What Could New Hampshire's Medicaid Work Experiment Mean for Community Health Centers?

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In 2018, the United States Department of Health and Human Services (HHS) approved New Hampshire's proposal to add a work requirement to its 1115 Medicaid expansion demonstration. The amendment would make ongoing Medicaid coverage for otherwise eligible, non-exempt adults age 19-64 contingent on continual proof of employment or other "community engagement." The demonstration, which launched in January 2019, begins to enforce the work and reporting requirement in June. The demonstration would continue for a five-year period, ending in 2023.

New Hampshire's work requirement is targeted at adults whose eligibility arises from the Affordable Care Act's (ACA's) Medicaid expansion. Its terms are among the most restrictive among the work experiments approved to date. The requirement extends through age 64, longer than other demonstrations, reaching well into the age at which the health of older low income Americans shows serious deterioration. The terms of the experiment require beneficiaries to demonstrate 100 hours of work per month on a year-round basis, with only one month to cure any month in which their work hours fall below this threshold. Certain activities such as job training, vocational education, and job search would qualify, but the HHS 1115 approval does not include funding to expand job or educational supports. Certain beneficiaries, including those who are pregnant, medically frail, or disabled, are exempt.

Approval of New Hampshire's work requirement is a reversal of HHS's prior denial in 2016 on the grounds that such requirements "could undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program." New Hampshire's current proposal, as well as the HHS approval, fail to include any estimate of Medicaid loss impact, even though Arkansas's Medicaid work experiment, launched in June 2018, showed significant and immediate coverage losses. An analysis of the potential impact of New Hampshire's work experiment undertaken by Leighton Ku and Erin Brantley estimates that between 30 percent and 45 percent of all adults subject to the requirement – 15,000 to 23,000 beneficiaries – would lose Medicaid within one year. Their analysis does not estimate the number of low income, Medicaid eligible adults subject to the work requirement who might be deterred from enrolling in the future because they are unable to meet the work requirements. A companion analysis by Sherry Glied, Dean of NYU's Wagner Graduate School of Public Service estimates spillover impact on the state's economy of between $114 million and $174 million in federal funds in 2020, equal to between 7 percent and 11 percent of the state's entire general

funds budget. https://www.commonwealthfund.org/blog/2019/how-medicaid-work-requirement-could-affect-new-hampshires-economy

The potential impact of the work requirement program on New Hampshire's community health centers

Major coverage losses can also affect health systems, especially those that anchor health care in medically underserved communities. The nation's community health centers provide a strong example of how providers caring for medically underserved populations might be affected by a major coverage loss, since health centers are located in low income communities experiencing primary care shortages and offer comprehensive primary care and related services to all community residents regardless of ability to pay. In 2017, 11 community health centers in New Hampshire, operating in 43 locations, served 91,440 patients, about one in 14 state residents. That year, 74 percent of the patient population was low-income (at or below 200% of the federal poverty level) and 30 percent were covered by Medicaid. Approximately one in seven Medicaid enrollees received care in health centers in 2017.

We have previously calculated the estimated impact of work requirement programs on health centers and their patients for Kentucky and Arkansas. In this analysis, we apply the Medicaid enrollment loss estimates developed by Ku and Brantley[1] and use data from the 2017 Uniform Data System (UDS) (collected by the federal government on all community health centers) to estimate the impact of coverage losses on New Hampshire health centers.

In 2017, New Hampshire health centers served 27,414 Medicaid-insured health center patients, 13,316 of whom were adults age 18 and older. In order to estimate the number of Medicaid expansion health center patients subject to work requirements, we calculated the percentage of non-elderly Medicaid adults in New Hampshire whose eligibility is based on the ACA Medicaid expansion, i.e., are not traditional beneficiaries. Using state-wide enrollment data for December 2017, 31,161 non-elderly adults had traditional Medicaid coverage (low-income non-disabled adults, low-income pregnant women, adults with disabilities, and Breast and Cervical Cancer Program enrollees), while 53,218 (63 percent of all non-elderly adults) were covered by virtue of the Medicaid expansion.

Assuming that 63 percent of the 13,316 health center Medicaid adults (ages 18 and older) were covered as a result of the ACA expansion, we estimate that 8,398 adult health center patients would be subject to the work requirements. (Most elderly adults with Medicaid coverage would be dually eligible for Medicare and would be captured in the count of patients with Medicare, rather than Medicaid). If 30 to 45 percent of this group lost Medicaid coverage,[2] then between 2,520 and 3,779 adult health center patients would lose Medicaid coverage. Losses of this magnitude account for between 9.2 percent and 13.8 percent of total New Hampshire health center Medicaid patients (**Table 1**).

[1] Ku, L. & Brantley, E. (May 9, 2019). New Hampshire's Medicaid Work Requirements Project Could Cause More Than 15,000 to Lose Coverage. Commonwealth Fund Blog. Available at https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss.

[2] Ku & Brantley, 2019

New Hampshire health centers reported $102.3 million in total revenue in 2017, and Medicaid accounted for 20 percent ($20.4 million) of total operating revenue. Assuming a proportional loss of Medicaid patients to Medicaid revenue, the work requirement program would result in $1.9 to $2.8 million in lost Medicaid revenue. This accounts for a loss of between 1.8 percent and 2.7 percent of total revenue.

This loss in total operating revenue as a result of lost eligibility among the patient population will translate into an estimated reduced patient care capacity of between 1,674 and 2,510 patients, a reduced visit capacity of between 7,286 and 10,929 visits, and (paradoxically perhaps) job losses of between 18 and 28 full-time equivalent (FTE) staff (**Table 2**). Reductions in staffing and patient care capacity could manifest itself in various ways. It might be implemented through across-the-board reductions in certain types of care, particularly health care services used most by adults (e.g., reduced treatment and management for older patients with multiple, co-occurring physical and mental health conditions). Alternatively, revenue and staffing losses could translate into reduced operating hours, longer waits for appointments, or a reduction in offsite services targeted at specific vulnerable populations such as outreach into more remote areas of the state. In short, because health centers must serve all community residents regardless of insurance status, Medicaid losses can be expected to have community-wide ramifications, affecting all patient categories, not simply those losing insurance.

The impact estimates and their consequences presented in this analysis may, if anything, be an underestimate. First, the adult Medicaid expansion extended coverage to many older adults previously ineligible for Medicaid and at higher risk for serious and chronic health conditions and who might incur higher than average Medicaid costs. To the extent that health centers have used the additional Medicaid revenue derived to expand relatively costly and intensive care, the actual financial losses may be greater than they would be for populations that use less care. Second, the impact on the number of Medicaid patients who may lose coverage due to the new work requirements is likely an underestimate. Between 2016 and 2018, New Hampshire's Medicaid expansion adults were enrolled in health insurance Marketplace coverage, similar to Arkansas' private option. Although the UDS manual instructs health centers to report Medicaid enrollees with Marketplace coverage as Medicaid patients, if they cannot be identified as Medicaid patients, they are reported as privately insured. The state's health center experts report that health centers struggled to identify which Marketplace enrollees actually were Medicaid expansion patients and likely underreported their actual Medicaid patients as a result. Because our estimates cannot account for this under-reporting of Medicaid patients as privately insured patients, our conclusions should be considered conservative; actual Medicaid enrollment at health centers may be significantly higher.

The loss of Medicaid carries the most direct consequences for the people whose coverage is eliminated or barred. But as our previous impact estimates have demonstrated in other work experiment states, Medicaid losses also carry implications for all community residents who depend on health centers and other safety net health care providers for the type of care that maintains health and promotes the ability to work.

Finally, in the most rural and isolated New Hampshire communities where health centers are the only source of primary care, the impact is likely to be more severe, since these communities lack alternatives. In these rural regions, lost capacity also may implicate larger public health concerns because the health care ecosystem in these parts of the state is so fragile. This is particularly true with respect to control of communicable disease, as well as the treatment and management of conditions that signal major public health crises such as the opioid epidemic, which has hit remote rural communities with special force.

Table 1. Potential loss of Medicaid coverage of patients at New Hampshire health centers

	Patients in 2017	Percent of all Medicaid patients
Total Medicaid patients served by New Hampshire health centers	27,414	
Total adult Medicaid enrollees at health centers	13,316	48.6%
Total adult Medicaid enrollees at health centers potentially subject to the New Hampshire Medicaid work requirements (63% of the adult Medicaid population)	8,398	30.6%
If 30% Lose Coverage	2,520	*9.2%*
If 45% Lose Coverage	3,779	*13.8%*

Source: Authors' analysis of the 2017 New Hampshire UDS report and Ku & Brantley, 2019

Table 2. Projected Medicaid revenue losses and resulting reductions in patient and visit capacity at New Hampshire health centers

	Total reported in 2017	**Projected Decrease, 30% Loss Scenario**	**Projected Decrease, 45% Loss Scenario**
Medicaid revenue	$20,367,064	$1,871,868	$2,807,802
Total revenue	$102,276,054	1.8%	2.7%
Total patients	91,440	1,674	2,510
Total visits	398,090	7,286	10,929
FTE staff	1,004	18	28

Source: Authors' analysis of the 2017 New Hampshire UDS report and Ku & Brantley, 2019