Changes to Medicaid eligibility in 2018
10 considerations for states seeking to pursue Medicaid work/community engagement requirements
About the Center for Government Insights

The Deloitte Center for Government Insights shares inspiring stories of government innovation, looking at what's behind the adoption of new technologies and management practices. We produce cutting-edge research that guides public officials without burying them in jargon and minutiae, crystalizing essential insights in an easy-to-absorb format. Through research, forums, and immersive workshops, our goal is to provide public officials, policy professionals, and members of the media with fresh insights that advance an understanding of what is possible in government transformation.

About the author

Jim Hardy is a Specialist Executive in Deloitte's State Health Practice. He has over 30 years of Medicaid and health care experience, including serving as Pennsylvania's Medicaid Director. He helps states improve the performance of Medicaid managed care programs and develop new payment and delivery models that increase value, improve quality and control costs for Medicaid's most complex populations. He also works with states to improve the organizational efficiency of their Medicaid programs. Over the years, Jim has worked with a number of clients, including the Commonwealth of Pennsylvania, the Commonwealth of Kentucky, the State of Maine, the State of New Hampshire, the State of Washington, the State of Kansas and the Centers for Medicare and Medicaid Services.
For the first time, federal and state policymakers are approving Section 1115 Medicaid waivers with a work or community engagement requirement as a condition of eligibility. Read on to discover ten of the most important considerations for states seeking to pursue a Medicaid work requirement.
A seismic change to Medicaid is on its way

For the first time in Medicaid’s fifty-two year history, the Centers for Medicare and Medicaid Services (CMS) will allow states to institute Medicaid work requirements and community engagement requirements as a condition of eligibility. The move is designed to assist states in their efforts to test whether such an experiment can improve the health and well-being of Medicaid beneficiaries.

CMS made the announcement in a letter to state Medicaid directors (SMD) dated January 11, 2018. States may request permission from CMS to institute work/community engagement requirements through Section 1115 waivers (see sidebar: “What are Section 1115 Medicaid Waivers?”)

What are Section 1115 Medicaid waivers?

States must adhere to minimum coverage and benefit standards, established by federal law in the Social Security Act, to receive guaranteed federal funding for their Medicaid program. However, states may submit waivers to the Secretary of the Department of Health and Human Services (HHS) under Section 1115 of the Act, requesting permission to waive federal rules for pilot projects that promote the Medicaid program’s overall objectives. The Secretary of HHS evaluates these requests and decides whether to approve or deny them. These pilot projects—often called “demonstrations”—are subject to all relevant public notice and transparency requirements, and states must demonstrate how they will evaluate the hypothesized outcomes of their demonstration.

Section 1115 waivers must also be budget neutral for the federal government. Over the life of the waiver, federal Medicaid expenditures must not exceed what they would have been without the waiver. Section 1115 waivers are generally issued for five years, and may be renewed for an additional three to five years.¹
Changes to Medicaid eligibility in 2018

Work requirements currently exist in two public assistance programs: Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). In the SMD letter, CMS encouraged states to align their proposed Medicaid work requirements with the ones they have in place for TANF/SNAP. The agency outlined several other suggestions and guidelines for proposed policies. For instance, pregnant women, the elderly, individuals with disabilities, and individuals the state deems “medically frail” should be exempt. CMS also reminded states that Section 1115 waivers are subject to state and federal public notice requirements. Figure 1 lists six key elements of CMS guidance to state Medicaid directors.

As of February 2, 2018, CMS has approved Medicaid waivers from Kentucky and Indiana that include work/community engagement requirements. As of February 2018, CMS is reviewing similar proposals from nine other states (figure 2), and more states are contemplating similar proposals.

Mandatory work and community engagement proposals in Medicaid have led to a great deal of political and partisan debate. This brief neither advocates for or against such proposals but, rather, outlines ten key considerations for states who seek to pursue these policy changes.

Figure 1: Six key elements of CMS guidance to state Medicaid Directors

- CMS encourages states to align Medicaid work requirements with SNAP and TANF requirements to streamline eligibility and verification processes across programs.
- States have the flexibility to apply work requirements to all adult beneficiaries that are non-elderly, non-pregnant, non-disabled and non-medically frail; states may choose to make further exemptions.
- States are required to comply with federal civil rights laws, including the Americans with Disabilities Act (ADA), when designing program criteria and exemptions.
- All 1115 Demonstrations are subject to budget neutrality rules and require 30-day state and federal public notice.
- States are required to submit their monitoring and evaluation plans to CMS and comply with CMS reporting requirements; evaluations should include measure of health outcomes.
- States are required to develop strategies to assist beneficiaries in meeting work/community engagement requirements; states may not use federal matching funds to provide these services.

Source: CMS Centers for Medicaid & CHIP Services SMD: 1B-002, January 11, 2018

Figure 2: States seeking to implement Medicaid work requirements through 1115 waivers

Ten considerations for states seeking to pursue Medicaid work/community engagement requirements

Good people can disagree on whether mandatory work/community engagement requirements are a good idea, but that debate is beyond the scope of this paper. Below, we outline ten key considerations for states who are pursuing these policy changes.

1. **Define the population subject to the work requirement.** One of the most fundamental decisions states must make when designing a work/community engagement demonstration is who will be subject to the requirement, and who will be exempt. CMS guidance states that children, the elderly, pregnant women, the medically frail, and those who qualify for the program on the basis of a disability cannot be subject to Medicaid work requirements. However, states still need to decide whether to include all the remaining adult population or create exemptions therein.

   As the CMS letter suggested, states may align these exemptions with those for their TANF/SNAP programs. Commonly-exempted populations for TANF/SNAP include caregivers, full-time students, individuals with disabilities, individuals with a substance use disorder (SUD), and others who may be unable to meet the requirements, such as homeless individuals, domestic violence victims, and people with mental illness. (See Appendix A for a summary of current waiver proposals and their target populations and exemptions.)

2. **Define work/community engagement activities, and determine the frequency and method for beneficiaries to report work activities.** According to CMS’s SMD letter, states have broad latitude to define activities, other than employment, that could satisfy this requirement and the number of hours per week one must participate in these activities. The agency supports aligning community engagement activities with those of states’ TANF/SNAP programs, including subsidized and unsubsidized employment, educational and vocational programs, job training, community service, and caregiving. (See Appendix A for a summary of current waiver proposals and how they define work activities.)

   States need to decide how often they will require beneficiaries to demonstrate they are completing the Medicaid work requirement. For instance, Arkansas would require beneficiaries to report their status electronically every month, while Utah’s proposal would require beneficiaries to demonstrate they’ve met the work requirement once, after which they would remain eligible for the rest of the 12-month eligibility period.

   States should also determine what constitutes credible proof of a work activity, particularly for activities that are more difficult to verify and prove, such as working on a resume or attending a job interview. States may want to create an easy way for beneficiaries to provide proof of work activities, such as a website where they can upload photos of relevant documents or a mobile app where they can “check-in” after completing a job interview. Beneficiaries may also be able to log onto
an online Medicaid system that can track and record participation in online training courses and other activities. A variety of technological mediums can be explored to reduce the burden of the demonstration on beneficiaries and the state. Finally, states may want to adopt or adapt existing TANF work verification procedures.

Determine the consequences for non-compliance, and the consequences of those consequences. Most waivers submitted to-date explicitly state that non-compliance would result in suspension of benefits/loss of eligibility. In Indiana, beneficiaries could regain benefits after fulfilling Medicaid work requirements for one full month. In Arkansas, beneficiaries who lose coverage due to non-compliance could not reapply until the following coverage year.

CMS stated in its letter to Medicaid directors that a waiver would be evaluated based on how much it improved health outcomes (and other goals established by the state). Specifically, states would need to track the health outcomes of (1) beneficiaries who remain enrolled in Medicaid and (2) those who are subject to the requirements but lose or experience a lapse in coverage due to non-compliance. States considering lock-out periods for non-compliance should consider how long their lock-out period would be, the potential impact of longer lock-out periods on beneficiaries’ health, and how they would go about monitoring the health status of those who are in a lock-out period. States may also want to consider whether to have a “reinstatement” policy should the health status of a person who has been “locked-out” deteriorate.

Beneficiaries who become uninsured due to non-compliance may continue to use the health care system through uncompensated visits to safety net hospitals, emergency rooms, and clinics. As such, states may wish to consider undertaking ongoing cost-benefit analyses of “lock-out” policies. (See Appendix A for a summary of current waiver proposals and how they plan to address non-compliance.)

Decide what support services to provide. Most non-elderly, non-disabled adult Medicaid beneficiaries who are unemployed cite illness or disability (36 percent), caregiving (30 percent), school (15 percent), and inability to find work (6 percent) as reasons for being unemployed.8 Those who say they cannot find work may face barriers to employment, such as substance abuse issues, criminal records, limited education, or lack of affordable transportation. States should link beneficiaries with resources, such as job training, child care, and transportation assistance, to help them overcome these barriers. However, states may not use federal Medicaid matching funds to finance work support programs for beneficiaries.9

States would, therefore, need to look to other federal, state and private-sector sources of funding to support Medicaid beneficiaries’ work and community engagement activities. For example, states may be able to augment existing workforce development programs and partnerships with community and non-profit organizations. Individuals that are subject to Medicaid work requirements may also be eligible for and enrolled in TANF or SNAP.
case managers, job training resources, and work verification systems. However, states may also have to scale, modify, or create new program infrastructure to meet the needs of the Medicaid population.

Assess the state’s labor market and work with community organizations to link individuals with job opportunities. The type and quantity of jobs and volunteer opportunities available to Medicaid beneficiaries can vary significantly depending on where they live and how well their skills and education match the demands of the labor market.

Before implementing a Medicaid work requirement, states may want to assess various aspects of local labor markets in their state, including the unemployment rate; the education and skills necessary to obtain jobs; and the skills and education of the Medicaid population subject to the work requirement. Education and job training programs could focus on providing the most locally in-demand skills. Economic development plans may focus on areas with the most Medicaid beneficiaries who are unemployed but able to work.

States may also consider whether their work requirement would remain in place during recessions when jobs are more difficult to find. For example, in the SNAP program, states can apply for a waiver from the SNAP work requirement when the state experiences an economic downturn, as was the case during the economic recession that began in 2008.10

10

Decide how to administer the new requirement, including how much the state can build on existing work/community engagement requirement infrastructure in TANF and SNAP. After making some of these foundational decisions, states can decide how the new requirement would be administered and overseen, and by whom. States’ previous experiences implementing work requirements in TANF and SNAP show that administrative challenges often result from the need to document, verify, and track beneficiaries’ participation in an approved work activity or combination of activities for the required number of hours each month.11 Administering these policies requires time, resources, and money.

States may be able to implement the requirement themselves through existing TANF/SNAP channels. They could also integrate with other programs in the work ecosystem, including their workforce, adult education, and vocational rehabilitation agencies. Alternatively, states may have third-party entities administer and monitor the program, including contractors or managed care organizations (MCOs).

Indiana’s waiver explicitly requires MCOs to develop beneficiary incentive programs that promote employment. MCOs may be well-suited to carry out this role because work requirements may create a new alignment between them and their members. Helping beneficiaries meet the requirement could help ensure that their members maintain coverage and that the MCO continues to receive capitated payments without
incurred the administrative costs of high-churn. But states could go further and ask MCOs to monitor and enforce requirements.

The administration method a state chooses is likely to be based on the capacity of its current resources and operating models as well as their ability to scale those models to accommodate the population newly subject to work requirements.

7 Assess current eligibility and enrollment technology systems and determine whether upgrades would be necessary to account for a work requirement. Work/community engagement demonstrations would impact eligibility and (re)enrollment and, ultimately, the information technology systems that support these functions. States should assess their technical assets to determine whether existing systems would need to be upgraded or replaced.

States that plan to align features of their Medicaid work requirement with those of TANF/SNAP may be able to streamline eligibility and operations across programs. Other states may adopt integrated eligibility systems to achieve these efficiencies.

Existing workforce management solutions may be modified to allow beneficiaries, employers, MCOs, and Medicaid eligibility and enrollment systems to communicate and share data with one another. Agencies should calculate the cost of system upgrades and have them in place before the policy is rolled out.

8 Determine if and how work/community engagement requirements fit into larger Medicaid personal accountability goals. Some states are making their work/community engagement requirements part of a larger campaign to encourage personal engagement among Medicaid beneficiaries. For example, in Kentucky, adults that pay a premium of at least $1.00 will receive a My Rewards incentive account, which can accrue funds through several activities, including completing specified healthy behaviors; completing work activities that exceed the required minimum of 80 hours per month; not having a non-emergency ER visit during the benefit year; and keeping all scheduled appointments in a year. (Pregnant women are not responsible for premium payments but may have an active My Rewards incentive account). Beneficiaries can use the funds in their incentive accounts to pay for vision and dental benefits, over-the-counter drugs, and part of a gym membership. States should consider whether to integrate their work/community engagement requirements into other personal responsibility goals and if so, how.
Develop a stakeholder outreach plan. To ensure a smooth implementation process, states should develop a plan to engage with stakeholders as early as possible, and maintain an open line of communication for the duration of the demonstration. Stakeholders include Medicaid beneficiaries, MCOs, providers, community partners, and human services agencies. If the new program’s administration were to include a state workforce agency, they would need to have a seat at the table as well.

States would need outreach campaigns to educate Medicaid beneficiaries about their new responsibilities, as well as the resources available to them to satisfy the requirements, well before the program goes into effect. States should negotiate any new MCO responsibilities in advance and reflect them in their annual contracts.

Develop a plan to monitor and evaluate the program. CMS’s SMD letter specifies that states must evaluate the health outcomes of Medicaid beneficiaries that are subject to the Medicaid work requirement, including those who have lost coverage for non-compliance. States should develop a plan to track health outcomes data for current and former Medicaid beneficiaries. In addition, states may wish to track the health insurance status of individuals who gain employment and are no longer eligible for Medicaid to see if they gain employer-sponsored coverage, Marketplace coverage, or become uninsured.
Looking ahead

Kentucky and Indiana are the first states to have received approval from CMS to implement a work/community engagement requirement in Medicaid, and the agency is reviewing similar proposals from nine other states. All eyes will be watching how states manage the cost and administrative complexities of their demonstration projects, and states’ ability to improve the employment, wages, and health outcomes of Medicaid beneficiaries.

This brief outlines ten initial considerations for states who are considering pursuing work/community engagement requirements. As implementation takes shape, states should monitor their own progress, share lessons learned, and adapt to achieve their desired outcomes.
## Appendix A

Summary of states’ work/community engagement requirement waivers submitted to CMS as of February 2018

| IN (waiver approved) | KY (waiver approved) | AZ | AR | KS | ME | MS | NH | NC | UT | WI |
|---------------------|---------------------|----|----|----|----|----|----|----|----|----|----|
| Target Population(s) | Non-elderly adult groups | Non-elderly adult groups | Expansion adults only | Expansion adults with incomes up to 100 percent of the federal poverty level (FPL)^* | Non-elderly adult groups | Non-elderly adult groups | Expansion adults only | Future expansion adults only^* | Non-elderly adult groups and future expansion adults^* | Non-elderly adults without children |
| Exempt Populations |
| Age groups | 60+ | 65+ | 55+ | 50+ | 65+ | 65+ | 65+ | 60+ | 50+ |
| Full-time Students | ✓ | ✓ | ✓ | ✓ | ✓ | Part-time students also exempt | Part-time students also exempt | Part-time students also exempt |
| Caregivers | ✓ | Primary caregiver, limited to one caregiver per household | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| People being treated for SUD | ✓ | ✓ | ✓ | Must be residing in a treatment facility | ✓ | Must be in a state-certified drug court program | ✓ | ✓ |
| Former foster youth | ✓ | ✓ | ✓ | ✓ |
| Victims of catastrophic events | ✓ | ✓ | ✓ |
| Others | TANF recipients; those with certified proof of temporary illness or incapacity; recently-incarcerated, chronically homeless | American Indians (AI); people who are homeless, have severe mental illness, or are victims of domestic violence | Unemployment benefit recipients; living with someone under 18; exempt from SNAP work requirements; medically certified as unfit for work; Alaskan and Native American Natives (AN) | Beneficiaries with traumatic brain injury (TBI), HIV, or in the Breast and Cervical Cancer Program | Beneficiaries enrolled under the Maine Breast and Cervical Health Program eligibility category. | Native Americans; enrolled in 1915(c) waivers; residing in an institution; physically or mentally unable to work; receiving unemployment benefits; in the breast and cervical cancer program | Those with certified proof of temporary illness or incapacity | Individuals receiving only family planning benefits | Parents below 60% FPL; unemployment benefit recipients; people in refugee employment services, Family Employment Program (FEP) recipients | Individuals who are mentally ill, physically or mentally unable to work; unemployment benefit recipients/ applicants |
| Work Activities |
| Full-time employment | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
## Changes to Medicaid eligibility in 2018

**Part-time employment**
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️

**Minimum of 30 hours/ week**  ✔️

**Attending School**
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️

- ✔️
- ✔️

**Job search activities**
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️

**Students are exempt**  ✔️

**Skills or educational training**
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️

**Volunteering/work experience**
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️
- ✔️

**Volunteering with approved agencies**  ✔️

**Other**
- Caregiving services for non-dependents; ESL classes; participation in SNAP requirement; participation in Pathways program for Pokagon Band of Potawatomi tribe
- SUD treatment; caregiving for a non-dependent relative
- ESL classes; parenting classes
- Participating in activities available the Arkansas Department of Workforce Services
- ESL classes
- Receiving unemployment benefits or complying with SNAP/TANF work requirements
- Participation with the Office of Employment Security; compliance with TANF/SNAP work requirements

**Satisfying work requirements in SNAP**  ✔️

**Penalties for non-compliance**
- Suspension of eligibility if work requirements are not fulfilled for at least 8 months of the 12-month calendar year. Eligibility may resume after one full month of requirements are fulfilled.
- Eligibility suspended until the first day of the month after the beneficiary completes the requirement.
- Initial 6-month grace period, benefits are then suspended until work requirements fulfilled for one full month.
- Disenrollment after three consecutive or nonconsecutive months of non-compliance in a year, cannot reapply until next coverage year.
- 3-month grace period, then removal from KanCare until compliance is achieved.
- Work requirement is a condition of eligibility, but exact penalty is not specified.
- Loss of eligibility on the first day of the month following non-compliance; beneficiary can be reinstituted upon future compliance.
- Work requirement is a condition of eligibility, but exact penalty is not specified.
- Work requirement is a condition of eligibility, but exact penalty is not specified.
- Loss of eligibility and removal from program, can become eligible again by completing all required activities, otherwise must reapply.
- Each month in which the work requirement is not met will count towards the beneficiaries 48-month eligibility limit.

**Source:** Deloitte Analysis of state Medicaid waiver proposals that include a work/community engagement requirement. All pending and approved waivers can be found on the CMS website: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
Acknowledgments

The author would like to thank Bill Eggers, Lindsay Hough, Wade Horn, Mohan Kumar, Kevin Pollari, China Widener, Aldila Lobo, Pat Howard, Kenneth Smith, and Sundhar Sekhar for their insightful contributions to this piece.
Changes to Medicaid eligibility in 2018

Get in touch

Jim Hardy
Specialist Leader | Life Sciences & Health Care
jihardy@deloitte.com
+1 206 716 6346

William D. Eggers
Executive Director
weggers@deloitte.com
+1 571 882 6585

Lindsay Musser Hough
Principal | Deloitte Consulting LLP
lhough@deloitte.com
+1 717 695 5367

Learn more about ‘Insights to action’

Insights to action is a community for sharing proven ideas during a time when government agencies are almost universally experiencing disruptive change. It shares insights from trusted leaders with extensive experience and diverse perspectives on leadership, strategy, business operations, innovation, and emerging capabilities.

Insights to action helps leaders and managers look again at the challenges and opportunities that come along with the evolution in government.
Sources


Changes to Medicaid eligibility in 2018
Changes to Medicaid eligibility in 2018