JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

December 2, 2017

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

Dear Acting Secretary Hargan:

The Bazelon Center for Mental Health Law submits these comments in response to New Hampshire's application to amend its Section 1115 demonstration waiver to add work requirements. The Bazelon Center is a national non-profit legal advocacy organization that promotes equal opportunity for individuals with mental disabilities in all aspects of life, including health care, community living, housing, education, employment, voting, and other areas.

We urge you to reject this proposal. While we fully support the goals of expanding employment and promoting independence and economic self-sufficiency, we believe that this ill-considered proposal actually *undermines* those goals by failing to ensure that affected individuals would have the assistance and services they need to engage in the level of employment or work-related activities required in order for them to maintain Medicaid coverage, and decreasing access to needed health and employment services necessary for many individuals with disabilities to secure and maintain employment. Furthermore, we believe that the statute does not authorize the Department of Health and Human Services to approve a Section 1115 waiver with these requirements.

1) **The Department of Health and Human Services (HHS) does not have the authority to grant New Hampshire's request.**

HHS lacks the authority to approve the proposal to condition Medicaid eligibility for individuals covered under the Section 1115 waiver on these individuals engaging in 20-30 hours/week of employment or work-related activities. As HHS has repeatedly stated, Section 1115 Waivers may only be approved for "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid program]."[1] New Hampshire's proposal meets neither of these requirements.

[1] Centers for Medicare & Medicaid Services, *About Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

New Hampshire's proposal does not promote the objectives of Medicaid.

The statutory objectives of the Medicaid program are to furnish (1) "medical assistance" to people with disabilities, seniors, and families with dependent children, whose income and resources are insufficient to secure needed medical services, and (2) services to help such individuals and families attain or retain independence and self-care.[2]

HHS's criteria for determining whether a proposed demonstration would promote Medicaid's objectives include whether the demonstration would:

> Improve access to high-quality, person-centered services that produce positive health outcomes for individuals; [. . .] Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals; Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making [. . .][3]

New Hampshire's proposed work requirements would neither promote the goals of furnishing medical assistance and services, nor improve access to high quality services, support strategies to address health determinants promoting upward mobility and independence, or strengthen engagement in individuals' healthcare and decision-making. In fact, they would have the *opposite* effect of reducing access to needed services, including those that enable people with disabilities to work.

Years of experience with work requirements in the TANF program—another program where participants receive benefits critical to their subsistence—have consistently shown that work requirements do not assist individuals in obtaining full employment or lift them and their families out of poverty. Studies of these requirements have shown that: (1) increases in employment among recipients subject to work requirements were modest and diminished over time, (2) stable employment among recipients subject to work requirements was the exception rather than the norm, (3) most recipients who had significant barriers to employment never found employment, and (4) the vast majority of individuals subject to work requirements remained poor, and some became poorer.[4] Indeed, within five years, "employment among recipients not subject to work requirements was the same as or higher than employment among recipients subject to work requirements in nearly all of the programs evaluated."[5]

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[2] 42 U.S.C. 1396-1.

[3] *About Section 1115 Demonstrations*, *supra* note 1.

[4] *See, e.g.*, LaDonna Pavetti, Center on Budget and Policy Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (June 2016), https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows. *See also* Marybeth Musumeci, Kaiser Family Foundation, *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (Aug. 18, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/.

These outcomes—together with the lack of any commitment in the waiver modification application to expand the availability of employment services, training programs, and other services that would enable participants to meet the work requirements—strongly suggest that many participants will not succeed in meeting the work requirements and hence will lose the critical coverage of health care that they receive through the Section 1115 waiver.

Without Medicaid coverage of needed health care services, individuals' employment opportunities will *decrease* rather than increase. As the Kaiser Family Foundation has observed, "[h]ealth coverage through Medicaid is an important precursor to and support for work."[6] The Foundation's surveys concerning the impact of health coverage on employment of Medicaid beneficiaries are instructive:

> Without health insurance, individuals may forgo needed services, and their health may deteriorate to a point that interferes with their ability to work. An analysis of Ohio's Medicaid expansion found that over half of enrollees who are working (without being required to do so) reported that having Medicaid made it easier for them to continue working. In addition, most Ohio expansion enrollees who were unemployed but looking for work reported that having Medicaid made it easier for them to seek employment. A study examining Michigan's Medicaid expansion found that nearly seven in 10 (69%) enrollees who were working said they performed better at work once they got Medicaid coverage. Over half (55%) of Michigan expansion enrollees who were not working indicated that having Medicaid coverage made them better able to look for work. Having access to regular preventive health care to manage chronic conditions and address health issues as early as possible before they worsen is important so that individuals are healthy enough to work. In addition, an unmet need for mental health or addiction treatment results in greater difficulty with obtaining and maintaining employment, and Medicaid is an important source of coverage for mental health and addiction treatment services, such as opioid addiction.[7]

New Hampshire's proposal is not an experiment, pilot, or demonstration of the sort contemplated by the Medicaid statute

Demonstration programs are not intended to serve as blind experiments with individuals' lives. They are supposed to contain clearly defined goals, identify a specific problem that is being addressed, have a reasonable basis to believe that the demonstration is likely to address the problem effectively and without harming individuals, and put measures in place to ensure that individuals are not harmed.

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[5] *Work Requirements Don't Cut Poverty*, *supra* note 4.

[6] *Medicaid Enrollees and Work Requirements*, *supra* note 4.

[7] *Id.*

New Hampshire states simply that the state seeks to "promote work opportunities." It does not identify how the current design of the program is failing to provide work opportunities or provide any data suggesting that individuals who are or will become eligible for Medicaid are not currently working. In fact, commenters at the state level, including the Medical Care Advisory Committee for the state's own Department of Health and Human Services, pointed out that 60% of Medicaid enrollees are already employed and 75% are members of working families.[8] Since New Hampshire proposes to exempt those who cannot work due to illness or disability, who are older than 65, are caretakers, students, and looking for work, it is unclear for whom this waiver will "promote" work.[9] The vague language on page 10 of the proposal that discusses New Hampshire's goals for the waiver does not clarify this point or provide any relevant statistics or information about how the system is currently failing or how the challenges identified are related to Medicaid. Indeed, New Hampshire states in response to comments that the state is still conducting this analysis—raising the question of why this waiver has been submitted before such analysis is complete.

2) Work Requirements Would be Particularly Harmful for People with Disabilities

There is no indication from the application that New Hampshire has considered how this work requirement proposal will impact people with disabilities. The overwhelming majority of people with disabilities want to and can work, but many are not working as a result of attitudinal barriers among employers, the need for reasonable accommodations that have not been provided, or the need for supported employment services that are scarcely available.

Consequently, the employment rate of people with disabilities has remained far lower than that of any other group tracked by the Bureau of Labor Statistics. Among working age adults, the employment rate of people with disabilities is less than half of that for people without disabilities.[10]

For people with serious mental illness, the employment rate is even lower; it has been estimated over time at about 22%, with approximately 12% working full-time.[11] Dr. Gary Bond, then Professor of Psychiatry at New Hampshire's Dartmouth Psychiatric Research Center, testified that the reason for the dramatic gap between the desire of people with serious mental illness to

[8] New Hampshire Medical Care Advisory Committee, Comment Letter (Sept. 28, 2017) available at https://www.dhhs.nh.gov/pap-1115-waiver/documents/hb517-nhhpp-work-reqs-amended.pdf.

[9] Waiver Application at 9-10.

[10] U.S. Department of Labor, Bureau of Labor Statistics, *Persons with a Disability: Labor Force Characteristics Summary* (June 21, 2017) (among persons age 16 to 64, the employment-population ratio in 2016 for people with disabilities was 27.7 percent, in contrast to 72.8 percent for people without disabilities), https://www.bls.gov/news.release/disabl.nr0.htm.

[11] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, Federal Financing of Supported Employment and Customized Employment for People with Mental Illness: Final Report vii (Feb., 2011), http://aspe.hhs.gov/daltcp/reports/2011/supempFR.pdf.

work and their low employment rates is not an inability to work, but rather "attitudinal, service, and system barriers" such as stigma and discrimination, inadequate treatment, and lack of employment services.[12]

In New Hampshire, as in most states, evidence-based supported employment services are not available for many people with disabilities who need them (even though the highly successful Individual Placement and Support approach to supported employment for individuals with mental illness was developed by researchers in New Hampshire). The state committed to expand these services for certain individuals under a settlement agreement with the Justice Department. Even for the individuals covered under that settlement, however, the state has not had a means of ensuring that they receive the appropriate amount of supported employment. The last Court Monitor's report under the settlement indicated that "[t]here is currently no mechanism for measuring whether individuals are receiving SE services consistent with their individual treatment plans, or whether SE services are delivered in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings."[13]

For all of these reasons, work requirements that cut off access to Medicaid if an individual does not work a sufficient number of hours or cannot obtain a job quickly will disproportionately harm people with disabilities. While the waiver application proposes to limit the work requirements to "able-bodied adults" as defined in 42 U.S.C. § 1396a(a)(110)(A)(i), for a host of reasons, many individuals with serious mental illness and a variety of other disabilities will not be captured by this definition of who is not "able-bodied." Moreover, putting the onus on individuals with disabilities to invoke this exception and provide the appropriate documentation to demonstrate that it applies will have the practical effect of this exception being unavailable to many individuals with disabilities.

While New Hampshire's desire to promote employment and independence is laudable, imposing work requirements on Medicaid beneficiaries is not an effective way to accomplish those goals. Voluntary employment services could and should be used to achieve these goals without the negative consequences associated with conditioning health benefits for low-income individuals on mandatory work requirements. New Hampshire's requested waiver modification should be denied.

Respectfully submitted,

Jennifer Mathis
Director of Policy and Legal Advocacy
jenniferm@bazelon.org

Bethany Lilly
Deputy Director of Policy and Legal Advocacy
bethanyl@bazelon.org

[12] Written Testimony of Dr. Gary Bond, U.S. Equal Employment Opportunity Commission public meeting on Employment of People with Mental Disabilities (March 15, 2011), https://www.eeoc.gov/eeoc/meetings/3-15-11/bond.cfm.

[13] New Hampshire Community Mental Health Agreement, Expert Reviewer Report Number Six, at 14 (June 30, 2017).