# Service Blueprint: Medicaid Work Requirements (1/4)

## Apply

**Medicaid expansion adults will have work requirements starting on Jan. 1st, 2027, or earlier if the state chooses.**

POLICY

The new work requirement policy carves out exemptions so that only adults who receive Medicaid as a result of Medicaid expansion after the Affordable Care Act was passed have to meet work requirements.

Work requirements are irrelevant for the 10 states who chose to not expand Medicaid: TX, WY, KS, WI, TN, MS, AL, GA, SC, FL.

**In order to be eligible for Medicaid, clients must be either exempt or already complying with work requirements for at least 1 month (up to 3 months) before applying.**

POLICY

States can choose to require a "lookback" period up to 3 months.

**Searching for jobs is not a qualifying activity for complying with work requirements.**

PAIN POINT

People newly applying to Medicaid because of a job loss will need to start doing qualifying activities (e.g., volunteering) in order to get Medicaid.

**A state can preemptively grant short-term hardship to all Medicaid applicants in a region for disaster + unemployment rates.**

POLICY

This is an option states can choose to take on, and would temporarily exempt everyone in that region from work requirements. Qualifying events include:

- Living in a county with a federally declared disaster
- Living in a county with an unemployment rate of 8% or 1.5 times the national average

**States will need to implement blanket hardship definitions in their systems, and ensure that it's coded at the county level.**

PAIN POINT

Many eligibility systems are not county-based already

**Client applies for Medicaid**

CLIENT ACTION

In addition to applying on paper or online, clients may also be able to apply on the phone.

**Because Medicaid work requirements are new, existing applications do not screen for exemptions or if the client has been compliant with work requirements.**

PAIN POINT

For example, questions do not ask about all categories of "community engagement"

**Re-design Medicaid application forms to take work requirements screening into account**

OPPORTUNITY

Many states have integrated benefits applications with SNAP. There is an opportunity to improve how and where to integrate relevant work requirement questions to effectively screen for exemptions or compliance.

## Figure out if the client is **exempt from work requirements**

### Process application

**For paper or phone applications, staff manually register the application.**

STAFF ACTION

**In some states, the eligibility system currently performs a real-time eligibility check.**

SYSTEM

The system determines automatically if someone is eligible for Medicaid or not, depending on data entered from their application.

This is especially relevant for online applications

**States with real time eligibility systems will need to modify system logic to incorporate work requirements checks**

PAIN POINT

The system should attempt to screen for and verify exemptions.

If no exemption could be found and verified, it should attempt to verify compliance with "community engagement."

**Eligibility systems with real time eligibility checks could automate generating a verification request based off of the application data.**

OPPORTUNITY

Expedite the process of requesting verification documents by determining which verifications will likely be needed from the client to demonstrate possible work requirement exemptions or compliance

### Determine if each person qualifies for an **exemption**

**Some categories of people are exempt from Medicaid work requirements, meaning they don't have to meet work requirements in order to get Medicaid.**

POLICY

People are exempt if they are:

- 18 or younger, or 65 or older
- Pregnant or postpartum
- Living in a household with a dependent 13 or younger
- A parent or guardian of someone with a disability
- On (or entitled to) Medicare
- Eligible for non-MAGI Medicaid
- Disabled veteran
- Medically frail/special needs as defined by the Secretary of the Dept of HHS, including blind, disabled, substance use disorder, disabling mental disorder, physical/intellectual/developmental disability, serious or complex medical condition
- On SNAP or TANF and have to meet (not exempt from) the work requirements
- Participating in drug or alcohol rehab
- Current (or within the last 3 months) inmate
- Indian, Urban Indian, California Indian, or IHS-eligible Indian

**Medicaid eligibility systems will need to be changed to represent exemptions from work requirements.**

PAIN POINT

States will need a way in their system to indicate that the individual is exempt from work requirements and why.

**Staff use application information to see if each member of the household qualifies for any exemptions**

STAFF ACTION

Age and household member exemptions can often be assessed just from the application:

- 18 or younger or 65 or older
- Living in a household with someone 13 or younger
- A parent or guardian of someone with a disability
- Pregnant or postpartum

**Staff use databases to see if any exemptions apply to each person in the household**

STAFF ACTION

Databases can demonstrate exemptions such as:

- If a client is enrolled in Medicare/non-MAGI Medicaid
- If a client is a current/recently released inmate (if connected to state department of corrections)
- Currently enrolled in SNAP and not exempt from those work requirements (if integrated with SNAP eligibility)
- Currently enrolled in SNAP E&T
- State Department of Education for student status
- Drug/alcohol rehab participant, based on state's behavioral health agency data
- "Medically frail" as determined by certain Current Procedural Terminology (CPT) codes

**In some states, database checks are done automatically.**

SYSTEM

Some of these may be automatically run and pulled into the case

**Identify, validate, and promote adoption of high-quality data sources for exemptions**

OPPORTUNITY

View a list of potential sources

**Staff determine if the client has indicated any exemptions that need to be verified manually by the client**

STAFF ACTION

**States can decide whether they will accept a client's self-attestation as sufficient verification or if they need additional proof.**

POLICY

**How will states approach situations where self-attested information and information from data sources differ?**

QUESTION

Will states require verification of discrepancies between self-attested income and income found from data sources, if the difference doesn't impact eligibility or whether a client is meeting work requirements?

What Payment Error Rate Measurement (PERM) implications will impact state choices on this?

# Service Blueprint: Medicaid Work Requirements (2/4)

## Figure out if the client is **exempt**, and, **if they're not,** if they are **meeting work requirements**

### If **not exempt**, determine if they are **meeting work requirements**

**If a client has to meet work requirements, they must be doing at least 80 hours a month of "community engagement" or earning more than $580 a month in order to be able to get Medicaid.**

POLICY

"Community engagement" could mean the client is:

- Working
- Volunteering
- In a work program
- In school half-time or more

Or, the client must be earning a monthly income that is at least:

- 80x the federal minimum wage, currently at least $580
- $580 per month once averaged across the previous 6 months, if the individual is a seasonal worker

**Medicaid eligibility systems will need to be changed to represent compliance with work requirements.**

PAIN POINT

States will need a way in their system to indicate the reasons why someone who doesn't have an exemption is also meeting the work requirements.

**If the client has listed they are working on their application, databases can verify if each household member is meeting the income or hourly requirements.**

STAFF ACTION

Common databases showing employment and income information include:

- Quarterly Wage Data, if allowable via policy
- The Work Number
- Other income data sources

**Quarterly Wage Data (QWD) is likely not fully usable to determine work requirement compliance.**

PAIN POINT

QWD is the standard income database currently used for Medicaid eligibility. It aggregates a person's wages every 3 months, meaning it is insufficient to demonstrate if a client is meeting the work requirements for a shorter (1 or 2 month) lookback.

**Improve use of income verification services to automatically determine if someone is already compliant**

OPPORTUNITY

Verification sources could show the client already meeting work requirements by:

- Working at least 80 hours a month, OR
- Earning at least $580/month

A report from the Urban Institute found that 52% of adults on Medicaid could be deemed exempt or compliant for Medicaid work requirements using ONLY data matches.

**How will regulation define "income" for Medicaid work requirements?**

QUESTION

If a person has income above a certain level (currently $580/month), they are exempt from Medicaid work requirements.

Will SSI, Unemployment Insurance, gifts, or other forms of unearned income qualify as "income" for someone to be exempt from work requirements? Are there any types of earned income that would be excluded, or will regulation align with the definition of income for MAGI?

**What will suffice as verification for volunteering?**

QUESTION

A client will qualify as meeting work requirements if they are volunteering for 80 hours a month.

Note: Meeting work requirements via volunteering will likely apply to a small minority of clients.

### If **not meeting**, determine if they have **hardship**

**States can choose to allow "short-term hardship" to count as meeting work requirements.**

POLICY

Not all states will implement this. Qualifying short term hardship events include:

- Receiving inpatient hospital or nursing services, or services of similar acuity
- Must travel outside of their community for an extended period of time for medical services for a serious or complex medical condition

**States will need to implement hardship request methods.**

PAIN POINT

States will need multiple methods of requesting hardship, including some or all of the following:

- Mail
- Fax
- In person
- Email
- Online portal
- Phone

**States will need to implement hardship indication in their eligibility systems.**

PAIN POINT

Including the time limit for how long short-term hardship can be granted before additional verification is needed

**A client can request short-term hardship**

CLIENT ACTION

Hardship (outside of disaster and unemployment) *must* be requested in order to be granted.

Ideally this comes through on the application. If not, the client should be told that they can report this during the request for verifications or at eligibility determination.

**Make the process of requesting hardship human-centered**

OPPORTUNITY

Make it 1) easy to understand which life events qualify as hardship, 2) clear what options are available to report hardship, and 3) easy to actually report hardship

**Staff process hardship request**

STAFF ACTION

Review the hardship request and determine if it is valid

**What will suffice as verification for hardship?**

QUESTION

For some reasons (e.g., disaster, regional unemployment), no verification will be needed.

For others, the Center on Medicare & Medicaid Services (CMS) may require additional verification depending on regulation that has yet to be written.

# Service Blueprint: Medicaid Work Requirements (3/4)

## Determine eligibility

**Staff manually mark in the eligibility system for each member of the household if any exemptions apply**

STAFF ACTION

Based off of information from the application, database checks, and submitted verification documents

**Some states have incorrectly determined Medicaid eligibility at the household level, not individual level, meaning some people did not get Medicaid coverage when they should be eligible.**

PAIN POINT

In the past, CMS has issued warnings to states to correct this in their eligibility systems.

**For Medicaid, data should be stored in eligibility systems at the individual-level, not household-level.**

BEST PRACTICE

Otherwise states run the risk of an eligibility error where either the income or work status of one person affects whether the entire household receives Medicaid.

This particularly affects children who would be eligible for Medicaid but their parents are not eligible due to the amount of income the parent makes.

**In some states and cases, staff must take action to process the eligibility determination.**

STAFF ACTION

**Some states have automated eligibility determination for Medicaid.**

SYSTEM

Some systems may have the ability to automatically mark a person eligible or ineligible once all verifications are in place.

**States will need to implement changes to the logic of how eligibility is determined in Medicaid.**

PAIN POINT

Eligibility determination logic will need to add a condition to ensure that before approving someone's Medicaid, they are either exempt from work requirements or have been meeting them (for the past 1-3 months for new applicants; for the past 1 month in the last 6 months for renewals).

**Client gets notified of their eligibility determination and if they have work requirements**

CLIENT ACTION

**Improve the eligibility determination notice to help set expectations for work requirements to recertify**

OPPORTUNITY

The eligibility determination notice is a critical opportunity to communicate the expectations for work requirement compliance. Make it easy to understand 1) which members of the household have to meet Medicaid work requirements for eligibility, 2) the changed certification period for those individuals, 3) what the lookback period will be when they renew benefits, and 4) what the client has to do when the lookback period will be assessed.

**If a person is ineligible for Medicaid, they should be sent to the Marketplace.**

SYSTEM

**If you have to meet Medicaid work requirements and aren't meeting them, you cannot buy subsidized health insurance from the Marketplace.**

PAIN POINT

The person would have to purchase full-price health insurance from the Marketplace.

**How does work verification happen with respect to the Marketplace?**

QUESTION

If someone is ineligible for Medicaid and handed to the Marketplace, how does work verification information get transferred? The Marketplace systems should not attempt to re-verify this information.

## Maintain benefits

### Reporting a change

**Clients must report changes in work status that could make them ineligible for Medicaid.**

CLIENT ACTION

Specifically if they are doing less than 80 hours a month of "community engagement," or no longer meeting the income requirements to meet work requirements or eligibility

**States will need to change systems to enable clients to report changes to their work status**

PAIN POINT

**Agencies must check electronic sources to verify the change before requesting verification from the client.**

POLICY

Under existing regulations, if the agency receives new information that may impact eligibility, the agency must attempt to contact the individual for additional information, but they must check electronic data sources first.

**If a client's work status cannot be verified with databases, the staff sends a client a notice of "non-compliance."**

STAFF ACTION

The notice of non-compliance is essentially a request for more information from the client to either prove that they 1) have been meeting the work requirements, 2) have an exemption, or 3) have a valid hardship reason why they could not meet the requirements.

**Design the "notice of non-compliance" so that it is clear and actionable.**

OPPORTUNITY

The notice of non-compliance will be a new notice states will be creating from scratch. Additionally, consider other more real-time outreach methods (i.e., texting).

**Clients receive the "notice of noncompliance" and have to respond to the notice within 30 days, or they will lose coverage**

CLIENT ACTION

Clients may respond with:

- Evidence of work activity
- Evidence of an exemption
- Hardship request

**The client's response will be received and processed.**

STAFF ACTION

# Service Blueprint: Medicaid Work Requirements (4/4)

## **Renewing benefits**, including automatically through an "ex parte" renewal

**The certification period for Medicaid expansion adults has changed from 12 months to 6 months.**

POLICY

Other groups of clients receiving MAGI or non-MAGI Medicaid keep their 12-month certification period.

This will take into effect by Jan. 1st 2027.

**Many clients will be in households where people have different renewal timelines, adding complexity for families to maintain health care coverage.**

PAIN POINT

**In order to renew Medicaid, clients must have been meeting work requirements for at least one month since their last certification.**

POLICY

Clients who need to meet Medicaid work requirements need to prove that they have been meeting them for at least one month since they last certified.

States can choose how the lookback period is structured. For example, they can choose to require the client to verify more months, such as monthly for the past 6 months.

**At least 30 days prior to the renewal date, states check electronic data sources to attempt an ex parte renewal**

SYSTEM

**Ideally, the state is able to use ex parte (or automated) renewals so that minimal work is required from clients.**

BEST PRACTICE

**Support states with ex parte renewals that accounts for new work requirements**

OPPORTUNITY

Ex parte renewals must attempt to verify BOTH work status AND exemptions, even if someone was not exempt for their prior certification period.

Ex parte logic is a large opportunity space for optimization and improvement.

**If a client's eligibility and work status, exemption, or hardship can be verified, they are renewed and their coverage is extended.**

STAFF ACTION

**Running ex parte more than 30 days early could result in early termination of coverage.**

PAIN POINT

If a state chooses to run ex parte more than 30 days early, and the client cannot be verified compliant for work requirements, the state must send a notice of noncompliance and a renewal packet.

If the "notice of non-compliance" is not returned within 30 days, the state is required to terminate coverage early.

**If a client cannot be renewed ex parte, they will be mailed a renewal form to complete manually.**

STAFF ACTION

Some states provide this form up to 90 days in advance of the end of coverage

**Clients who have to manually renew will need to submit forms twice as often as they used to in order to keep getting their Medicaid coverage.**

PAIN POINT

**Clients must return the renewal form**

CLIENT ACTION

Clients will need to return their renewal form with either:

- Evidence of work activity
- Evidence of an exemption
- Hardship request

**Clients will likely need to submit verifications that demonstrate either their continued exemption status or that they are meeting the work requirements.**

PAIN POINT

**If the state cannot verify if a client is complying with work requirements, it will send the client a "notice of non-compliance."**

SYSTEM

This could be the case if the client doesn't return the renewal form, or doesn't provide sufficient needed verification to show they are meeting work requirements.

The client has 30 calendar days, beginning on the date the notice is received, to provide information to show compliance. The individual continues to receive coverage during the 30-day period.

**If the client does not show they have been meeting the work requirements by the deadline on the "notice of non-compliance," the state terminates their coverage by the end of the next month.**

STAFF ACTION