WORK REQUIREMENTS IN MEDICAID WAIVERS

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KEY FINDINGS

- The Centers for Medicare & Medicaid Services (CMS) issued guidance outlining parameters for states to condition Medicaid eligibility on work and community engagement activities through section 1115 Medicaid demonstration waivers.
- Kentucky, Indiana, and Arkansas recently received waiver approvals to impose work and community engagement requirements on able-bodied adult Medicaid beneficiaries.
- Several states are awaiting CMS approval for similar demonstrations, and other states are in the early stages of pursuing this policy option.
- Consumer groups and policy organizations are concerned about CMS' authority to make this policy change and about the effect of work and community engagement requirements on beneficiaries and coverage.

BACKGROUND

In a January 11, 2018, letter to state Medicaid directors, CMS officially announced a significant policy change: The agency gave states guidance on section 1115 demonstration waivers that require beneficiary work and community engagement as a condition of eligibility, a condition of coverage, a condition of receiving enhanced benefits, or a condition of paying reduced premiums or cost sharing.[1] The letter was accompanied by a frequently asked questions document, which provided more guideposts to states pursuing this approach.[2] Previous administrations only approved referrals to job training and support programs, including in waivers for Arizona, Arkansas, Indiana, Montana, and New Hampshire. Ohio, Pennsylvania, and Indiana previously tried to incorporate work and community engagement requirements as a condition of eligibility into their waiver proposals, but the Obama administration denied those proposals.

The administration late last year signaled movement toward this new approach. In a November 2017 address at the National Association of Medicaid Directors conference, CMS Administrator Seema Verma expressed strong support for waiver applications that require work or community engagement for Medicaid beneficiaries. During her remarks, Verma said, "One of the things that states have told us time and time again is that they want more flexibility to engage their working-age, able-bodied citizens on Medicaid."[3]

RATIONALE FOR POLICY SHIFT

CMS justified this policy shift in part by emphasizing the need for state flexibility in Medicaid. More broadly, recent regulations and guidance from CMS—such as ceding oversight of health insurance marketplace plans to states—have sought to increase state flexibility on the grounds that states are best positioned to meet the needs of their respective populations. In the January 11 letter, the agency argued that work and community requirement proposals should promote better health and help beneficiaries rise out of poverty and attain independence. CMS only has statutory authority to approve section 1115 waivers that "assist in promoting the objectives" of the Medicaid program.[4]

States will have to link section 1115 demonstration proposals to improved health and wellbeing outcomes.

CMS PROVIDES GUIDEPOSTS

CMS said it is committed to allowing states to test new and innovative approaches, provided that the agency determines demonstrations promote the objectives of the Medicaid program. States will have to link section 1115 demonstration proposals to improved health and wellbeing outcomes, and demonstrate that proposals further the health and wellness objectives of the Medicaid program.[5]

Qualifying Activities

The agency encourages state Medicaid directors to define work and community engagement activities broadly and to consider a wide variety of allowable activities, including:

- subsidized and unsubsidized employment;
- education and vocational programs;
- job search and readiness;
- job training;
- community service;
- caregiving; and
- time spent in medical treatment for substance use disorder.

Allowing a variety of qualifying activities is important to accommodate beneficiaries who live in areas of high unemployment or who are caregivers for children or elderly family members. States also should offer services—such as career planning, job training, and job referrals—that reflect individual employability and potential contributions to the labor market.

Exemptions

CMS encourages states to tailor work and community engagement requirements to specific eligibility groups or subpopulations within such groups. In general, the letter is directed to states seeking to apply work requirements to nonpregnant, nonelderly adult populations that qualify for Medicaid on a basis other than disability. States must exempt the medically frail, and should exempt those with acute medical conditions that act as a barrier to employment and are validated by a medical professional. CMS also encourages states to consider exemptions or modifications for a variety of other populations with extenuating circumstances, including:

- individuals receiving intensive treatment for substance use disorder;
- primary caregivers of dependents;
- victims of domestic violence; and
- full-time students.

Alignment with Other Programs

Where appropriate, CMS supports states' efforts to align work and community engagement requirements with those already in place for the Temporary Assistance for Needy Families (TANF) program and the Supplemental Nutrition Assistance Program (SNAP). This could include requirements related to excepted populations, protections for individuals with disabilities, beneficiary reporting requirements, and allowable activities that qualify as community engagement and work support programs. Individuals who are enrolled in and compliant with, or exempted from, a TANF or SNAP work requirement must automatically be deemed compliant with Medicaid work requirements.

Beneficiary Support

States are required to describe the strategies they will use to assist beneficiaries subject to work and community engagement requirements, such as linking beneficiaries to job training, child care assistance, transportation, and other employment resources and support. However, a federal match will remain available only for allowable services under current statute, making states responsible for the costs associated with beneficiary support. States also are encouraged to implement procedures that ensure Medicaid beneficiaries' due process rights are protected, such as processes to assess barriers to employment and self-sufficiency and reasonable accommodations that would allow participation in work and community engagement activities.

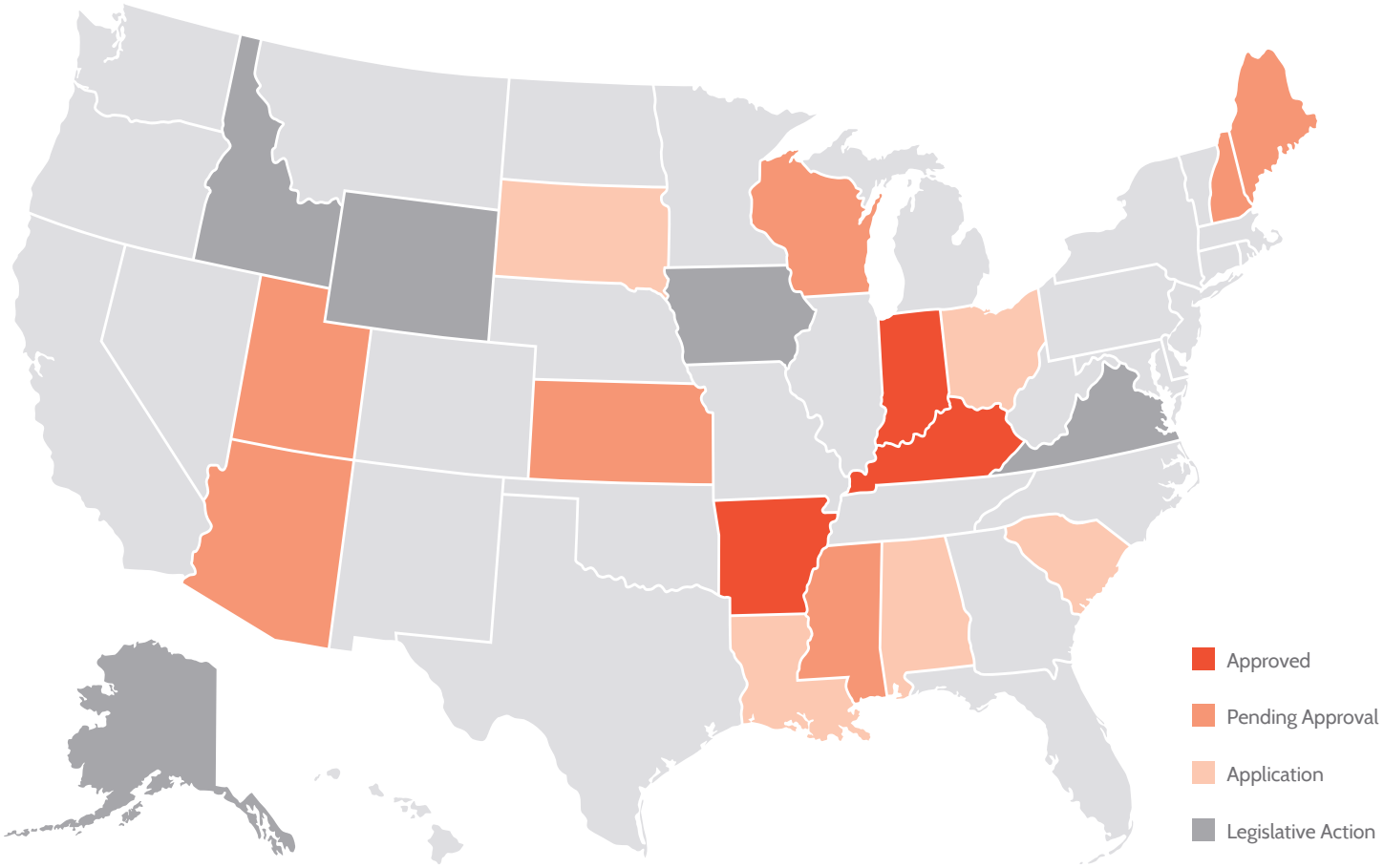
Monitoring and Evaluation

States pursuing a waiver that includes work and community engagement requirements must monitor and evaluate the effect of their program and demonstrate that work requirements further the objectives of the Medicaid program and are linked to improved beneficiary health and wellbeing. CMS will require states to develop and submit to the agency regular monitoring reports with specified metrics describing progress, effects on beneficiary enrollment and access, and overall function of the demonstration. CMS will conduct its own monitoring activities, work closely with states to offer technical assistance, and review state reports quarterly. Additionally, states must implement an evaluation that captures health and other outcomes of beneficiaries; determines whether the demonstration meets objectives; and assesses the overall effect on beneficiaries.

KENTUCKY GOES FIRST

Kentucky originally expanded its Medicaid program through the traditional path offered under the Affordable Care Act (ACA). However, after the recent gubernatorial election, the state chose to pursue a different path. In 2016, the state submitted a section 1115 waiver application to

STATUS OF WAIVER APPLICATIONS INCORPORATING WORK REQUIREMENTS



manage its expansion population, called Kentucky Helping to Engage and Achieve Long Term Health (HEALTH), and incorporate work and community engagement requirements for beneficiaries.

In January, CMS approved Kentucky's waiver application, which closely aligns with the new work and community requirement guidance.

Kentucky's waiver applies work requirements to beneficiaries ages 19 to 64, with exemptions for former foster care youth, pregnant women, primary caregivers (limited to one per household), the medically frail, beneficiaries with a medical condition preventing them from compliance, and full-time students. Beneficiaries must complete up to 80 hours per month of work or community engagement activities, which include employment, education, job skills training, participation in a substance use disorder treatment program, and community service. Beneficiaries also can satisfy the waiver requirements by meeting (or being exempt from) SNAP and/or TANF requirements, or if they are enrolled in the state's Medicaid employer assistance program or employed for 120 hours or more a month. These beneficiaries are not required to document their participation in qualifying activities, but must report any eligibility changes to the state.

Beneficiaries that fail to complete the required hours face coverage suspension, with the ability to have their coverage reinstated the month after they complete 80 hours of community engagement (within a 30-day period) or a state-approved health or financial literacy course (one time per 12-month benefit period). If beneficiaries are suspended on their redetermination date, enrollment will be terminated and they must submit a new application for coverage. The state waives suspension for those with

good-cause as specified in the waiver, including disability, the birth or death of a family member, severe inclement weather, and family emergencies.

Kentucky will submit for approval an evaluation plan and timeline within six months of waiver approval. Working with CMS, the state will ensure necessary oversight that allows for program adjustments as needed.[6]

INDIANA AND ARKANSAS FOLLOW

Indiana

Under the previous administration, CMS did not approve work requirements as part of Indiana's Medicaid expansion waiver, the Healthy Indiana Plan (HIP). However, the state encouraged employment, outside of the waiver, through a work search and job training program, known as "Gateway to Work." Indiana incorporated the Gateway to Work program into a waiver extension amendment, which CMS approved on February 1, making Indiana the second state to receive approval of Medicaid work requirements.

Indiana is phasing in work requirements over an 18-month period. Adult HIP beneficiaries will be required to participate in community engagement activities a minimum number of hours per week, starting at five hours per week and increasing up to 20 hours over the course of one year. Excess hours in a week can be applied to the rest of the calendar month. Community engagement activities include employment, education, job skills training, job search activities, and volunteer work. Pregnant women, the medically frail, students (full- and part-time), caregivers of dependent children below the compulsory education age or a disabled dependent, the homeless, individuals incarcerated within the last six months, and beneficiaries in active substance use disorder treatment are exempt.

Compliance is required for eight months of the calendar year, allowing beneficiaries four months in which they do not have to satisfy the requirements. The state will assess beneficiary compliance annually in December. Noncompliance in a calendar year will result in suspended coverage in the next calendar year; suspension will last until the month after the state is notified that the beneficiary completed one month of the required community engagement hours. If beneficiaries fail to comply with the community engagement requirements by their redetermination date (45 days before the beneficiary's current eligibility ends), they will be disenrolled and will have to reapply for Medicaid absent good cause. Currently, there are good-cause exemptions for the disabled and victims of domestic violence. The state will conduct outreach to disenrolled beneficiaries to ensure understanding of paperwork requirements and to encourage compliance with the requirements. If beneficiaries are disenrolled, they will not be able to re-enroll in the program for three months. However, noncompliance with the community engagement requirements will not factor into the state's decision on whether the beneficiary can reenroll in HIP.

As with Kentucky's waiver, Indiana will submit an evaluation plan and timeline within six months of waiver approval and work with CMS to ensure necessary oversight of the demonstration.[7]

Arkansas

In March, CMS approved modifications to Arkansas' private option expansion waiver, Arkansas Works, allowing the state to require participation in work and community engagement activities as a condition of eligibility for able-bodied adult beneficiaries ages 19 to 49. The requirements will not apply to medically frail individuals, full-time students, beneficiaries with validated physical or mental conditions that interfere with employment, pregnant women, primary caregivers, individuals receiving unemployment benefits, and those undergoing treatment for alcohol abuse or substance use disorders.

Beneficiaries must either work or participate in a variety of community engagement activities for a minimum of 80 hours per month. Qualifying activities include job training, enrollment in an educational program, community service, and participation in classes on health insurance, health system navigation, or healthy living. Beneficiaries must electronically report compliance for the previous month by the fifth of each month; they will be disenrolled if they fail to meet the requirements in any three months of a plan year. Those who are disenrolled will not be allowed to re-enroll until the following plan year, after filing a new application to receive an eligibility determination. Noncompliance with the work and community engagement requirements will not be factored into state eligibility determinations. The state will not penalize beneficiaries who demonstrate good cause, defined to include the same exemptions as in Kentucky. Beneficiaries who meet a good-cause exemption will receive retroactive coverage to the date coverage was ended without having to submit a new application.

Like Indiana and Kentucky, Arkansas will submit an evaluation plan and timeline within six months and work with CMS to ensure necessary oversight.[8]

FIGURE 1 HOURLY REQUIREMENTS, ELIGIBILITY, AND NONCOMPLIANCE PENALTIES FOR PENDING REQUESTS, BY STATE

STATE	WORK AND COMMUNITY REQUIREMENT SPECIFICATIONS	AGE ELIGIBILITY, EXCLUDING EXEMPTIONS	NONCOMPLIANCE PENALTY
Arizona	20 hours per week	19 to 55	Six-month grace period before enrollment termination; re-enrollment possible after demonstrated compliance for at least 30 days Failure to comply with work requirements also triggers five-year lifetime limit
Kansas	20 hours per week	19 to 65	Three-month grace period before removal from program until compliance is achieved
Maine	20 hours per week	19 to 64	Beneficiaries have a three-month grace period in a 36-month period where they do not have to meet the requirements. Noncompliance, after the three-month allowance is exhausted, results in disenrollment. Beneficiaries will remain disenrolled until compliance is achieved.
Mississippi	20 hours per week	19 to 65	Loss of coverage; reinstatement possible if requirements are met and beneficiary is within the original eligibility period
New Hampshire	25 hours per week after 12 months of benefits; 30 hours per week after 24 months of benefits over beneficiary's lifetime	19 to 65	Coverage termination. Re-enrollment process not yet determined.
Utah	30 hours per week	19 to 60	Loss of eligibility and removal from program. Beneficiaries must reapply for program benefits. Open enrollment requirements will not apply to individuals applying for benefits in the month following the month they complete all required activities.
Wisconsin	80 hours	19 to 49	For noncompliance in any month, beneficiary will accrue time toward a 48-month lifetime benefit limit

WHO WILL BE NEXT?

Seven states—Arizona[9], Kansas[10], Maine[11], Mississippi[12], New Hampshire[13], Utah[14], and Wisconsin[15]—now have pending requests for new or updated section 1115 demonstrations to incorporate work and community engagement requirements. The waiver requests all exempt certain populations, focusing requirements on able-bodied, working-age adults (a mix of ACA expansion and traditional populations). The pending requests include a variety of activities that would satisfy the requirements—from job training to caregiving to pursuing education. And all requests include noncompliance penalties, most often the suspension of enrollment until requirements are satisfied. It is unclear how each state would operationalize its proposal.

While the pending proposals have many similarities, they also have some nuances. Hourly requirements and eligibility vary, as shown in Figure 1. Two of the proposals—in Arizona and

Wisconsin—would tie compliance with work requirements to lifetime limits on Medicaid coverage. In Arizona, beneficiaries who fail to comply with work requirements would be subject to a five-year lifetime limit for able-bodied adults, and in Wisconsin participation in work activities would "stop the clock" on accruing a 48-month benefit limit.

Ohio is also in the early stages of its 1115 waiver application—referred to as the Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver. The application is under a public notice and comment period, which will be followed by submission to CMS. Ohio's waiver seeks to align work and community engagement requirements with existing SNAP requirements. Beneficiaries, ages 19 to 50, would have to work or participate in a community engagement activity for a minimum of 20 hours a week, or 80 hours averaged monthly. Failure to comply with the requirements would result in termination of Medicaid eligibility.

Other states see this new waiver approach as an attractive option for addressing their expansion populations or reconsidering expansion. Alabama, Louisiana, South Carolina, and South Dakota also are drafting waiver applications that would tie work and community engagement requirements to Medicaid eligibility. Legislatures have also focused on pursuing this policy approach—with Virginia, Iowa, Idaho, Alaska, and Wyoming seeing activity in their respective states houses.

Idaho lawmakers have introduced bills that would direct the state to apply for a section 1115 waiver with work and community engagement requirements. In Virginia, the House of Delegates has passed work requirement legislation, which now awaits action in the state Senate.[16]

WHAT DOES THIS MEAN?

While many states are pursuing work requirements, there is great concern from consumer groups and policy organizations that such requirements might negatively affect coverage. The Center on Budget and Policy Priorities, for example, estimates that 15 percent, or at least 97,000 people, will lose coverage in Kentucky due to work requirements and other provisions in the state's Medicaid waiver.[17] Critics of the requirements argue that taking coverage away from the unemployed people will result in poorer health and make finding employment more difficult, and that the burden of documenting compliance could cause working beneficiaries to lose coverage. Critics also contend that work requirements and the associated administrative costs are unnecessary given that most Medicaid beneficiaries already work or face significant barriers to employment that would qualify them for exemptions.[18] Lastly, there is concern that this policy might signal a larger change to federal eligibility in the future.

In response to CMS' approval of waivers with work requirements, some groups are contesting the agency's legal authority to condition Medicaid participation on work and have vowed to challenge the requirements in court. The first suit filed against Medicaid work requirements, *Stewart v. Azar*, was filed in federal court on January 24. Fifteen Kentucky Medicaid beneficiaries—represented by the National Health Law Program, Kentucky Equal Justice Center, and Southern Poverty Law Center—contend they will lose coverage because of the state waiver's work requirements and that CMS' work requirement policies (both in the January 11 letter and Kentucky's waiver) are invalid because the agency acted beyond the scope of its section 1115 statutory authority.[19] The state has countersued the plaintiffs, asking the court to declare the program legal.[20]

In addition to the justifications advanced by CMS, supporters of Medicaid work requirements assert that coverage implications will be minimal, pointing to data showing most beneficiaries eligible under the requirements already are working.[21] Proponents also highlight that CMS is not forcing states to adopt this policy approach. Rather, states that seek to impose work and community engagement requirements must seek permission from the agency. Further, they note that the intent of state demonstration projects is to test new and innovative approaches to public policy. Polling shows support for work requirements in Medicaid (although some results fall sharply along party lines and responses vary depending on how the issue was framed in the polling).[22,23,24]

Researchers have used work requirements under SNAP and TANF to draw correlations about the effects of such requirements on Medicaid beneficiaries. To date, there is little data proving whether work requirements in those programs truly help vulnerable populations rise out of poverty. Data collection and evaluation requirements for the new section 1115 waivers could offer new opportunities to analyze this policy approach.

CMS has promised to work with states seeking to incorporate work and community requirements into their Medicaid programs. Stakeholders will closely keep watch as CMS reviews and approves waiver requests from other states, and as legal challenges make their way through the courts.

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