
May 23, 2018

States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries

By Jennifer Wagner and Judith Solomon

Executive Summary

Numerous states have proposed or are considering Medicaid demonstration projects, or “section 1115 waivers,” that would take coverage away from people who don’t meet work requirements, pay premiums, or renew their coverage on time, and the Centers for Medicare & Medicaid Services (CMS) has recently approved unprecedented barriers to coverage in several states. Rather than further the objectives of Medicaid as federal law requires, these proposals undermine Medicaid’s goals by making it harder for people to stay covered and thereby reducing access to care.¹ These proposals will have additional — and likely unintended — adverse effects due to their complexity, which poses major implementation challenges for states and major challenges for *eligible* individuals seeking to maintain their coverage.

Challenges for states. To implement pending and proposed waivers, states will need to undertake a variety of difficult tasks, including: substantially modifying their eligibility systems, creating new systems for beneficiaries to document compliance with the new rules, evaluating this large volume of documentation, informing beneficiaries of the new rules, establishing new systems to exchange data between Medicaid and other programs, acquiring or making new use of claims data from Medicaid managed care plans, training and/or hiring additional caseworkers to make determinations about exemptions and other new rules, and hiring additional staff to address a higher volume of appeals related to coverage denials.

States are also required to develop new processes to identify and assess people protected by the Americans with Disabilities Act (ADA) and either offer them reasonable accommodations that would allow them to meet the new requirements or exempt them from the requirements altogether.

Challenges for beneficiaries. Even beneficiaries who *meet* rigid new work requirements, pay premiums, and comply with new procedural requirements will face significant obstacles to keeping

¹ Hannah Katch *et al.*, “Medicaid Work Requirements Will Reduce Low-Income Families’ Access to Care and Worsen Health Outcomes,” Center on Budget and Policy Priorities, February 8, 2018, <https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen>.

their coverage. For example, people who are working or participating in work-related activities will need to understand the following: which activities qualify toward the requirement and how many hours they must complete (which would vary over time in some states), how to document their hours in these activities, and how to obtain appropriate documentation (for example, from multiple employers). They also must understand how to report compliance with the work requirement through state-prescribed processes and in accordance with sometimes tight deadlines (for example, within five days of the end of the month in Arkansas).

Likewise, people eligible for exemptions from work requirements will need to understand the criteria for exemptions, obtain documentation to prove they are exempt, sometimes report sensitive health or other information to state caseworkers (regarding a substance use disorder, for example), submit documentation to the state in accordance with state specifications (Arkansas, for example, accepts only online submissions), and periodically renew their exemptions.

This added complexity will lead to high administrative costs for states and the federal government and substantial coverage losses among eligible people, as explained below.

High administrative costs for states and the federal government. Implementing the steps described above will cost states and the federal government (and in some cases counties) tens of millions of dollars for eligibility system changes, notices, and increased staff to track compliance, address questions, and handle appeals. A large share of this spending will go to information technology (IT) vendors and other contractors to change notices and forms, reprogram eligibility systems to add and track the new requirements, and establish mechanisms to track premium payments. States will also need to hire staff to administer and monitor compliance with the myriad new requirements.

For example:

- Kentucky plans to spend \$186 million in state fiscal year 2018 and an additional \$187 million in 2019 to implement its approved waiver.
- Alaska projects that its proposed work requirement would cost the state \$78.8 million over six years, including about \$14 million per year in annual ongoing costs.
- A Pennsylvania state official testified that a proposed work requirement would cost \$600 million and require 300 additional staff to administer.
- In Minnesota, counties (which determine Medicaid eligibility in that state) would have to spend an estimated \$121 million in 2020 and \$163 million in 2021 to implement proposed work requirements. Counties estimate that it will take on average 53 minutes to process each exemption, 22 minutes to refer a client to employment and training services, and 84 minutes to verify non-compliance and suspend Medicaid benefits.

See the Appendix for a more comprehensive list of available state estimates.

While states and the federal government may ultimately save money on net from the new policies, savings will come entirely from people losing coverage and access to care. *Effectively, these proposals divert some state and federal resources from paying for health care to paying for new bureaucracy.*

Moreover, while federal matching funds are available for system changes and increased staffing, *no* federal funds are available to provide transportation, child care, or job training to help people find jobs and meet the new requirements. If states choose to provide any services to help enrollees meet new requirements, they will generally bear the full cost of doing so.

Substantial coverage losses among eligible individuals. Evidence from other eligibility restrictions in Medicaid shows that many eligible people will not overcome the substantial barriers that complexity creates to maintaining coverage. For example, when Washington State increased documentation requirements and made other changes that made it harder to enroll and stay enrolled, enrollment dropped sharply; enrollment rebounded when the state reverted to its prior processes. Similarly, when parents were required to provide proof of their children’s citizenship, many eligible children lost coverage.

Certain vulnerable groups are particularly ill-equipped to cope with additional red tape, which is why studies of work requirement policies in other federal programs have found that people with physical disabilities, mental health needs, and substance use disorders were disproportionately likely to lose benefits, even though many should have qualified for exemptions. Likewise, people experiencing homelessness or housing instability are especially likely to get tripped up by requirements to renew their coverage on time, since they may never receive the mail that instructs them to do so.

State errors in implementing new requirements will lead to additional coverage losses among eligible individuals. Even with large investments in new bureaucracy, past experience from Medicaid and other programs shows that states will still make mistakes, especially as they implement major systems changes. In fact, two states with newly approved waivers, Kentucky and Arkansas, have struggled to implement other major policy and system changes, leading tens of thousands of enrollees to lose coverage.

The net result is that many or even most of those losing coverage under new state waivers may be *eligible* enrollees. For example, among Medicaid enrollees who could be subject to work requirements under CMS guidance, more than 90 percent are working, in school, or report that they are unable to work due to illness, disability, or caregiving responsibilities. As noted, past experience with introducing or removing red tape or paperwork requirements in Medicaid suggests that coverage losses or interruptions in coverage could affect many more eligible individuals than the individuals who are the notional targets of the policy.²

² In addition, many working people may lose coverage because they do not meet the new work requirements *every month*. See Aviva Aron-Dine, Raheem Chaudhry, and Matt Broaddus, “Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements,” Center on Budget and Policy Priorities, April 11, 2018, <https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>.

Barriers to Coverage Include Work Requirements, Premiums, Lockouts

This paper focuses on eligibility restrictions that have been approved by CMS in a number of states and have been proposed or are under consideration in others. They include:

- **Taking coverage away from people who can't meet rigid work requirements.** In four states (Arkansas, Indiana, Kentucky, and New Hampshire), CMS has approved work requirements, which require enrollees to work or engage in work-related activities for up to 100 hours a month (depending on the state) to stay covered, unless they qualify for limited exemptions.
- **Premiums.** A number of states have received permission to charge premiums, and Kentucky has federal approval to charge some enrollees as much as 4 percent of household income.
- **Lockouts for failure to renew eligibility or report income changes on time.** Enrollees who don't complete their annual renewals of eligibility on time will lose coverage for six months in Kentucky and three months in Indiana. Also, in Kentucky, enrollees who don't report certain changes in their incomes on time would lose coverage for up to six months.
- **Lockouts related to work requirements or failure to pay premiums.** Arkansas enrollees who don't meet the state's work requirement would lose coverage for the rest of the calendar year. Enrollees in Indiana and Kentucky who fall 60 days behind on their premiums lose coverage for six months.

Complexity of New Policies Creates Major Implementation Challenges for States

Just to implement and enforce policies such as work requirements, premium payments, and lockouts (see box) — without taking any steps to help Medicaid enrollees enter or succeed in the workforce — will require major changes to states' systems and processes. Key tasks for states include:

- Programming extensive new rules into eligibility systems and adding new fields to applications and other documents to reflect new requirements that beneficiaries must meet to establish and maintain their eligibility.
- Establishing web portals for beneficiaries to report exemptions from, and compliance with, work requirements.
- Creating multiple notices to inform enrollees of complex new requirements, including criteria and processes to obtain exemptions, how to report compliance, “good cause” reasons for non-compliance, appeals processes, and penalties for non-compliance.
- Establishing or modifying interfaces with eligibility and employment and training systems in the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) to determine whether beneficiaries receiving SNAP or TANF as well as Medicaid are complying with (or exempt from) those program's work requirements and thus would be compliant with or exempt from Medicaid work requirements.³
- Connecting to Medicaid claims data usually maintained by multiple managed care organizations in the state to determine who qualifies for work requirement exemptions because they are medically frail.

³ See CMS State Medicaid Directors Letter (18-002), January 11, 2018, <https://www.medicicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

- Establishing mechanisms to determine the correct premium amount based on beneficiary income, both initially and when beneficiaries report changes, and to report premium obligations to managed care organizations that collect the premiums.
- Creating the infrastructure necessary to collect and track premium payments (the cost of which may substantially exceed the amount collected), usually in coordination with managed care organizations.⁴
- Developing systems to ensure beneficiaries pay no more than 5 percent of their income in out-of-pocket costs (the limit set by federal law), which requires tracking premiums and cost-sharing payments to providers on a monthly or quarterly basis and providing monthly or quarterly statements to beneficiaries.⁵

States will also need to train eligibility workers, who often work on other programs in addition to Medicaid, to take on new duties. And they will likely need to hire additional staff to:

- Process exemptions from work requirements and quickly determine whether to grant requests for “good cause” exceptions to avoid termination of coverage for failure to meet the requirement in a particular month.
- Regularly review enrollee reports of hours spent on work and work-related activities to determine if enrollees are eligible to stay covered.
- Process an increased volume of re-applications from those losing coverage, which will require a determination of factors such as whether the enrollee had good cause for not complying, has met the conditions for reinstatement, or has completed a lockout penalty.
- Track benefit receipt and compliance to determine the applicable hourly work requirement (in states where the hourly requirement varies by months of Medicaid participation) and whether enrollees have used up allowable months of coverage without complying in states that allow a grace period.
- Terminate coverage and impose lockout periods for non-compliance.
- Collect, process, and track premium payments in coordination with managed care organizations, which may conduct some of these activities.
- Determine an applicant’s or enrollee’s exact income to determine the premium amount, likely requiring additional documents from enrollees.⁶

⁴ Melissa Burroughs, “The High Administrative Costs of Common Medicaid Expansion Waiver Elements,” Families USA, October 20, 2015, <http://familiesusa.org/blog/2015/10/high-administrative-costs-common-medicaid-expansion-waiver-elements>.

⁵ Medicaid.gov, “Cost Sharing Out of Pocket Costs,” <https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html>.

⁶ This requirement runs counter to one of the simplifications ushered in by the Affordable Care Act, known as reasonable compatibility, which compares the individual’s attestation of income on his or her application or renewal form to data sources such as quarterly wage data or “The Work Number” income database. If both the attestation and the data source are below, at, or above the eligibility threshold, they are considered reasonably compatible and a worker can make an eligibility determination without requiring further documentation, since the precise amount of income is not needed. But by setting premium amounts based on narrow income brackets, states would have to make a more refined income eligibility determination, potentially requiring additional documents from beneficiaries. Jennifer Wagner, “Reasonable Compatibility

- Handle what will likely be a substantial increase in appeals for enrollees terminated from coverage.

States are also required to identify people with disabilities who are protected under the ADA and make reasonable accommodations to help them comply with new requirements under the waiver. This requires:

- Assessing an enrollee’s circumstances to determine whether they are entitled to protection under the ADA.
- Exempting individuals determined unable to participate in work or work-related activities or unable to comply with other requirements due to disability.
- For those not exempt from the work requirement, modifying the number of hours of required participation based on the individual’s circumstances.
- Providing appropriate supportive services if necessary to make participation possible.

Complexity of New Policies Creates Major Challenges for Eligible Individuals

To keep their coverage in states with waivers, Medicaid enrollees must not only comply with the new requirements related to work or premiums but also meet strict time limits and complex procedures for reporting and documenting their compliance. Tripping up on any of these rules could cause them to lose coverage.

Work Requirements

In states imposing work requirements, enrollees who are working or engaged in other qualifying activities for a sufficient number of hours each month will have to:

- **Understand which activities qualify.** Enrollees may not realize that certain activities, such as volunteering, searching for a job, or attending school can help them meet the work requirement, or understand how many hours they can count. For example, in Arkansas people looking for work get three hours’ credit for each contact they make searching for a job, but job search can only count for 39 hours of the 80-hour monthly requirement, so people would have to combine job search with another activity to meet the monthly requirement.⁷
- **Understand how to document their hours.** Even if they know which activities qualify, they will have to figure out how to document that they are engaged in one or more of those activities for the required number of hours each month.

Policy Presents an Opportunity to Streamline Medicaid Determinations,” Center on Budget and Policy Priorities, August 16, 2016, <https://www.cbpp.org/research/reasonable-compatibility-policy-presents-an-opportunity-to-streamline-medicaid>.

⁷ “Arkansas Works Information,” Notice and Flyer Samples, <https://ardhs.sharepointsite.net/ARWorks/default.aspx>.

- **Understand how many hours they must complete.** In some states, the hourly requirement varies based on how long someone has been enrolled in Medicaid. For example, Indiana’s requirement rises over time, from five hours per week to 20 hours per week.⁸
- **Report compliance with the work requirement according to the state’s specification.** Enrollees will have to regularly report on the hours they worked or engaged in other qualifying activities to continue receiving benefits. Kentucky has established an online portal for reporting and, as noted, Arkansas will only accept documentation online.
- **Report compliance in time to meet often tight deadlines.** Arkansas will require all enrollees to “demonstrate electronically” that they are meeting the work requirement by the fifth of the following month. Reports made after that date won’t be considered in determining compliance for the previous month.

In these states, enrollees eligible for exemptions from these requirements will need to:

- **Understand the criteria for exemptions.** All states must exempt enrollees who are “medically frail,” but how states interpret this term and similar terms such as “serious and complex medical condition” may be hard for beneficiaries to understand. Beneficiaries also may not know that other activities, like caring for an ill person or participating in drug and alcohol treatment, qualify for an exemption.
- **Obtain documentation to prove they are exempt.** Most states require beneficiaries to submit proof that they qualify for an exemption, sometimes using a specific form. Beneficiaries must bring this form to a doctor or other professional to complete, which may be difficult if they lack health insurance and haven’t been receiving regular care.
- **Submit documentation to the state.** Enrollees will have to submit the necessary paperwork, often through an online portal. This portal may be difficult for some to access and use, and beneficiaries may have trouble reaching caseworkers to ask questions or get assistance. In Kentucky, for example, 42 percent of Medicaid enrollees lack broadband access and 19 percent lack any Internet access, according to recent research.⁹
- **Share sensitive information with caseworkers.** States with approved work requirements either count substance use disorder treatment as a qualifying activity or exempt people in treatment from the work requirement. But to get an exemption or count treatment as a qualifying activity, people with such disorders would have to disclose their current or past substance use.¹⁰

⁸ Demonstration Approval of the Healthy Indiana Plan, Centers for Medicare & Medicaid Services, February 1, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf>

⁹ Anuj Gangopadhyaya and Genevieve M. Kenny, “Who Could Be Affected by Kentucky’s Medicaid Work Requirements, and What Do We Know about Them?” Urban Institute, February 2018, https://www.urban.org/sites/default/files/publication/96576/3.26-ky-updates_finalized_1.pdf.

¹⁰ “Harm to People With Substance Use Disorders From Taking Away Medicaid for Not Meeting Work Requirements,” Center on Budget and Policy Priorities, updated May 9, 2018, <https://www.cbpp.org/research/health/how-medicaid-work-requirements-will-harm-people-with-substance-use-disorders>.

- **Periodically renew their exemptions.** Enrollees who successfully claim an exemption may periodically have to prove that they continue to qualify. According to its proposal, Arkansas plans to require some enrollees to do so every two months.

Premiums

In states imposing premiums, enrollees will have to:

- **Understand whether they are required to pay premiums.** In many states, enrollees may or may not be required to pay premiums depending on their income, how they qualified for Medicaid, and what plan they are enrolled in.
- **Remember to pay premiums each month.** Unlike in private insurance, where employers deduct premiums from paychecks, Medicaid enrollees must drop off or mail premium payments each month.
- **Figure out how to pay premiums.** Some states restrict the acceptance of cash payments for premiums, which creates additional logistical challenges for a population that may rely more heavily on cash. For example, in Kentucky, the only way for applicants to ensure their coverage begins the first day of the month they apply is to make a payment using a “credit card or similar payment method,” though many low-income individuals may not have credit or debit cards.¹¹

Unlike work requirements, which were never allowed in Medicaid until this year, several states have experimented with charging premiums, so there is evidence of the effects of the associated hassles on coverage. In Indiana, which has collected premiums from Medicaid enrollees under the HIP 2.0 program since 2015, 55 percent of individuals eligible to pay a premium either never made a first payment and consequently were never enrolled or missed a payment after enrolling. Among those who never made a payment, 22 percent said the reason was confusion about the payment process.¹²

Lockouts

In states locking enrollees out of coverage for failure to complete renewals, beneficiaries seeking to comply with the requirements — and who in fact remain eligible for Medicaid — will still face challenges, including:

- **Not receiving renewal notices.** Enrollees may not receive renewal notices if they move or have problems receiving mail. This is a particular problem for beneficiaries who are

¹¹ Kentucky proposes allowing applicants to make a “Fast Track” payment of \$10 with their application, which would allow coverage to begin the first day of the month in which they applied. Without the Fast Track payment, coverage would not begin until the first day of the month in which the application was approved. Fast Track payments can only be made online through the self-service portal, and would be limited to “credit card or similar payment methods.” Kentucky HEALTH Program Requirements Specification, April 4, 2017 draft, prepared by Deloitte Consulting, <http://media.mcguirewoods.com/mwc/kentucky-medicaid-expansion-2.pdf>.

¹² The Lewin Group, “Healthy Indiana Plan 2.0: POWER Account Contribution Assessment,” March 31, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>.

experiencing homelessness or housing instability. In 2016, 1.4 million people spent at least part of the year in a homeless shelter, and many times that number experienced evictions or other types of housing instability.¹³

- **Not knowing what information they need to submit.** Redetermination of eligibility is a complex process, often requiring beneficiaries to complete and submit renewal forms and pay stubs and other supporting documentation.
- **Not realizing that they may need to turn in renewal paperwork, even if they do not currently need Medicaid coverage.** Some enrollees may let their coverage lapse because they got a job and no longer qualify for coverage. If they lose their job and reapply for Medicaid, they may find they are locked out of coverage. In Kentucky, this may not be a “good cause” reason for not renewing coverage on time, which could leave people uninsured for months. In Indiana, such individuals could be eligible for an exception to the lockout but would need to know about the exception and be able to prove they meet the exception criteria during the re-application process.

Kentucky will also impose a six-month lockout for failure to report even minor changes in income or other circumstances that affect eligibility. Given the complexity and multiple new requirements in Kentucky’s waiver, enrollees will need a detailed understanding of the new rules to know when to report changes to avoid losing coverage. Low-income families experience frequent changes in income as they gain and lose employment and their work hours vary; the size of their households can also change.¹⁴

In states implementing lockouts for failure to meet work requirements, pay premiums, renew coverage, or report income or other changes on time, individuals who qualify for an exception from the lockout or are eligible to resume their coverage will need to:

- **Understand and claim exceptions to the lockout.** Most waivers provide “good cause” exceptions for failing to complete a required activity, such as hospitalization, eviction, or natural disaster. However, these vary among the different requirements and are difficult to understand and claim, particularly if an enrollee is experiencing a severe crisis. Moreover, the time lag between submission of a claim for an exception and the state’s determination of whether good cause exists will likely still leave people facing gaps in coverage.
- **Understand how to regain coverage.** Some states provide a path back to coverage during the lockout, but enrollees may not understand the requirements, which may also be time consuming and burdensome. For example, Kentucky allows enrollees who fall short of the required hours in a given month to regain coverage by making up those hours in the next month or by completing a health or financial literacy course.

¹³ “The 2016 Annual Homeless Assessment Report (AHAR) to Congress,” U.S. Department of Housing and Urban Development, December 2017, <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf>.

¹⁴ Judith Solomon, “Locking People Out of Medicaid Coverage Will Increase Uninsured, Harm Beneficiaries’ Health,” Center on Budget and Policy Priorities, February 22, 2018, <https://www.cbpp.org/research/health/locking-people-out-of-medicaid-coverage-will-increase-uninsured-harm-beneficiaries>.

- **Know how long to wait before they reapply.** Individuals can reapply after the lockout period but must understand what that timeframe is. In some cases, it is a set number of months, in others the rest of the calendar year.

Complexity Will Significantly Raise Administrative Costs

Implementing the steps described above will cost states and the federal government hundreds of millions of dollars for eligibility system changes, notices, and increased staff to track compliance, address questions, and handle appeals. A large share of this spending will go to IT vendors and other contractors to change notices and forms to capture additional information, reprogram eligibility systems to add and track the new requirements, and establish mechanisms to track premium payments. Increased funds are also needed to hire staff to administer and monitor compliance with the myriad new requirements.

The Appendix provides a full list of available estimates of the administrative costs of implementing new requirements, but the following are a few examples.

- Kentucky plans to spend \$186 million in state fiscal 2018 and an additional \$187 million in 2019 to implement its waiver.¹⁵ Most of the funding is going to fund computer system changes to enable the state to track compliance with the work requirement and other changes under its waiver.
- Alaska projects that its proposed work requirement would cost the state \$78.8 million over six years, including about \$14 million per year in annual ongoing costs.¹⁶
- A Pennsylvania state official testified that a work requirement would cost \$600 million to implement and require 300 additional staff.¹⁷

In some states, counties would face higher costs as well:

- Minnesota estimates that counties will have to spend \$121 million in 2020 and \$163 million in 2021 to implement proposed work requirements. Counties estimate that it will take on average 53 minutes to process each exemption, 22 minutes to refer a client to employment and training services, and 84 minutes to verify non-compliance and suspend Medicaid

¹⁵ Deborah Yetter, “Bevin’s Medicaid changes actually mean Kentucky will pay more to provide health care,” *Louisville Courier Journal*, February 14, 2018, <https://www.courier-journal.com/story/news/politics/2018/02/14/kentucky-medicaid-changes-bevin-work-requirements/319384002/>.

¹⁶ Alaska Department of Health and Social Services, Summary of SB 193 Fiscal Notes, http://www.akleg.gov/basis/get_documents.asp?session=30&doid=55448.

¹⁷ Harold Brubaker, “Pa. Human Services head cites expense of forcing Medicaid recipients to get jobs,” *The Inquirer*, March 6, 2018, <http://www.philly.com/philly/business/pa-human-services-head-cites-expense-of-forcing-medicaid-recipients-to-get-jobs-20180306.html>.

benefits.¹⁸ Minnesota’s Hennepin County, which covers Minneapolis, estimates implementing a work requirement would require 300 additional caseworkers just in that county.¹⁹

- Ohio counties would have to spend \$380 million over five years to implement work requirements, according to the Center for Community Solutions.²⁰

Notably, some of the additional costs associated with implementing new requirements are fixed costs associated with eligibility system modifications, rather than costs that rise with caseloads. In states that have not expanded Medicaid under the Affordable Care Act (ACA), work requirement proposals will generally apply to comparatively few people, simply because few non-elderly adults not receiving disability assistance are eligible for Medicaid in these states. As a result, these states’ *per-enrollee* costs to impose new requirements will be particularly large.

States will shift a large share of these administrative costs to the federal government. Federal funds will cover 90 percent of eligibility system costs and 75 percent of most staff costs to determine whether Medicaid applicants and beneficiaries comply.²¹ While Section 1115 waivers must be budget neutral to the federal government — that is, federal expenditures with the waiver may not exceed what they would have been without the waiver — administrative costs are not considered in calculating a waiver’s federal budget impact.

In contrast to the enhanced federal match for systems changes and new staff, the federal government won’t provide a match for state costs related to employment and training or supportive services to help enrollees find and retain employment.²² Virginia estimates that it would cost nearly \$200 million per year to support a “high touch” approach to provide case management and other services that would help Medicaid beneficiaries meet the work requirement; the state would bear nearly all of those costs.²³

¹⁸ Minnesota Office of Management and Budget Local Impact Note, S.F. 3611, <https://www.dropbox.com/s/d78ufnkqonmxfq/SF3611%20Local%20Impact%20Note.pdf?dl=0>.

¹⁹ Glenn Howatt, “Proposed Medicaid work requirements could end up costing Minnesota,” *Star Tribune*, March 18, 2018, <http://www.startribune.com/proposed-medicaid-work-requirements-could-end-up-costing-minnesota/477217293/>.

²⁰ Lydia Coutre, “Ohio’s proposed Medicaid eligibility requirements could cost counties millions,” *Crain’s Cleveland Business*, March 13, 2018.

²¹ CMS Letter to State Medicaid Directors (16-004), March 31, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16004.pdf>.

²² See CMS letter to state Medicaid directors (18-002), *op cit*.

²³ Virginia Department of Planning and Budget 2018 Fiscal Impact Statement, Bill HB 338, <http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB338FH1122+PDF>. Even a low-touch approach, with minimal case management, would cost about \$7 million per year in addition to the cost of the eligibility system changes.

Complexity Will Cause Many Eligible People to Lose Coverage

Regardless of how much states spend, a large share of enrollees in states with approved waivers are at risk of losing coverage due to their own confusion and state errors. Vulnerable beneficiaries such as those with physical disabilities, mental health needs, and substance use disorders or other challenges like homelessness face especially high risks.

Losing Coverage Due to Red Tape

Even with states' large investments in bureaucracy and new staff, beneficiaries will be left largely on their own to sort through these complex rules and meet the requirements. Most Medicaid enrollees do not directly interact with a caseworker when applying for or renewing coverage and will receive information about the new eligibility conditions through long, complex paper notices.²⁴ Further, enrollees will be primarily directed to online portals to request exemptions, report compliance and income changes, and pay premiums — an approach that presents obstacles to enrollees with limited Internet access and doesn't permit them to ask questions about their obligations.

Expecting enrollees to understand the details of complex requirements, and imposing a penalty period for even inadvertent failures to comply, increase the chance that eligible individuals will lose coverage. Moreover, because the re-enrollment provisions are complex, many individuals who are eligible to reapply will likely be unaware they can regain eligibility and will instead go without health care.

Increasing documentation and verification requirements is antithetical to efforts to streamline and simplify the Medicaid eligibility process, which started with the 1997 enactment of the Children's Health Insurance Program (CHIP) and became even more significant with the ACA's 2010 enactment. States can no longer require an in-person interview, must rely on electronic data matches to verify eligibility to the greatest extent possible before requesting documentation from applicants, and must annually renew eligibility without requesting information from beneficiaries if eligibility can be determined using electronic data.²⁵ Many state Medicaid enrollment processes are now automated and require little or no caseworker intervention.

These changes to the enrollment process addressed barriers that experience shows kept eligible people from getting coverage.²⁶ For example, when Washington State increased documentation requirements and made other changes that made it harder to enroll and stay enrolled, enrollment dropped sharply; enrollment rebounded when the state reverted to its prior processes.²⁷ Similarly, in

²⁴ In Arkansas, for example, the notice to enrollees subject to the work requirement does not include any information on exemptions or protections under the ADA. Information on exemptions is included in a flyer accompanying the notice, but there is no mention of the ADA. "Arkansas Works Information," Notice and Flyer Samples, <https://ardhs.sharepointsite.net/ARWorks/default.aspx>.

²⁵ "Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process," Kaiser Family Foundation, February 28, 2018, <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/>.

²⁶ Michael Perry *et al.*, "Medicaid and Children: Overcoming Barriers to Enrollment," Kaiser Family Foundation, December 31, 1999, <https://www.kff.org/medicaid/report/medicaid-and-children-overcoming-barriers-to-enrollment/>.

²⁷ "Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process," *op cit.*

the months after 2006 federal legislation required states to ask families to present proof of their citizenship and identity — generally by producing a birth certificate or passport and proof of identity — when applying for or renewing their Medicaid coverage, states reported large declines in Medicaid enrollment, particularly among children. There was no evidence that those losing coverage were ineligible. Instead, it was the difficulty of obtaining the documents that caused large numbers of children to lose coverage.²⁸

Barriers to coverage will not affect all beneficiaries equally: vulnerable groups will likely be particularly at risk. For example, mental illness often affects the cognitive functions needed to navigate complex bureaucratic systems, making it hard for someone to qualify for an exemption.²⁹ Similarly, people experiencing homelessness will likely miss important notices from the state explaining exemptions and paperwork requirements because they lack a reliable address. And, as noted, people with substance use disorders may be unwilling to disclose private and sensitive information regarding their condition and treatment.

Studies of work requirement policies in other federal programs confirm that people with physical disabilities, mental health needs, and substance use disorders were disproportionately likely to lose benefits, even though many should have qualified for exemptions.³⁰ Those sanctioned were individuals with the greatest barriers to compliance with work requirements.³¹

Losing Coverage Due to State Errors

The new policies in these waivers will disrupt the current streamlined processes by requiring beneficiaries to supply additional information at application, renewal, and in between, much of which will require caseworker intervention to process, likely leading to delays in determinations of eligibility and increased numbers of procedural denials for failure to submit paperwork. Even with additional staff, already under-resourced agencies will likely struggle with these new burdens, resulting in increased backlogs and erroneous determinations.

States' experience with work requirements in SNAP and TANF shows how challenging implementing work requirements and other complex policies will be. A 2016 Agriculture Department Office of the Inspector General report found that SNAP policies are difficult for states to implement and create a substantial risk that people who are exempt or meet the work requirement

²⁸ Donna Cohen Ross, "New Medicaid Citizenship Documentation Requirement is Taking a Toll: States Report Enrollment is Down and Administrative Costs Are Up," Center on Budget and Policy Priorities, revised March 13, 2007, <https://www.cbpp.org/research/new-medicaid-citizenship-documentation-requirement-is-taking-a-toll-states-report>.

²⁹ Richard G. Frank, "Work Requirements and Medicaid: What Will Happen to Beneficiaries with Mental Illnesses or Substance Use Disorders?" Commonwealth Fund, April 2018, <http://www.commonwealthfund.org/publications/q-and-a/2018/may/work-requirements-and-medicaid>.

³⁰ LaDonna Pavetti, Michelle K. Derr, and Heather Hesketh Zaveri, "Review of Sanction Policies and Research Studies: Final Literature Review," Mathematica Policy Research, Inc., March 10, 2003, <https://www.mathematica-mpr.com/our-publications-and-findings/publications/review-of-sanction-policies-and-research-studies-final-literature-review>.

³¹ Yeheskel Hasenfeld, Toorjo Ghose, and Kandyce Larson, "The Logic of Sanctioning Welfare Recipients: An Empirical Assessment," University of Pennsylvania, June 2004, https://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.

will erroneously lose coverage.³² A separate study of the implementation of the SNAP time limit identified tracking benefit receipt over time as problematic, burdensome, and a major challenge.³³

Specific types of state errors that are likely to occur frequently under the new waivers include:

- Delays and mistakes as states process paperwork related to documenting work hours or exemptions and determine good cause for non-compliance.
- Failure to correctly apply criteria for exemptions and exceptions for non-compliance, particularly in complex cases. Examples include individuals with multiple health conditions that together make it impossible for them to work and cases where the exception criteria are highly subjective, as with “good cause” exceptions for family emergencies or “severe inclement weather.”
- Failure to properly identify people protected by the ADA or to provide reasonable modifications for those who are protected.
- Mistakes in tracking compliance and penalty periods.

These errors are especially likely as states start up new systems and in states with newly approved waivers that have struggled to administer even the existing eligibility rules. Arkansas³⁴ and Kentucky³⁵ both experienced recent problems with their eligibility systems that caused thousands of eligible people to lose coverage. More generally, experience shows states often have difficulty implementing complex policy and system changes, leading to termination of coverage or other harm to eligible enrollees.³⁶

Conclusion

Current waiver proposals and recently approved waivers will cause large numbers of eligible people to lose coverage and will increase administrative costs. Those who lose coverage will have less access to care, less financial security, and worse health outcomes. States are essentially redirecting a share of their spending from health care for vulnerable families to complex bureaucracy that beneficiaries will struggle to navigate and states will have difficulty administering accurately.

³² U.S. Department of Agriculture, Office of the Inspector General, “FNS Controls Over SNAP Benefits for Able-Bodied Adults Without Dependents,” September 29, 2016, <https://www.usda.gov/oig/webdocs/27601-0002-31.pdf>.

³³ John L Czajka *et al.*, “Imposing a Time Limit on Food Stamp Receipt: Implementation of the Provisions and Effects on Food Stamp Participation,” Mathematica Policy Research, Inc., September 4, 2001, <https://fns-prod.azureedge.net/sites/default/files/abawd.pdf>.

³⁴ David Ramsey, “The Arkansas Medicaid verification mess: what went wrong,” *Arkansas Times*, August 10, 2015, <https://www.arktimes.com/ArkansasBlog/archives/2015/08/10/the-arkansas-medicaid-verification-mess-what-went-wrong>.

³⁵ Deborah Yetter, “New Ky benefits system disrupting aid for many,” *Courier Journal*, March 25, 2016, <https://www.courier-journal.com/story/news/politics/2016/03/25/new-ky-benefits-system-disrupting-aid-many/82206656/>.

³⁶ Gina Mannix, Marc Cohan, and Greg Bass, “How to Protect Clients Receiving Public Benefits When Modernized Systems Fail: Apply Traditional Due Process in New Contexts,” Clearinghouse Community, January 6, 2016, http://nclaj.org/wp-content/uploads/2016/01/ClearinghouseCommunity_Mannixetal-Published-Article-with-Copyright.pdf.

Appendix: State Estimates of Administrative Costs for Medicaid Eligibility Restrictions

Alaska: An official state fiscal analysis of legislation that would end Medicaid coverage for people not meeting a work requirement projects implementation costs of \$78.8 million over six years.³⁷ Costs include hiring new staff to monitor compliance and process terminations, hiring additional administrative law judges to hear appeals of Medicaid terminations, and providing supportive services to assist enrollees in meeting work requirements.

Kentucky: Kentucky has budgeted \$186 million for fiscal year 2018 and \$187 million for 2019 to implement its federally approved waiver.³⁸ Most of the costs will be for changes to the eligibility system to administer the new requirements, and the state plans to seek federal funding for 90 percent of those costs.

Louisiana: A fiscal note on a 2017 bill proposing a Medicaid work requirement estimated that changes to the eligibility system alone would cost \$4 million in the following fiscal year.³⁹

Michigan: The House Fiscal Agency estimates that the administrative costs of proposed legislation to impose a work requirement on Medicaid enrollees would be \$15 to \$30 million per year.⁴⁰ These costs would arise from “added administrative casework and information technology updates required to verify hours worked, qualifying exemptions, and other casework each month.”

Minnesota: Minnesota Management and Budget released a “local impact note” on proposed legislation to end Medicaid coverage for people failing to meet a work requirement, detailing the cost to the counties that determine Medicaid eligibility in the state.⁴¹ The note estimates that the proposal would cost local governments \$121 million in 2020 and \$163 million in 2021. Based on county surveys, the note estimates that it would take counties an average of 53 minutes to process an exemption, 22 minutes to refer a client to employment and training services, and 84 minutes to verify noncompliance and suspend Medicaid benefits. Providing compliance monitoring and employment and training services to enrollees through contractors could cost \$1,157 per enrollee.

³⁷ Alaska Department of Health and Social Services, Summary of SB 193 Fiscal Notes, http://www.akleg.gov/basis/get_documents.asp?session=30&docid=55448.

³⁸ Deborah Yetter, “Bevin’s Medicaid changes actually mean Kentucky will pay more to provide health care,” *Louisville Courier Journal*, February 14, 2018, <https://www.courier-journal.com/story/news/politics/2018/02/14/kentucky-medicaid-changes-bevin-work-requirements/319384002/>.

³⁹ Louisiana Legislative Fiscal Office Fiscal Note, SB 188, <http://www.legis.la.gov/legis/ViewDocument.aspx?d=1034038>.

⁴⁰ Michigan House Fiscal Agency Legislative Analysis, SB 897, <http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-755E178A.pdf>.

⁴¹ Minnesota Management and Budget Local Impact Note, S.F. 3611, <https://www.dropbox.com/s/d78ufnkqonrnxfq/SF3611%20Local%20Impact%20Note.pdf?dl=0>.

Ohio: The Center for Community Solutions estimates that a proposed work requirement would increase costs for counties, which determine Medicaid eligibility in Ohio, by over \$378 million over five years to provide case management services to enrollees.⁴²

Pennsylvania: The Secretary of Human Services testified that implementing Medicaid work requirements in Pennsylvania would cost \$600 million and require hiring 300 additional staff.⁴³

Tennessee: A fiscal note on a work requirements bill recently signed into law estimates that it would cost over \$34 million per year to implement, in addition to \$5.6 million in costs to change the new Medicaid eligibility system scheduled to go live next year.⁴⁴

Virginia: A fiscal note estimates that a work requirement bill would require \$5 million to implement necessary system changes.⁴⁵ It also estimates that a “high touch” case management approach, with services based on the TANF model would cost around \$200 million per year; a “low touch” approach, with nominal case management, would cost around \$7 million per year.

⁴² Loren Anthes, “Medicaid Work Requirement Waiver Analysis: Budget Neutrality,” Center for Community Solutions, March 13, 2018, <https://www.communitysolutions.com/research/medicaid-work-requirement-waiver-analysis-budget-neutrality/>.

⁴³ Harold Brubaker, “Pa. Human Services head cites expense of forcing Medicaid recipients to get jobs,” *The Inquirer*, March 6, 2018, <http://www.philly.com/philly/business/pa-human-services-head-cites-expense-of-forcing-medicaid-recipients-to-get-jobs-20180306.html>.

⁴⁴ Tennessee General Assembly Fiscal Review Committee Fiscal Note, HB 1551 – SB 1728, <http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf>.

⁴⁵ Virginia Department of Planning and Budget 2018 Fiscal Impact Statement, Bill HB 338, <http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB338FH1122+PDF>.