

Medicaid & Work Requirements: Likely Impact on the HCH Community

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In January 2018, the Centers for Medicare and Medicaid Services (CMS) released [guidance to states](#) outlining how they could implement work requirements as a condition for Medicaid. Work requirements are not a new concept for food and housing assistance, but linking them to Medicaid is unprecedented. Currently, four states (AR, IN, KY, and NH) have received federal approval to require Medicaid beneficiaries to work (or engage in some form of community activity) in order to receive medical assistance, eight other states (AL, AZ, KS, ME, MS, OH, UT, and WI) have applications pending approval at CMS, and several others have proposals under consideration. A federal court recently struck down the Kentucky work requirement, but it is uncertain how that decision will impact other states. In the meantime, states are continuing to move forward.

While details vary in each state's approach, work requirements pose a barrier to care and will likely have a significant impact on people who are homeless and on the health care providers who serve them. The National HCH Council opposes work requirements and [released a statement](#) in February 2018 outlining why they are poor public policy. This issue brief outlines some of the common elements in these approaches, the implications of these provisions on clients and community service providers, and offers some actions to consider to help ease implementation and for advocacy. *We need service providers and clients directly involved in the struggle to strengthen Medicaid, not weaken it.*

Common Qualifying Activities

Each state has identified a specific list of activities that count toward the work requirement. Though these details are different in each state, common activities include:

- Paid or unpaid employment (usually at least 20 hours/week)
- Job or vocational training
- Community service
- Job search activities
- Participation in GED or other educational program

Common Exemptions

All states have included a list of those who are not subject to the work requirement. While these lists *appear* helpful, there are many barriers to proving an exemption, and many bureaucratic steps that can jeopardize coverage. While the specifics vary widely, some common exemptions include:

- Older adults
- Pregnant or post-partum women
- Children
- People with disabilities
- Those determined to be medically frail
- Those participating in drug treatment programs*
- Caregivers to a young child or incapacitated/disabled adult
- Those determined physically or mentally unable to work (but not formally disabled)
- Homeless (sometimes "chronic homeless")
- Those with recent hospitalizations or a serious illness
- American Indians/Alaskan Natives
- Full-time students
- Those exempt from state SNAP or TANF work requirements

* Note: Critically, only 1 in 10 people with an addiction is in treatment; meaning 9 in 10 people with an addiction would not meet this exemption and are at an increased risk of losing the very health coverage that would pay for treatment.

An exemption based on homelessness is advantageous, but the HCH community is familiar with the challenges of formally proving homelessness. Exempting those who are “chronically” homeless misses the majority of the population who are homeless for shorter periods of time as well as the most vulnerable who have been homeless for longer, but may not have used shelter services. It also discounts those who are recently housed, but still in need of care. Housing status changes frequently, making this a tenuous exemption at best.

Implications

Work requirements policies will create three groups of people: those who are exempt from the requirement (which means *proving* the exemption); those who are not exempt and can meet the requirements (which means *proving* work hours); and those who are not exempt and do not meet the requirements (which means *losing health coverage*). **Unfortunately, states are choosing to use precious resources to create bureaucratic complexities and “red tape” rather than provide health services and/or simplify the system so it is more effective.** States are also choosing to take time and energy away from addressing chronic and communicable disease, the opioid and mental health crises, and other public health priorities. Under the guise of encouraging “self-sufficiency” and asserting employment as a social determinant of health, these policies are an open attempt to push low-income people off Medicaid and deny them care. Hence, there is little incentive for states to make these systems easy to navigate or conducive to the needs of vulnerable populations.

Likely Impact on Clients

Those who meet the requirements for an exemption will need to successfully apply for and receive an exemption using the process and timeline the state identifies (this may need to be done periodically in order to maintain the exemption). This may mean taking forms to care providers to be filled out and/or authorized. For those that work, it means regularly reporting hours to the state. This could be through an online database or other process that needs to be completed (possibly weekly or monthly). If work hours fluctuate or your exemption status changes, it might mean losing coverage. Working additional hours to qualify for Medicaid may make it harder to find time for health care appointments at the usual place of care and emergency room visits might increase. If coverage is lost, any treatment or prescriptions could get cut off; visits to the emergency room and to the hospital won’t be covered, and it’ll be harder to find treatment for mental health and addiction issues. Missing a deadline for submitting information because of no mailing address, insufficient phone or internet access, illness, misunderstanding the process, or other reason may mean losing health insurance.

Likely Impact on Providers

Requirements to demonstrate medical frailty, disabling conditions, homeless status, or other provisions to exempt patients from the work requirement will likely mean clinical time is spent conducting assessments and filling out forms (a process that may be required multiple times a year). Time will also be spent submitting information to the state, responding to requests for more information, correcting errors, and appealing decisions. Clients may be less able to engage in care because they are striving to meet the work requirements, increasing the likelihood of missed appointments and decreased opportunities for health care interventions.

If patients lose coverage because they are unable to meet the requirements or secure an exemption, treatment and care plans are interrupted, clinical options for treatment and the ability to refer to specialists are more limited, prescription drug options may be curtailed, and coordinating care across venues may be more difficult. Financial losses may occur when declining (or fluctuating) coverage curtails provider reimbursements and/or when reimburseable clinical visits are replaced with non-reimburseable administrative visits. Strategic planning, revenue projections, plans for growth, staff retention, and other operational functions may also become more difficult.

Missing from the conversation is the burden these policies put on clinicians and other service providers. A wide range of screenings and interventions already take place during a clinical visit, in addition to treating the patient’s specific needs. Assessments include screenings for substance use disorders, mental health/suicide prevention, trauma, cancer, diabetes and other chronic illness, health literacy, incarceration history, smoking cessation, healthy weight, nutrition/food insecurity, violence, veteran status, and housing status (among others). While these are clinically relevant tasks that are part of a medical standard of care—adding paperwork related to compliance with work requirements (even to justify a patient’s exemption) is burdensome and takes critical time away from needed clinical care.

The Missing Link to Employment

The vast majority of people who are homeless want to work, do work, and/or have worked in the past. However, there are numerous barriers to employment when one is without stable housing (most notably, *the lack of stable housing*). It is difficult to work when one is living in a homeless shelter, on the street, or unstably moving around.

Work requirements employ a flawed logic: employment does not increase good health; rather, health coverage—like Medicaid—supports good health, which in turn facilitates employment. States should be bolstering employment by providing high-quality, comprehensive health care as well as the additional supports people need in order to work, such as housing, living wages, child care, transportation, legal assistance, job training, and adult education.

10 Advocacy Actions to Consider

1. **Prevent work requirements in your state by rigorously advocating against them!** Testify at legislative hearings, respond to public comment periods, and look for every opportunity to oppose these measures.
2. Partner with the legal community to challenge the work requirement in the courts. Engage clients as potential plaintiffs.
3. Describe the negative impacts on vulnerable clients (and to your own operations) to the Medicaid director, the Governor, legislators, and other state and local policymakers.
4. Use traditional and social media to raise awareness of these changes and organize opposition from clients, community partners, and others with a shared mission.
5. Use your voice as a service provider and/or client to illustrate why work requirements don’t work. Tell your story about difficulty proving exemptions (or work hours) and the impact of discontinued or fluctuating coverage.
6. Promote access to work by advocating for health care, housing, living wages, child care, transportation, legal assistance, job training, adult education, and other supports that people need.
7. Advocate to remove public policy barriers to employment like “Ban the Box” measures that preclude those with criminal records from gaining employment.
8. Expand Medicaid to single adults (in states that have not yet) and use Medicaid waivers to expand services (case management, housing support services, etc.), rather than curtail them.
9. Illustrate that work requirements are *directly in conflict* with making progress on the opioid epidemic (and substance use disorders broadly), the mental health crisis, the drive to reduce chronic illness, and other health care priorities. Also point out they create needless bureaucratic red tape.
10. Keep track of changing declining coverage rates, health outcomes effects, and/or financial impacts at your organization and use this data in your advocacy.

10 Implementation Actions to Consider

1. **If it is not possible to prevent work requirements from being implemented, work assertively with the state to create exemptions that can broadly apply to vulnerable populations and be easily implemented** (e.g., a wide definition of homelessness that can be demonstrated with a data-match to the homeless management information system, or other automated process).
2. Work with the state to create template exemption forms (or other processes) that are easy for clients and providers to complete and are not disruptive to the provision of health care services.
3. Identify staff who can help clients document compliance with requirements or exemptions.
4. Identify the exemption provisions that are most likely to apply to clients who are homeless (e.g., medical frailty, participation in drug treatment, disabling conditions, etc.) and develop a system for efficiently tracking and submitting information to the state.
5. If possible, amend clinic hours and/or staffing to accommodate changes in patient work schedules (evening hours, weekends, etc.).
6. Identify computer availability so clients can document their work hours (or exemption information) on state online systems (note: some states are online *only* and do not have alternative reporting systems).
7. Create volunteer or employment activities for clients at your program (or through community partnerships) that will help meet requirements.
8. Increase clinical and support staffing to fulfill administrative requirements and conduct more assessments to determine medical frailty or other clinical basis for exemptions.
9. Create internal tracking process to help ensure patients do not erroneously lose coverage (and raise appeals to the state to reinstate coverage quickly), or partner with Legal Aid.
10. Work with the state to develop clear and understandable explanations and communications to clients (and in multiple languages as appropriate). Develop internal fact sheets to share with clients if the state does not establish clear directions.

**EMPLOY A HARM REDUCTION
APPROACH TO
IMPLEMENTATION.
DO WHATEVER IT TAKES TO
REDUCE THE RISK OF LOSING
MEDICAID COVERAGE.**

Further Research on Work Requirements

Research shows that work requirements don't work. Below is some of the leading research on these policies. Use this material in your advocacy activities.

- Kaiser Family Foundation: [Understanding the Intersection of Medicaid and Work](#) (January 2018)
- Urban Institute: [Work Requirements in Safety Net Programs: Lessons for Medicaid from TANF and SNAP](#) (April 2018)
- Centers on Budget Policies & Priorities: [Medicaid Briefs: Who is Harmed by Work Requirements?](#)
 - Especially recommended: [How Medicaid Work Requirements Will Harm People Who Are Experiencing Homelessness](#)

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