Work and Community Engagement Requirements in Medicaid: State Implementation Requirements and Considerations

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Introduction

In January 2018, the Centers for Medicare & Medicaid Services (CMS) released a State Medicaid Director Letter (SMDL) providing guidance to states as to the circumstances under which CMS would approve 1115 demonstration waivers making work/community engagement (CE) requirements a condition of Medicaid eligibility. Since then, CMS has approved state work/CE waivers in Arkansas, Indiana, Kentucky, and New Hampshire, and additional states have submitted or are poised to submit similar waivers.

Notably, on June 29, 2018, the US District Court issued a ruling in *Stewart v. Azar* that invalidated the U.S. Department of Health and Human Services' approval of Kentucky's Medicaid waiver for failing to consider the impact of work requirements on coverage, which the court determined was a key objective of the Medicaid program. While the *Stewart* decision does not apply beyond Kentucky, states will want to consider the administrative burden they are taking on and the implications for beneficiaries before moving forward in light of the court's ruling. The implementation tasks are complicated and costly, and how states implement work/CE programs will determine whether beneficiaries find jobs, maintain or lose health insurance coverage, and experience improved health and well-being, the last goal being the stated objective of these demonstrations. Because work/CE requirements are being implemented under the demonstration provisions of the federal Medicaid law, states are obligated to monitor and evaluate their programs: these evaluations and the ongoing monitoring will be essential to assessing whether in fact work/CE requirements improve beneficiary health and well-being.

The charts that follow outline the legal, policy, financial and operational tasks and issues that states will face in adding a work/CE condition to their Medicaid program. They are drawn from federal law, regulations and guidance, the terms and conditions of approved waivers, and research on states' early implementation documentation. This information is intended to highlight for states the complexity of administrative tasks associated with implementing a work/CE requirement.

Chart 1. Features of Approved State Work/Community Engagement Waivers

This chart catalogues the key features of approved work/CE waivers. States considering work/CE waivers will have to consider each element and determine the specific policies that will apply in their state, including to whom the work/CE requirements apply, which beneficiaries will be exempt, what activities will be considered in assessing compliance with the requirements, and the consequences for beneficiaries of non-compliance. These policy decisions will provide the basis for implementation and ongoing administration of the program.

Chart 2. CMS Guidance and Waiver Special Terms and Conditions

This chart identifies requirements set forth in CMS' SMDL and approved demonstration special terms and conditions (STCs) that articulate states' implementation responsibilities.[1] The STCs governing the four approved waivers are similar, but not identical. This chart provides a summary overview of common provisions that states must have the capacity to operationalize, but it does not capture all distinctions among the four approved state programs.

Chart 3. Streamlined Medicaid Application, Eligibility, and Enrollment Requirements

Federal law and implementing regulations require a coordinated and streamlined eligibility and enrollment process in Medicaid. Approved demonstration STCs sometimes cross-reference specific Medicaid eligibility and enrollment regulations, and reference states' ongoing obligations to maintain compliance with regulations that require states to have in place systems that minimize burden on applicants and beneficiaries in various ways, including by promoting reliance on electronic data exchange to verify eligibility. This chart provides an overview of the eligibility and enrollment rules to which states must adhere in implementing their work/CE rules.

Chart 4. Information Technology Business Requirements Related to Work/Community Engagement Implementation

States are modifying their information technology (IT) systems to add compliance with work/CE requirements as a new eligibility condition. The reliance on technology is driven by automation efficiencies and the opportunity to access enhanced federal matching dollars. This chart outlines at a high level the business requirements that must be accommodated to achieve IT systems readiness (including eligibility and enrollment, Medicaid Management Information Systems (MMIS), and the client portal) in the context of new work/CE requirements. In light of past challenges with IT builds, systems modifications represent an area of high risk for states in implementing work/CE requirements, especially states on a fast-track implementation schedule.

Chart 5. State Costs Associated with Implementing Work/Community Engagement Requirements

CMS has advised that states must support beneficiaries in meeting the work/CE requirements, but that Medicaid funds will not be available to underwrite the costs of these supports (e.g., child care, job training, transportation, etc.). Thus, states must use state general fund dollars to underwrite these costs. While federal Medicaid funds are generally available for IT systems development and operations as well as related staffing costs, the state share can be significant. For example, Kentucky expects to spend $17.5 million in state funds and $170 million in federal funds to build the technology to support its new waiver, including work/CE requirements.[2] Ohio state budget experts estimate that case management services for nearly 234,000 beneficiaries would cost more than $378 million over five years.[3] Tennessee, by comparison, estimates a $44 million cost over one year to support approximately 37,000 beneficiaries.[4] This chart delineates the areas in which states will likely incur costs. With the exception of beneficiary supports (services that can help individuals find and secure jobs), the state should be able to claim a federal match for these costs.

Chart 1: Features of Approved State Work/Community Engagement Waivers

The following chart catalogues key features of approved Medicaid work/CE waivers and highlights the various programmatic features that states will have to implement to ensure compliance with waiver special terms and conditions.

	Arkansas[5]	Indiana[6]	Kentucky[7]	New Hampshire[8]
Target Population				
Target Eligibility Groups	Expansion adults with incomes ≤138% FPL	Expansion adults with incomes ≤138% FPL, parents/caretakers, and Transitional Medical Assistance (TMA) beneficiaries	Expansion adults with incomes ≤138% FPL, parents/caretakers, and TMA beneficiaries	Expansion adults with incomes ≤138% FPL
Target Ages	19-49	19-59	19-64	19-64
Key Features of Work/CE Requirements				
Required Hours of Participation in Work/CE	80 hours/month	20 hours/week (phased in from date of implementation)	80 hours/month	100 hours/month
Frequency that State Assesses Compliance	Monthly	Annually	Monthly	Monthly
Reporting Mechanism	› Access Arkansas electronic portal[9] › No non-electronic option is available	› N/A	› Citizen Connect electronic portal[10]	› NH EASY electronic portal (New Hampshire DHHS, oral communication, April 2018)
Penalties for Non-Compliance	› Coverage terminated if individual does not comply with work/CE requirements for 3 consecutive or non-consecutive months within a plan year › May not re-enroll until start of next plan year unless individual meets circumstances described below	› Coverage suspended on January 1 if individuals fail to comply for >4 months during the previous calendar year › Coverage terminated for individuals whose coverage remains suspended at redetermination	› Coverage suspended after 1-month grace period ("opportunity to cure"); individual can avoid suspension by completing missed hours from prior month or completing a health or financial literacy course › Coverage terminated for individuals not in compliance at redetermination	› Coverage suspended after 1-month grace period ("opportunity to cure"); individual can avoid suspension by demonstrating an exemption (including a good cause exemption) or completing missed hours from prior month › Coverage terminated for individuals not in compliance at redetermination
Options to Re-activate or Re-enroll in Coverage	› Turn age 50 › Qualify for another Medicaid eligibility category not subject to work/CE requirements › Unable to report a good cause exemption because of a "catastrophic event or circumstances beyond the individual's control"	› Meet requirements for 1 month › Meet an exemption, including a good cause exemption › Become eligible for a Medicaid eligibility group not subject to work/CE requirements	› Meet requirements for 1 month › Complete a health or financial literacy course › Meet an exemption (does not include good cause exemptions) › Become eligible for a Medicaid eligibility group not subject to work/CE requirements	› Complete missed hours that resulted in suspension › Meet an exemption, including a good cause exemption › Become eligible for a Medicaid eligibility group not subject to work/CE requirements
Timing for Re-enrolling in Coverage After Termination	› Terminated beneficiary cannot re-enroll until start of the next plan year unless he/she meets one of the criteria above	› Terminated beneficiary may re-apply at any time	› Terminated beneficiary may re-apply at any time	› Terminated beneficiary may re-apply at any time

	Arkansas[5]	Indiana[6]	Kentucky[7]	New Hampshire[8]
Exemptions				
Pregnant women (required by CMS)	√	√	√	√
Individuals who are exempt from TANF or SNAP work/CE requirements (required by CMS)	√	√	√	√
Medically frail as defined in 42 CFR 440.315(f) (required by CMS)	√	√	√	√
Individuals with an acute medical condition validated by a medical professional that would prevent him or her from complying with work/CE requirements (required by CMS)	√	√	√	√
Individuals with a disability as defined by the ADA, Section 504 or Section 1557, who are unable to comply with the requirements due to disability-related reasons (required by CMS)	√	√	√	√
Individuals who are physically or mentally unfit for employment	√			
Individuals who experience a hospitalization or serious illness or who reside with an immediate family member who experiences a hospitalization or serious illness		√		√
Women who are 60-days postpartum	√			√
Primary caregiver of dependent child (maximum age varies by state; some states only permit one individual per household to be exempt on this basis)	√	√	√	√
Caregiver of disabled/incapacitated individual (some states limit exemption to a dependent; some states only permit one individual per household to be exempt on this basis)	√	√	√	√

	Arkansas[5]	Indiana[6]	Kentucky[7]	New Hampshire[8]
Individuals residing with an immediate family member who has a disability as defined by the ADA, Section 504, or Section 1557, who are unable to meet the requirement for reasons related to the disability of that family member		√		√
Individuals receiving unemployment benefits	√			
Individuals participating in substance use disorder (SUD) treatment or a state-certified drug court program	√	√		√
Full-time students	√	√	√	
Part-time students		√		
Individuals who are homeless		√		
Individuals who were recently incarcerated		√		
Victims of domestic violence		√		
Individuals who receive TANF benefits	√			
Hardship or Good Cause Exemptions				
Individuals with a disability or an immediate family member with a disability as defined by the ADA, Section 504, or Section 1557, who are unable to comply with the requirements due to disability-related reasons	√	√	√	√
Individuals who experience a hospitalization or serious illness or who reside with an immediate family member who experiences a hospitalization or serious illness	√	√	√	√
Birth or death of household member	√		√	√
Severe inclement weather	√		√	√
Family emergency	√		√	√

	Arkansas[5]	Indiana[6]	Kentucky[7]	New Hampshire[8]
Domestic violence	√	√	√	√
Divorce	√		√	√
Qualifying Activities				
Compliance with SNAP/TANF work requirement (required by CMS)	√	√	√	√
Paid or unpaid employment	√	√	√	√
Job search (some states limit number of hours permitted)	√	√	√	√
Job training	√	√	√	√
Vocational training	√	√	√	√
Education	√	√	√	√
Volunteering/community service	√	√	√	√
Caregiving for a non-dependent relative or other individual		√	√	√
Participation in state workforce program	√	√		
Participation in MCO employment program		√		
Participation in tribal workforce program		√		
Homeschooling		√		
Participation in class on the health care system or healthy living	√			
Participation in SUD treatment			√	√

KEY

ADA = Americans with Disabilities Act
CE = Community engagement
CMS = Centers for Medicare & Medicaid Services
FPL = Federal poverty level
MCO = Managed care organization
Section 1557 = Section 1557 of the ACA
Section 504 = Section 504 of the Rehabilitation Act of 1973
SNAP = Supplemental Nutrition Assistance Program
SUD = Substance use disorder
TANF = Temporary Assistance for Needy Families
TMA = Transitional Medical Assistance

Chart 2: CMS Guidance and Waiver Special Terms and Conditions

This chart identifies key requirements in CMS' State Medicaid Director Letter (SMDL) and approved demonstration special terms and conditions (STCs) that guide states' implementation responsibilities.[1] The STCs governing the four approved waivers are similar, but not identical. This chart provides a summary overview of common provisions that states must have the capacity to operationalize, but it does not capture all distinctions among the four approved state programs.

Consumer Outreach and Education	
Notices	STCs: › States must provide beneficiaries with timely and adequate notices about: » Timing of a beneficiary becoming subject to work/CE requirements and required number of hours to comply » Exemption availability, status, and how to seek exemptions, including good cause exemptions » Right to reasonable modifications » Activities that satisfy requirements, how hours will be counted, and how to report compliance » Differences between SNAP/TANF and Medicaid work/CE requirements » Failure to comply with work/CE requirements in a particular month and how to come into compliance » Suspension/termination for failure to meet work/CE requirements » Appeals rights (upon suspension, termination, good cause exemption denial, if applicable) » Other sources of care if eligibility is terminated » Resources to help connect beneficiaries to opportunities for work/CE activities » Beneficiary supports
Eligibility Operations: Exemptions, Compliance, and Penalties	
Identify Populations Subject to Requirements	SMDL: › States must identify populations subject to work/CE requirements; states may target requirements by eligibility group and may tailor requirements to sub-groups within each eligibility group › States must establish mechanisms to: » Ensure reasonable modifications are available, including exemptions due to disability » Make modifications to the number of hours of participation required » Provide support services where participation is possible with supports › States may phase in programs as states build required infrastructure to support beneficiaries

Exempt Populations	SMDL: › States must exempt the following populations: » Children, pregnant women, adults age 65 or older, and individuals eligible for Medicaid based on disability » Individuals determined by the state to be "medically frail" » Individuals with "acute medical conditions" validated by a medical professional that would prevent them from complying with the requirements » Individuals who are exempt from TANF or SNAP work requirements › States may exempt additional populations
Standard Eligibility and Enrollment Functions	STCs: › Ensure application assistance is available to beneficiaries (including in person and by phone) › Maintain ability to report on and process applications in person, via phone, via mail, and electronically › Assure that termination, disenrollment, or denial of eligibility only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f) › Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements › Maintain timely processing of applications to avoid further delays in accessing benefits once the disenrollment period is over › Assure timeliness of transfers between Medicaid and other insurance programs at any determination, including application, renewal, or non-eligibility period › Maintain compliance with coordinated agency responsibilities under 42 CFR 435.1200
Range of Covered Activities	SMDL: › States must define qualifying activities for compliance › States should consider a wide range of activities to satisfy work/CE requirements, including career planning, job training and referral, job support services, skills training, volunteer activities, tribal employment programs, and SUD treatment STCs: › Ensure that specific activities to satisfy CE requirements are available during a range of times and through a variety of means (e.g., online, in person) at no cost to the beneficiary
Alignment of Policy and Reporting with SNAP and TANF	SMDL: › States must automatically deem individuals who are compliant with, or exempt from, TANF or SNAP work requirements to be compliant with, or exempt from, Medicaid work/CE requirements; states should make a reasonable effort to align good cause exemptions › States should communicate to beneficiaries any differences in program requirements that individuals will need to meet in the event they transition off of SNAP or TANF, but remain subject to a Medicaid work/CE requirement › States may align work/CE programs with SNAP and TANF in the following areas: exempted populations, protections, and supports for people with disabilities; allowable activities; modifications due to economic or environmental factors; beneficiary reporting requirements; and the availability of work supports STCs: › Assure that beneficiaries do not have to duplicate requirements to maintain access to all public assistance programs that require CE and employment

Compliance Reporting and Verification	STCs: › Ensure that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, and systems to permit beneficiaries to report hours or obtain an exemption (in accordance with 42 CFR 907(a), 435.916(c), and 435.945) › Provide reasonable accommodations for beneficiaries with disabilities who are unable to report, or have difficulty reporting, work/CE activities. If state is unable to provide such modification, then the state must provide a modification in the form of an exemption
Suspension and Termination	STCs: › Maintain system capabilities to operationalize suspension and denial/termination of eligibility, as well as lifting of suspensions › Maintain mechanisms to stop payment to beneficiary's health plan upon suspension (if applicable) and/or termination, as well as trigger payments once suspension is lifted › Determine eligibility for other Medicaid eligibility groups or other insurance affordability programs prior to disenrollment › Provide full appeal rights in accordance with 42 CFR Part 431, subpart E, prior to suspension (if applicable) and termination/disenrollment; maintain eligibility for beneficiaries who submit an appeal request or report a good cause exemption prior to disenrollment
Re-enrollment	STCs: › Permit re-enrollment subject to meeting criteria established in STCs
Beneficiary Supports	
Beneficiary Supports	SMDL: › States must describe beneficiary support strategies and must link individuals to such supports (e.g., job training, child care, transportation, etc.) in waiver application › Medicaid financing is not available for such supports › States must design programs to protect beneficiary due process rights › States may offer individualized assessment of individuals' disabilities, medical diagnoses, and other barriers to employment and self-sufficiency to identify appropriate activities, necessary supports, and reasonable modifications STCs: › Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting work/CE requirements, including available non-Medicaid assistance with transportation, child care, language access services and other supports › In addition to providing reasonable modifications, make good faith efforts to connect beneficiaries with disabilities with services and supports necessary to enable them to meet work/CE requirements

Reasonable Modifications	SMDL: › States must comply with all federal civil rights laws (e.g., Americans with Disabilities Act) › States must provide reasonable modifications (e.g., exemptions from participation, modification in the number of hours, provision of support services) for people who need them, including individuals with disabilities and individuals with a SUD › States must evaluate individuals' ability to participate and the types of reasonable modifications and supports needed › States may not use Medicaid funding for supportive services that may be necessary as reasonable modifications STCs: › Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to meeting work/CE requirements › Maintain a mechanism/system that provides reasonable modifications related to meeting the work/CE requirement to beneficiaries with disabilities › Assure compliance with protections for beneficiaries with disabilities under the ADA, Section 504, and Section 1557 › Ensure that the state will assess whether people with disabilities have limited job or other opportunities for reasons related to their disabilities; address these barriers if they exist
Attention to Market Forces and Structural Factors	SMDL: › States may phase in or periodically suspend requirements in geographic areas with limited employment opportunities, lack of transportation, etc. › States should detail how they will support individuals in meeting work/CE requirements during times when they experience trouble complying with program requirements due to market forces or structural barriers STCs: › Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the work/CE requirements and/or additional mitigation strategies, so that the work/CE requirements will not be unreasonably burdensome for beneficiaries to meet
Other Implementation Considerations	
Budget Neutrality	SMDL: › States may not accrue waiver savings from a reduction in enrollment that may occur as a result of work/CE requirements
Monitoring and Evaluation	SMDL: › States will be required to develop monitoring plans and submit regular monitoring reports to monitor and evaluate program changes to assure that stated objectives are advanced in both the short- and long-term › Monitor enrollment and termination of eligibility for failure to meet work/CE requirements › Evaluate the impact on individuals who remain in the program as well as those who lose Medicaid coverage and either gain other coverage or become uninsured STCs: › Certain states must submit an eligibility and enrollment monitoring plan within 90 calendar days after approval of the work/CE amendment of this demonstration › Assure processes are in place to identify various data points related to implementation of work/CE requirements

KEY

ADA = Americans with Disabilities Act
CE = Community engagement
SMDL = State Medicaid Director Letter
SNAP = Supplemental Nutrition Assistance Program
STC = Special Terms and Conditions
TANF = Temporary Assistance for Needy Families

Chart 3: Streamlined Medicaid Application, Eligibility, and Enrollment Requirements

Federal Medicaid law and implementing regulations require a coordinated and streamlined eligibility and enrollment process in Medicaid. Approved demonstration STCs sometimes cross-reference specific Medicaid eligibility and enrollment regulations but also—without reference to regulations—refer to states' ongoing obligations to maintain compliance with regulations that require states to have in place systems that minimize burden on beneficiaries in various ways, including by promoting reliance on electronic data exchange. Unless a specific provision of law is waived, states implementing Section 1115 work/CE waivers are required to comply with all existing requirements relating to application, eligibility determinations and enrollment requirements. The following regulatory provisions should guide states' implementation approaches.

Requirement	Citation	Description
Application	42 CFR 435.907	States must use a single, streamlined application for Medicaid and other insurance affordability programs, and that application must be accepted online, by telephone, by mail, in person, or through other commonly available electronic means. An in-person interview may not be required for individuals whose income is determined based on modified adjusted gross income (MAGI) methodologies.
Attestation	42 CFR 435.945(a)	States may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household).
Verification	42 CFR 435.940-435.965	Taken together, these regulations require verification of any eligibility criteria through available electronic databases, the individual's account, or an electronic data exchange. Electronic verification may be systems-automated or completed manually by an eligibility worker without requiring additional information from the beneficiary.
Noticing content and timing	42 CFR 435.917-435.919	States must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Notices must be written in plain language, accessible to individuals with limited English proficiency, and available electronically. The state also must give beneficiaries timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility, or to reduce or discontinue services they may receive under Medicaid.
Appeals processes	42 CFR 431.200-431.250	States must provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly, or who is subject to suspension, termination, reduction of services, or denial of a good cause exemption. Medicaid regulations specify detailed requirements related to hearing notices, rights, and procedures.
Change in circumstance	42 CFR 435.916(d)	States must promptly redetermine eligibility between regular renewals of eligibility whenever they receive information about a change in a beneficiary's circumstances that may affect eligibility.
Renewals	42 CFR 435.916	Ex parte renewals (renewals that do not require any action by the beneficiary) should be processed based on reliable information available in the beneficiary's account and/or new information that the state has verified through electronic data sources. To the extent the state needs additional information to complete a renewal, the state must issue a pre-populated form that includes all eligibility-related information available to the state and requests new information required to renew eligibility.
Coordinated eligibility and enrollment	42 CFR 435.1200	States must ensure coordinated eligibility and enrollment processes, including for eligibility renewal, among Medicaid, marketplace, and other insurance affordability programs to minimize burden on the individual; comply with eligibility information-sharing requirements; and ensure prompt determinations of eligibility and enrollment without undue delay.

Chart 4: Information Technology Business Requirements Related to Work/Community Engagement Implementation

States are modifying their information technology (IT) systems to add compliance with work/CE requirements as a new eligibility condition. The reliance on technology is driven by automation efficiencies and the opportunity to access enhanced federal matching dollars. This chart outlines at a high level the business requirements that must be accommodated to achieve IT systems readiness (including eligibility and enrollment, Medicaid Management Information Systems (MMIS), and the client portal) in the context of new work/CE requirements. In light of past challenges with IT builds, systems modifications represent an area of high risk for states in implementing work/CE requirements, especially states on a fast-track implementation schedule.

Responsibility	Business Requirements
Outreach/Education	› Launch new website or landing page with applicant/beneficiary information › Develop online applicant/beneficiary and assister trainings and "explainer" tools
Application	› Collect new information related to work/CE requirements through online, paper, and phone application (e.g., homelessness, domestic violence)
Eligibility	› Identify populations subject to work/CE requirements and those who are exempt › Automate system flags for exemption (e.g., pregnancy, homelessness, SMI) › Create indicator for work/CE status (exempt, compliant, non-compliant)
Claims/Financial Processing	› Suspend/re-activate MCO capitation and other provider payments › Communicate via 834 to MCOs when beneficiaries are non-compliant, at risk of coverage suspension or termination, suspended, or terminated
Exemptions	› Collect applicant/beneficiary-reported exemption information/documentation › Link beneficiary-reported information to beneficiary case › Interface with SNAP/TANF systems to validate exemptions › Connect to new data sources for exemption verification › Flag beneficiaries who require case worker review and verification › Determine beneficiary exemption eligibility
Work Activity Compliance	› Collect beneficiary-reported work/CE activity information/documentation › Link beneficiary-reported information to beneficiary case › Interface with SNAP/TANF systems to confirm activity compliance › Connect to new data sources for compliance information verification › Flag beneficiaries that require case worker review and verification › Determine beneficiary compliance
Notices	› Issue new notices on work/CE requirements, exemption determination, qualifying activities, right to reasonable modifications, non-compliance determination, suspension, termination, lock-out, appeal

Disenrollment	› Effectuate coverage suspensions for non-compliance › Evaluate eligibility for other groups or programs prior to disenrollment › Terminate eligibility for non-compliance › Effectuate eligibility lock-out penalty periods › Enable beneficiary re-enrollment under permissible circumstances › Enable beneficiary re-enrollment at the end of the lock-out period
Responsibility	**Business Requirements**
Renewals/Change in Circumstance (CIC)	› Incorporate work/CE compliance checks into ex parte renewal › Incorporate work/CE status into CIC reporting
Appeals	› Administer appeals (exemptions, suspension, termination)
Beneficiary Supports	› Flag beneficiaries requiring assessments › Effectuate referrals to beneficiary supports

KEY

MCO = Managed care organization
SMI = Serious mental illness
SNAP = Supplemental Nutrition Assistance Program
TANF = Temporary Assistance for Needy Families

Chart 5: State Costs Associated with Implementing Work/Community Engagement Requirements[2-4,11-17]

CMS has advised that states must support beneficiaries in meeting the work/CE requirements, but that Medicaid funds will not be available to underwrite the costs of these supports (e.g., child care, job training, transportation, etc.). Thus, states must use state general fund dollars to underwrite these costs. While federal Medicaid funds are generally available for IT systems development and operations as well as related staffing costs, the state share can be significant. For example, Kentucky expects to spend $17.5 million in state funds and $170 million in federal funds to build the technology to support its new waiver, including work/CE requirements. Ohio state budget experts estimate that case management services for nearly 234,000 beneficiaries would cost more than $378 million over five years. Tennessee, by comparison, estimates a $44 million cost over one year to support approximately 37,000 beneficiaries. This chart delineates the areas in which states will likely incur costs. With the exception of beneficiary supports (services that can help individuals find and secure jobs), the state should be able to claim a federal match for these costs.

Medicaid Costs	Examples
Development of and Updates to IT Systems	› Updates to eligibility and enrollment (E&E) systems › Updates to Medicaid Management Information System (MMIS) › Updates to case management systems › Development of new work/CE portals for beneficiary reporting › Linkages between Medicaid, SNAP, TANF, and other state data systems
Additional Staffing	› Eligibility determinations › Case management › Disability determination staff › Consumer assistance/call center › Appeals › Audit and compliance › Employment supports › Program administration
Other Administrative Costs	› Staff training/re-training › Development of new regulations › Development of call center scripts › Development, printing, and mailing of new notices › Office space and IT equipment for new staff › Waiver development, administration, monitoring, and evaluation, including contractor support
Beneficiary Supports	› Childcare › Employment training › Transportation › Other

Other Costs	› Additional physician visits by individuals seeking an exemption from work/CE requirements › Loss of enhanced match for individuals who seek a disability determination and move from the expansion group to another eligibility group with a lower match rate › Higher capitation payments to plans for individuals who seek a disability determination (to secure permanent exemption from work/CE requirements) and move from the expansion group to a higher cost eligibility group › Higher capitation rates resulting from healthier individuals having less of an incentive to comply with work/CE requirements and who are disenrolled, creating a sicker risk pool › Increased uncompensated care costs as a result of individuals losing coverage

KEY

IT = Information Technology
SNAP = Supplemental Nutrition Assistance Program
TANF = Temporary Assistance for Needy Families

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ABOUT MANATT HEALTH

This brief was prepared by Patricia Boozang, Allison Orris, Mindy Lipson, and Deborah Bachrach. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system.

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Endnotes

1. Centers for Medicare & Medicaid Services. *State Medicaid Director Letter, SMD 18-002: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries.* Washington, DC: U.S. Department of Health and Human Services; 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf Accessed July 9, 2018.

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