Center for Health Care Strategies

Medicaid Work Requirements Implementation Series:

A Summary of Federal Medicaid Work Requirements

The 2025 budget reconciliation bill (H.R. 1, also known as P.L. 119-21) signed into law on July 4, 2025, introduces new work requirements, also referred to as community engagement requirements, for certain Medicaid enrollees. The provision makes continued Medicaid eligibility contingent upon participation in work or other qualifying activities. This policy change has significant implications for Medicaid members, state agencies, health care providers, and managed care organizations.

H.R. 1 mandates that Medicaid members aged 19-64 who are covered through the Affordable Care Act Medicaid expansion or an 1115 demonstration waiver that provides minimum essential coverage must engage in employment, education, a work program, or community service to maintain their Medicaid eligibility.

Medicaid Eligibility in Context

Medicaid, a joint federal and state program, provides health coverage to low-income people, including children, pregnant women, elderly adults, and people with disabilities. Historically, Medicaid eligibility has been based primarily on income and other categorical requirements (such as disability status) without conditions related to employment. While some states have implemented limited work requirements through waiver authorities, the introduction of federal work requirements represents a significant policy shift aimed at integrating employment into Medicaid eligibility criteria.

Below are key points to know about new Medicaid work requirements:

Key Facts

1. Implementation Timeline

Guidance release: On December 8, 2025, the Centers for Medicare & Medicaid Services (CMS) issued initial guidance to states. On June 1, 2026, CMS released additional implementation guidance, providing further definitions and clarifications of the bill text. Following a comment period, these provisions take effect on July 31, 2026.

- **State implementation**: States are required to implement work requirements by January 1, 2027, though they may choose to do so sooner through 1115 waivers. Nebraska became the first state to implement the new work requirements on May 1, 2026. The legislation permits the Health and Human Services (HHS) Secretary to grant extensions until December 31, 2028, for states that can demonstrate a good faith effort to meet the requirements. CMS has indicated that such extensions will only be granted for cases in which extraordinary or unexpected issues hinder implementation.

MEDICAID WORK REQUIREMENTS IMPLEMENTATION SERIES

With new federally mandated work requirements for Medicaid eligibility enacted, states have an opportunity to design strategies that mitigate the risk of unintended disenrollment. This series from the Center for Health Care Strategies (CHCS) offers actionable approaches to support implementation that minimizes administrative burden and is informed by the experiences of Medicaid members. **LEARN MORE**

2. Work Requirements

- **Activities required**:
  - **Demonstrate monthly income of $580** (equivalent to 80 hours at the federal minimum wage). States may allow seasonal workers to demonstrate average income over six months. For individuals with income not meeting the monthly threshold, income may be converted to hours and combined with the below activities; ***OR***
  - **Demonstrate 80 hours per month of one or more of the following activities**:
    - **Work**: Paid work, work in exchange for goods or services, or certain unpaid work (outside of "community service" as defined below).
    - **Participation in a work program**: Certain federally or state recognized employment and training programs.
    - **Enrollment in an educational program**: At least half-time enrollment in an institution of higher education, a career and technical education program, a high school, or a high school equivalency program.
    - **Community service**: Unpaid work for community benefit that takes place within a structured program overseen by a public or nonprofit organization.
    - **A combination of these activities**: Individuals may meet the 80-hour monthly requirement through any combination of the activities listed above.
- **Non-waivable**: The work requirements may not be waived via an 1115 demonstration waiver.

Key Terms Related to Populations Impacted by Work Requirements

H.R. 1 statutory language and subsequent guidance use the following terms for populations subject to or exempt from work requirements:

- **Applicable individual** refers to people subject to work requirements.
- **Mandatory exceptions** and **short-term hardship exceptions** apply to applicable individuals and satisfy compliance with work requirements, as detailed further below.
- **Specified excluded individuals** refers to nine categories of people who are not subject to work requirements, as detailed further below. Specified excluded individuals are not considered "applicable individuals." Work requirements are not a condition of specified excluded individuals' eligibility for Medicaid and states are prohibited from assessing whether these individuals meet work requirements.

Distinctions between the above categories are important as they impact how states must operationalize work requirements verification processes, including the order in which data is assessed to determine exceptions and work requirements compliance. Additionally, different time periods are used for assessing whether individuals are "specified excluded individuals" or have exceptions.

3. Populations

- **Applicable individuals**: Adults enrolled in Medicaid under the Affordable Care Act's Medicaid expansion — which includes nearly all individuals who fall between the state's traditional Medicaid income eligibility threshold and 138 percent of the Federal Poverty Level in states that have adopted the expansion — ***or*** through a waiver program that provides minimum essential coverage, ***and*** who do not qualify for an exception/exclusion (see below). Note, as of July 2025, 41 states have adopted Medicaid expansion, with over 20 million adults currently receiving benefits as part of the expansion population.

- **Exceptions**: Some applicable individuals qualify for exceptions to work requirements. Note that this is different than specified excluded individuals (see "Key Terms" sidebar on the previous page).
  - **Mandatory exceptions** include individuals:
    - Under the age of 19;
    - Entitled to, or enrolled in benefits under Medicare part A, or enrolled in benefits under Medicare part B;
    - Included in mandatory Medicaid eligibility groups, but have since lost their status;
    - Specified excluded individuals; ***AND/OR***
    - Individuals incarcerated in the prior three months.
  - **Short-term hardship exceptions**: States may optionally allow exemptions for certain extenuating circumstances, including individuals receiving care in hospitals, nursing facilities, psychiatric facilities, or other intensive care settings, individuals in a federally declared disaster area, individuals living in counties with unemployment rates higher than eight percent, or 1.5 times the national unemployment rate (pending permission from HHS Secretary), and individuals or their dependents who are required to travel outside their home for medical care for an extended time. States choosing to implement this option must allow exceptions for all short-term hardship categories.

4. Specified Excluded Individuals

As with the above exceptions, specified excluded individuals are not subject to work requirements. See the "Key Terms" box above for an overview of the distinction between exceptions and specified excluded individuals.

- **Former foster care youth**: Individuals under age 26 who were in foster care until they aged out, were enrolled in Medicaid while in foster care, and are not included in a mandatory eligibility group.
- **Indian Health Service members**: Individuals recognized as American Indians or Alaska Natives and eligible for health services through the Indian Health Service.
- **Caregivers**: Defined as "parent, guardian, caretaker relative, or family caregiver of a dependent child 13 years of age and under or a disabled individual." CMS describes caregiving as providing regular assistance within a "significant relationship," as defined through criteria such as co-residence, familial relationship, or at least 80 hours of care per month.
- **Disabled veterans**: Defined as a veteran "with a disability rated as total under Section 1155 of Title 38, United States Code" (section of law that establishes the schedule for rating veterans' disabilities and governs how compensation is determined).
- **Medically frail individuals**: People whose physical, mental, or other behavioral health conditions significantly impair their ability to comply with work requirements. To qualify, individuals must:
  - Meet one of the following five categories: are blind or disabled, have a substance use disorder, a disabling mental disorder, a physical, intellectual, or developmental disability, or have a serious or complex medical condition; ***AND***
  - Demonstrate impaired capacity to meet work requirements.
- **Individuals already subject to work requirements**: Those meeting Temporary Assistance for Needy Families (TANF) work requirements or subject to the Supplemental Nutrition Assistance Program (SNAP) work requirements.

- **Individuals participating in a qualifying substance use disorder (SUD) treatment program**: Defined as SUD programs that meet SNAP-related federal requirements, run by nonprofit organizations or public community mental health centers.
- **Incarcerated**: Individuals who are currently incarcerated.
- **Pregnant and postpartum individuals**: Defined as "pregnant or entitled to postpartum medical assistance under paragraph (5) or (16) of subsection (e)" (the 12-month Medicaid continuous postpartum extension).

Focus on Medical Frailty

The June 2026 guidance defined medical frailty more narrowly than many states and other stakeholders had expected based on H.R. 1's statutory language. Specifically, the rule added the requirement that medically frail individuals must demonstrate impaired ability to conduct work activities, in addition to a qualifying condition. This definition will pose barriers to Medicaid coverage and introduce additional administrative burden for states, individuals, and providers.

In general, it will be up to states to further define both the conditions and the level of severity/impairment that qualify individuals as medically frail. States must develop auditable, justifiable, and regularly updated lists of diagnoses or conditions (e.g., through ICD-10 codes lists) to further define these categories, with the following parameters:

- **Blind or disabled**: Defined in alignment with the Social Security Action section 1614. Note that individuals qualifying for Medicaid through the mandatory Supplemental Security Income (SSI) pathway would not need a medical frailty exclusion as work requirements do not apply to mandatory Medicaid eligibility groups.
- **SUD**: Excludes individuals in recovery for five or more years.
- **Disabling mental disorder**: No further CMS definition.
- **Individuals with physical, intellectual, or developmental disability**: Inclusion is limited to impairments impacting Activities of Daily Living (does not count impairment to Instrumental Activities of Daily Living).
- **Serious or complex medical condition**: May include conditions that are life threatening, seriously disabling, cause significant pain or discomfort, require major effort to manage, are associated with severe consequences to the individual or negative impacts on others, affect multiple organ systems, require treatment with risk of serious complications, or require lifestyle adjustment.

To identify people who are medically frail, diagnosis data alone is insufficient but may be used in combination with additional data (e.g., service utilization data or provider documentation) to indicate condition severity/functional impairment. States cannot use claims or encounter data older than 12 months to identify medical frailty. The June 2026 rule leaves uncertainty around what level of documentation or criteria is sufficient to demonstrate impaired capacity to meet work requirements.

5. Outreach

- **Initial outreach**: State Medicaid agencies are required to conduct member outreach between June 30 and August 31, 2026, through regular mail (or, if elected by an individual, an electronic format) and one or more additional forms, such as by telephone, text message, website, and "other commonly available electronic means." Outreach is required to contain information on work requirement compliance, an explanation of exemptions, consequences of non-compliance, and reporting instructions.
- **Periodic outreach**: States are also required to conduct outreach to impacted members on a periodic basis, such as following a determination or redetermination of eligibility, occurrence or end of a relevant short-term hardship event, and following the loss of a beneficiary's specified excluded individual status.

6. Verification Process

- **Look-back period**: At application, states must perform a "look-back" review to determine whether a Medicaid member met the work requirement in a period of at least one and up to three months before their application. States must also verify that current enrollees meet the requirements for at least one month within each six-month eligibility review period. Note that while work activities and exceptions are assessed during these look-back periods, specified excluded individual status is assessed over a different time frame (at the time of application or renewal).
- **Data matching**: States are required to use available data, such as payroll data, or Medicaid payment and encounter data, to verify compliance before requesting additional information from applicants.
- **Self-attestation**: The June 2026 rule limits use of self-attestation for verifying work requirement activities or exclusions to 2027. Beginning Jan. 1, 2028, when reliable data is not available to the state (e.g. case records, claims data, other state and federal data sources, etc.), states must generally require documentation to verify work requirements or exclusions, when documentation is reasonably available. There are some exceptions to this broader rule, including for medically frail individuals (self-attestation may be used once during an enrollment period) and mandatory exceptions.

7. Consequences for Non-Compliance

- **Notice of non-compliance**: States must issue a notice of non-compliance (via mail and at least one other form of contact) to the Medicaid member or applicant if verification fails. During Medicaid renewal, this may be sent alongside or after issuance of a renewal form.
- **Disenrollment**: After receiving a notice of non-compliance, members have 30 days to show compliance before disenrollment.

8. Impact Estimates

- **Medicaid spending**: The Congressional Budget Office estimates that the implementation of work requirements will reduce Medicaid spending by $344 billion over 10 years.
- **Coverage loss**: The Congressional Budget Office estimates that 11.8 million people will lose Medicaid coverage due to H.R. 1 in the next 10 years. 4.8 million of those will be due to the implementation of work requirements.

Note: these estimates were developed prior to the June 2026 rule that included a narrower definition of medical frailty (see "Focus on Medical Frailty," previous page) and may underestimate the impact of work requirements.

9. Funding

- **Implementation funding**: The bill appropriates $200 million to CMS in FY26 and instructs HHS to distribute an additional $200 million to states ($100 million of which is distributed equally among 50 states, and $100 million of which is distributed based on states' Medicaid population size) as implementation funding in FY26.

Why Does This Matter?

The introduction of work requirements in Medicaid represents a significant policy shift with wide-ranging implications. State Medicaid agencies have a major implementation task ahead, with limited funding and a short window of time in which to accomplish it. In addition to the baseline challenge of H.R. 1 implementation, the June 2026 guidance included a narrower definition of medical frailty and less flexibility for use of self-attestation for work requirement compliance than many stakeholders expected, further complicating implementation. States will need to rapidly develop systems for verifying eligibility and compliance, tracking hours, managing exemptions, and addressing potential administrative challenges in an effective, timely manner.

For Medicaid members, these requirements will mean additional administrative hurdles to acquiring and maintaining coverage, particularly for those already facing barriers to employment. Payers and health care providers will also see changes in enrollment patterns and increased administrative costs. Understanding the implications of these requirements is crucial for policymakers and stakeholders as they navigate the balance between meeting federal requirements and ensuring access to essential health services for people eligible for Medicaid in their states.

What's Next?

Following the June 2026 guidance, states face the task of finalizing H.R. 1 policies and implementation approaches. As states begin sending outreach notices and implementing work requirements, there will be much to learn about what implementation strategies best support members, approaches states are taking to overcome implementation challenges, and the ultimate impact of broad work requirements on Medicaid enrollment. Regardless of the specific approach, implementing Medicaid work requirements is expected to be a significant administrative undertaking for states — one that will require cross-sector coordination and clear, consistent engagement with Medicaid members to ensure responsive and effective implementation.

Learn More

- **H.R. 1 - Full Text**, July 4, 2025.
- **H.R. 1 SEC. 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals** *(excerpted Medicaid work requirements provision of H.R. 1)*, July 4, 2025.
- **December 2025 CMCS Informational Bulletin** (*additional guidance*), December 8, 2025.
- **June 2026 Interim Final Rule: Medicaid Program; Community Engagement Requirement for Certain Individuals** *(additional guidance),* June 3, 2026.
- ***A Closer Look at the Medicaid Work Requirement Provisions in the "Big Beautiful Bill,"*** KFF, June 20, 2025.
- ***What Health Care Provisions of the One Big Beautiful Bill Act Mean for States***, National Academy for State Health Policy, July 8, 2025.
- **New CMS Interim Final Rule on Medicaid Work Reporting Requirements.** State Health and Value Strategies, Webinar, June 9, 2026.

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