Medicaid Work Requirements: Mitigating Harm through Implementation

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On July 4, 2025, the President signed the so-called One Big Beautiful Bill Act (OBBBA), which includes an unprecedented federal mandate to implement work requirements for the adult Medicaid expansion group. The Congressional Budget Office (CBO) estimates that, by 2034, these new work-related sanctions will reduce Medicaid enrollment by 5.3 million.[1]

Though the legislation includes various exemptions, prior experience with Medicaid work requirements in Arkansas and Georgia suggests that the processes for obtaining exemptions and accommodations create substantial red tape that leads to coverage loss for people with disabilities. States have some opportunities to reduce administrative burden for applicants, enrollees, and agency staff through their implementation decisions. This brief explains the structure of the work requirement and provides short and longer-term steps that states can take to mitigate the reporting burdens and ensure that people who should be exempt, or who meet the work requirement but are required to report, do not lose access to care.

Discussion

Section 71119 of OBBBA establishes mandatory work requirements for adults eligible through the Medicaid expansion group.[2] The statute makes clear that the Secretary cannot waive any of the provisions of section 71119.[3]

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[1] Phillip L. Swagel, Cong. Budget Off., *Distributional Effects of Public Law 119-21* (Aug. 11, 2025), https://www.cbo.gov/publication/61367#data (*see* Excel attachment Uninsured Impacts).
[2] An act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("OBBBA"), Pub. L. No. 119-21, § 71119, 139 Stat. 72, 306 (2025) (codified at 42 U.S.C. § 1396a(xx)). Work requirements also apply to individuals eligible through approved section 1115 projects that cover Medicaid expansion adults. *See* 42 U.S.C. § 1396a(xx)(9)(A).
[3] *Id.* § 1396a(xx)(10).

These provisions go into effect January 1, 2027 unless a State requests and obtains a good faith extension.[4] States may impose work requirements earlier.[5] With such a compressed timeline, states are already making important implementation decisions, even before HHS has released regulations or guidance.[6]

The adult Medicaid expansion covers over 20 million people, including millions of people with disabilities, parents, caregivers, and low-wage workers who will be affected by work requirements. States generally have not tracked disability or health status for expansion enrollees because neither was, until now, a necessary eligibility criterium. However, survey data from several states show a significant fraction of expansion enrollees have a disability. On the order of 20% to 30% report mental health disabilities.[7] Rates of substance use disorder and other disabling conditions are also relatively high.[8] KFF estimates that 1 in 5 Medicaid enrollees under 65 who use institutional LTSS, and 1 in 10 people who use Medicaid Home and Community-Based Services (HCBS) are eligible through the Medicaid expansion.[9]

States now face significant challenges to identify which expansion group adults qualify for exemptions. The steps they take during planning, procurement, and enrollee outreach will shape how successful they are in preventing coverage loss in this group.

Work Requirement Basic Structure

Broadly, applicants and enrollees in the expansion population will have to complete at least 80 hours of "community engagement" activities per month or qualify for an exemption to enroll and stay enrolled in Medicaid. Individuals must complete their 80 hours through some combination of work, community service, education, or participation in a work program. Alternatively, they can satisfy the requirement through enrollment in an education program at

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[4] *Id.* § 1396a(xx)(11).
[5] *Id.* § 1396a(xx)(1).
[6] *See* OBBBA, § 71119(d) (codified at 42 U.S.C. § 1396a note) (requiring the HHS Secretary to promulgate an interim final rule for implementing the work requirements by June 1, 2026).
[7] *See, e.g.,* Penn. Dep't. Hum. Servs*., Medicaid Expansion Report*, 52 (2017) [Showing 18.8% of Pennsylvania's Medicaid expansion enrollees had mental health conditions and 11.5% has a substance use disorder]; Renuka Tipirneni et al., *Employment Status and Health Characteristics of Adults with Expanded Medicaid Coverage in Michigan*, 178 JAMA INT. MED. 564 (2018) [showing that 32% of expansion enrollees reported a mental health condition, with 19.9% reporting a mental health impairment and 22.9% a physical impairment].
[8] *Id.*
[9] Priya Chidambaram et al., KFF, *Who Uses Medicaid Long-Term Services and Supports?* (2023), https://www.kff.org/medicaid/who-uses-medicaid-long-term-services-and-supports/.

least half time or by showing their monthly income exceeds a minimum threshold. Specifically, that threshold equals the federal minimum wage times 80, or $580/month in 2025. Seasonal workers can also comply by showing their 6-month average monthly income exceeds the same threshold.[10] In 2018, Arkansas implemented a similar income threshold as part of its work requirement. More than half of the beneficiaries relieved from the need to actively report (52%) qualified through this method.[11]

The statute gives states options for structuring work requirement compliance:

- **Application lookback:** States must require applicants to show "community engagement" compliance for **at least 1 month, but up to 3 consecutive months**, immediately *prior* to the application month.[12]
- **Frequency of compliance verification:** States must verify compliance with the work requirements when they redetermine eligibility **every 6 months** but have the option to verify more frequently.[13]
- **Months of verified compliance for enrollees:** States must require enrollees to meet the work requirements for **1 or more months (at state option), whether or not consecutive,** during each eligibility period.[14]

States looking to reduce administrative burden for beneficiaries and agency staff would thus include only 1 month of lookback at application, would only verify compliance every 6 months, and would require beneficiaries to show only 1 month of compliance between verifications.

[10] 42 U.S.C. § 1396a(xx)(2).
[11] Robin Rudowitz et al., KFF, *February State Data for Medicaid Work Requirements in Arkansas* (Mar. 25, 2019), https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/.
[12] 42 U.S.C. § 1396a(xx)(1)(A).
[13] *Id.* § 1396a(xx)(4). States that cover only a subset of the expansion population through a section 1115 project have the option to verify less frequently than every 6 months. *See id.*; 42 U.S.C. § 1396a(e)(L) (added by OBBBA § 71107).
[14] *Id.* § 1396a(xx)(1)(B).

Minimizing Missed Exemptions

Congress included a list of mandatory exemptions from work requirements.[15] These are:[16]

- Parents, guardians, caretaker relatives, or family caregivers of a disabled individual or of a dependent child under 14;
- Medically frail individuals or persons with special medical needs (as defined by the Secretary);
- Veterans with a total disability rating;
- Participants in a drug addiction or alcoholic treatment and rehab program;
- American Indian/Alaska Native;
- Individuals in compliance with TANF requirements;
- A member of a household receiving SNAP and not exempt from SNAP work requirements;
- Pregnant or entitled to postpartum Medicaid; or
- An inmate of a public institution or who has been an inmate for any of the 3 months prior to the compliance check month.[17]

With respect to medically frail individuals or persons with special medical needs, the Secretary's definition must at least include individuals who:

- Are blind or disabled according to the Social Security criteria;
- Have a substance use disorder;
- Have a disabling mental disorder;
- Have a serious or complex medical condition; or
- Have a physical, intellectual or developmental disability that significantly impairs one or more activities of daily living (ADLs).

It is unclear the degree to which the Secretary will defer to an existing regulation defining "medically frail" for purposes of determining mandatory enrollment in an Alternative Benefit Plan.[18] That regulation allows states to add additional categories of people who qualify as

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[15] "Exemptions" as discussed in this document include: (1) "exceptions" that can apply to "applicable individuals" subject to work requirements but who, if they meet a list exception, will be deemed compliant, *see* § 1396a(xx)(3) and "exclusions" which apply to "specified excluded individuals" to whom work requirements do not apply as set forth in § 1396a(x)(9)(A)(ii),
[16] *Id*. § 1396a(xx)(9)(A)(ii) (defining "specified excluded individual").
[17] 42 U.S.C. § 1396a(xx)(9)(A)(ii).
[18] *See*, 42 C.F.R. § 440.315(f).

medically frail, which would be appropriate for work requirements as well. For example, many individuals with disabilities have impairments that do not directly affect an ADL but still represent special medical needs that affect their activities in the community. They may have difficulty concentrating for long periods of time, using the phone or a computer, lifting items, or traveling to work. To capture people with these impairments, the Secretary (and, if permitted, states) should consider adopting criteria related to the impairment of an instrumental ADL.

Additionally, some special or complex health conditions have the potential to improve with comprehensive treatment, but may also lead to deteriorating health if treatment gets interrupted. For example, people with Post-Traumatic Stress Disorder (PTSD) or Substance Use Disorder (SUD) often experience symptoms and limitations that require continuity of care, even if they are managed through ongoing treatment and/or medication. These individuals' special medical needs persist despite any stabilizing effect of their treatment. Exemption policies must account for the episodic but serious nature of these conditions and should never disqualify someone because their underlying condition is well-managed under treatment.

States looking to mitigate harms should also add temporary hardship exemptions for individuals receiving care in hospitals, nursing facilities, or similar institutions and for people who travel to receive services for a serious or complex medical condition (for themselves or for a dependent).[19] States may also request temporary exemptions for residents of a county with a presidentially-declared emergency or disaster or with a high unemployment rate.[20]

Finally, while not an exemption, states have an existing obligation to provide information about the right of individuals to choose their Medicaid eligibility category, if they are eligible for more than one. This allows them to enroll in a category to which work requirements do not apply.[21] Many individuals with disabilities who might qualify for SSI or SSDI and receive Medicaid through that pathway instead enter through the expansion pathway, because it is an easier and less time-consuming process. States could invest in programs that seek to identify and help these individuals enroll in SSI/SSDI, so they qualify for Medicaid through a pathway that does not have a work requirement. States who have invested in assistance programs like these in the past more than doubled the approval rate for initial SSI/SSDI applications.[22]

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[19] *Id*. § 1396a(xx)(3)(B).
[20] The unemployment threshold is 1.5x the national unemployment rate or 8%, whichever is less. *See* 42 U.S.C. § 1396a(xx)(3)(B)(ii)(II).
[21] *See* 42 C.F.R. § 435.404.
[22] J.F. Kauff, E. Clary, K.S. Lupfer & P.J. Fischer, *An Evaluation of SOAR: Implementation and Outcomes of an Effort to Improve Access to SSI and SSDI*, 67 PSYCHIATR. SERV. 1098 (Oct. 2016), https://doi.org/10.1176/appi.ps.201500247.

Exclusion from Work Requirements Should Not Require Exclusion from Work

Generally, most of the mandatory statutory exemptions, including the medically frail/special medical needs exemption, are **not** contingent on individuals showing they are **unable** to work. This distinction is important.

Disability and health exemptions in other public program work requirements **do** have a history of requiring disabled people to prove they cannot work. Social Security disability requires applicants to show they cannot participate in "substantial gainful activity." SNAP's exemption includes such an "unfit for employment" condition. Congress could have done something similar in Medicaid, but it chose not to. With the exception of a subcategory that includes people who meet the Social Security criteria, the Medicaid program's medically frail/special medical needs exemptions require only that a person has a qualifying health condition or impairment. More specifically:

- States should never use an individual's past or current work status to disqualify them from seeking a health or functional status-related exemption; and
- Except where inability to work is specifically referenced, such as with Social Security disability or VA total disability, the statute does not support tying specific components of the medically frail or special medical needs exemption to an individual attesting or otherwise showing their inability to work.

Any language that narrows the exemption by requiring an attestation of inability to work would create an employment disincentive. Medicaid expansion enrollees with qualifying health and functional status impairments already work, but they would face a decision to give up that work (to seek an exemption) or risk losing access to critical services if they lost their job or had their hours unexpectedly cut. Interpreting this exemption as written – focused on the presence of functional or health impairments alone – avoids this disincentive. It also acknowledges their higher risk of harm should they lose access to coverage. In short, the statute clearly allows such individuals to work when they can without having to worry about losing access to Medicaid.

Establishing Fair Policies Regarding the Length of Exemptions

Exemption policies need to account for the variable presentations of different disabilities and complex and serious medical conditions. Many people with disabilities and serious medical conditions have a persistent health and functional status that is not expected to improve. In these situations, requiring regular verification of a health-related exemption would be inappropriate and would put people at risk.

Exemption identification should also take into account the variable nature of some chronic conditions and disabilities. For example, traumatic brain injuries can cause intermittent symptoms that may wax and wane even as the underlying status persists. Screening forms to identify these conditions on applications should reflect that reality by reviewing a long enough window of time to identify someone who might not currently be experiencing symptoms. They might be living with a long-lasting condition that would qualify as a special medical need. After initial identification, such an individual should not have to demonstrate they qualify for an exemption at every compliance verification if their disability or health condition is chronic or long-lasting. Instead, states that require verification of exemptions should account for the fact that special health care needs are often lifelong and, as a result, minimize the reporting and paperwork requirements for verification checks.

Improving *Ex Parte* Validation of Income and Exemptions

OBBBA requires states to establish processes and use available data to verify that individuals have met the work requirements (or an exemption) without asking individuals to submit additional information, where possible.[23] Employment databases with household income can be critical resources to deem large swaths of the Medicaid expansion population compliant with work requirements. These databases, such as The Work Number, have numerous gaps and flaws. For example, they do not generally capture gig work or self-employment income. However, they can still be important mechanisms to mitigate coverage losses.

Disability data matching may have even more gaps. States may be able to use available claims data – through managed care encounter data or other sources like the Veterans Administration – to automatically identify applicants and enrollees for an exemption. Some states have health plans that target individuals with behavioral health needs, for example, who might be exempted as a group.[24] All data matching of this sort must protect the confidentiality of individual health and disability information, but creative ideas to connect data sources will help make or break the success of data matching for disability and other exemptions.

Minimizing Verification Requirements for Exemptions and Hours Reporting

In many cases, states will be unable to determine compliance with the work requirements through *ex parte* verification, and individuals will have to provide additional information. Again,

[23] 42 U.S.C. § 1396a(xx)(5).
[24] For example, North Carolina's tailored care plans target people with serious mental illness, SUD, intellectual and developmental disabilities, and traumatic brain injuries.

the goal should be to minimize reporting burden for individuals, which also reduces administrative time for state agency staff.

To the extent possible, accepting information from an individual's forms or from *ex parte* databases as verification will smooth application and renewal processing. Past experience with has found this method reliable.[25] Adding layers of verification increases the risk of errors (wrongly denying an eligible individual), failure to complete the process (procedural denials), and processing costs for states.[26] While the Secretary will likely provide more guidance on state verification practices for reporting work-related activities, the statute allows states to "elect to not require an individual to verify information resulting" in their classification as exempt.[27] States interested in mitigating harm should take up this option.

Finally, the current single streamlined application asks only a single disability-related question.[28] HHS and states will have to develop and test new questions to ensure applicants are prompted to provide the information necessary to establish disability and health status exemptions (in addition to other potential exemptions).

Developing Effective Outreach and Other Notices

Outreach: While the immediate focus of advocacy may center on how states structure their work requirements and eligibility systems to minimize coverage loss, plans should soon be underway to identify messengers and resources to inform beneficiaries about work requirements. The statute only requires outreach 3 months ahead of implementation, which likely is too short.[29] States that previously tried work requirements struggled mightily with

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[25] MaryBeth Musumeci et al., KFF, *Medicaid Public Health Emergency Unwinding Policies Affecting Seniors & People with Disabilities: Findings from a 50-State Survey* (2022), https://www.kff.org/report-section/medicaid-public-health-emergency-unwinding-policies-affecting-seniors-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/ (noting that when New Jersey compared self-attestation with actual electronic asset verification in a representative sample of applicants from 2015-2016, it found a 0% error rate).

[26] Amy M. Tiedemann & Kimberly Fox, Rutgers Center for State Health Policy, *Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements* (2005), https://dms.cshp.rutgers.edu/sites/default/files/normalized/1442458770/2005-brief-tiedemann-627.pdf.

[27] 42 U.S.C. § 1396a(xx)(3)(A).

[28] Application for Health Coverage & Help Paying Costs, OMB No. 0938-1191 (Oct. 2013), https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/single-streamlined-application.pdf (*see* page 2, question 9).

[29] 42 U.S.C. § 1396a(xx)(8).

outreach and even shut down implementation due to repeated failures.[30] In addition to describing the work requirement structure and reporting process, outreach information should describe how to apply for a disability-related category and inform individuals about their right to enroll through another Medicaid category (not subject to work requirements) if eligible.

Outreach efforts should include communications targeted for people with disabilities, including by enlisting key messengers from the disability community, such as Aging and Disability Resource Centers, Centers for Independent Living, State Developmental Disabilities Councils, and Protection and Advocacy agencies. Appropriate translation and access to interpretation services for interactions with state agencies and call centers will be another key component of successful outreach.

Notices of non-compliance: States must develop and send individual written notices of non-compliance that detail how to comply and who is exempt and provide a 30-day deadline to respond.[31] Notices should contain specific, individualized information the state relied on to determine non-compliance so the individual can rebut such information.[32]

Notices of adverse action: Before a state can deny or terminate someone's Medicaid on the basis of non-compliance it must conduct an *ex parte* review and provide a written notice of adverse action that includes a statement about hearing rights.[33] This *ex parte* review is used to determine whether the individual is eligible for Medicaid under a different category; this includes conducting a disability determination when information available to the state indicates one may exist and evaluating potential eligibility under a Medicaid waiver program.[34]

For all outreach and notices, states should attend to plain language principles for their materials and make information available in formats accessible to individuals with all different disabilities. All materials should adhere to user-centered design principles to convey information clearly.[35] Most importantly, advocates should push their states to subject notices

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[30] *State Delays Implementation of Medicaid Work Requirements, Citing Potential Coverage Losses*, NHFPI BLOG (July 11, 2019), https://nhfpi.org/blog/state-delays-implementation-of-medicaid-work-requirements-citing-potential-coverage-losses/.
[31] 42 U.S.C. § 1396a(xx)(6)(B).
[32] *See* Jane Perkins, Nat'l Health Law Program, *Q&A: Due Process and Medicaid Notice and Hearing Standards*, TASC (Feb. 2016).
[33] 42 U.S.C. § 1396a(xx)(6)(A)(iii)(II).
[34] *Id.* at § 1396a(xx)(6)(A)(iii)(I); 42 C.F.R. §§ 435.930(b), 435.916(f)(1); *Crawley v. Ahmed*, No. 08-14040, 2009 WL 1384147, at *21 (E.D. Mich. May 14, 2009).
[35] Civilla, *Human-Centered Work Requirements for Medicaid* (Fall 2025), https://civilla.org/assets/files/Civilla-Human-Centered-Work-Requirements-Medicaid-Report.pdf.

and outreach materials to user-testing to reduce the likelihood of confusion and help avoid erroneous terminations. Additionally, individuals with disabilities will need to be given the option to designate an authorized representative to receive notice on their behalf.[36]

Promoting Transparent Reporting and Accountability

Appropriate oversight of disenrollments and declined applications for failure to meet work requirements will be critical to evaluate the effects of the new policies on the Medicaid expansion population and on people with disabilities enrolled through that group. Unfortunately, the statute includes few requirements related to reporting. States will have to add new reason categories to their termination notices that specify work-requirement related non-compliance. They should also consider how to track terminations separately from applications denied only due to the work requirement.

Conclusion and Recommendations

State advocates should begin conversations with state officials now over how to minimize coverage loss from the work requirements. In these conversations, advocates can highlight the actions states can take to reduce coverage losses among people with disabilities, including:

1. Opt for a 1-month lookback at application, 1 month of compliance between each verification, and verification only every 6 months.

2. To the extent allowed under forthcoming regulations, define the medical frailty and special medical needs exemption to capture the full range of individuals who reasonably fit under these definitions due to their health or disability status.

3. Adopt policies that recognize special medical needs, including disabilities, are often persistent, lifelong conditions and do not require onerous verification processes once an individual is granted an exemption under this category.

4. Accept temporary hardship exemptions for people seeking treatment or helping a dependent seek treatment. Screen applicable individuals granted short-term hardship exemptions to determine if they should be entitled to a longer duration medical frailty or special medical need exemption.

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[36] *See* 42 C.F.R. § 435.923.

5. Request exemptions for counties with high unemployment.

6. Accept self-attestation as verification where possible, and do not require additional information for exemptions, as permitted under the statute.

7. Work with eligibility programmers, advocates, and beneficiaries to expand *ex parte* verification of work requirement exemptions and compliance, taking into account any concerns about data privacy.

8. Remind states of their obligation to conduct an *ex parte* review of eligibility under all other categories of Medicaid prior to termination. This includes undertaking a disability determination where information possessed by the state indicates a disability may exist as well as determining whether individuals remain eligible through a Medicaid waiver.

9. Ensure that notices – including notices of non-compliance and notices of adverse action – detail the specific, factual bases the state relied on to justify its finding or adverse action. Notices must be provided in an accessible format and manner.

10. Highlight the state's obligation to allow choice of Medicaid category and incorporate this right, as well as information about how to establish eligibility for disability related Medicaid, in outreach materials, and fund/pilot programs to identify and help people with disabilities enroll in SSI or SSDI, so that those who qualify have a pathway to coverage without work requirements.

11. Collect and transparently report data about the effect of work requirements on enrollment and health outcomes, including for people with disabilities.