February 2026

# Medicaid Work Requirements are Now Law

## What You Need to Know about Implementation


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# Introduction

For years, the evidence we have analyzed on Medicaid work requirements has been consistent: they function as administrative obstacles that reduce coverage without increasing employment. That debate is now settled by law. The One Big Beautiful Bill Act (H.R. 1), signed July 4, 2025, established the first federally mandated Medicaid work requirements in the program's 60-year history; a fundamental shift in a program whose sole statutory purpose has always been to provide health insurance to people with low incomes.

The policy question has changed. It is no longer a question of whether work requirements should exist, but of how they will be implemented. The decisions states make in the coming months will determine whether millions of eligible individuals lose coverage due to procedural failures, or whether policymakers take every available step to minimize that harm. This brief is written with that goal in mind.

## What the Law Requires

H.R. 1 requires adults ages 19 - 64 enrolled in Medicaid expansion – or in Section 1115 waiver coverage that functions like expansion – to demonstrate at least 80 hours per month of qualifying activity (employment, job training program, community service, education, or a combination) to maintain health insurance coverage. The requirement applies across the 41 states (including Washington, D.C.) that have adopted Medicaid expansion, affecting more than 20 million adults.

States must implement these requirements by Jan. 1, 2027, with an option to act earlier via an 1115 waiver or a Centers for Medicare & Medicaid Services (CMS)-approved state plan amendment. States demonstrating good-faith effort may request a deadline extension (from the Department of Health and Human Services) limited to Dec. 31, 2028. Beginning Dec. 31, 2026, states must also shift from annual to semi-annual eligibility redeterminations for their Medicaid expansion population – meaning the same individuals subject to new work requirements will face twice-yearly eligibility reviews, compounding the risk of procedural coverage loss due to burdensome administrative requirements.

One consequence of this law cannot be overstated. Individuals who lose Medicaid coverage for failing to meet or report work requirements are also barred from receiving Affordable Care Act (ACA) Marketplace premium tax credits. Because they remain classified as Medicaid-eligible for Marketplace purposes even after disenrollment, they cannot access subsidized exchange coverage. There is no safety valve. Loss of coverage under these provisions creates a complete gap in affordable health insurance, with no alternatives.

The Congressional Budget Office (CBO) estimates that H.R. 1's work requirements will reduce Medicaid spending by $326 billion over ten years. CBO's earlier analysis of the House-passed version projected that 4.8 million people would become uninsured specifically due to work requirements; updated coverage estimates for the enacted law have not been published to date.

These statistics underscore the anticipated human impact of the law. Meanwhile, federal implementation efforts have focused on addressing logistical and technological challenges facing states.

Implementation presents a significant IT undertaking. State Medicaid systems were not designed to pull and track data from the disparate sources required to verify compliance with work, training, education, and community service activities. States have estimated it would cost between $3 million and $10 million to build the necessary eligibility determination systems, and the law allocates only $200 million in federal grants to help – an amount states say will fall well short of actual costs.

In response, CMS announced that ten leading technology vendors – Accenture, Acentra Health, Conduent, GDIT, Deloitte, Gainwell, Maximus, Curam by Merative, Optum, and RedMane – have voluntarily pledged more than $600 million in free and discounted services to support the rollout. All ten companies already hold Medicaid eligibility and enrollment contracts with states.

The agency is also developing an open-source tool, EMMY, that states can use as an alternative to participating vendors, and is working with the General Services Administration (GSA) to streamline technology procurement. Critics have noted that the $600 million figure reflects potential discounts on services the vendors would have charged for anyway, and that the arrangement largely benefits incumbent contractors already embedded in state Medicaid operations.

## What CMS Guidance Says, and Doesn't Say

The law requires HHS to issue implementation guidance to states by June 1, 2026, including definitions and clarifications of statutory terms. CMS got an early start: on Dec. 8, 2025, it issued its first Informational Bulletin on what it calls "community engagement requirements," framed around four principles: centering the connection between health and communities; balancing state flexibility with potential costs; aligning policies with existing requirements across Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and the insurance Marketplace; and ensuring that states' determinations and verifications are easily auditable.

The December guidance confirms several key operational elements. States must conduct outreach to affected enrollees between June 30 and August 31, 2026, through both regular mail and at least one additional method, explaining the work requirements, available exemptions, consequences of noncompliance, and reporting instructions. Before requesting documentation, states must first attempt to verify compliance using existing data sources such as payroll records, Medicaid encounter data, and educational enrollment information. If verification through data fails, individuals must receive a notice of noncompliance and have 30 calendar days to demonstrate compliance or qualify for an exemption – with coverage continuing throughout that 30-day window.

The guidance also clarifies that managed care organizations may not determine compliance with work requirements, though CMS suggests they could support outreach and help enrollees submit documentation, drawing on managed care organization (MCO) participation during the pandemic-era Medicaid unwinding.

At the time of application, states must perform a look-back review covering at least one and up to three months prior. For current enrollees, states must verify compliance for at least one month within each six-month eligibility review period. States may verify more frequently, but may not dictate which specific months count: meeting the requirements for the required number of months during any portion of the eligibility period is sufficient.

What the guidance does not address is, in many ways, more consequential for implementation planning than what it does. Georgetown University's Center for Children and Families characterized the bulletin as leaving states "hanging," while State Health & Value Strategies noted it "remains high-level and stops short of addressing the many operational questions states must resolve."

## *Critical Gaps*

The guidance does not define key statutory terms: what constitutes a "serious or complex medical condition," what qualifies someone as "medically frail," or how broadly to interpret the RAISE Family Caregiver Act's definition of "family caregiver." These definitions will determine who is exempt and who is not. Without federal clarity, states are likely to interpret these terms inconsistently, and in some cases, far too narrowly.

The guidance does not resolve how states should verify exemptions. This matters because the statute allows states to self-attest for mandatory exemptions, but CMS' December 2025 bulletin emphasizes a data-first approach (using payroll records, Medicaid claims, encounter data, and educational enrollment records) without addressing whether self-attestation is permissible. If it is not, proving an exemption becomes significantly harder, particularly for unpaid caregivers who are invisible in claims data and for people with frail medical conditions whose diagnoses may not yet appear in Medicaid records, especially if they were previously uninsured or their conditions are not captured in standard encounter data.

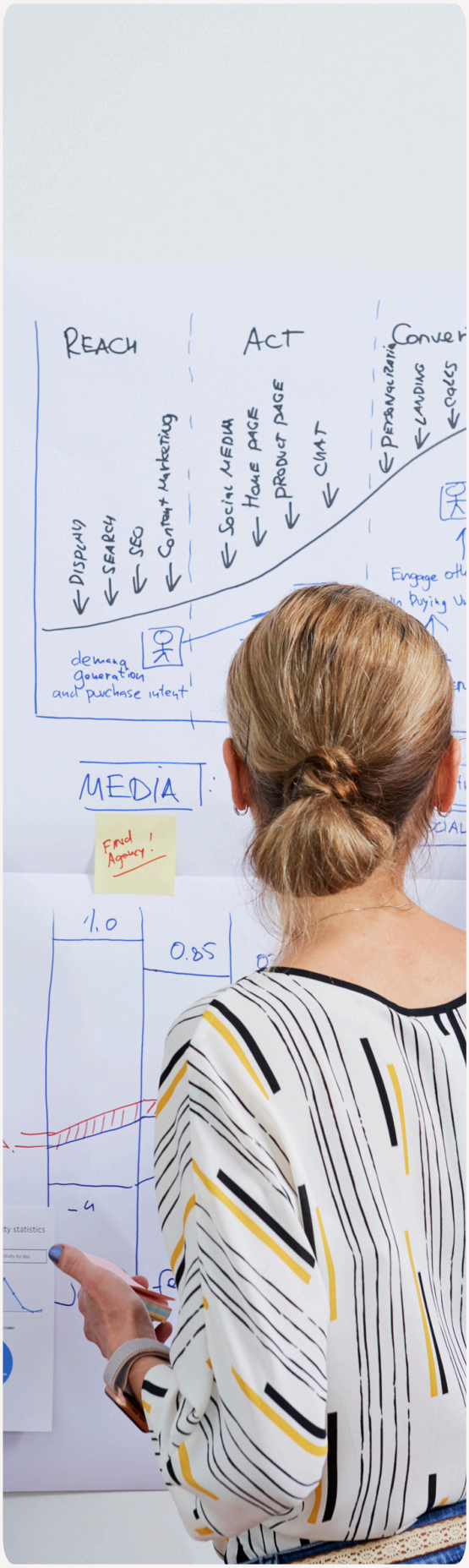
The guidance does not address how work requirements interact with the six-month redetermination cycle in operational terms, nor does it clarify the MCO's role beyond excluding individuals from compliance determinations. CMS has indicated that an interim final rule is under development, expected by June 2026 (the statutory deadline), with additional guidance to follow on verification, the role of MCOs, and other implementation specifics.

That timeline creates its own problem. If the interim final rule arrives in June 2026 and the implementation deadline is Jan. 1, 2027, states will have roughly seven months to translate regulatory guidance into eligibility business rules, build or modify IT systems for verification and compliance tracking, establish new data-matching processes across Medicaid, SNAP, TANF, and workforce agencies, hire and train eligibility staff, and conduct the required enrollee outreach – all while simultaneously preparing to implement six-month redeterminations for expansion adults, which take effect on the same date. A KFF survey found that many state Medicaid officials expect to proceed on multiple parallel tracks before clear federal guidance is available, increasing costs and the risk of errors.

Several states are already engaged in multi-year IT modernization projects, complicating additional system redesigns under a compressed timeline. State Health & Value Strategies has warned that the timeline "would be unrealistic for states to achieve for even smaller projects," and that states implementing by Jan. 1, 2027, face "significant risk" of coverage loss for eligible individuals and substantial fiscal penalties under the federal Payment Error Rate Measurement (PERM) program. Given these constraints, many states are expected to seek good-faith extensions, though CMS has signaled that approvals will be limited to states experiencing severe or unexpected barriers, and the formal process for requesting and evaluating extensions has not yet been established.

For organizations planning now, the federal regulatory landscape remains unsettled. States are being asked to build systems, train staff, and design enrollment processes for a program whose operational rules are still being written. CMS has made $200 million in implementation funding available, half distributed equally among all states and Washington, D.C., (approximately $1.96 million per state), half proportional to expansion enrollment.

To put that in context: a 2019 Government Accountability Office (GAO) review of the first five states with approved work requirement waivers found administrative cost estimates ranging from $6.1 million in New Hampshire to $271.6 million in Kentucky. Arkansas spent $26.1 million to implement a work requirement covering roughly 60,000 enrollees that lasted only nine months. Georgia has spent $54.2 million in administrative costs alone on its Pathways program – more than double its actual health care spending – while enrolling fewer than 10,000 of the nearly 250,000 people eligible. The $200 million appropriated under H.R. 1 does not approach what even a single large state spent under far more limited waiver programs, and it does not cover ongoing operational costs – staffing, interagency data agreements, and enrollee outreach – that recur every six months.




## Who is Protected, and Who Must Prove it

The law creates three tiers of protection: categorical exclusions, individual exemptions, and short-term hardship exceptions. Organizations working with affected populations need to understand all three:

**Categorical exclusions** apply automatically to groups whose Medicaid eligibility is not based on expansion: people aged 65 and older, those dually eligible for Medicare and Medicaid, individuals enrolled through aged, blind, or disabled pathways, and pregnant or postpartum individuals.

**Individual exemptions** apply within the expansion population, but, unlike categorical exclusions, must be verified. Exempt groups include: 1) people who are "medically frail" (those with substance use disorders, disabling mental disorders, physical or intellectual disabilities affecting daily living, or "serious or complex medical conditions" – a standalone category requiring no disability determination); 2) family caregivers under the RAISE Family Caregiver Act, which explicitly covers care for older adults, not just children; 3) former foster youth under age 26; 4) American Indians and Alaska Natives; 5) disabled veterans with a total disability rating; 6) people meeting SNAP or TANF work requirements; 7) individuals actively participating in a qualifying SUD treatment program (this is a distinct, program-participation-based exemption – separate from the medically frail category, which covers SUD as a disabling condition; a person in treatment need not meet the medically frail standard to qualify here); and 8) those currently or recently incarcerated (within three months of release).

**Short-term hardship exceptions** constitute a third, distinct category – temporary, state-adopted, and not automatic. States may exempt individuals who are 1) hospitalized or in intensive care settings; 2) located in a federally declared disaster area; 3) living in counties with unemployment rates above 8 percent or 1.5 times the national average (currently about 6.6 percent); or 4) traveling for extended medical care. These are optional: states that decline to adopt them leave affected individuals unprotected.

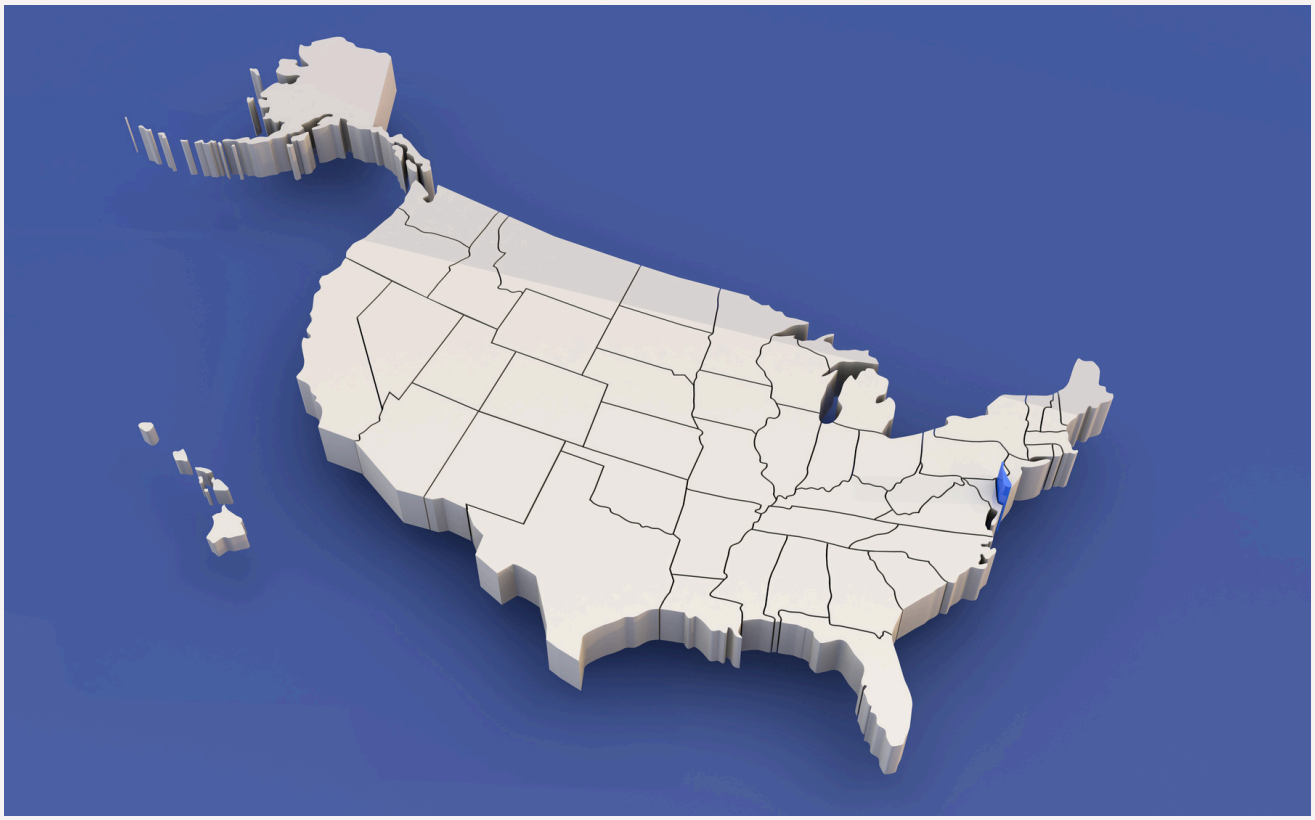
**Why definitions matter.** The practical impact of the three categories will depend largely on how states and CMS resolve several open definitional questions. "Serious or complex medical condition" appears nowhere in the statute or in CMS's December 2025 guidance; Health Affairs has published an important analysis on the stakes of getting that definition right. The scope of the caregiver exemption – whether states honor the full RAISE Act definition or narrow it to parent-child relationships – is already being contested. The verification question raised earlier applies with particular force here: many exempt individuals, especially unpaid caregivers and those with undocumented medical conditions, cannot produce the proof that data systems do not capture.

## Where States Have Discretion

Federal law sets the floor, but states' decisions right now will determine how many people lose coverage. They choose their compliance look-back period (1 to 3 months), reporting frequency (at least every 6 months, potentially monthly), whether to adopt hardship exceptions, and whether to implement them before the January 2027 deadline.

These are not abstract policy choices. Arkansas showed what's at stake: 18,000 eligible people lost coverage not because they failed to meet requirements, but because of reporting confusion and system failures. Georgia's Pathways program reinforced the same pattern through steep administrative costs and chronic enrollment shortfalls.

Implementation concerns are widespread. Washington State's Health Care Authority anticipates 620,000 Apple Health enrollees will be affected and is seeking an extension. North Carolina, which only expanded Medicaid in December 2023, has called H.R. 1 "one of the most significant unfunded mandates" in generations. Connecticut estimates 100,000 to 200,000 HUSKY enrollees could lose coverage, and has acknowledged that no state has yet achieved seamless implementation of work requirements.



## State Spotlight: Nebraska Goes First

Nebraska is the first state in the nation to implement federal Medicaid work requirements, with enforcement beginning May 1, 2026 – eight months ahead of the Jan. 1, 2027 federal deadline. Governor Jim Pillen announced the accelerated timeline in December 2025, joined by CMS Administrator Dr. Mehmet Oz. Nebraska is proceeding through a state plan amendment rather than an 1115 waiver, meaning it must align fully with federal statutory requirements. The state estimates approximately 72,000 expansion enrollees could be affected, though roughly 65% of those already work 80 or more hours per month or are enrolled in school, according to KFF analysis. The state initially projected 30,000 people could lose coverage – a figure critics immediately flagged as evidence that Nebraska is not prepared to administer the requirements without significant procedural error rates.

**What Nebraska has decided.** In its Jan. 15, 2026, Medicaid Advisory Committee meeting – the first public window into any state's implementation planning – Nebraska officials disclosed several key operational choices. The state has selected a minimum one-month look-back period for both applicants and renewals, which is the least burdensome option available and the least likely to result in procedural terminations. Compliance verification will rely on existing data sources first; if the state cannot verify compliance through available data, individuals will be contacted and given an opportunity to submit documentation. Nebraska Medicaid will accept pay stubs, school transcripts, and documentation of volunteer or work program hours. Individuals who earn at least $580 per month – equivalent to 80 hours at the current federal minimum wage – will be deemed compliant without an hour-by-hour accounting. Seasonal workers may use average monthly earnings over a six-month period to demonstrate compliance.

**Exemptions and hardship exceptions.** Nebraska has adopted all of the mandatory individual exemption categories required by H.R. 1, including: pregnant women; people receiving Medicare Part A or B; medically frail individuals; foster youth up to age 25; American Indian and Alaska Native tribal members; disabled veterans with total disability status; individuals meeting SNAP or TANF work requirements; those participating in substance use disorder treatment; and individuals currently or recently incarcerated (within three months of release). The state's public-facing materials also exempt caregivers of disabled individuals, as well as parents or caregivers of children up to age 13. On hardship exceptions, Nebraska has adopted the hospitalization exception and the extended medical travel exception.

It has also adopted the high-unemployment county exception. Critically, the state is still working with CMS on details of the medically frail determination – the definition of "serious or complex medical condition" remains unresolved at the federal level, meaning Nebraska must apply that exemption category without settled guidance on who qualifies.

**Staffing and systems.** State officials confirmed at the January MAC meeting that Nebraska does not plan to hire additional staff to implement work requirements or any other eligibility changes required by H.R. 1. Existing DHHS eligibility staff and the Department of Labor will manage verification, redeterminations, and outreach. CMS staff traveled to Nebraska in January 2026 to assist with implementation planning, and the state continues to work with the agency as federal guidance develops. As of January 2026, Nebraska was still running models to determine how many enrollees could be identified as compliant or exempt using currently available data – meaning the ex parte verification infrastructure was not yet fully operational, with fewer than four months until the May 1 enforcement date.

**Outreach**. Nebraska began outreach earlier than federally required. By Jan. 1, 2026, DHHS mailed notices to all Medicaid expansion enrollees and sent electronic notifications to those who had opted in to receive email or text notifications. The state also launched a dedicated webpage on work requirements and an FAQ document in English and Spanish. Under Nebraska's one-month look-back approach, current enrollees will be assessed for compliance at their next regularly scheduled renewal after May 1; new applicants on or after May 1 must demonstrate compliance at the time of application.

**Why this matters beyond Nebraska.** Nebraska's experience will be the first real-world test of the choices described throughout this brief – and one conducted without the interim final rule, without fully operational verification systems, and without additional staff. Advocacy organizations, providers, and community groups in Nebraska and nationwide should closely monitor outcomes. Nebraska is making some protective choices (one-month look-back, data-first verification) while leaving critical questions unresolved (medically frail definition, ex parte system readiness). Whether eligible people lose coverage will depend on how well the state's outreach reaches affected enrollees, how effectively its data systems identify exempt individuals before contacting them, and whether the state corrects errors quickly when they occur. Nebraska's rollout is, in effect, the national early warning system for everything that can go wrong – and everything that can go right.

## What is Going Wrong

Even before implementation begins, concerning patterns are emerging. Some states are applying Social Security Administration disability standards to the "medically frail" definition, despite broader statutory language. Others are narrowing the caregiver exemption to parent-child relationships, ignoring the explicit inclusion of caregivers of older adults. The "serious or complex medical condition" category – a freestanding exemption – is being folded into other disability-based categories, limiting eligibility.

Existing data systems pose similar risks. Federal law requires automated (ex parte) verification, which could reduce enrollee administrative burdens if done well. But if states use payroll data to disprove exemptions rather than identify people who qualify – or rely solely on Medicaid claims data with the data gaps described above – automated systems will generate the same procedural terminations that stripped coverage from eligible Arkansans.

## What You Should be Doing Now

**Healthcare providers** should begin identifying patients enrolled through Medicaid expansion who may be subject to work requirements. Build clinical documentation workflows for medically frail determinations, substance use disorder treatment, and caregiver status, and "serious or complex medical condition" exemptions – the last of which remains undefined, so document broadly. Prepare to issue verification letters before the mandatory state outreach period begins in mid-2026, and designate staff to manage patient exemption documentation requests.

**Human services providers** should map their client populations against the full set of exemption categories. Many of the people you serve will qualify for exemptions they do not know exist. Prepare to assist with caregiver, foster youth, incarceration-related, and other exemption documentation, and track whether your state honors the full RAISE Family Caregiver Act definition or narrows it to parent-child relationships. Build referral pathways to legal assistance for clients whose exemptions are denied. Engage directly in your state's implementation planning process – your knowledge of how these requirements affect real people is exactly what state agencies need before they finalize their approach.

**State and local government** officials face discretionary choices that carry direct coverage implications. To minimize harm: choose the shortest look-back period (one month), verifying compliance no more frequently than every six months,

adopt all hardship exceptions, and invest in ex parte verification systems that identify both compliance and exemptions before contacting enrollees.

Fund outreach adequately and build interagency data-sharing agreements now. The mandatory outreach window opens in mid-2026 – states that are not ready will repeat Arkansas's procedural coverage losses.

**Foundations/philanthropy** should recognize that federal implementation funding is wholly inadequate to cover state and community needs – as the historical cost comparisons above make plain. Fund the gap: community education on requirements and exemption options; navigator capacity for exemption documentation; legal services for wrongful denials; and community-based organizations' capacity to bridge affected populations and state systems. Build rapid-response grant mechanisms for organizations that will be first to see coverage losses, and fund independent monitoring of implementation outcomes – coverage data should not depend solely on the states administering these requirements.

**Advocacy organizations** have a window to shape state implementation that is open now and won't stay open long. Push for the broadest defensible definitions of medically frail, family caregiver, and serious or complex medical condition. Monitor for the narrowing patterns described above and challenge them as they emerge. That work is already underway: in February 2026, a coalition led by the Legal Action Center – including the American Association on Health and Disability and the Lakeshore Foundation – submitted formal comments to CMS pressing for clear, protective definitions of the SUD and mental health exemptions under the medically frail category. This is exactly the kind of engagement that can shape how the interim final rule resolves the definitional questions states are already getting wrong. When the Interim Final Rule is published, expected in mid-2026, engage in the federal comment process and mobilize your networks to do the same.

The federal law is set. But outcomes hinge on decisions made at every level, from state capitols to clinic front desks, and on whether community organizations closest to affected communities are involved when those decisions are made.

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