Stakeholders: CMS' New Medicaid Work Req Mitigation Plan Falls Short

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Medicaid stakeholders are cheering some of the flexibilities CMS granted in a new worksheet for states to report common issues with implementing Medicaid work requirements, but Manatt Health noted many proposed mitigations in the document will not ensure that eligible Medicaid beneficiaries can retain their coverage.

The worksheet obtained by *Inside Health Policy*, first reported by *The Washington Post*, lists potential deficiencies along with possible solutions for states looking to request mitigation from CMS when implementing Medicaid work requirements. The possible solutions cheered by stakeholders include extending reconsideration periods beyond 90 days and letting some states temporarily extend their lookback periods.

But Manatt says some of the other solutions offered up by CMS might not work. These include relying on social media when states have limited beneficiary outreach options or beefing up call center support if the state hasn't been able to update its Medicaid application forms with the work requirement questions.

CMS says states can fill out the agency's checklist and then send it to CMS, which will reportedly begin meeting with states in November about their mitigation plans -- a rather short window to make adjustments before work requirements begin Jan 1, 2027.

Titled "Proposed State Mitigation and Optional Strategies to Support Implementation of Community Engagement and Other Eligibility & Enrollment Provisions of the Working Families Tax Cut (WFTC) Legislation," the document lists a variety of deficiencies states might encounter: unable to update eligibility process to first check if a beneficiary is exempt from the work requirements, unable to send performance data on work requirements to CMS, un-updated eligibility notices, unable to send notices when exemption status changes, and unable to send notice of noncompliance and request information to verify compliance with work requirements.

Another possible deficiency is when states haven't updated their application form online or by phone or online to include work requirement questions. Among the solutions CMS suggested for this issue was expanding call center hours and capacity.

"Directing people to a call center does not resolve missing work reporting questions on a paper application or a system's inability to apply the required verification hierarchy, particularly if call centers are already overwhelmed," Manatt Health said in a Wednesday (Oct. 28) email to *IHP*.

State agencies that lack a connection to a required reliable data source to complete ex parte or automatic renewals was another possible deficiency on the list. CMS suggested states with this problem temporarily accept self-attestation as verification until that connection is established.

"A state without claims data connections may accept self-attestation, but it will lose an opportunity to identify medically frail individuals ex parte; those whose eligibility cannot otherwise be renewed automatically will need to respond to a renewal form and could be procedurally disenrolled if they miss it," Manatt said.

Solutions to beneficiary outreach troubles, like states being unable to reach out to beneficiaries using two modalities, also concerned Manatt.
"Social media outreach cannot substitute for an accurate eligibility determination notice, and streamlining income verification does not resolve a state's inability to verify an exclusion," Manatt said.

"These limitations underscore the importance of CMS considering broader flexibility to delay disenrollments while states put the necessary coverage protections in place," Manatt added. "CMS also gives states flexibility to propose their own mitigation strategies. States are encouraged use that opportunity to identify state-specific approaches that address their implementation challenges and seek additional protections where the proposed strategies fall short."

But Manatt's analysis also found "several proposed strategies offer meaningful flexibility."

For states struggling to meet federal eligibility processing timelines, Manatt pointed out the state's legislatures could pass a temporary one-month review period instead of a longer period, "offering a path forward where state legislatures have required more demanding lookback periods, such as three months."

The document has also made permanent the options to improve ex parte renewals like using SNAP income findings and previously verified income when data checks return no information.

Manatt also cheered CMS for extending reconsideration periods beyond 90 days, accepting self-attestation when required data connections are unavailable and delaying procedural disenrollments -- where beneficiaries lose coverage due to paperwork issue -- by up to one month while conducting additional outreach.

But, Manatt noted, "The document does not clearly establish whether CMS will approve a broader pause on disenrollments while states resolve implementation gaps."

News of the worksheet comes after five states asked CMS for more time for implementing Medicaid work requirement by Jan. 1, 2027, citing concerns that they don't have enough time to make the necessary operational, technological and administrative changes.

It also comes around the time 25 states celebrate a judge's decision Thursday (Oct. 29) that the Trump administration's medically frail exemption process goes beyond the law and barred implementation of the "ability to work" test in those states. Other parts of the work requirement interim final rule are still in effect.

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