Hospital Systems as Work Requirement Infrastructure

When institutional missions collide with eligibility instability.

Hospitals occupy a unique position in work requirement implementation that differs fundamentally from physician practices examined in Article 9B. Health systems are simultaneously employers of expansion adults who face work requirements, exemption documentation sources for patients seeking medical exemptions, emergency department operators who see coverage loss consequences firsthand, and community benefit providers with obligations to serve vulnerable populations. When Medicaid work requirements take effect in December 2026, hospitals inherit institutional responsibilities extending far beyond direct clinical care.

The financial stakes are substantial. If coverage losses materialize at scale, hospitals face increased uncompensated care, reduced Medicaid revenue, and operating margin pressure concentrated among facilities already struggling financially. Rural hospitals, safety-net systems, and academic medical centers serving disproportionate shares of Medicaid patients face the most severe exposure. Understanding these dynamics requires examining hospitals not as passive recipients of policy effects but as active infrastructure that can either mitigate or amplify coverage instability.

Hospitals as Employers

Large health systems are among the largest employers in many communities, and their workforces include substantial numbers of Medicaid expansion adults. Environmental services, food service, patient transport, medical records, billing, and entry-level clinical support positions often employ workers earning wages that qualify them for Medicaid expansion coverage. These employees face work requirements like any other expansion adults.

The employer documentation burden from Article 5 applies to hospitals as employers. Health systems must provide verification letters, integrate with state systems for automated verification, and manage the administrative infrastructure enabling their Medicaid-eligible employees to maintain coverage. The irony is acute: hospitals simultaneously depend on Medicaid revenue for patient care and employ workers who depend on Medicaid for their own coverage.

Workforce stability concerns compound the employer dimension. If hospital employees lose Medicaid coverage due to work requirement non-compliance, they may seek employment elsewhere, particularly in states where alternative employers offer employer-sponsored insurance. High turnover in service positions disrupts operations, increases training costs, and affects patient experience. Health systems have institutional interest in helping their own employees maintain Medicaid coverage, creating motivation for robust internal navigation programs that few other employers share.

Some health systems have begun developing employee-focused work requirement support. HR departments can proactively identify employees enrolled in Medicaid expansion, provide documentation automatically through payroll systems, offer flexible scheduling enabling employees to attend verification appointments, and connect employees to internal navigation resources when exemption questions arise. The hospital's interest aligns with the employee's

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

interest in maintaining coverage, creating partnership opportunities that employment relationships in other industries may lack.

The scale of hospital employment amplifies these dynamics. A major academic medical center might employ 15,000 to 25,000 workers. If 10 percent qualify for Medicaid expansion coverage, the system has 1,500 to 2,500 employees directly affected by work requirements. Managing documentation, verification, and exemption support for this internal population requires infrastructure investment, but the institutional benefits from workforce stability justify the cost.

Emergency Departments as Early Warning Systems

Emergency departments see coverage loss consequences before other care settings. When someone loses Medicaid coverage, they don't stop needing healthcare. They present to emergency departments for conditions that primary care might have prevented, for medication refills when pharmacy benefits disappear, for crisis intervention when behavioral health access evaporates. EMTALA requires emergency departments to provide screening and stabilization regardless of coverage status, making EDs the default care site for newly uninsured populations.

The pattern recognition opportunity emerges from this reality. Emergency department utilization data can reveal coverage loss trends before administrative reports confirm them. Rising uninsured ED presentations, increasing self-pay percentages, patients reporting recent Medicaid loss during registration, and medication-related emergencies from discontinued prescriptions all signal coverage instability that hospitals can detect in near real-time.

Some health systems are building dashboard systems tracking coverage status at ED registration. When a patient previously covered by Medicaid presents as uninsured, the system flags the case for follow-up. Social workers or financial counselors can intervene during the ED visit, helping patients understand why coverage was lost and initiating re-enrollment or exemption processes while the patient is physically present and motivated to address the problem.

The intervention window during ED visits represents a unique opportunity. Patients in crisis are engaged with the healthcare system and available for navigation support. A financial counselor spending 20 minutes during an ED visit helping a patient complete exemption documentation may prevent weeks of coverage loss that would otherwise require the patient to independently navigate bureaucratic processes while uninsured. The ED becomes not just a treatment site but a coverage recovery point.

Data from Arkansas's work requirement experience and the Medicaid unwinding illustrate the emergency department dynamic. When coverage losses occurred, emergency department utilization among affected populations shifted from insured to uninsured categories. Hospitals absorbed increased uncompensated care costs while providing the same services. The Commonwealth Fund documented uncompensated care rates rising by a third during Medicaid redeterminations, from 6.4 percent in early 2023 to 8.7 percent by mid-2023. Work requirements create ongoing coverage instability that sustains this uncompensated care pressure rather than resolving after a one-time enrollment event.

Inpatient Stays and Exemption Documentation

Hospital admissions create natural opportunities for exemption documentation that outpatient settings lack. Patients hospitalized for serious conditions are demonstrably ill in ways that exemption systems should recognize. The hospitalization itself provides documentation of medical severity that exemption applications require.

The discharge planning integration opportunity flows from this reality. When someone hospitalized for congestive heart failure exacerbation is discharged, care coordination addresses medication management, follow-up appointments, and home health needs. Adding work requirement status assessment to discharge protocols extends care coordination to coverage maintenance. Does this patient face work requirements? Are they compliant? Do they qualify for exemption based on the condition that caused hospitalization? Can discharge documentation support an exemption application?

Some health systems are training discharge planners to incorporate work requirement assessment. A checklist during discharge planning includes questions about Medicaid enrollment status, work requirement applicability, and exemption eligibility. When patients answer affirmatively about Medicaid enrollment and negatively about current employment, the discharge planner can initiate exemption documentation using hospitalization records and treating physician attestation.

The timing advantage of inpatient exemption documentation matters. Someone hospitalized for diabetic ketoacidosis clearly cannot work during hospitalization and likely cannot work immediately after discharge. Documenting this during the hospital stay, when medical records are fresh and treating physicians are available, creates stronger exemption applications than attempting documentation weeks later when clinical details have faded and provider access is harder to obtain.

Behavioral health hospitalizations offer particular exemption documentation opportunities. Psychiatric hospitalization for serious mental illness provides clear evidence of functional impairment that work requirement exemptions should accommodate. Substance use disorder treatment admissions demonstrate treatment engagement that most state frameworks exempt. Hospital behavioral health units can systematically generate exemption documentation as part of treatment planning, ensuring that patients discharged from psychiatric care have coverage protection enabling continued outpatient treatment.

The challenge is building workflow infrastructure that doesn't exist in most hospitals. Discharge planners focus on clinical coordination, not benefits navigation. Adding work requirement assessment requires training, templates, state system access, and time allocation that compete with existing discharge planning demands. Hospitals already struggle to achieve timely discharges and prevent readmissions. Layering additional administrative requirements onto discharge processes creates workload pressure that institutions may resist.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

The Uncompensated Care Calculus

Hospital financial exposure from work requirements depends on how many patients lose coverage, how utilization patterns shift, and whether losses concentrate among specific patient populations or facilities. The arithmetic is straightforward even if the projections are uncertain.

Current baseline establishes the starting point. Medicaid pays for roughly 20 percent of hospital care nationally, though percentages vary dramatically by facility type. Safety-net hospitals may derive 40 to 60 percent of revenue from Medicaid. Academic medical centers account for 29 percent of Medicaid inpatient days while representing only 5 percent of hospitals. Rural hospitals depend heavily on Medicaid for obstetric services, with 47 percent of rural births covered by the program.

Coverage loss from work requirements translates to uncompensated care when patients continue seeking services. Unlike elective procedures that patients might defer, emergency care, maternity services, and urgent medical needs don't disappear when coverage does. Hospitals must provide these services regardless of payment source. When patients lose Medicaid, hospitals either absorb costs as charity care, pursue collections that rarely succeed against low-income populations, or experience bad debt write-offs.

The Urban Institute projected that eliminating Medicaid expansion would increase hospital uncompensated care by $6.3 billion annually, with total healthcare spending reductions of $31.9 billion affecting hospitals specifically. Work requirements don't eliminate expansion but create coverage instability that generates ongoing uncompensated care exposure. If 15 to 25 percent of expansion adults lose coverage annually due to work requirement non-compliance, hospital uncompensated care increases proportionally.

Disproportionate Share Hospital payments theoretically offset some uncompensated care, but DSH funding has been repeatedly reduced and delayed since ACA implementation assumed coverage expansion would reduce uncompensated care needs. Hospitals cannot rely on DSH to cover uncompensated care increases from work requirement coverage losses. The American Hospital Association has documented uncompensated care increases during Medicaid redeterminations while DSH cuts continued, creating financial pressure from multiple directions.

The concentration problem intensifies financial impact. Coverage losses don't distribute evenly across hospitals. Facilities serving high Medicaid populations experience disproportionate uncompensated care increases. Safety-net hospitals already operating on thin margins face the steepest exposure. A hospital with 50 percent Medicaid patient volume and 3 percent operating margin cannot absorb significant coverage losses without service reductions or financial distress.

Rural Hospital Vulnerability

Rural hospitals face compounded exposure that threatens institutional survival in some communities. The baseline financial situation is already precarious: 46 percent of rural hospitals have negative operating margins, and over 700 are at risk of closure according to the Center for Healthcare Quality and Payment Reform. Since 2010, 182 rural hospitals have closed or converted to models excluding inpatient care. Work requirements add financial pressure to facilities with limited capacity to absorb additional losses.

The Medicaid dependence of rural hospitals amplifies work requirement exposure. Over 16 million people living in rural communities are covered by Medicaid. In nine states, over 50 percent of the Medicaid population lives in rural communities. Rural hospitals depend on Medicaid for 47 percent of births and serve as primary care access points for populations with few alternatives. Coverage losses affect rural hospitals more severely than urban facilities with diverse payer mixes.

The geographic concentration of vulnerability follows Medicaid expansion patterns. Two-thirds of rural hospital closures since 2014 occurred in states that had not expanded Medicaid. Rural hospitals in expansion states have median operating margins of 1.5 percent compared to negative 1.5 percent in non-expansion states. Work requirements apply to expansion adults, so the coverage instability affects rural hospitals in expansion states that have been relatively more stable financially.

The service line implications extend beyond general financial pressure. Rural hospitals losing Medicaid revenue may cut service lines that aren't financially sustainable without Medicaid volume. Obstetric services have already declined, with 116 rural hospital labor and delivery units closing since 2020 and another 127 at risk. Behavioral health services, chemotherapy, and other specialty services face similar pressure. Work requirement coverage losses accelerate service line reductions that affect rural communities regardless of individual Medicaid enrollment.

Community economic effects ripple beyond healthcare. When hospitals close, per capita income falls 2.7 to 4 percent. Physicians relocate, reducing primary care access. Economic activity dependent on hospital employment and spending disappears. Work requirements threatening rural hospital viability affect entire communities, not just Medicaid enrollees.

Community Benefit Obligations

Tax-exempt hospitals operate under Section 501(r) requirements that include community benefit obligations. The IRS has signaled renewed focus on community benefit compliance, with the Tax Exempt and Government Entities division identifying tax-exempt hospital compliance as a strategic enforcement priority for 2025. Community Health Needs Assessments must address community health priorities, and implementation strategies must describe how hospitals will meet identified needs.

Work requirement implementation creates community health needs that 501(r) obligations arguably require hospitals to address. If community health needs assessments identify coverage instability, insurance navigation, or work requirement compliance as barriers to community health, implementation strategies should include responses. Hospitals documenting high rates of coverage loss among their patient populations face implicit pressure to develop navigation programs addressing the identified need.

The community benefit connection enables navigation program investment. Hospitals can count navigation services, exemption documentation assistance, and coverage retention programs as community benefit activities. Financial counseling helping patients maintain Medicaid coverage reduces both uncompensated care and community health barriers. Framing work requirement support as community benefit activity creates budgetary justification for programs that also serve hospital financial interests.

Some health systems are explicitly incorporating work requirement navigation into community benefit programming. Community health workers funded through community benefit budgets help patients navigate verification and exemption processes. Hospital-based enrollment assistance programs extend to work requirement compliance support. Partnerships with community organizations providing navigation services receive hospital funding as community benefit investments. The programmatic infrastructure serving community benefit purposes also protects hospital revenue by maintaining patient coverage.

The strategic alignment is notable: community benefit obligations, financial self-interest, and patient welfare all point toward hospital investment in work requirement navigation infrastructure. The question is whether hospitals recognize this alignment and act on it before coverage losses materialize and uncompensated care increases force reactive responses.

The Safety-Net System Perspective

Safety-net health systems face the most severe work requirement exposure because their missions center on serving exactly the populations subject to requirements. Academic medical centers, public hospital systems, and community hospital networks serving high Medicaid concentrations cannot easily shift patient mix toward commercial payers. Their identity and community role depend on serving vulnerable populations who now face coverage instability.

The mission tension is real. Safety-net hospitals exist to provide care regardless of ability to pay. Work requirements create administrative barriers that patients must navigate to maintain coverage. Hospitals investing in navigation programs are essentially helping patients comply with requirements that some in the safety-net community view as harmful policy. The practical necessity of protecting both patient coverage and institutional revenue conflicts with advocacy positions opposing work requirements as policy.

Most safety-net leaders have resolved this tension pragmatically: regardless of policy views, patients need help maintaining coverage, and hospitals need to protect revenue enabling continued mission fulfillment. Investing in navigation infrastructure doesn't endorse work requirements; it acknowledges operational reality. The parallel to other safety-net functions is clear: hospitals don't advocate for homelessness but build programs serving homeless patients; they don't advocate for substance use disorders but build treatment programs. Work requirement navigation is another practical response to patient circumstances created by external policy.

The resource allocation challenge remains. Safety-net systems already stretch limited resources across enormous needs. Adding work requirement navigation competes with clinical programs, community health initiatives, and other priorities. The investment calculation depends on projected coverage loss volume, uncompensated care cost increases, and navigation program effectiveness. Systems that invest early may prevent losses that exceed program costs. Systems that wait may face financial pressure leaving fewer resources for any programming.

Building Hospital Response Infrastructure

Hospital systems preparing for work requirements face infrastructure decisions spanning clinical operations, financial services, information technology, and community partnerships. The integration challenge is substantial: work requirement response touches discharge planning,

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

emergency department operations, registration systems, financial counseling, community health workers, and external partner relationships.

Registration system modifications enable coverage status tracking. When patients register, systems should capture Medicaid enrollment status, work requirement applicability, and compliance status. This information enables targeted intervention, outcome tracking, and population-level analysis. Most hospital registration systems don't currently collect this information because it wasn't relevant before work requirements. Building data infrastructure requires IT investment and registration workflow changes.

Financial counselor training extends to work requirement navigation. Financial counselors already help patients apply for Medicaid, charity care, and payment programs. Adding work requirement assessment and exemption facilitation to financial counselor competencies expands their role but builds on existing skills. Training curricula, workflow protocols, and supervision structures must incorporate work requirement content.

Discharge planning integration requires clinical staff engagement. Nurses and social workers managing discharge planning must understand work requirement implications for patient coverage continuity. Someone discharged after surgery who faces work requirements needs different planning than someone with stable employer coverage. Incorporating work requirement assessment into discharge protocols requires clinical buy-in that administrative directives alone cannot achieve.

Community partnership development leverages external navigation capacity. Hospitals cannot build all navigation infrastructure internally. Partnerships with community organizations, faith communities, and workforce development programs extend navigation reach beyond hospital walls. Hospitals can fund community partners, provide space for navigation services, refer patients to external resources, and receive referrals from community organizations identifying people at coverage risk. The ecosystem approach from Articles 8A through 8E applies to hospital community benefit strategies.

Technology platform integration connects hospital systems to state eligibility infrastructure. Real-time eligibility checking enables immediate coverage status verification during patient encounters. Provider portal access enables direct exemption documentation submission. Data sharing agreements enable hospitals to receive notifications when patients lose coverage, triggering outreach before uncompensated care accumulates. These integrations require state cooperation that varies by jurisdiction and technical capability.

The Quality and Outcomes Dimension

Hospital quality measures may suffer from work requirement coverage instability in ways that current measurement systems don't adequately capture. Readmission rates, patient satisfaction, and chronic disease management outcomes all depend on post-discharge care access that coverage loss undermines.

The readmission dynamic illustrates the problem. Someone discharged after heart failure treatment who loses Medicaid coverage may not fill discharge medications, may skip follow-up appointments, and may deteriorate until readmission becomes necessary. The hospital receives readmission penalties for quality failures rooted in coverage instability outside hospital control.

Current quality measurement doesn't adjust for coverage loss between discharge and readmission.

Chronic disease management populations face similar dynamics. ACO quality measures examined in Article 9A depend on longitudinal care continuity that coverage instability disrupts. Hospital-based ACOs and clinically integrated networks face quality measure degradation when attributed patients lose coverage and drop out of managed care relationships. The quality impact extends beyond individual patient outcomes to institutional performance metrics affecting reimbursement and reputation.

Patient satisfaction scores may decline as coverage-related distress affects patient experience. Someone worried about losing Medicaid coverage during a hospital stay experiences stress that affects satisfaction ratings independent of clinical care quality. The administrative burden of work requirements creates anxiety that spills into healthcare encounters, affecting Press Ganey scores and other patient experience measures.

Hospitals tracking quality metrics should monitor work requirement implementation effects. Stratifying quality outcomes by patient coverage status enables identification of coverage-related quality gaps. If readmission rates rise specifically among patients who lost Medicaid coverage, the cause is identifiable and the response can target coverage retention rather than clinical protocol changes that won't address the actual problem.

Looking Ahead

Hospital response to work requirements unfolds over the 14 months before December 2026 implementation and continues through the years of operational experience that follow. The institutions that recognize work requirements as infrastructure challenge rather than external policy event will navigate the transition more successfully.

Article 10 series examines universities and community colleges as qualifying activity hubs, exploring how educational institutions become essential infrastructure for work requirement compliance pathways. The provider perspective continues expanding from individual practices to hospital systems to educational institutions that enable compliance through training and education credits.

For hospitals, the immediate priority is infrastructure assessment: understanding current Medicaid patient volumes, projecting coverage loss scenarios, evaluating navigation capacity gaps, and developing investment plans that protect both patient coverage and institutional financial sustainability. The institutions that begin this work now will be better positioned than those waiting for clearer policy signals that may not arrive before implementation deadlines demand operational response.

Next in series: Article 10A, "Universities and Community Colleges as Qualifying Activity Hubs"

Previous in series: Article 9B, "Physician Practices and the Exemption Burden"

References

1. Commonwealth Fund. "Federal Cuts to Medicaid Could End Medicaid Expansion and Affect Hospitals in Nearly Every State." Commonwealth Fund, May 2025.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

https://www.commonwealthfund.org/publications/issue-briefs/2025/may/federal-cuts-medicaid-could-end-medicaid-expansion-affect-hospitals

2. American Hospital Association. "Unwise DSH Cuts Combined with Rise in Uncompensated Care Due to Medicaid Redeterminations Coverage Losses Further Threaten Hospitals' Financial Stability." AHA News, September 2023. https://www.aha.org/news/blog/2023-09-20-unwise-dsh-cuts-combined-rise-uncompensated-care-due-medicaid-redeterminations-coverage-losses-further
3. American Hospital Association. "Fact Sheet: Uncompensated Hospital Care Cost." AHA, 2020. https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost
4. Robert Wood Johnson Foundation and Urban Institute. "Hospital Revenue Losses and Increased Uncompensated Care if Medicaid Funding Is Cut." RWJF, March 2025. https://www.rwjf.org/en/insights/our-research/2025/03/hospital-revenue-losses-and-increased-uncompensated-care-if-medicaid-funding-is-cut.html
5. Chartis Group. "2025 Rural Health State of the State: Rural Hospital Closures and Care-Access Crisis." Chartis, February 2025. https://www.chartis.com/insights/2025-rural-health-state-state
6. Center for Healthcare Quality and Payment Reform. "Rural Hospitals at Risk of Closing." CHQPR, 2024. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
7. Kaiser Family Foundation. "10 Things to Know About Rural Hospitals." KFF, September 2025. https://www.kff.org/health-costs/issue-brief/10-things-to-know-about-rural-hospitals/
8. American Hospital Association. "Rural Hospitals at Risk: Cuts to Medicaid Would Further Threaten Access." AHA, June 2025. https://www.aha.org/fact-sheets/2025-06-13-rural-hospitals-risk-cuts-medicaid-would-further-threaten-access
9. Nixon Peabody LLP. "Revisiting Section 501(r) Compliance in 2025." Nixon Peabody, March 2025. https://www.nixonpeabody.com/insights/alerts/2025/03/18/revisiting-section-501r-compliance-in-2025
10. Internal Revenue Service. "Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r)." IRS.gov. https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r
11. MACPAC. "Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States." March 2024. https://www.macpac.gov/wp-content/uploads/2024/03/Chapter-3-Annual-Analysis-of-Medicaid-Disproportionate-Share-Hospital-Allotments-to-States.pdf
12. AAMC. "Proposed Cuts to Medicaid Would Harm Patients and Hospitals." Association of American Medical Colleges, 2025. https://academicmedicine.aamc.org/stories/proposed-cuts-medicaid-would-harm-patients-and-hospitals

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

13. Washington University School of Public Health. "Medicaid Expansion Reduced Uncompensated Care Costs, May Have Prevented Hospital Closures." October 2025. https://schoolofpublichealth.washu.edu/medicaid-expansion-reduced-uncompensated-care-costs-may-have-prevented-hospital-closures/
14. Fierce Healthcare. "Rural Hospitals' Labor and Delivery Closures Increased in 2025." November 2025. https://www.fiercehealthcare.com/providers/rural-hospitals-labor-and-delivery-closures-increased-2025
15. Sommers, Benjamin D., et al. "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care." Health Affairs, vol. 39, no. 9, 2020, pp. 1522-1530.