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ISSUE BRIEF

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STATES MOVE TO IMPLEMENT MEDICAID WORK REQUIREMENTS

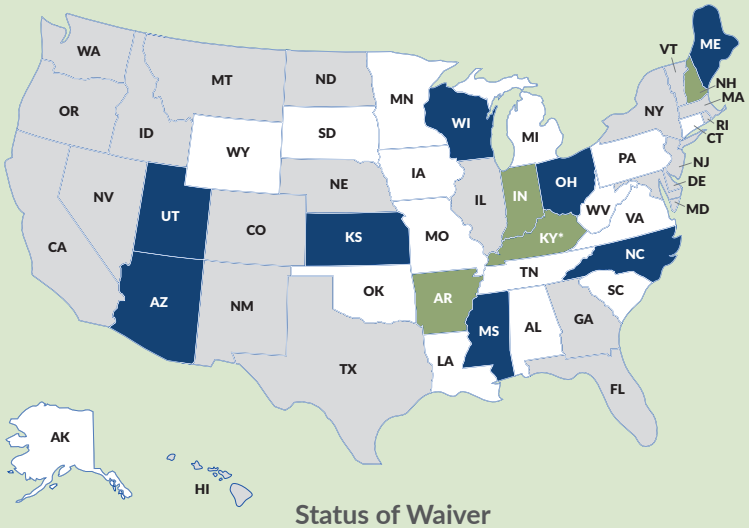
For the first time, beneficiaries in some states may be required to work as a condition for continued Medicaid coverage

Introduction

In January 2018, the federal government officially signaled its willingness to approve the implementation of work requirements in the Medicaid program. As a result, states now have a new Medicaid eligibility option that previous administrations, both Republican and Democratic, were unwilling to approve.

The option is based on Section 1115 of the Social Security Act, which gives the federal government authority to waive certain

States That are Implementing or Considering Work or Community Engagement Requirements for Some Adult Medicaid Enrollees as a Condition for Continued Medicaid Eligibility or Coverage, 2018.



*Federal court voided CMS approval of Kentucky's waiver on June 29, 2018.

Source: KHI analysis of publicly available documents.

KEY POINTS

- ✓ In January 2018, the federal government officially signaled its willingness to approve the implementation of work or community engagement requirements in the Medicaid program.
- ✓ Since January, Medicaid work requirements have been approved for four expansion states: Arkansas, Indiana, Kentucky and New Hampshire.
- ✓ Most proposals to implement work requirements apply to able-bodied adult enrollees, age 19-64, but states have also identified a number of exempted populations.
- ✓ States have proposed requiring either traditional work or community engagement activities, such as job training, education or community service.
- ✓ A federal court voided CMS approval of Kentucky's work requirements program on June 29, 2018.
- ✓ CMS has expressed concerns about the implementation of work requirements in states that have not expanded Medicaid.
- ✓ The KanCare work requirements proposal was submitted to CMS in December 2017 and is awaiting approval.
- ✓ A recent survey found that, of Kansans currently enrolled in Medicaid or uninsured and presumably eligible for Medicaid if it were expanded, 49 percent said they were already working, another 34 percent had a disability that prevented them from working, and 17 percent were otherwise not working.

provisions of federal Medicaid law to allow states to undertake demonstration projects—such as work requirements—in their Medicaid programs, as long as the projects further program objectives.

Work Requirements

Federal Actions

On January 11, 2018, the Centers for Medicare and Medicaid Services (CMS) sent a letter to all state Medicaid directors that provided policy guidelines for submitting Section 1115 demonstration proposals to implement work or community engagement requirements—such as community service, caregiving, volunteer service, education and job training—for some adult enrollees as a condition for continued Medicaid eligibility or coverage. In the letter, CMS encouraged states to submit proposals designed to "promote health and well-being" and to "help individuals and families rise out of poverty and attain independence" consistent with Medicaid program objectives.

On the following day, January 12, CMS approved the Section 1115 demonstration proposal submitted in July 2017 by Kentucky, a Medicaid expansion state. The Trump administration has stated that Kentucky's program is an experiment designed to promote the health of the state's expansion population.

Since January, CMS has approved Section 1115 demonstrations to implement Medicaid work requirements for three additional expansion states: Indiana, Arkansas and New Hampshire. Eight more states, both expansion (Arizona and Ohio) and non-expansion (Kansas, Maine, Mississippi, North Carolina, Utah, and Wisconsin) have submitted Section 1115 demonstration proposals to CMS that include work requirements, and 16 additional states have publicly announced their interest in implementing work requirements for their Medicaid enrollees.

Affected Populations

Most proposals to implement work requirements apply to able-bodied adult enrollees, age 19–64, although some states have proposed lower upper-age limits. A small number of states have included 18-year-olds, while the majority specifically exempt them from the requirements.

Primary caregivers for dependent minor children or disabled adult dependents are one of the exempt populations identified by various states to be exempt from work requirements.

States also have identified other exempt populations, including:

- Pregnant women, or those who are 60- to 90-days post-pregnancy;
- Primary caregivers for dependent minor children or disabled adult dependents;
- Medically frail individuals;
- Students, full-time or part-time;
- Individuals already working 20 or more hours per week;
- Individuals with a certified temporary illness or incapacity;
- Individuals in active substance use disorder treatment;
- Former foster children under age 26;
- Chronically homeless individuals;
- Individuals who already meet or are exempt from work requirements for the Supplemental Nutrition Assistance Program (SNAP) or the Temporary Assistance for Needy Families (TANF) program;
- Individuals who are medically certified as physically or mentally unfit for employment;
- Individuals diagnosed with a mental illness;
- Individuals receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI);

- Individuals receiving or applying for unemployment insurance;
- Individuals participating in state-certified drug court programs;
- Native Americans;
- Individuals receiving long-term care;
- Individuals enrolled in or on waiting list for certain Home and Community-Based Services programs;
- Victims of domestic violence; and,
- Individuals recently impacted by a catastrophic event, such as a natural disaster.

For details on each state's proposed exempted populations, please refer to the supplemental document posted online at bit.ly/2tRijx1.

Work/Community Engagement Activities

Almost all states considering the requirement propose requiring non-exempt individuals to perform at least 20 hours of work or community engagement per week (80 hours per month). In addition to employment, states have proposed alternative community engagement activities, including:

- Job skills training, vocational education/ training or other education related to employment;
- Job search activities;
- General education, such as GED programs or community college;
- Community work or public service;
- Caregiving services for a non-dependent relative or other person with a chronic, disabling health condition;
- Accredited English as a Second Language education; and,
- Volunteering with approved agencies.

For state-specific information on work and alternative community engagement activities, please refer to the supplemental document posted online at bit.ly/2tRijx1.

Penalties for Failure to Comply

In general, states have proposed that the penalty for failure to comply with the state's work or community engagement requirements is suspension or temporary loss of benefits, termination of or removal from coverage, and lockout from participation in the Medicaid program for some period of time.

General education, such as GED programs or community college, is an alternative way some states propose members can meet community engagement requirements.

Kentucky

Kentucky's demonstration proposal, entitled *Helping to Engage and Achieve Long Term Health* (HEALTH), was submitted in July 2017 and approved by CMS on January 12, 2018. The program includes work or community engagement requirements that were to be implemented beginning in July 2018. The state's community engagement requirement—a condition of eligibility—applies to both the current expansion population and other adult beneficiaries already covered by Medicaid age 19–64.

In its application, Kentucky stated that the demonstration "is part of an overall initiative to transform the Kentucky Medicaid program to empower individuals to improve their health" and provides individuals with opportunities to "take control of their life through taking an active role in not only their health, but also in their communities by working to gain skills needed for long-term independence and success."

To remain eligible for coverage, non-exempt beneficiaries must complete 80 hours per month of work or community engagement activities (see the supplemental document posted online at bit.ly/2tRijx1 for a detailed list of eligible activities). Beneficiaries are also deemed to satisfy the requirement if they (1) satisfy Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) work requirements or are exempt from those requirements, (2) are enrolled in the state's Medicaid employer premium assistance program, or (3) are employed for 120 hours or more a month.

During their 12-month benefit period, beneficiaries are given a one-month "opportunity to cure," in which they are given time to comply with the work or community engagement requirements. After that time, those who still fail to comply will have their eligibility suspended, but can reactivate it by completing 80 hours of work or community engagement in a 30-day period or by completing a state-approved re-enrollment health literacy or financial literacy course. Reactivated eligibility is effective the first day of the month following completion of the required hours or course. During a suspension period, any beneficiary who becomes eligible for Medicaid under a group that is exempt from work or community engagement requirements can have their eligibility reactivated with an effective date consistent with their new eligibility category or status. Beneficiaries who are in an eligibility suspension on their redetermination date will have their enrollment terminated and will be required to submit a new application.

In addition to the work or community engagement requirements, Kentucky's approved demonstration also requires premium payments for some beneficiaries and disenrollment for up to six months for beneficiaries who fail to submit their eligibility redetermination paperwork in a timely manner.

In estimated enrollment and fiscal projections submitted to CMS in July 2017, the state projected that total member months would be reduced by 699,000 (the equivalent of about 58,250 enrollees over a year) and state and federal expenditures combined would be reduced by $467.4 million for demonstration year 2019 with implementation of the waiver.

A federal court voided CMS approval of Kentucky's work requirements program on June 29, 2018.

Arkansas

Arkansas, the first state to expand Medicaid using a Section 1115 demonstration, submitted an amendment to its *Arkansas Works* demonstration project on June 30, 2017, that included a proposal to institute work or community engagement requirements as a condition of eligibility. In the amendment, Arkansas stated it would "test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions between and among *Arkansas Works*, ESI (employer-sponsored insurance), and the Marketplace" for its enrollees. On March 5, 2018, CMS approved Arkansas' amendment.

The state's work or community engagement requirements apply to *Arkansas Works* beneficiaries age 19–49. To maintain their Medicaid eligibility, non-exempt beneficiaries must complete at least 80 hours per calendar month of one, or any combination of, qualifying activities. Beneficiaries also are required to electronically report their previous month's qualifying activities into the state's online portal by the fifth day of each month.

Beneficiaries who do not comply with the work or community engagement requirements or who fail to report for any month within a coverage year will receive monthly notices of non-compliance that explain how to come into compliance before they are disenrolled. Disenrollment is effective the first day of the month after the notice is provided during the third month of non-compliance, unless a timely appeal is filed or a good cause exemption is requested. Beneficiaries who are non-compliant for any three months (consecutive and non-consecutive) will have their eligibility terminated until the next plan year, when they must file a new application to receive an eligibility determination.

On June 1, 2018, the state began its phased in implementation of the work or community engagement requirements by age group beginning with beneficiaries age 30-49. Those age 19–29 will be phased in during the first quarter of 2019. The state announced on April 2, 2018, that it had launched the website that beneficiaries must use to prove compliance with the work or community engagement requirements. In its Eligibility and Enrollment Monitoring Plan filed with CMS on May 24, 2018, Arkansas stated there were 171,449 *Arkansas Works* beneficiaries age 19–49.

Indiana

Indiana submitted a waiver extension application for its existing Section 1115 demonstration—the *Healthy Indiana Plan* (HIP)—on January 31, 2017, and then submitted an amendment on July 20, 2017, to propose implementing work or community engagement requirements for the HIP population beginning in 2019. CMS approved the request on February 1, 2018. In the original HIP, Indiana implemented its *Gateway to Work* (GTW) initiative, which was a voluntary program to connect HIP members to job training and employment services. In its amendment submission, Indiana stated it was seeking to require members to participate in GTW as a condition of eligibility to increase participation, increase employment among HIP members and "reduce dependence on public assistance."

Indiana's work or community engagement requirements apply to all able-bodied HIP members. To remain eligible for coverage, non-exempt beneficiaries must work at least 20 hours per week over eight months of an eligibility cycle, be enrolled in full-time or part-time education, or participate in the GTW initiative.

The work or community engagement requirements will be phased in, beginning in 2019 with a member grace period of six months and building to the 20 hours per week requirement. Following the grace period, non-exempt HIP members who are unemployed or working fewer than 20 hours per week will be required to participate in the GTW program. Compliance will be required for eight months of the calendar year and beneficiaries will have four months in which they do not need to meet the requirements. Members who fail to meet the eight-month requirement in a calendar year will have their eligibility suspended in the new calendar year until the month following notification to the state that they have completed a calendar month of required participation hours. If a suspended beneficiary does not meet the requirements or qualify for an exemption in the month of their redetermination, they will be disenrolled from Medicaid at that time and will have to reapply. During a suspension period, any beneficiary who becomes exempt can reactivate eligibility with a new effective date consistent with their new eligibility status.

In the waiver amendment submitted to CMS in July 2017, Indiana stated that as of January 1, 2017, there were 438,604 enrollees in HIP. The state estimated that 30.3 percent (132,704) of these enrollees would be participating in the GTW program.

New Hampshire

New Hampshire submitted an amendment to CMS on October 24, 2017, to amend its existing Section 1115 premium assistance demonstration, the *New Hampshire Health Protection Program* (NHHPP), to add a community engagement program for the expansion population, referred to as *New Hampshire Health Protection Work Promotion and Personal Responsibility*. The amendment was approved on May 7, 2018, for implementation on or after January 1, 2019. In its amendment submitted to CMS, New Hampshire stated that the program seeks to "empower individuals ... to improve their health by taking an active role in engaging in their communities and by working to gain the skills necessary for long term independence and success."

The amendment authorizes the state to require work or community engagement as a condition of eligibility for non-exempt beneficiaries age 19–64. To maintain eligibility, non-exempt beneficiaries will be required to participate in 100 hours per month of work or community engagement activities. All currently enrolled beneficiaries will have 75 calendar days after the implementation date before they must meet the hours requirement. Beneficiaries who fail to meet the work or community engagement requirements in a month will receive notice that their eligibility will be suspended at the end of the following month until they demonstrate good cause for failing to meet the requirements, demonstrate an exemption status, or satisfy the work or community engagement requirements by making up the deficient hours for the month that resulted in noncompliance. If a beneficiary is out of compliance with the requirements and fails to respond to the notice, the state will suspend eligibility effective the first of the month following the one-month opportunity to cure. The suspension will remain in effect until the beneficiary reactivates eligibility, which they can do by satisfying the deficiency in work or community engagement hours that resulted in non-compliance, meeting the qualifications for an exemption, demonstrating good cause, or becoming eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement.

Beneficiaries who are scheduled for redetermination and whose eligibility has been suspended due to failure to meet the work or community engagement requirements will receive notice informing them of their upcoming redetermination period. During redetermination, the state will terminate eligibility for beneficiaries who are not in compliance with the requirements. Beneficiaries whose eligibility has been terminated at redetermination can reapply at any time.

The Kentucky Lawsuit —*Stewart v. Azar*

On January 24, 2018—12 days after CMS approved Kentucky's work requirements waiver demonstration—15 Kentucky Medicaid enrollees, ranging in age from 20–62, filed a lawsuit in the U.S. District Court for the District of Columbia. That lawsuit, *Ronnie Maurice Stewart, et al., v. Alex M. Azar II, et al.*, challenges the authority of CMS to issue the January 11 policy guidelines and to approve Kentucky's demonstration project. In addition to U. S. Department of Health and Human Services (HHS) Secretary Azar, the defendants include CMS Administrator Seema Verma and other CMS officials.

In their complaint, the plaintiffs asked the court to declare the work requirements policy and Kentucky's waiver illegal so it cannot be implemented. They assert that HHS "bypassed the legislative process and acted unilaterally to 'comprehensively transform' Medicaid" and put them at risk of losing their coverage by creating new eligibility criteria. In its policy guidance issued in January, CMS stated that it was allowing work or community engagement waivers to test whether they will result in more beneficiaries being employed or engaging in other community activities that would produce improved health and well-being. In issuing the work requirements guidance and approving Kentucky's waiver, HHS relied on its authority under Section 1115 of the Social Security Act, which permits HHS to waive certain provisions of federal Medicaid law to allow states to undertake demonstration projects that the Secretary determines will further program objectives.

In a memorandum filed with the court on April 25, 2018, the federal government argued that Section 1115 gives the secretary broad authority to approve state demonstration projects and that it complied with all required Administrative Procedure Act standards. The government also characterized Kentucky's program as an experimental project designed to "test innovative methods to promote health" for members of its Medicaid expansion population.

On June 29, 2018, Judge James E. Boasberg issued an opinion in the case and vacated Secretary Azar's approval of Kentucky's work requirements program. In his opinion, Judge Boasberg stated that while the secretary has broad discretion to approve demonstration projects like Kentucky's, he found that the secretary had not adequately considered whether the project would, in fact, further the objectives of the Medicaid program and help the state furnish medical assistance to its citizens. He also stated that his review of the administrative record showed the secretary had not "adequately considered" how many people might lose coverage if the waiver was approved. In vacating the waiver, the court remanded, or returned, the waiver to HHS to correct the error and issue a decision supported by the administrative record. In the meantime, the court's decision prevents Kentucky from implementing its work requirements program.

HHS and Kentucky have 60 days to appeal Judge Boasberg's decision and CMS officials have indicated they are conferring with the U.S. Department of Justice about how to proceed. Although the court's decision only impacts Kentucky's waiver, states with pending waiver applications will certainly be watching to see how the case is resolved.

The 'Subsidy Cliff'

On May 1, 2018, CMS Administrator Seema Verma expressed concerns about individuals who might lose coverage if CMS were to approve work requirements in states such as Kansas that have not expanded Medicaid. She referred to the "subsidy cliff" that would occur if individuals begin to earn enough income to make them ineligible for Medicaid but not enough to qualify for financial assistance (tax credits) on the Affordable Care Act (ACA) marketplaces. In addition to Kansas, the non-expansion states of Maine, Mississippi, North Carolina, Utah and Wisconsin have also submitted proposals for work requirements as a condition of eligibility for their Medicaid programs. While Ms. Verma did not rule out approving work requirement waivers for non-expansion states, she stated that CMS was seeking solutions to address the subsidy cliff.

On May 23, 2018, South Dakota, a non-expansion state, posted a draft proposal on its website to implement a pilot Medicaid work requirements program, entitled the *Career Connector* program, in two of its most populated counties. However, it appears the state is attempting to address CMS's concerns about the subsidy cliff by providing "Transitional Medical Benefits" for a period of 12 months to individuals who lose eligibility due to increased earnings. As enrollees make more money, the state would move them into a premium assistance program to help them purchase employment-based insurance or coverage through the ACA marketplace. The program would provide these individuals with coverage assistance until they reach 150 percent of FPL for one

year when they would be eligible for both premium tax credits and cost-sharing subsidies for marketplace coverage. The proposal indicates that the state will finance the non-federal share of expenditures using state general funds.

KanCare 2.0

In the KanCare 2.0 renewal application submitted to CMS on December 26, 2017, the state proposed the implementation of work requirements for "some able-bodied" adults on or after January 1, 2019. Unlike the states whose work requirements have already been approved, Kansas has not expanded Medicaid and is proposing to apply its work requirements to some of its otherwise-eligible adults. KanCare members who would not be subject to the work requirements include:

- Members receiving long-term care, including institutional care and Money Follows the Person;
- Members enrolled in or on the waiting list for Home- and Community-Based Services waiver programs;
- Children (age 0-18);
- Pregnant women;
- Members who have disabilities and are receiving Supplemental Security Income (SSI);
- Caretakers for dependent children under 6 years or those caring for a household member who has a disability;
- Medicaid beneficiaries who have an eligibility period that is only retroactive;
- Members enrolled in the MediKan program;
- Members presumptively eligible for Medicaid;
- Persons whose only coverage is under a Medicare Savings Program;
- Persons enrolled in Programs of All-Inclusive Care for the Elderly (PACE);
- Members with tuberculosis, HIV or in the Breast and Cervical Cancer Program;
- Members who are age 65 years and older; and,
- Certain caretakers of KanCare members age 65 and older who meet criteria specified by the state.

The state proposes to assess beneficiaries at the point of application or redetermination to determine if they would be required to meet the work requirements. Similar to the requirements already in place for its existing Temporary Assistance for Needy Families (TANF) program, the minimum weekly work requirement would be 30 hours in a one-adult household without children under age 6. Under TANF, the requirement for one-adult households with a child under age 6 is reduced to 20 hours; whereas under KanCare 2.0 the work requirement would be eliminated entirely. Minimum weekly requirements in two-adult households would be 35 hours for households not using subsidized childcare and 55 hours for those that do. For any given individual, the maximum requirement is 40 hours per week.

Activities that would meet the state's definition of work include:

- Unsubsidized employment, full or part-time;
- Subsidized public employment, such as temporary staffing, federal work study, Job Corps, or Workforce Innovation and Opportunity Act paid work experience in which wages are subsidized by TANF or other public funds;
- Subsidized private employment in which wages are subsidized by TANF or other public funds;
- Work experience, such as an unpaid, supervised assignment to help the member develop work history, improve work habits and increase self-confidence and esteem;
- On-the-job training;
- Supervised community service;
- Vocational education;
- Job search/job readiness activities;
- Job readiness case management (one-on-one services);
- Job skills training directly related to employment;
- Education related to employment, including adult basic education, English as a Second Language, and other courses designed to provide knowledge and skills for a specific job; and,
- Secondary school attendance, including efforts toward GED or completing a high school degree.

Members who fail to comply with the work requirements would be removed from KanCare until compliance is achieved. Disenrollment would occur the first day of the month following the month in which the member was found to no longer meet the work requirements. The disqualification period would continue until the member complies with all work requirements.

The current KanCare program provides for transitional Medicaid coverage, referred to as TransMed, which is designed to provide temporary health coverage to families moving to economic self-sufficiency. Similar to the South Dakota proposal, TransMed provides an additional 12 months of coverage for families who were previously eligible for Medicaid but who lost eligibility due to increased earnings. In the KanCare 2.0 renewal application, the state said it is considering the creation and funding of "Independence Accounts," a type of health savings account, for adults enrolled in TransMed, to encourage them to maintain employment and transition out of Medicaid into private coverage. Unlike South Dakota's proposal, the Kansas TransMed program description does not indicate that transitional assistance would remain in place until enrollees reach at least 150 percent of FPL.

Kansas Work Requirements Survey

In late 2017, Commonwealth Fund and REACH Healthcare Foundation commissioned researchers from the Harvard T. H. Chan School of Public Health at Harvard University to conduct a telephone survey of Kansans, ages 19-64, and with family incomes at or below 138 percent of the federal poverty level (who would presumably be eligible if the state expanded Medicaid). When asked about the implementation of work requirements in the Kansas Medicaid program, of those currently enrolled in Medicaid or without any insurance coverage, 49 percent reported that they were already working, 34 percent had a disability that kept them from working, and only 17 percent were otherwise not working. Breaking down the 17 percent who were otherwise not working, 11 percent said they would be more likely to look for work if that was required to obtain Medicaid, and 6 percent said they would not be more likely to look for work even if required.

Opposition to Work Requirements

In addition to the lawsuit filed by Kentucky Medicaid enrollees, numerous national groups and organizations representing health care, disability rights, criminal justice and faith-based organizations have expressed their opposition to work requirements. On February 15, 2018, 160 organizations— including the National Alliance on Mental Illness (NAMI), the Center for Law and Social Policy (CLASP), the American Heart Association/American Stroke Association, the American Lung Association and the American Diabetes Association—sent a letter to HHS Secretary Alex Azar expressing their concerns about the CMS decision to approve work requirements in Medicaid. The most commonly cited concerns included:

- Some individuals who do not meet the Social Security disability requirements may have a chronic illness or disability that would prevent them from gaining or retaining employment;
- Some individuals with criminal records may not be able to secure employment or even engage in volunteer activities;
- Work requirement programs will require significant state investment in infrastructure, will necessitate new administrative processes and programs, and will require considerable financial and human resources;
- The effectiveness of work requirements implemented in other social service programs—such as SNAP, TANF and federal housing programs—have not consistently produced an increase in stable employment or financial independence;
- Individuals who are no longer eligible for Medicaid will likely wait to seek care until their conditions are more serious and costly to treat; and,
- Work requirements could lead to higher uninsured rates and an increase in emergency room visits.

Conclusion

With the Trump administration's support of Medicaid work requirements, it is likely that the states that have already submitted, or plan to submit, Section 1115 demonstration proposals will soon receive approval for those programs. However, non-expansion states may be asked to modify their proposals to include additional program elements addressing CMS concerns about the "subsidy cliff." This may prove challenging if these alternative coverage provisions require states to fund additional costs.

ABOUT THE ISSUE BRIEF

This brief is based on work done by Linda J. Sheppard, J.D., and Lawrence J. Panas, Ph.D. It is available online at khi.org/policy/article/18-16.

KANSAS HEALTH INSTITUTE

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