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Implementing Medicaid Work Requirements: A Guide for States

An implementation-focused perspective on new rules introduced by H.R. 1

August 2025

The passage of H.R. 1 places new community participation requirements (also called “work requirements”) on Medicaid participants, and requires state Medicaid agencies to implement new system changes in order to support and verify recipients’ compliance. While much is still unclear about where regulations and guidance will steer final implementation of these requirements, the spirit of this explainer is to help reduce harm to eligible clients and support states in early planning for January 2027. This explainer lays out the new requirements from an implementation-oriented perspective.

Disclaimer

Consult with your policy team before any implementation of public benefit systems. This explainer is not legal advice, nor is it guaranteed to be valid and correct in every context and situation.

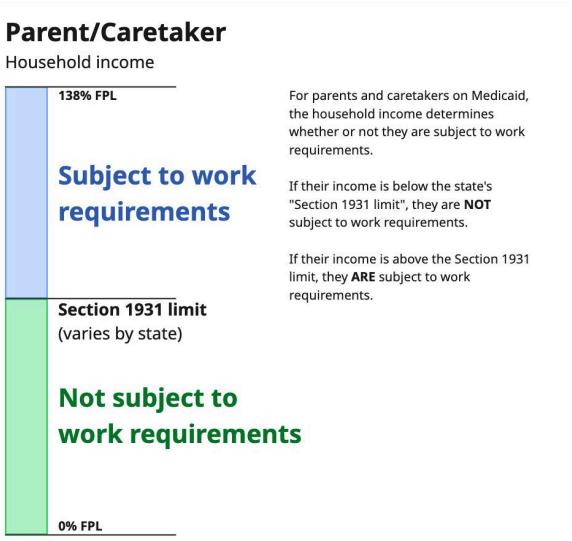
⚠️ Individual Eligibility ⚠️

It’s important to remember that when evaluating a client for work requirement compliance, the person should be evaluated **as an individual.**[1] Even though their compliance may be dependent on their household circumstances, a person is compliant (or not) **as an individual, not a household.**

Applicable individuals

The legislation specifies that the new **work requirements apply only to the expansion adult population**—adults who are between the ages of 19 and 64, not pregnant, blind, or disabled, and not eligible for any other Medicaid group (also called “Group 8”).[2]

If someone falls into any other eligibility category, they are not an “applicable individual,” and **work requirements don’t apply to them**. These individuals are **automatically excluded** from work requirements; nothing further needs to be done to determine if they satisfy the new rules.



Policy detail: Parents and caretakers

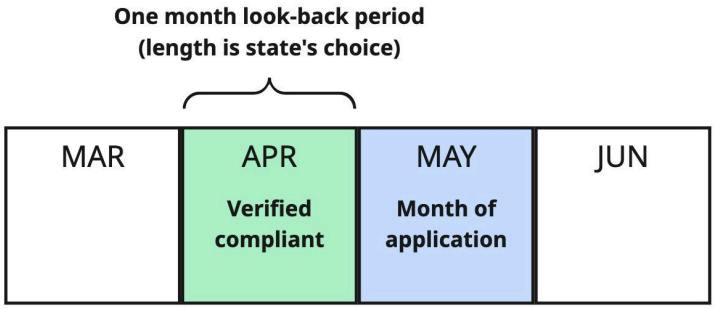
In expansion states, parents and caretakers are eligible for Medicaid up to 138% of the Federal Poverty Level (FPL). However, their income determines if they are eligible under the “expansion” adult population or the “pre-expansion” parent/caretaker population, also called the “Section 1931 limit.”

Each state has a different Section 1931 limit.

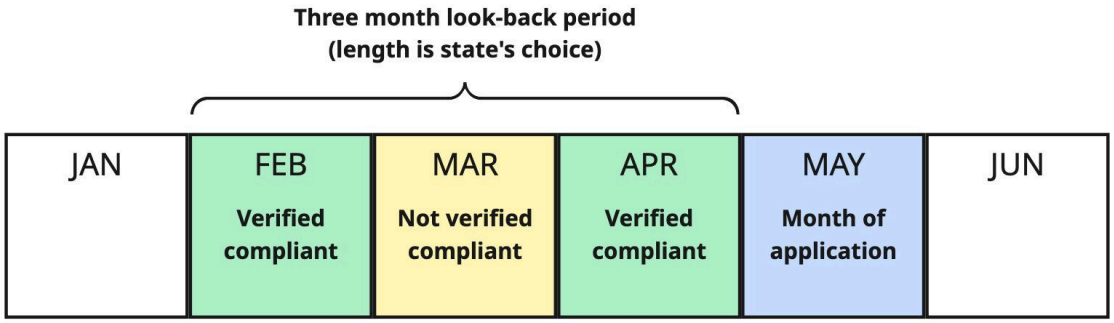
If the parent/caretaker's income is below the Section 1931 limit, they **are not** subject to work requirements. If their income is above the limit (and below 138% FPL), they **are** subject to work requirements. Depending on the age or disability status of the child/individual under care, the parent may be **exempt** for one or more months (see Step 2 below: Screening for exemptions).

The application/renewal look-back

Unlike SNAP Able-Bodied Adult Without Dependents (ABAWD) rules (which look forward), the new Medicaid rules look *backward*. This means an applicant (or a participant who is renewing) must be compliant with the new rules for **one to three months** immediately prior to their application.[3]



In this example, the applicant applies in May. The state has a one month look-back, so they verify April only. The client was verified compliant in April, so they are compliant with the requirements.



In this example, the applicant applies in May. The state has a three-month look-back, so they verify February, March, and April. The client was not verified compliant in March, so they are not compliant with the requirement.

📃 State policy option: Look-back period length 📃

States have the option to determine the length of the look-back period. This period must be greater than or equal to one month, and less than or equal to three months, but **must immediately precede the application month.** Extending the look-back period may incur additional administrative costs as more interfaces will need to be queried and additional evidence will need to be verified.

Upon renewal, a similar look-back period is used to check compliance.[4] However, these months **do not have to be immediately preceding** the renewal month; they can be any months between the last certification and current certification. It's likely that regulation and guidance will provide additional clarity on how to choose the look-back months on renewal.

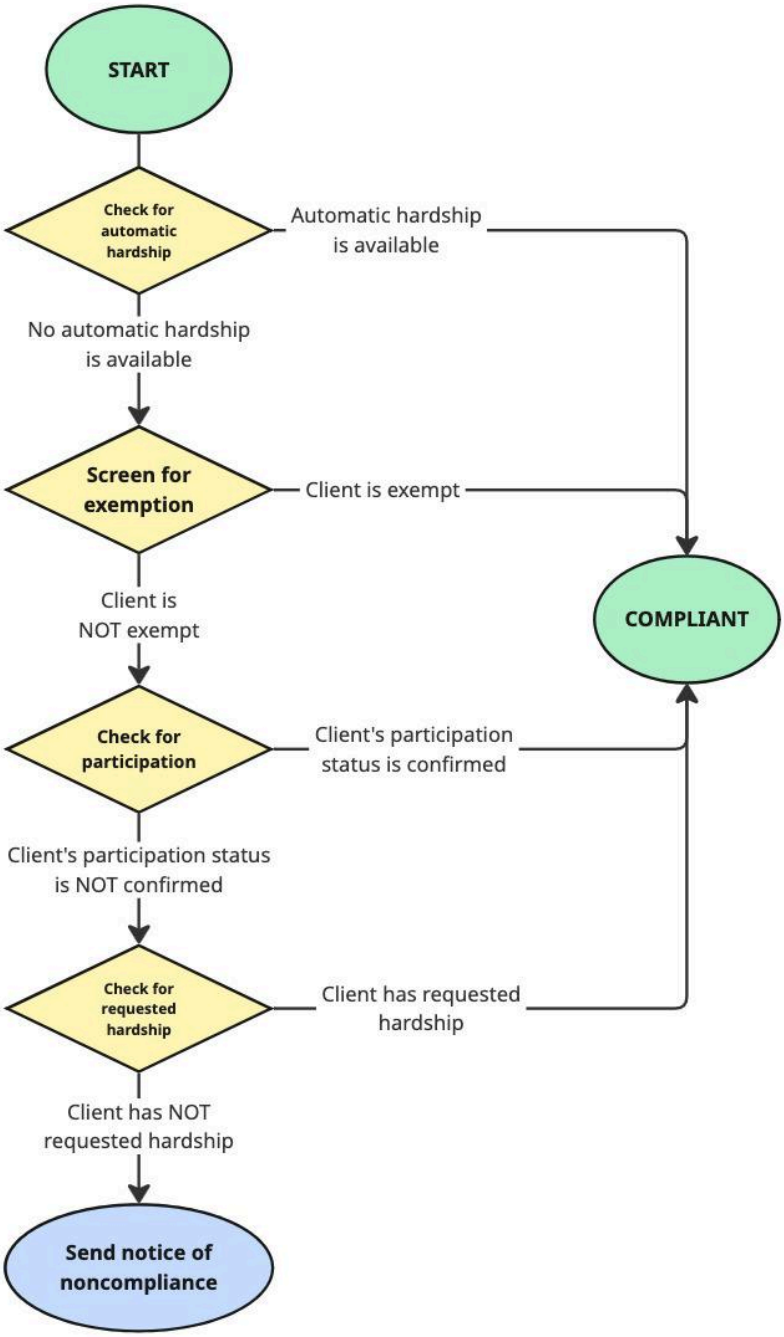
Finally, states have the option to verify compliance **more frequently** between renewals.[5] The frequency is up to the state, but verification is **required** at application and renewal.

A four-step compliance flow

The new legislation describes three components for determining someone's compliance status for the purposes of Medicaid work requirement eligibility. What follows is an **interpretation** of how these components could be most effectively implemented. These steps will be broken down and detailed in following sections.

1. **Check for automatic hardship—**At state option and the Centers for Medicare & Medicaid Services (CMS) approval, certain circumstances make clients *automatically* compliant. If the state elects this option and obtains the applicable CMS approval, then any clients subject to work requirements in the given month are automatically compliant.
2. **Screen for exemption—**Certain exemption statuses (veteran disability rating or substance use disorders, for example) can change over time. Any time eligibility is re-determined, a person should be automatically screened for exemption statuses and manually screened if automatic screening fails.
3. **Check for participation—**If a person is **not** exempt from the requirements, the agency should determine their compliance with the participation requirements laid out in statute. If they are meeting the requirements through at least one activity or a combination of activities, they are compliant.
4. **Check for requested hardship—**At state option, if a person is **not** exempt and their participation status **cannot** be determined, they can request a short-term hardship exception. If a client has a qualifying hardship and they have requested it, they are considered compliant with the requirements.

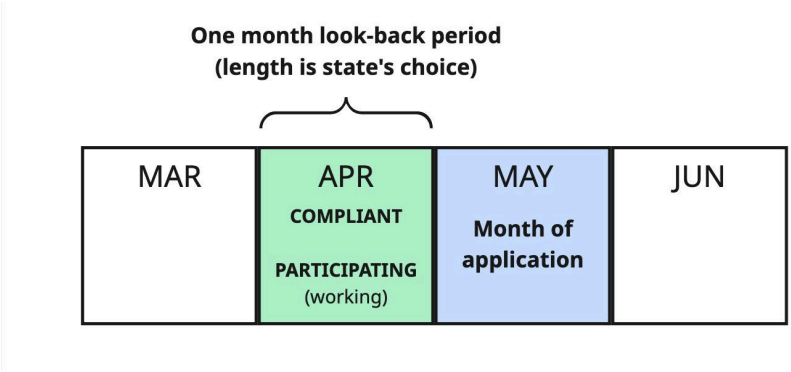
Medicaid community-engagement compliance flow: high-level overview



Evaluating each month

The described steps should be followed *for each month the state is evaluating*! For example, an applicant could be exempt one month, participating the second month, and experiencing hardship the third month—**this would be compliant**.

Example 1: Full compliance (one month look-back)

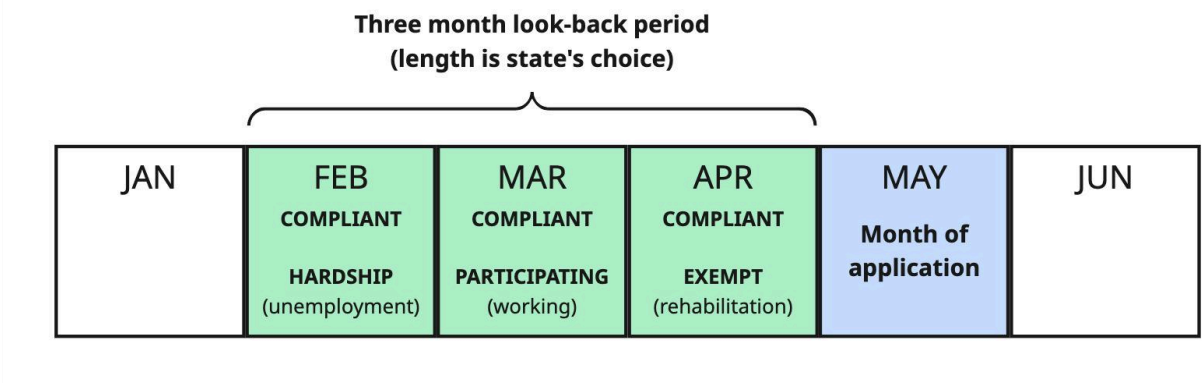


In the above example, the client was compliant for the one-month look-back period:

- In April, they worked 80 hours per month. They are compliant under **participation requirements**.

The client applies in May. Because they were compliant for the one month in the look-back period this state has elected, they are **compliant with the work requirements** and eligible (pending other eligibility factors).

Example 2: Full compliance (three-month look-back)

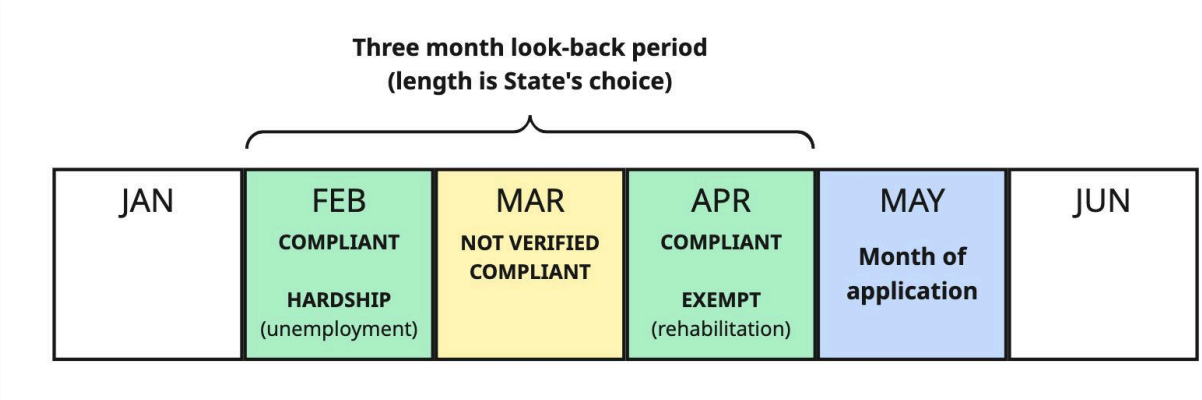


In the above example, the client was compliant for all three months:

- In February, the unemployment rate was over 8% in their county, and their state had an approval from CMS. They are compliant under **short-term hardship**.
- In March, they worked 80 hours per month. They are compliant under **participation requirements**.
- In April, they entered a rehabilitation program. They are compliant under **an exemption**.

The client applies in May. Because they were compliant for all three months in the look-back period this state has elected, they are **compliant with the work requirements** and eligible (pending other eligibility factors).

Example 3: Non-compliance



In the above example, the client was **NOT** compliant for all three months:

- In February, the unemployment rate was over 8% in their county, and their state had a waiver from CMS. They are compliant under **short-term hardship**.
- In March, they did not meet any exemptions, were not participating in covered activities, and were not experiencing hardship. They are **not verified compliant** for this month.
- In April, they entered a rehabilitation program. They are compliant under **an exemption**.

The client applies in May. Because they were not verified compliant for all three months in the look-back period, the state cannot determine them eligible at this time. The state, at this point, **must send a letter of noncompliance** (see below) before denying the application.

Step 1: Check for automatic hardship

States have the *option* of allowing for "short-term hardship." Under this option, a client can be considered compliant for a month if their county meets certain circumstances that may have prevented them from participating. As a first step, the state should check for automatic hardship—if these circumstances apply, **all clients subject to work requirements in the given month are considered compliant**.

Unemployment hardship requires a state request to CMS in order to utilize.

Type of hardship	Requires state request to CMS?
County emergency or disaster	No
County unemployment rate ≥ 8%	Yes
County unemployment rate ≥ (1.5x national unemployment rate)	Yes

❓ Policy unknown: Unemployment hardship requests ❓

Hardship can be automatically granted if an individual's county experiences unemployment that is greater than or equal to 8% or 1.5x the national unemployment rate. These can only be granted, however, **upon request of the state to CMS**. It's currently unclear what information CMS will require in order to consider and/or approve hardship due to unemployment.

Step 2: Screening for exemptions

Whenever eligibility is re-determined, a client should be screened for **all possible exemptions**. H.R. 1 allows states to choose to accept clients' statements about characteristics and situations that confer exemptions, but some states may still choose to require verification.[6] Regulations and guidance will provide additional information, but **previous verification requirements** can provide a starting point for implementation. Under the new statute, states must attempt an *ex parte* verification for compliance and exemptions **before contacting the individual**.

During real-time enrollment or *ex parte* renewals, data sources should be automatically checked for exemptions. During the manual processing of an application or renewal packet, the eligibility worker should check **both documentation associated with the case and any interfaces available to them**.

Exemption Type	Verification currently required?	Potential data sources	Potential manual verification sources
Parent/guardian of a child age 13 or under or disabled individual (not Section 1931)	No, but the household member should also be considered for coverage	N/A	N/A
Indian, Urban Indian, California Indian, IHS-eligible Indian	No, but this information is asked as part of the application[7]	N/A	N/A
Medicare-eligible	Yes	Federal Data Services Hub, Social Security Administration	Medicare enrollment letters
Medically frail	Varies[8]	Unknown—possible medical record sources such as MMIS	Medical documentation

Veteran with total disability	Medicaid currently doesn't require this information	Veterans Affairs API[9]	Disability determination notice
SNAP participant, NOT exempt from work requirements	Medicaid currently doesn't require this information	Supplemental Nutrition Assistance Program (SNAP) E&E system, SNAP E&T system[10]	SNAP notices
TANF participant, in compliance with state work requirements	Medicaid currently doesn't require this information	TANF E&E system	TANF notices
Drug/alcohol rehab participant	Medicaid currently doesn't require this information	Unknown—potentially claims data	Admission documentation
Current or recent inmate	Medicaid currently doesn't require this information—but some states may have pre-release enrollment[11]	State Department of Corrections	Incarceration or release documentation

Step 3: Check for participation

If a client is **not exempt** during a given month, the state should next check to determine if the person participated in activities that made them compliant with the new rules. Their participation must be in the month that's being evaluated.

Regulations and guidance will provide additional information on how participation can be verified, but **previous verification requirements** can provide a starting point for implementation.

Activity type	Verification currently required?	Potential data sources	Potential manual verification sources
Working 80+ hours per month	Medicaid currently doesn't require hours worked	Third party data sources, potential government data sources	Pay stubs
Volunteering 80+ hours per month	Medicaid currently doesn't require volunteer hours	Unknown	Volunteer logs

In a work program 80+ hours per month	Medicaid currently doesn't require work program hours	Unknown	Work program documentation, logs
In school half-time	Medicaid currently doesn't require school enrollment time	State Department of Education	Enrollment letters, transcripts, registration confirmation
Doing any combination of the above activities for 80+ hours per month	See above	See above	See above
Has a monthly income above $580	Yes	Unclear—existing data sources should be used as applicable prior to sending requests to client	Pay stubs, employer letters, profit and loss statements
If a seasonal worker, has an average monthly income over six months of $580	Yes	Unclear—existing data sources should be used as applicable prior to sending requests to client	Pay stubs, employer letters, profit and loss statements

❓ Policy unknown: income ❓

The new rules state that monthly income can be used to determine participation. However, they do not define what types of income should be included or excluded. Regulations and guidance will likely fill in the gaps around income calculation, but in general, it is likely to be similar to existing processes.

Step 4: Allow for requestable hardship

If a client is **not exempt and not participating** in a given month, they may still be eligible via a short-term hardship request. Unlike automatic hardship, a requestable hardship **must** be explicitly requested by the client. Regulation and guidance will provide detail on how requests may be submitted and verified, however an easy-to-use mechanism for requesting hardship exemptions **should** be added to applications and renewal forms.

There are two types of requestable hardship: **hospital, nursing, or other medical needs** and **travel for medical services**.

Notice of "noncompliance"

Whenever a state **can't determine a person's compliance** with the work requirements, they must send a "notice of noncompliance."[13] While the title of this notice implies the client is not complying with the work requirements, this notice is **actually a request for information**. The notice must provide the client with the following:

- What information they can provide to the state to demonstrate their compliance
- How they can reapply if they are denied or disenrolled

When the client submits additional information in response to the notice, the four steps should be repeated: **check for automatic hardship, screen for exemption, check for participation, allow for requestable hardship**.

Moving forward

There are still many gaps in the work requirements process for regulations and guidance to fill. However, states can begin to plan (and implement) around the existing statutory requirements in order to be ready when new information becomes available. Beginning work **now** will reduce the amount of work needed to come into full compliance, and ensure states and beneficiaries are protected.

Are you a state, county, or other organization implementing work requirements?

We'd love to talk about how Code for America can partner with you. Connect at codeforamerica.org/partner-with-us.

References & Notes

[1] Center for Medicaid and Chip Services. “State Letter: Ensuring Compliance with Requirements to Conduct Medicaid and CHIP Renewal Requirements at the Individual Level”. August 30th, 2023. **https://www.medicaid.gov/sites/default/files/2023-08/state-ltr-ensuring-renewal-compliance.pdf**

[2] H.R.1. §71119(a)(xx)(9)(A)(i)

[3] H.R.1. §71119(a)(xx)(1)(A)

[4] H.R.1. §71119(a)(xx)(1)(B)

[5] H.R.1. §71119(a)(xx)(1)(B)

[6] H.R.1. §71119(a)(xx)(3)(A)

[7] Verification may be required at state option. Healthcare.gov. “American Indians & Alaska Natives” **https://www.healthcare.gov/american-indians-alaska-natives/medicaid-chip/**

[8] KFF. “Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults” **https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/**

[9] VA.gov. “Veteran Service History and Eligibility API” **https://developer.va.gov/explore/api/veteran-service-history-and-eligibility**

[10] Wagner, Jennifer. “Leveraging SNAP Information to Renew Medicaid Eligibility in a Post-Unwinding World” Center on Budget and Policy Priorities. May 29th, 2024. **https://www.cbpp.org/research/health/leveraging-snap-information-to-renew-medicaid-eligibility-in-a-post-unwinding-world**

[11] KFF. “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State” August 1, 2025. **https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/**

[12] H.R.1. §71119(a)(xx)(3)(B)(ii)(II)(bb)

[13] H.R.1. §71119(a)(xx)(6)