# Recommendations for Mitigating Harms to People with Disabilities, Older Adults, and Caregivers from Medicaid Work Requirements

The adult Medicaid expansion covers over 20 million people, including millions of people with disabilities, older adults, parents, caregivers, and low-wage workers who will be affected by new Medicaid work requirements signed into law in July 2025. Congressional leaders have made clear in public statements and in the law itself that Congress intended to exempt certain groups of people in the Medicaid expansion from this policy. Prior experience has shown, however, that people who are exempt from work requirements often lose coverage anyway due to poor outreach or excessive red tape. This brief offers implementation strategies to minimize wrongful coverage loss and protect people's access to care.

## Many Medicaid Expansion Enrollees are People with Disabilities or Caregivers

States generally have not tracked disability or health status for expansion enrollees because that information was not needed to determine eligibility. However, survey data from several states show a significant percentage of expansion enrollees have a disability. On the order of 20% to 30% report mental health disabilities.[1] Rates of substance use disorder and other disabling conditions are also relatively high.[2] 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.[3] States have also not tracked caregiver status. Nonetheless, analysis of adults ages 19-64 enrolled in Medicaid shows that many are not working due to caregiving responsibilities.[4] While Congress included exemptions for these groups, many of these individuals are at risk of losing Medicaid coverage if they are not appropriately identified as exempt through the eligibility process.

## Exempted Individuals

Congress specifically excluded certain groups from the work requirements, including American Indians and Native Alaskans, parents and caregivers of dependent children under 14 or disabled individuals, people who are medically frail or have special medical needs, and pregnant people. While many individuals in each of these groups have jobs, their inclusion in the list of "specified excluded individuals" acknowledges that Congress found it inappropriate to subject them to Medicaid work requirements. As states implement this new policy, no one should lose access to vital Medicaid services, including HCBS, because they have fallen through the bureaucratic cracks when they should qualify for an exemption under the law.

### Exemptions for people who are medically frail or have special medical needs

Under the statute, any individual who is "medically frail or otherwise has special medical needs (as defined by the Secretary)" is exempt as a "specified excluded individual." The statute sets a minimum of five groups that must be included in this definition: individuals who are blind or disabled (as defined in Section 1614), have a substance use disorder, have a "disabling mental disorder," have a physical, intellectual, or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living (ADL), or have a serious or complex medical condition.[5]

The scope of these categories will determine who qualifies for an exemption. For example, the statute indicates that an individual who is "medically frail or otherwise has special medical needs" includes any person with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more ADLs. This category should encompass the many people with a disability who need cueing, reminders, or supervisory help to perform ADLs, as well as those who need hands-on assistance.

The other categories include people with health or functional limitations that are not ADL-specific. For example, some Autistic individuals and individuals with mental health disabilities may need assistance with instrumental activities of daily living (IADLs), such as using transportation, communicating, and medication management, but would not be captured under the "1 ADL" category if they did not also need help with ADLs. They may have difficulty concentrating for long periods of time, following instructions, or performing other daily activities. They fall within and should be captured under either the "serious or complex medical condition" category or the "disabling mental disorder" category.

Further, the five listed categories set a floor, not a ceiling. Congress indicated that the "medically frail" exemption "includ[es]" these categories but it did not limit the exemption to

the listed categories. As states identify new groups that may not fit cleanly within the five listed minimum categories but are nevertheless "medically frail or otherwise ha[ve] special medical needs," they should have discretion to add those individuals to the medically frail/special medical needs definition to ensure that no one who should be exempt ends up losing coverage. States may also need to add questions to their Medicaid applications to identify the full scope of people who meet the medically frail/special medical needs exemptions.

Additionally, the breadth of each category and the potential overlap between categories may create confusion about who is covered, and many people could fit under multiple categories. It is therefore critical to make clear that the scope of the medically frail/special medical needs designations include, for example, individuals needing help with IADLs and other groups of people with health or functional limitations that do not impact ADLs. As with people in the "1 ADL" category, subjecting these individuals to work requirements risks worsening their health if they lose access to services needed for their health condition.

States should describe exemptions to applicants and Medicaid enrollees in plain language and in a way that allows eligible individuals to identify that an exemption applies to them. For example, the term "medically frail" is not a commonly used term, and therefore not every individual who qualifies for this exemption would identify themselves as such. While examples of conditions that qualify for this exemption can be helpful to illustrate, eligibility for this exemption should not be limited to a finite list of conditions.

## Prohibiting unlawfully restrictive criteria for the "medically frail" exemption

Many people with health and functional impairments face substantial barriers to work. In 2024, the employment rate for working age people with disabilities (37.4%) was just over half the rate of nondisabled people in the same age group (74.9%).[6] Considering only individuals actively participating in the workforce, people with disabilities are twice as likely to be unemployed as people without disabilities (8.1% versus 3.9%).[7] These statistics reflect the substantial barriers to employment people with disabilities face, including inadequate accommodations, inaccessible workplaces, and outright stigma.[8] Older adults aged 50 to 64 can face age discrimination and other barriers to employment as well.[9]

The plain language of the statute related to the medically frail and special medical needs exemption prohibits states from requiring someone to show they are unable to work as a criterion to qualify. States may not graft "inability to work" onto the medically frail categories listed under the statutory definition, with the exception of one subcategory related to people

with social security disability determinations that explicitly incorporate whether an individual can participate in "substantial gainful activity." More specifically:

- States should be prohibited from using an individual's past or current work status to disqualify them from seeking a health or functional status-related exemption; and
- State implementation of specific components of the medically frail or special medical needs exemption should not be tied to an individual attesting or otherwise showing their inability to work.

Asking individuals to attest to their inability to work would create an employment disincentive. Many people who are medically frail or have special medical needs do work despite facing added barriers, especially when they have access to necessary supports and accommodations. An exemption that requires an attestation of their inability to work would force them to either seek an exemption (and give up their jobs or goals for employment) or forego the exemption and risk access to the services they need to stay in the community if they lose their job, get their hours cut, or their health condition changes and prevents them from working temporarily. Interpreting the medically frail and special medical needs exemption as written – focused on the presence of health or functional impairments alone – avoids this catch-22. Just as it does with parents and caretaker relatives with dependent children under 14, caregivers of older adults and people with disabilities, pregnant women, and Native Americans, the statute thus allows a beneficiary with a qualifying health or physical impairment to work if they can without having to worry about losing access to Medicaid due to the work requirement.

## Family caregiver exemption

The statute exempts family caregivers as a category of "specified excluded individual" and specifies that the definition of family caregiver is "(as defined in section 2 of the RAISE Family Caregivers Act)." The full definition of family caregiver from the RAISE Family Caregivers Act is inclusive:

> The term "family caregiver" means an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.[10]

Importantly, this definition encompasses caregivers for older adults and others who may not identify as having a disability. Congress made their intent to encompass caregivers for older adults in this exemption by describing the statute's work requirements as not applying to people who have "elderly parents in their care."[11]

Many Medicaid enrollees and their families do not think of themselves as a caregiver, but rather as someone providing help or support to a loved one. State exemption screening processes and outreach should align with the RAISE definition, as H.R. 1 requires. Further, as discussed above with respect the medically frail exemption, the statutory language for the caregiver exemption does not require someone to show they are unable to work because of their caregiving duties. States should comply with the RAISE definition without adding additional requirements not in the statute.

### Short-term hardship exceptions

The statute provides states the option to include a short-term hardship exception for individuals who need to travel outside of their community for an extended period to receive medical services that are necessary to treat a serious or complex medical condition and that are not available within their community of residence. This also applies to an individual accompanying a dependent who receives such services.

The statute also allows states to provide a short-term hardship exception for individuals receiving inpatient hospital services, nursing facility services, services in an Intermediate Care Facility, or such other services of similar acuity (including outpatient care relating to other services specified in this subclause). Services of similar acuity should include community-based alternatives to psychiatric hospitalization or other inpatient care, including but not limited to Assertive Community Treatment and mobile crisis services. People with disabilities can have acute-care needs met in the community and should not need to rely on institutional care to keep Medicaid. Additionally, Psychiatric Residential Treatment Facilities (PRTFs) should be clearly identified as a service of "similar acuity," in order to except 19, 20, and 21-year olds that may utilize PRTFs rather than psychiatric hospitals.

States should adopt these temporary exceptions and provide clear explanations and instructions on how individuals can qualify for these exceptions in their outreach materials. States should also automatically screen and help individuals experiencing these hardships to transition into a longer-term exemption as a specified excluded individual where appropriate.

## Reduce Burden on Exempted Individuals

Many people who qualify for an exemption as "medically frail" or someone who "otherwise has special medical needs" have conditions that are unlikely to change over time. The burden of having to take action to frequently renew or redetermine an exemption based on their health or disability status puts them at risk of procedural disenrollment, systems errors, and

missteps that cause them to fall through the cracks and lose access to care. Gaps in coverage could significantly worsen their outcomes. To avoid such gaps, states have a statutory obligation to maximize the effectiveness of their *ex parte* reviews and minimize the need to renew exemptions for people whose status is not likely to change. For example, states could use a previous assessment that an enrollee was exempt based on a static condition or disability to process *ex parte* renewals.

States should examine potential ways that data could be misused to disqualify people with disabilities and chronic conditions from an exemption. As discussed above, many people with disabilities work and Medicaid coverage is often key to making that possible. Nonetheless, disabilities and chronic conditions can and often do interfere with ability to work, and so these same working individuals may be eligible for an exemption from the work requirement. States should never use payroll or other data as evidence that individuals are ineligible for an exemption, as such an application would be inconsistent with the exemptions in the statute.

## Use Efficient Verification Processes

The statute gives states the option to accept information that indicates an individual is exempt without further verification. This is the most efficient and least burdensome way to process eligibility, whether the information comes from a signed application or renewal form or through the *ex parte* data collection. States have long been successfully relying on beneficiary-provided information in making medical frailty determinations, as verification for Medicaid eligibility, including for "caretaker relative" status (e.g., Arkansas's verification procedures), and for asset verification.[12] Past experience has found this approach reliable and less expensive for states.[13]

If states opt for more cumbersome verification procedures, they risk increasing error rates in eligibility processing, including denying benefits to individuals who should be exempt. People with limited income and disabilities or complex health conditions will face barriers in demonstrating that they are a specified excluded individual. People who have disabilities and/or chronic conditions and are eligible for Medicaid expansion are unlikely to have other health insurance. Yet, access to health care may be necessary if the medically frail exemption requires them to produce documentation of their disability or diagnosis. States should thus use this option to help people get the health care they need with minimal administrative burden. Helping people meet their health needs through Medicaid coverage also reduces the risk and expense of unnecessary hospitalizations and health emergencies due to gaps in care.

States should also provide exemptions to qualifying caregivers without added verification of the health status of the person they are caring for, to reduce paperwork burden on both the caregiver and the state. Specifically, this avoids the complication of verifying information about the person being cared for – who may not be enrolled in Medicaid.

## Other Considerations

Finally, the new requirements to get and keep Medicaid will require significant and new policies and practices. Under both Title II of the ADA, and Section 504 of the Rehabilitation Act, a major change such as this triggers a new Self-Evaluation to determine whether the people with disabilities will have an equal opportunity to access and benefit from the programs. Additionally, these laws require states to comply with affirmative obligations such as providing equal opportunity and making reasonable modifications for people with disabilities. Some standard inquiries should include:

- Whether the Medicaid program has additional staff available to help people with disabilities apply for exemptions, and/or apply for reasonable modifications to the requirements.
- Whether the Medicaid program has provided additional training for staff on how to recognize and work with people who have hidden disabilities (such as chronic illnesses, mental health disabilities, or intellectual disabilities).
- Whether the Medicaid program has accessible systems to help remind Medicaid recipients of the new reporting requirements, and re-application requirements. (e.g. text notifications, emails, etc.)

This brief does not detail several other important implementation issues. For example, states should consider strategies for successful outreach, developing accessible and understandable notices regarding how to ask for accommodations as well as how to request administrative hearings, and developing adequate state reporting to understand the full impacts of the new requirement over time.[14] States should also develop reporting criteria to track the impacts of work requirements on Medicaid enrollment, employment, and outcomes for people left uninsured due to the work requirement. Given the past record of Medicaid work requirements at the state level, documenting these outcomes will be critical to evaluate the true effects of this new federal policy.

# Endnotes

[1] *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].
[2] *Id.*
[3] 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/.
[4] Jennifer Tolbert et al., KFF, *Understanding the Intersection of Medicaid and Work: An Update* (2025), https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/.
[5] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V).
[6] Bureau of Labor Statistics, *Persons with a Disability: Labor Force Characteristics – 2024*, 2 (Feb. 25, 2025), https://www.bls.gov/news.release/pdf/disabl.pdf.
[7] *Id.* at 4.
[8] Silvia Bonaccio et al., *The Participation of People with Disabilities in the Workplace across the Employment Cycle: Employer Concerns and Research Evidence* 35 J. BUSINESS AND PSYCHOL. 135 (2020), https://link.springer.com/article/10.1007/s10869-018-9602-5; Sarah Parker Harris et al., Univ. Ill.-Chicago, *Mental Health, Employment, and the ADA* (2019), https://adata.org/research_brief/mental-health-employment-and-ada.
[9] Rebecca Perron, AARP Research, *Age Discrimination Holds Steady among Older Workers in 2025* (Sept. 23, 2025), https://www.aarp.org/pri/topics/work-finances-retirement/employers-workforce/age-discrimination-workplace/.
[10] RAISE Family Caregivers Act, Pub. L. No. 115-119, (Jan. 22, 2018), § 2.
[11] U.S. Senate Committee on Finance, *Finance Committee Title* (Aug. 2025), https://www.finance.senate.gov/imo/media/doc/finance_committee_summary3.pdf.
[12] Arkansas' MAGI-Based Eligibility Verification Plan (Dec. 8, 2017), https://www.medicaid.gov/medicaid/eligibility/downloads/arkansas-verification-plan-template-final.pdf; MaryBeth Musumeci et al., KFF, *Key State Policy Choices about Medical Frailty Determinations for Medicaid Expansion Adults* (June 2019), https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medical-Frailty-Determinations-for-Medicaid-Expansion-Adults.
[13] 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 electronic asset verification in a representative sample of applicants from 2015-2016, it found a 0% error rate).
[14] Civilla, *Human-Centered Work Requirements for Medicaid* (2025), https://civilla.org/assets/files/Civilla-Human-Centered-Work-Requirements-Medicaid-Report.pdf.