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The Health Wonk Shop: How Will States Implement Medicaid Work Requirements?

Larry Levitt: Hello, I'm Larry Levitt from KFF. Welcome to the latest episode of the Health Wonk Shop, where we regularly dive into timely and complex health policy topics with experts from a variety of perspectives. Health policy discussions in recent months have been dominated by the Medicaid and ACA changes and the tax and spending law passed by Congress, otherwise known as the One Big Beautiful Bill Act. The law represents the biggest rollback in federal health spending ever, and the biggest source of savings is a new work in community engagement requirement in Medicaid, and while many of the Medicaid reductions will take years to go into effect, the work requirement begins January 1st, 2027 or potentially even earlier in some states. Now conceptually, a work requirement for Medicaid enrollees is simple, but actually making it work, especially in a way that avoids eligible people falling through the cracks is anything but simple.

We have four experts here today, including leaders working in the trenches to run Medicaid programs to help us understand what the new law does and how it might play out. Caprice Knapp is a former Medicaid director and currently the acting director of the Center for Medicaid and CHIP Services at CMS. Emma Sandoe is the Medicaid director in Oregon and also previously served in North Carolina and at CMS as well. Jennifer Strohecker is the Medicaid director in Utah and was a practicing pharmacist. And Jen Tolbert is the deputy director of KFF's Medicaid policy program and leads our work on state health policy and data.

A little bit of housekeeping before we get to the discussion. If you have questions, submit them at any time through the Q&A button in Zoom. We'll get to as many of them as we can. Also note that this session is being recorded and an archived version should be available later today. We have ASL interpretation available. To access it, click on the globe icon in the Zoom control panel. Now let's jump in. Jen Tolbert, let me start with you. Give a brief summary of the work requirement and what the timeline is for implementation.

Jennifer Tolbert: So starting January 1st of 2027, or earlier at state options, states will need to verify that individuals applying for coverage or enrolled in coverage through the Medicaid expansion meet these new work requirements. Now our current understanding of the law is that enrollees in partial expansions waiver programs

in Wisconsin and Georgia will also be subject to these new requirements. So to meet the requirements, individuals will need to work or engage in qualifying activities such as community service for at least 80 hours a month or be enrolled in school half-time. The law exempts certain individuals from these requirements, including parents of children ages 13 and under, individuals who are medically frail, and those who are enrolled in substance use disorder programs, among others. States can also allow for certain hardship exceptions for individuals in certain circumstances, including those who are in the hospital as well as those who live in counties with high unemployment rates.

So states will have to verify that individuals are meeting these requirements at application and every six months at renewal or more frequently if a state chooses, and at application, states will need to look back one to three consecutive months immediately preceding the application month to confirm compliance. And then at renewal, states will look back one or more months between those verification periods. States will also have to use available data sources where possible to confirm work or exemption status without requiring documentation from individuals. But if a state is unable to verify compliance, the individual will have 30 days to submit documentation or prove that they are meeting the requirements before being dis-enrolled.

I will note the implementation timeline here is pretty tight. As noted, the requirements go into effect in January of 2027. Those states can apply for a waiver to implement earlier. The secretary is required to issue an interim final rule by June 1st of 2026, and states must begin outreach to enrollees and others three months before the start of the first look-back month. So for states that are implementing in January of 2027, that first look-back month will be December, meaning they will need to begin outreach in September of 2026. Now states may apply for a good faith waiver to delay implementation until December 2028, however, the secretary will have discretion over whether to approve those waivers.

Larry Levitt: Jen, just quickly, what did the Congressional Budget Office project would be the effect of the work requirement in terms of number of people uninsured, federal savings?

Jennifer Tolbert: Sure. So the CBO estimated that these new work requirements will reduce federal Medicaid spending by $326 billion over 10 years and will lead to 5.3 million more people being uninsured in 2034.

Larry Levitt: Thanks. So Caprice, when Jen says the secretary has to issue regulations by June 1st, 2026, that's you, right? I mean, this is all moving quite quickly. Describe to the extent you can at this point how you're thinking about implementation,

what type of guidance will CMS be providing to states, and when we can expect that.

Caprice Knapp: Sure. So understand that we understand that states will need some type of guidance before the interim final rule in June, and we are working on that now. As I look through and our team looks through the statute and the provisions on how things are written, what we're encouraging and our approach and what we're encouraging states to do, one, there are clear pieces in the statute where there are no exceptions, either that the states do not have options or we at CMCS, the secretary does not have discretion. And so you can think of things like if someone doesn't meet the work requirements, their ability to go to marketplace, the statute is very clear that they cannot. So first we would encourage states as they're looking through the provisions to look through on the pieces where there's no discretion and no options and to start to move forward with your planning.

Second, and I think Jennifer mentioned some of these, there are areas where states do have options and they should begin those debates now. The look-back period is one that was mentioned. Short-term hardship exceptions is another area where the state has the ability to say, for example, "Do we want to create short-term, hard-term exceptions for things like public health emergencies and counties where unemployment rates are 8% or higher?" So states can have those debates. They don't need to wait on us. Really what you're waiting on CMS to push out are the areas in the statute where it talks about secretary discretion, you've mentioned several of those, and then we also will have sub-regulatory guidance just to help steer states on even some of the things that they get to decide.

So for example, if the state wants to take on the short-term hardship of counties where you have higher than 8% unemployment insurance rates or unemployment rates, states will still be looking to us for guidance on the process for that. So for example, are we going to ask states to confirm and attest that Burleigh County, Cass County, for example, have higher than 8% or is CMCS going to have a process by which we confirm this is what we show, whether it's in census data or et cetera, these are the counties. And so we will work through that sub-regulatory guidance and the processes, and again, understand, we've tried to look at these and prioritize and we will be trying to push out the guidance as it relates to the key policy decisions, and those that will impact the way your IT systems are being built out, and we've reached out for feedback on that, and then there will be prioritization in terms of what we get out.

So for example, a state might think that it's more important for you to tell us about the verification process in terms of should we be verifying all the

qualifying activities, maybe that's perhaps more important than this unemployment decision in counties. So that's how we're moving forward. We understand the timeliness of this and understand how that impacts your builds and also your staffing and your resources.

Larry Levitt: Got it. Thank you. Emma, let me bring you in. I mean, Caprice talked about elements of the law where there doesn't seem to be much flexibility, but there are areas where there may be. What kinds of flexibilities are you hoping to see from CMS and also kind of what are some of the things CMS can do in your view that could help states with implementation?

Emma Sandoe: Sure. So I, as you mentioned at the top, had the privilege of working in two state Medicaid programs, Oregon and North Carolina, and we're already 11 minutes into a Medicaid Health Wonk and no one has said once you know one Medicaid program you know one Medicaid program, and after going to my second state I can very much say that that statement is true in so many different ways. I admit once you know two Medicaid programs you know two Medicaid programs. So I can't speak with experience on every state, but I do know that every state is different.

And so that flexibility is so incredibly important because all of the ways in which IT systems are designed are different, but many other aspects are different. For instance, in North Carolina we had a hundred counties each with their own eligibility workers and county-run eligibility systems, and that's very different from in Oregon where we have the eligibility processes at the state level, but we have 16 what we call coordinated care organizations or regional managed care networks that are different, in different parts of the state. And so they play a much larger role than in North Carolina where there were only a handful of statewide managed care entities.

And so what role do managed care entities play in this is an example of that, what role do county-based eligibility systems play differing from statewide eligibility system, for example. Those are some of the just every state is different and every state will have to be grappling with how they're doing this in a different way. I think unwinding really taught us how IT systems are layered in and how IT systems touch different aspects of each individual state's set of data that the state has is really important. But one thing that I would just want to center us around and return to is the experience of the member. So the experience of the person is really at the center of all of this, and that's how we're guiding our work because what we want to do is make sure that we are working on implementation with the member in mind and the member-focused experience.

But systems get talked about so quickly because if you think about it, for example, somebody going through having a condition that is medically fragile or SUD treatment, for example, substance use disorder treatment, and my apologies, they may go see a provider. That provider has a period of time in which they can build a managed care entity, for example, and then that managed care entity has a period of time which they can adjudicate the claim. Maybe there's issues with how it was entered in the system and they have to go back and forth with the provider. And then there's a series of time where the managed care entity has to submit it to the state and then that goes to a state IT system over here, and then that state IT system over here has to talk to the IT system over here.

And so all of that, we don't always know when a member is receiving care the moment they walk into a provider's office. And so what we can do to streamline and make systems work faster, more streamlined so that we can have that data, that flexibility, and that the member if they are eligible for one of these exceptions are able to respond or it's low or no touch to the member because they are doing what is required under the law, and we want them to continue to receive those SUD treatments or other important treatments that they are getting.

Larry Levitt: So I mean, you mentioned systems and IT issues, we will definitely return to those whether we want to or not. Jennifer Strohecker, let me bring you in. Utah has been out ahead in preparing a waiver for a Medicaid work requirement even before the law passed. So you've been working, so to speak, on a work requirement already. What are some of the knotty issues you struggled with in that and how have you approached dealing with them?

Jennifer Strohecker: Yeah, thank you for the question, Larry. Utah is a state that does value work. We recognize that work is connected to so many things, economic stability of the individual as well as even a connection to health. It's a social determinant. And so with this in mind, certainly Utah did begin to draft and actually submitted an 1115 waiver to CMS for work requirements in early July before the bill passed. As we were thinking about what some of our goals were with regard to drafting our own waiver, there were some key differences with what we drafted versus of course what passed in the bill, but one key element was the fact that the member would actually be enrolled in Medicaid prior to participation in the work requirement. And so I think as then we went through the public comment period and took feedback from so many others, it really did build a proposal for us that thought about how we achieve our goals of really valuing the component of work, but also supporting the member to be successful in their application to Medicaid and finding that path to be eligible for Medicaid.

I'll give a couple of reasons of why we came about that approach. One is we're an integrated state. So when the application process happens, for Utah we have an integrated application with other programs like SNAP additionally. So the experience on the front end from the member is thinking about applying for Medicaid, you also apply for SNAP. Knowing what that looks like on the back end for our teams as they go about processing that application, there is a work component to SNAP today. About 42% of adult expansion members also qualify for SNAP here in Utah. And so as we thought about our approach, we were looking for alignment of achieving work requirements and compliance with some of those activities, while also thinking about process and streamlining kind of the workflows that way.

Now we're going to have to modify our approach, right? So knowing that the bill introduces a different pathway for Medicaid eligibility and compliance with work requirements than what we have on our SNAP side, because we have a homegrown eligibility system we'll make modifications to that approach. But certainly that was one thing we had at front of mind.

Second, I mentioned that work is a social determinant and contributes to health, but we were also very conscious of the fact that health also translates to a person's ability to work, and looking at those individuals again with that core goal in mind of thinking of these are individuals who are eligible for Medicaid and we want to find the pathway of helping people get to Medicaid eligibility and really providing supports to do that. Some of our goals that we've really been focused on over the last few years are closing gaps, gaps in care, and we learned a lot through unwinding. Utah had a high procedural termination rate and we made many incremental steps to improve our process through unwinding to really address sort of those gaps that we saw even in the Medicaid application. Additionally, we look at high risk areas of transitioning from one setting to another.

And so this was also front of mind as we were thinking about our work requirement proposal is how do we build in those supports so that people understand what needs to be done, we're able to connect with people, they understand what's required of them so they can be compliant, and then also how do we build in automation and those data sources correctly so that kind of eases the workload off the member. So I think that's a bit of what we were thinking. At this point, of course we're pivoting. We're adopting the federal model of community engagement and certainly we've been able to complement our original intent with what the goals and objectives are today, and so we'll talk more about that I'm sure. But that was the thinking that we had early on, again, thinking again broadly around our goals around work and the value of work, but also connecting people to healthcare and the coverage that they qualify for.

Larry Levitt: Jennifer, I mean, you had this waiver submitted, states can move earlier as Jen Tolbert said. Are you planning at this point to move earlier than the January 1st, 2027 deadline?

Jennifer Strohecker: Yeah, thank you for the question. At this point, we do not intend to go early with our waiver. It's a different approach and certainly the resources and the bill required to put that approach in place and then transition would not be something that we're going to pursue at this time. But before we knew what the final bill would look like, we were certainly interested in considering alternate pathways.

Larry Levitt: Jen Tolbert, so I mean, two states have implemented work requirements, one of those, Georgia, does have it in effect now. The experience of those states we know influenced how CBO, the Congressional Budget Office, viewed the projections here. Briefly, what happened in Arkansas and what has happened in Georgia with the work requirement and what are some of the differences between what those states did and what the new work requirement nationally will do? Oh, you're on mute I think.

Jennifer Tolbert: Sorry about that. Right, so Arkansas and Georgia were the two states to implement work requirements, and I think there are certainly lessons to be learned from both states. What we know from Arkansas is that they were in fact able to data match over two-thirds of the individuals subject to the work requirements. But among those who they were not able to identify as meeting the work requirements or as qualifying for an exemption, most of those people never did report any information about their current situation, and we know now after the fact that many of those individuals in fact were working or would have qualified for an exemption. And so some of the reasons, again, we were able to have the benefit of looking back and conducting research on what happened, and it does seem that the majority of the individuals just simply didn't know that they needed to report. They had difficulties navigating the somewhat complex monthly reporting requirements, and that meant that many of these eligible people, a total of 18,000, ended up losing coverage.

Now importantly in Arkansas, the work requirements only applied to people who were enrolled in the program. So it was not at application. Now in Georgia, they have a slightly different situation in which people do have to qualify at application, but the state has experienced similar issues with individuals having confusion about what they need to submit to verify that they are meeting requirements, and as a result, enrollment to date in the Pathways program in Georgia is much lower than what was anticipated. Only about 8,600 individuals have enrolled compared to the estimates of 25,000 in the first year and 64,000 over five years.

There were also significant costs in Georgia to set up the systems and the reporting systems and in fact the state as a result of some of the barriers and the low enrollment kind of modified the reporting requirements over time to try and make it easier. I just will note one other impact from the Georgia interim evaluation report which coincides with our data and analysis that we have done which is that older adults were particularly affected and had faced greater barriers to meeting the requirements and the reporting requirements and enrolling in coverage.

Larry Levitt: And just to clarify, when we're talking about older adults, it's not Medicare beneficiaries, people over age 65, but older but under age 65?

Jennifer Tolbert: Yes, and I shouldn't use that term because... but I meant to say adult ages 50 to 64.

Larry Levitt: And just to clarify, the work and community engagement requirement here applies to Medicaid expansion enrollees, as you said, or possibly states like Georgia and Wisconsin where they are serving that population through waivers. So we keep talking about these systems and IT issues which I think are going to be central here. Caprice, if you can, describe some of the resources the federal government may be able to provide. I've heard CMS administrator, Dr. Oz, talk about an app that's being piloted that may connect directly to payroll systems like ADP. Are there going to be some resources available to help kind of smooth the way for the state [inaudible 00:26:19]

Caprice Knapp: Sure. I'll mention a couple things which just would say that encourage you all to reach out to Georgia themselves. Their experience is slightly different and I would say they worked really, really hard to try to engage with their members and they stood up work requirements not once but twice. And so they've got a interesting and a good story that we've all been learning lessons from. So on the IT side, a couple of things. We have two work streams going on the IT side, one is about internally at CMCS, what are the resources that we'll be providing states. As you know, there are advanced planning document requests that we get from states to fund IT systems. Those provide an enhanced Medicaid match in both the development stage and the maintenance and operation stage. And so we're working with our data systems group on how we will process those in a timely manner as states put those forward. So that's a funding source.

Second thing is that the bill itself has $200 million as it pertains to community engagement that we will be able to provide to states, a hundred of million of which, and this is going to be familiar to people who have heard us talk about the Rural Health Transformation Fund, a hundred million of which will be more equally be divided amongst the states. The other hundred million we will have a formula by which Congress has said we need to think about dividing it about

number of individuals that are impacted by community engagement requirements. So that money will be coming as well. So that's an internal work stream that we are working on. We also have been putting pen to paper about thinking about help states, helping states go through the technical requirements as they start to figure out how their systems are going to evolve.

I'll just say quickly, and I don't want to speak for Jennifer, Emma, but this is not one system. This is an eligibility system. This is services and tools that sit on top of an eligibility system. This could be a closed loop referral system, and then off to the side you have lots of things like notifications that come out of systems. So it's not one system. So just want to be clear that that's not what we're describing.

Our second work stream that we have, as you mentioned, US Digital Services under the realm of Amy Gleason has been working on an income verification system. We are piloting this out with two states now and we have more states that are interested. Again, I would describe that as sort of the tools and services part of the cake, the layers that you have in your system. And so Amy is piloting that out with states now. That's the app that Dr. Oz was referring to. We're doing demonstrations with all states in October on that app if they're interested. We think it will be a more cost-effective way for states to verify income.

In addition, Amy's group during COVID lended technical assistance to all states with procurement as they were helping to quickly stand up IT systems for COVID tracking and notifications and things of that nature. And so Dr. Oz put a letter out to governors that went out in July outlining those resources that we have available and we will continue to work through with states on those resources.

Larry Levitt: So, Emma, you mentioned this idea, let's say someone with substance use disorder who is actively in treatment somehow connecting the claim system to confirm that treatment with the eligibility system that is confirming the exemption from the work requirement. Have you started to sort of figure out how that might work? I mean, how daunting a task is this? How much might this cost the state to put this all together?

Emma Sandoe: Yeah, that's definitely the work that we're working on right now is trying to figure out all of the different IT systems that we'll need to touch. That was just one example. But as we get into the complicated lives that people have and the spaces of what about somebody in this type of work like gig economy work, being able to track that, how about people in trade schools, which schools in our state are connected to the systems that track people that are enrolled in school, et cetera, we have to piece together all of those various IT systems, and that's the work that's definitely part of our 2025 plan. As we are getting all of that

together, all of that will lead into a additional request for IT system builds and whatnot both at the state level and then to CMS and how we build that is going to be quite complicated.

Any assistance that we can, whether it is directly with CMS, I will just applaud CMS during the pandemic like Caprice noted with all of that technical assistance around our IT systems builds to respond to the pandemic, and then again the unwinding. I can't even begin to count the number of hours of calls with CMS that states had to ensure that all of our IT systems are responding to all the unwinding requirements and documentation and getting the IT systems and the policy people in the same room so that we were able to speak the same language which is a complication whether you're inside of Medicaid or outside of Medicaid. It is always a challenge and how we can do that, how we can make sure that we're all headed in the same direction and not using any valuable time looking at something that may not unnecessarily pan out is really, really important.

I'll just also underline I'm now in a state with a fully integrated eligibility system with our SNAP and TANF eligibility systems and wasn't before. Well, it was sort of integrated but not in the same way that it is in Oregon, and that presents a unique challenge as well, as well as a unique opportunity to ensure that those requirements that people are meeting for SNAP and TANF are transitioned over, the data is transitioned over. We just know there's always complications between different programs or different programs in terms of SNAP and TANF and what is defined in certain data elements, and so that's also something that we're looking at as well.

Larry Levitt: Thanks. Jen Strohecker, as you worked through the waiver and you mentioned the unwinding... and just for the initiated, unwinding was the unwinding of the requirement during the public health emergency that people not be disenrolled from Medicaid. Have you had any estimates of how many people you think you might be able to confirm through automatic data matching that they qualify for the work requirement, the community engagement requirement exemptions from the requirement?

Jennifer Strohecker: [inaudible 00:34:01] question. We've actually early on as we were doing our own evaluation of our proposal we were able to create clearer estimates because we created alignment with our SNAP benefit. Utah has had a work requirement waiver in the past that was approved and went live just as the pandemic started so we had to pause it. So we had had some experience looking at what type of exemptions we might put in place, and certainly with alignment of SNAP we were able to get better estimates.

I'd say for now we're still looking for greater clarity on some of the policy pieces that haven't been fully defined, and again, we're seeking and asking for some flexibility in how states may interpret some of those pieces. But with that, I think we've made some high-level estimates early on, and as we've moved further we're really trying to better understand, for example, medical frailty, how and what exactly that would mean with regard to the individuals that might fall underneath that definition. So at this point we're having high-level conversations about it, but certainly not putting too much out with regard to how many we predict would fall into one category or another.

Larry Levitt: So we have a ton of questions from the audience and I want to start getting to those, and we have a number on medical frailty which you just mentioned, Jen. Caprice, is that an area where the law is pretty clear or where you think you have some discretion in terms of how to define medical frailty and if you can share anything about some thinking around that?

Caprice Knapp: No, I mean, nothing to share other than that's part of what we're working through. There is some federal regulation around that definition, and so as we look through all of these places where it's pointing to CMS for rules or guidance we will always defer back to places where things already exist because that makes it easier, and some of that may come from sister agencies. So for example, under the education qualifying events, we will be working with sister agencies in the Department of Education and looking for definitions, regulations, sub-regulatory guidance that already exist.

Larry Levitt: Got it. Emma, I mean, you mentioned specifically substance use disorder which is specifically referenced in the law. I mean, are there other types of medical frailty that you would like to see as potential exemptions that you think would interfere with people's ability to work?

Emma Sandoe: Yeah, and medical frailty gets so complex in part because just returning back to the lives of members and what that means for members and what types of work are available in a community, a person's condition, it's hard to say when we're looking at claims data or other things whether that prevents somebody from doing work or doing community engagement activities when we just know that people's lives are just so incredibly complex. And so as much flexibility in that space as possible would certainly help. I'm thinking about a disabled veteran, for instance, where there may be certain opportunities available where they live and work in their community, but their disability may not allow them to participate in that, how we can ensure that we fully understand because when you start to put exact guardrails on people's lives it sometimes obscures that complexity. So I'm thinking mental health disorders as well, depression, other things like that that can be very debilitating.

But I'm just looking at what is submitted in claims by providers or if somebody is not necessarily seeing a provider that is the right provider for them that we may not have the evidence of why it is hard for them to be able to work, be able to experience the community engagement activities, and how we can ensure that they are getting the care that they need to address that underlying disability, that underlying thing that is preventing them from those engagements so that we can get them to participate in work and participate in the community as much as possible.

Larry Levitt: Jen Strohecker, in Utah's waiver had you included an exemption for medical frailty and how was that defined in the waiver?

Jennifer Strohecker: Yeah, thank you. We did include a definition of medical frailty in our submission, and I don't think we had a specific definition in mind, but I'll just add on to Emma's comments as we're thinking about how complex people can be. One of the opportunities we have as we think about our goals around engaging in work while also achieving stability with healthcare is that it's not just the first application someone has and they're new to Medicaid and we don't have existing data. It's also those renewals that will take place, and I think the work we have cut out for us and I think the opportunities we have especially when you consider individuals who really do have complex ongoing chronic health conditions ranging from diabetes care to mental health conditions and things that actually could be well-controlled with medications and other medical interventions.

I think the way we've really been thinking about it is connecting the dots for people and making sure that as we're really developing our program and thinking about as we're encountering people and we recognize which conditions they have, which medications they're using, that we're supporting them. We're supporting them not just in achieving maintenance with those treatments, but also really building the services and the knowledge so that people are understanding what's required of them to be compliant with this, and I think that's two things. One, making sure that our data capture is accurate so that we can capture the diagnoses that may be exempted. There's an array of ways we could approach that, of course, which is why I think states are asking for some flexibility in how we define medical frailty, but I also think there's an obligation for people who are working and also receiving ongoing medical care on how we can help support them with compliance with work.

And so I think really what it comes down to is we look at sort of how we might define things behind the scenes. There will be thousands, millions upon millions of people who really will be compliant, and I think our ultimate goal is to help them maintain that compliance at their renewal phases so that they can

continue forward with the care that they are receiving and also have access to health insurance they qualify for.

Emma Sandoe: Larry, if I may, I just want to say that Jennifer raised a very important point on there that we've been sort of focused on the IT systems build and what the state can do and all the policies, but there's a huge component on working with members, member engagement communications, and that should not be lost. They're really at the same level here. We learned so much from our lessons in unwinding on how to meet members where they are, how to use new systems, new ways of communicating with people. If you look 10 years ago at the way in which Medicaid programs communicated with members, it would be letters in the mail and that's sometimes it. Now we've got text messages, emails, pings from mobile apps, people out in the community where people are in community events, laundromats, all sorts of places where people have time to have a conversation and so that we can explain and get into the details as well as making sure all of our materials makes sense.

Looking back at some of those materials that had been communicated to members before unwinding, some of them were written in legalese that were difficult to understand, and we made such a huge effort in ensuring that we were explaining what the next step was and what we were doing, why we were doing it, and what people can do to ensure that they maintain coverage. I had the privilege to work in two states where a lot of people did maintain coverage after the unwinding period, and I would credit a lot of that due to the very, very hard work to engage the community in understanding what the Medicaid enrollment process was like.

Larry Levitt: Emma, you mentioned earlier the role of managed care plans. Are you imagining that you would use the plans to help communicate with folks too about the work requirement?

Emma Sandoe: Yeah, and one of the things that Oregon did during the unwinding period was to ensure that as we were developing materials that our partners and the managed care entities also had those same materials so we weren't creating additional confusion, that the talking points and all of the rest of the call centers, people got the same pieces of information rather than trying to parse out, well, I heard this thing over here, I'm hearing this other thing over here. And so as much as we can ensure that we're using those pathways, those... or not systems, I do not mean IT systems, but those processes that were developed for unwinding. We learned so much and it would be a waste to forget all of the efforts that had been made to make sure that we are all working together across partners that deal with members' issues and respond to members in a one-on-one basis because those partnerships were strengthened so tremendously and we need to keep them strong.

Larry Levitt: I think the IT systems were also improved a lot during unwinding which positions states well here. Caprice, so returning questions from the audience, we had one about Montana's application to implement the work requirement earlier than the deadline. I believe it's the only state so far. I mean, you don't have the regulations out. Can you say anything about how you're going to look at these early requests from states and review them?

Caprice Knapp: So we have a normal review process for all 1115 demonstrations. Clearly ones that are already aligned with what the statute says we'll help that process, but we understand it's not just Montana. We know from two other states they have already signaled they want to start early and the 1115 is the route to do that. Our 1115 state demonstrations group actually has a lot of experience in this because they've processed these applications, they've already been working with states even though they had to take a pause and now they're back. And so as we've met as a team and started to go through to make policy decisions, they actually have quite a lot of wisdom in this to bring to the table in helping think through this.

Larry Levitt: Caprice, we had another question about the income verification app that's being piloted in a couple states. Are you in a position to say which those states are and anything about what the experience has been?

Caprice Knapp: Sure. We've said that publicly Louisiana and Arizona have used US Digital Services app, and so we're happy to again put people in touch if they're interested in that. One of the great things about that app and the way it pulls down income to verify is that it brings in gig worker information as well, and we know for the Medicaid population that's really important and it brings in very timely income information.

Larry Levitt: Great. Caprice, sticking with you, we talk about as a shorthand, this is a work requirement. It does have a community engagement volunteer component as well. Has there been any thinking about how that's defined, how you might verify that, how that might differ from the work part of it?

Caprice Knapp: I just want to repeat your question because I want to make sure I understand.

Larry Levitt: Yeah, yeah, yeah.

Caprice Knapp: You've got income, you've got education, you've got job services, and you've got volunteering, right? If I think of sort of from a top down, there are portions of those qualifying events that are much easier to get out with data, whether that's income and even to some extent education because we know in Georgia, for example, they were able to tap in at least folks that were in the university system. That might be slightly more difficult if you're in a state that doesn't

track things like community college or technical schools. But as I think top down, there's some of those that are more easy to rely on data sorts that exist. At the bottom would be volunteering.

So as we're thinking through those things, discussions we're having, there are some states, we actually got contacted by a state last week that wants to build out a whole platform by which volunteer organizations would register, that everything would be tracked, that then the information would be pulled in and it would be just another data feed. We've also talked with other states that are thinking about this in terms of is this a form that they want to create which can be signed by a supervisor. So we are taking feedback on all different ways that states want to do this, but understand as you think about that hierarchy that that is the place where data is not the most obvious.

Larry Levitt: Got it. We have a few questions about the implementation costs, and Caprice, you talked some about that. Jen Tolbert, I mean, what do we know about what the cost was, let's say, in Georgia and in Arkansas to set up these systems? Oh, sorry, mute again.

Jennifer Tolbert: I am so sorry. Yeah, so there is some cost data available. I think in Georgia it has been estimated that as of the end of 2024 the state had spent $86 million in federal and state costs to stand up its systems. The GAO in a report issued on this that compiled all of the data from earlier state waivers on the estimated costs associated with implementing work requirements found that the cost estimates range from about $10 million to 270 million. I think it depends on where states their starting point and what changes they anticipate making. But I think regardless, the anticipated costs can be expected to be significant.

Larry Levitt: Jen Strohecker, have you done all the work or is there more work to do you think in terms of implementation costs?

Jennifer Strohecker: We've begun initial evaluation and estimates of cost. We've worked with our legislative fiscal analysts and our governor's office to certainly begin that task. Some factors that maybe help Utah is that we do have a homegrown system, and so with that we're able to think about how we can build it without necessarily having to lean into vendors as much as some other states do. So we do see that as an advantage. I'll also note that while there is a cost with implementation, we're also recognizing that some of those costs are offset by some of the disenrollments that may occur, and while we want to minimize that for individuals who are qualifying for Medicaid and certainly would meet eligibility criteria, some of the cost impacts certainly have to be evaluated against that too. So anyway, yes, we've started the work on that. We've begun those conversations, but certainly we don't have all the answers yet.

I think Caprice pointed out nicely we have a high engagement in volunteerism in Utah, for example. We're often cited as one of the top states for volunteering, but we're not exactly sure how to capture that yet. And so we're looking for input from our community partners, and we're in the same process that I think many other states are in thinking about how we gather that data. And so there's a cost tied to that ultimately that we haven't been able to quite put a dollar sign on. And then there are other advantages. We happen to have a statewide educational portal where our universities and our trade schools, almost every school in the state minus two or three, are plugged into a statewide system that does report all of that data. So those are some advantages that we see that kind of lower our overall costs, but certainly we haven't been able to assess all of them yet simply because we haven't defined how we're going to do some of the work.

Larry Levitt: Got it. Caprice, I mean, we talked about the states that may move earlier through the 1115 waiver process. There's also a question about states that may look for an extension based on a good faith effort to implement. Is that a process you've thought about or worked through at all or gotten inquiries from states?

Caprice Knapp: So no inquiries from states I will say, other than just general conversation. We'll work through those policy decisions. The statute is clear though that under good faith effort extensions, states have to provide quarterly reporting there and that no extensions can go beyond December 31st of 2028. So that's very clear in the statute.

Larry Levitt: Got it. Emma, I mean, had there been any discussions in an Oregon of trying to look for a delay or you feel like you're on track for January 1st, 2027 implementation? I think Emma might've gotten frozen, so let's move on. Jen Tolbert, I mean, we've talked a lot about, and you talked about the experience in Arkansas, we've talked a lot about the verification. Just quickly, I mean, how many people, what are our estimates of how many people would qualify, would seem to qualify for work or for an exemption and how many wouldn't qualify based on at least current estimates?

Jennifer Tolbert: Sure. So we've done extensive data analysis on this issue and based on the data it appears and when we narrow... and I should note that what we try to do in our work is to narrow the population and focus in on the people most likely to be subject to the new requirements. So we did focus on Medicaid adults who do not receive disability payments, who are not enrolled in Medicare, and who do not have dependent children. We weren't able to separate out just parents with children over age 14.

So what we found is the majority of adults in this group are working or were in school. So a total of 62% of adults were either working or in school. Another 17% qualified or were not meeting the work requirements but reported reasons that would appear to qualify them for an exemption. So they reported either illness or disability as a barrier or caregiving responsibilities. So that left about one in five individuals in this group who were not meeting the work requirements and did not appear to qualify for an exemption so that they might be at risk for losing coverage.

I will note however that this does include a large share of adults ages 50 to 64 and 11% of those adults indicated that they were retired and provided that as the reason for not working. In many cases, they worked for many years in physically demanding jobs and simply are at a point in life where they can't work those jobs anymore. So I think the reasons why people may not be meeting the work requirements are varied, and I think it will be important as we think about the exemptions and defining the exemptions and the processes for claiming exemptions important to provide as much flexibility as possible.

Larry Levitt: Got it. We've talked about medical frailty. These are Medicaid expansion adults, so they are not qualifying for Medicaid based on a disability pathway, but that doesn't mean there aren't people in this group who aren't what we would normally consider disabled or medically frail.

Jennifer Tolbert: That's right. We estimate that nearly half, in fact 44% of adults in the expansion group reported having a chronic physical health or behavioral health conditions. So including nearly a quarter of adults in this group who reported having a mental health condition or a substance use disorder. So again, while these individuals do not qualify for Medicaid on the basis of disability, I think this is a group that has a long-standing and pretty significant, in some cases, healthcare needs. And so as we think about implementing and operationalizing some of these requirements, it's good to keep some of those issues in mind.

Larry Levitt: Thanks. Well, we are unfortunately coming close to the end of the hour. We've had a number of questions for requests for more webinars on this topic, so we will absolutely return to it. But let me just as a final question ask Jennifer, Emma, and Caprice, what are you optimistic about over the next year and a quarter as this gets implemented and what keeps you up at night. Jennifer, let me start with you.

Jennifer Strohecker: Certainly. So I'm optimistic about the engagement we've had so far. I think overall we've begun working together internally as a program, and we have designated staff and a lot of attention being put on this and heavy engagement with a commitment to keep the members center of our work and to really engage new stakeholders as well in the conversation, recognizing that getting

started now is going to serve members better in the future. So we're excited about that. We've been thankful also with partnership with CMS and been able to get into many conversations with them and other Medicaid programs as well in order to problem solve because this is complicated and work that many of us have not undertaken.

What keeps us up at night is the same thing. It's complicated. It's a short timeline. There's a lot to do. When you think about why we do the work that we do, because we believe that Medicaid members should have access to services they qualify for, and understanding and appreciating the value of work, we want to make sure people are able to fully comprehend that. So making sure the messaging is right, making sure people receive that message, and we have good partnership in our community to be able to carry that message and be able to support the overall objectives of the program as they evolve and implement these new requirements.

Larry Levitt: Emma, now that you're unfrozen.

Emma Sandoe: Yes, thank you. I think this goes to one thing that keeps me up at night is the IT systems as I just demonstrated are sometimes extremely frustrating. But more what actually keeps me up at night is the fear that members that are eligible for Medicaid and are trying to get healthcare services would fall through the cracks and lose coverage. What keeps me optimistic is there are 56 Medicaid programs across the country, including DC and the territories, that are working to implement many of the provisions of H.R.1 together, and the connections between our states and the ways in which our states have worked together and learned together is something that is inspiring and how we can continue to share best practices is what I'm hopeful for.

Larry Levitt: Great. Caprice, you get the last word.

Caprice Knapp: Yep. I'm just going to hit on actually the positive. So two things here. What I am excited about is that if you want something done, ask a Medicaid director. These two colleagues of mine on the line are fantastic. I sat in that seat. When the job is there, they will get it done and always having the member at the center. The second thing is the opportunity to really think about intergenerational poverty. I mean, like Jennifer said, work is a social deterrent of health, and if people can get connected to work with the right employment supports and in a way that helps them, that's a fantastic... just even the idea of that I think is inspirational to us. So again, thank you for inviting us. Thank you for having us today, and I'm looking forward to working with all 51 of our partners as we walk through this.

Larry Levitt: Well, thanks to all of you for a great discussion, the first of what I think will be many discussions on this topic, and thanks to the audience as well for watching and for the terrific questions.