate achievable conditions of continued coverage. And any loss of coverage as the result of noncompliance must be weighed against the benefits New Hampshire hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.

It would be counterproductive to deny states the flexibility they need to implement demonstration projects designed to examine innovative ways to incentivize beneficiaries to engage in desired behaviors that improve outcomes and lower healthcare costs, as well as innovative ways to stretch limited state resources, given that states have the prerogative to terminate coverage for non-mandatory services and populations. Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment.

Some comments argued that a demonstration cannot advance the Medicaid program's objectives if the project is expected to reduce Medicaid enrollment or Medicaid spending. We recognize that some individuals may choose not to comply with the conditions of eligibility imposed by the demonstration, and therefore may lose coverage, as may occur when individuals fail to comply with other requirements like participating in the redetermination process. But the goal of these policies is to incentivize compliance, not reduce coverage. Indeed, CMS has incorporated safeguards into the STCs intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with the state to ensure that the demonstration advances the objectives of Medicaid. Furthermore, we anticipate that some beneficiaries may dis-enroll from Medicaid if they obtain employer-sponsored or other commercial coverage and no longer qualify for the program. Finally, we note that in some cases, reductions in Medicaid costs can further the Medicaid program's objectives, such as when the reductions stem from reduced need for the safety net or reduced costs associated with healthier, more independent beneficiaries. These outcomes promote the best interests of the beneficiaries whose health and independence are improved, while also helping states stretch limited Medicaid resources and ensure the long-term fiscal sustainability of the states' Medicaid programs.

As noted above, section 1115 of the Act explicitly contemplates that demonstrations may "result in an impact on eligibility"; furthermore, the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration, if the state were unable to continue its Medicaid expansion program. Other comments predicted that Granite Advantage will fail to achieve its intended effects. For instance, some comments argued that beneficiaries subject to the community engagement requirements will be unable to comply. To some extent, these comments reflect a misunderstanding of the nature of the community engagement requirements, which some of the comments described as a work requirement. In fact, the community engagement requirements are designed to help beneficiaries achieve success, and CMS and New Hampshire have made every effort to devise a requirement that beneficiaries should be able to meet. For example, the community engagement requirements may be satisfied through an array of activities, including education, job skills training, job search activities, and community service.

More generally, these comments reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making. As HHS previously explained, demonstrations can “influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other [s]tates.” 77 Fed. Reg. at 11680. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See, e.g., Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which New Hampshire’s demonstration project succeeds in achieving the desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. As long as the Secretary determines that the demonstration is likely to assist in promoting Medicaid objectives, he is authorized to approve the demonstration notwithstanding that its ultimate outcomes cannot be known in advance.

Consistent with state law regarding coverage of the ACA expansion population, this demonstration is part of the state’s plan for fiscal sustainability of its Medicaid program. In analyzing whether approval of the demonstration promotes the objectives of Medicaid, it must be understood that the alternative to coverage under this demonstration design ultimately could be reduced coverage or no coverage in the case of the ACA expansion population. This demonstration is also designed to improve health outcomes and financial independence, and reduce dependency on public assistance, by giving beneficiaries the choice either to engage in community engagement activities or to stop participating in Medicaid.

#### *Comments on Waiver of Retroactive Eligibility*

Many commenters expressed concern that the waiver of retroactive eligibility could result in unmet health needs and decreased financial security for beneficiaries, as well as increased uncompensated care costs for providers. CMS has taken these comments into consideration as part of its approval and will require the state to carefully evaluate how the waiver of retroactive eligibility is affecting beneficiaries and providers. CMS will not permit the state to waive retroactive eligibility for beneficiaries who, at any time during the otherwise applicable 3-month period of retroactive eligibility, were pregnant women (including women who are 60 days or less postpartum), infants under age 1, children under age 19, parents or caretaker relatives, or as individuals eligible in aged, blind, or disabled eligibility groups (including those who are applying for a long-term care determination).

Commenters also asserted that there is no experimental purpose associated with the waiver of retroactive eligibility. However, as indicated in the state’s application, this demonstration is designed to test whether eliminating retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy, without increasing the rate of churn in and out of the program. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, and to increase the uptake of preventive services by continuously covered beneficiaries, with the ultimate objective of improving beneficiary health.

Commenters also expressed concern that waiving retroactive eligibility does not promote the objectives of the Medicaid program. As discussed above, the waiver of retroactive eligibility is intended to incentivize beneficiaries to maintain coverage even when well, promote continuity of coverage, and encourage the receipt of preventive care, with the overall goal of improving health outcomes for beneficiaries. To increase awareness of this waiver authority and help ensure that it promotes the objectives of the Medicaid program as intended, New Hampshire will provide outreach and education to the public and to providers about how to apply for and receive Medicaid coverage. Per STC 28, no later than 90 days after approval of the demonstration, the state is required to submit an implementation plan that includes a discussion of topics such as outreach, application assistance, and notices as they relate to the waiver of retroactive eligibility. The state will also evaluate the financial impacts of the waiver on beneficiaries and providers.

In evaluating the impact of a waiver of retroactive coverage, it is important to keep in mind that the new adult group members affected by this waiver are eligible for coverage now, and should have an incentive to obtain it, rather than waiting until they get sick to apply and having their bills retroactively covered. This entire demonstration design also will assist in making New Hampshire's Medicaid program fiscally sustainable over time, better ensuring continued coverage of individuals and services for which coverage is optional under Medicaid.

### **Other Information**

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Mr. Emmett Ruff. He is available to answer any questions concerning your section 1115 demonstration. Mr. Ruff's contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
Mail Stop: S2-25-26  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Email: [emmett.ruff@cms.hhs.gov](mailto:emmett.ruff@cms.hhs.gov)

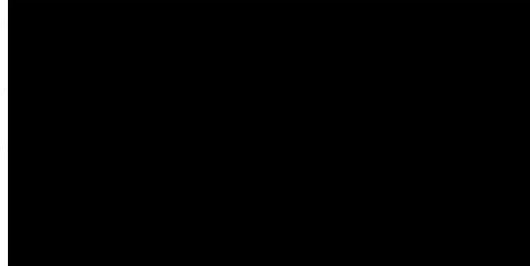
Official communications regarding program matters should be sent simultaneously to Mr. Ruff and Mr. Richard McGreal, Associate Regional Administrator (ARA), in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal  
Associate Regional Administrator  
Centers for Medicare & Medicaid Services  
Division of Medicaid and Children's Health Operations

15 Sudbury Street, JFK Federal Building  
Boston, Massachusetts 02203

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in New Hampshire, over the past months to reach approval.



Enclosures

cc: Richard McGreal, Associate Regional Administrator, CMS Boston Regional Office