



Ohio Medicaid Work Requirement Implementation



What we know, what we don't
know, and what we need to do now

Ohio Medicaid Work Requirement Implementation: What we know, what we don't know, and what we need to do now

Ohio's path toward Medicaid work requirements was initially shaped by the Ohio General Assembly, which twice required the state to seek federal approval for such policies. The legislature first mandated Medicaid work requirements in the state budget adopted for 2017–2018, directing the Ohio Department of Medicaid (ODM) to submit a Section 1115 demonstration waiver to Centers for Medicare and Medicaid Services (CMS). In response, ODM submitted a waiver in 2019 proposing that Medicaid expansion adults complete 80 hours per month of work or community engagement as a condition of eligibility. That waiver was approved in early 2020 during the first Trump administration, but implementation was halted due to the COVID-19 pandemic, and then CMS, under the Biden administration, formally withdrew approval in 2021.

The legislature renewed its directive in the FY 2024–2025 state budget (House Bill 33), again requiring ODM to pursue a work requirement waiver for Medicaid expansion adults—this time structured around a 20-hour-per-week standard. ODM submitted the waiver to CMS as required.

However, the environment shifted dramatically in July 2025 with the passage of the One Big Beautiful Bill Act (H.R.1). The law established a nationwide Work and Community Engagement Requirement, mandating that non-exempt Medicaid adults ages 19–64 document 80 hours per month of employment or qualifying community engagement activities. This federal requirement supersedes Ohio's pending waiver and places the state on a hard implementation timeline, with full enforcement required no later than January 1, 2027.

On Friday, November 7 and Wednesday, November 12 the Ohio Department of Medicaid hosted a webinar featuring Patrick Beatty, Deputy Director – Chief Policy Officer, discussing how ODM plans to operationalize the new federal law. It offered the most detailed picture yet of how Ohio will move forward, how Medicaid beneficiaries will be affected, and what partners across the state should prepare for as implementation moves forward.

A new federal requirement with a deadline

H.R.1 requires states to enforce an 80-hour-per-month work or community engagement standard for Medicaid expansion adults who are not exempt. States must begin implementation by January 1, 2027, though extensions into early 2029 are possible. Ohio must align its approach with the federal model, rather than its prior waiver designs.

The requirement applies exclusively to Group VIII adults—Ohioans ages 19 to 64 who qualify for Medicaid based on income at or below 138 percent of the federal poverty level.

Who is in Group VIII currently?

ODM provided updated demographic information as of July 2025 on the 774,342 Ohioans currently enrolled in Group VIII:



- 57 percent are between ages 21–44
- 35 percent live in three major urban counties
- 61 percent white; 27 percent Black
- 54 percent male
- 94 percent enrolled in managed care

The population is predominantly working age and is concentrated in urban counties, reflecting diverse employment patterns and health needs.

Most enrollees already meet the federal standard

According to ODM’s analysis, 77.7 percent of current Group VIII members already meet the requirements outlined in H.R.1 through employment, disability status, caregiving responsibilities, education, or other qualifying activities.

Among the 601,882 individuals who already qualify:

- 42.5 percent are working
- 18.4 percent are medically frail or disabled
- 9.6 percent qualify for Medicaid through another eligibility category
- Smaller shares qualify as caregivers, pregnant or postpartum individuals, formerly incarcerated individuals, foster youth, or people meeting age-based exemptions

Approximately 22.3 percent (172,460 individuals) will require additional assessment or documentation to determine whether they meet an exemption or need to begin completing qualifying activities. These individuals are likely at highest risk of losing their coverage.

Who is exempt under federal law?

H.R.1 includes a broad list of exemptions from the requirement. Individuals are exempt if they are:

- Under age 19 or over age 64
- Pregnant or in the postpartum coverage period
- Caring for a child age 13 or younger or a disabled dependent
- Those with disabilities or experiencing serious health conditions
- Participating in a substance use disorder treatment program
- Incarcerated or recently released
- Veterans with a total disability rating
- Meeting work requirements through SNAP or TANF
- Current or former foster youth under age 26
- Members of federally recognized Native American tribes



What counts toward the 80-hour requirement?

Non-exempt individuals may meet the requirement through:

- 80 hours of paid work
- 80 hours of community service
- 80 hours in an approved work program
- Half-time enrollment in an accredited educational program
- Any combination of the above totaling 80 hours

Income verification may be used when available to confirm work hours.

Outreach, notices, and communication requirements

Federal rules require states to complete targeted outreach to impacted individuals at least three months prior to implementation. ODM's strategy includes multiple layers of communication:

1. Pre-Notice Letter (Late 2025/Early 2026): Alerts individuals who may fall into Group VIII, prompting early engagement and preparation.
2. Formal Outreach (Three Months Before Implementation): Explains requirements, exemptions, qualifying activities, documentation methods, reporting procedures, and potential consequences for noncompliance.
3. Verification Requests: Sent when Ohio cannot verify exemption or compliance through existing data. Members receive 30 days to respond before disenrollment (for renewals) or denial (for new applicants).

Documentation requirements for enrollees

H.R.1 sets the broad exemption categories in federal law, but it gives states significant discretion in determining how individuals document those exemptions and qualifying activities. Ohio can decide how frequently documentation must be updated, how [ex parte data sources](#) are used, and which verification systems or portals will support reporting. While Ohio cannot narrow or redefine federal exemptions, their documentation standards will shape the practical accessibility of each exemption and will play a major role in determining how burdensome or streamlined compliance is for Medicaid enrollees.

ODM gave the following examples of the kinds of documentation that Group VIII Medicaid beneficiaries might be required to submit such as:

- Medical statements verifying pregnancy or medical frailty
- Birth certificates, custody documents, or disability-related paperwork
- Foster care records
- Participation records from educational institutions or work programs
- Employers pay stubs or work-verification letters

ODM will provide detailed checklists outlining acceptable documentation.



New processes for applicants

As part of the initial application, ODM must first evaluate whether the applicant appears to qualify for an exemption or meets the requirement based on existing data sources. This includes automated checks using wage records, unemployment and new-hire databases, SNAP or TANF participation files, incarceration data, Medicare enrollment, and other state and federal datasets.

H.R.1 requires states to verify that applicants met the work or community engagement requirement during a period prior to applying, but the statute does not specify how long that period must be. As a result, the length of the look-back window is currently a state-level decision: Ohio could adopt a one-month standard, or a three-month standard. It is generally felt that requiring an applicant to be compliant or exempt for only one month before their application is the best approach because it will reduce case worker errors and possible penalties and result in more eligible persons obtaining coverage.

If ODM cannot confirm exemption or compliance through available data, the applicant will receive a Verification Request accompanied by a detailed checklist outlining the specific documents the state needs to complete the determination. This may include employer statements, pay stubs, school enrollment records, proof of community service, medical verification of pregnancy or frailty, foster care documentation, or evidence of participation in a substance use disorder treatment program. Applicants will have 30 days to submit the required documents, and failure to provide adequate verification within that window will result in the application being denied.

This new process is likely to be one of the most operationally complex components of the program. ODM must build systems capable of identifying potentially impacted applicants upfront, matching them against multiple external data sources, generating individualized checklists, and processing highly variable documentation. County caseworkers will face increased workload and more complicated adjudications, particularly for applicants with inconsistent work hours, unstable employment, housing insecurity, or limited access to their own records. The combination of a look-back requirement, strict timelines, and extensive documentation needs means applicants will face a higher risk of delayed or denied coverage if they cannot rapidly produce the necessary information.

Changes to the renewal process

Renewal procedures will include:

1. Ex Parte Review
2. Renewal Packet Review
3. Verification Requests and Checklists

If the individual cannot be verified as exempt or compliant via an ex parte review, they receive a noncompliance notice and have 30 days to supply documentation before coverage is discontinued.



Expectations for impacted recipients

New applicants must demonstrate compliance for a one- to three-month look-back period. Current enrollees must demonstrate compliance at least once every six months. Failure to verify exemption or compliance triggers a notice of noncompliance.

How stakeholders can help

ODM outlined important roles for community partners and advocacy organizations:

1. Educate Group VIII members using the Partner Packet materials ODM plans to distribute.
2. Use the FAQ to answer questions and direct people to county case workers or the Self-Service Portal.
3. Share feedback about recurring questions or gaps in the materials.
4. Monitor updates from ODM as CMS guidance evolves.

What we still don't know

While ODM's webinar provided the clearest picture yet of how Ohio is preparing for the new Work and Community Engagement Requirement, many important details remain unsettled. Several components of the program depend on federal regulations that CMS will not finalize until June 2026, and those rules will ultimately determine much of the operational structure states must follow. As a result, Ohio's implementation model is still preliminary and may require significant adjustments once federal guidance is released.

Key unknowns include:

- How CMS will define “qualifying community engagement,” including which types of community service, education, or training programs will count.
- How CMS will define serious medical condition and what documentation will be required.
- What specific documentation standards will be federally required, and which verification methods states may adopt or automate.
- Whether states will be permitted to rely on self-attestation for certain exemptions or temporary hardships.
- How temporary hardship exemptions—such as medical crises, homelessness, or domestic violence—will be structured, documented, and time-limited.
- How work, education, or community service hours must be reported: monthly, quarterly, at renewal, or through continuous reporting systems.
- What due process protections CMS will require, including notice standards, fair hearing timelines, and reinstatement rules for individuals who cure a compliance failure.
- How closely Medicaid work requirements must align with SNAP or TANF work programs, and whether state or county agencies must coordinate data or systems.
- What technology or reporting tools ODM will deploy to allow members to submit documents, log hours, or update information. Will it be an online experience “mobile first”
- The role Medicaid managed care plans will be expected to play in outreach, navigation support, and documentation assistance.



- The administrative capacity and staffing needs for counties, and whether additional funding will be provided to support the workload.

These unknowns highlight that Ohio's framework is best understood as a work in progress. The federal regulations expected next summer may resolve some of these questions, but they may also require the state to modify parts of its current plan. Stakeholders should expect continued updates as implementation evolves.

ODM emphasized that several aspects of implementation depend on additional CMS guidance and systems updates. The state will release:

- A refreshed Ohio Benefits page
- A new Work and Community Engagement webpage
- An expanded Partner Packet and FAQ

These resources will be central tools as the January, 2027 implementation deadline approaches.

Conclusion

ODM's webinar provides an initial roadmap for how Ohio will meet the federally mandated Work and Community Engagement Requirement under H.R.1. While the majority of Group VIII members appear to already satisfy the requirement through employment, education, disability status, or caregiving responsibilities, a significant minority will need direct support, communication, and documentation assistance. We must also remember that this is not a static group of individuals. People churn in and out of Medicaid eligibility based on income, health status, and other life-changing events. Documenting eligibility will be a continual process.

ODM noted that several components of the Work and Community Engagement Requirement will ultimately depend on forthcoming federal regulations. Although H.R.1 establishes the statutory framework, CMS is not expected to release final rules until June 2026, and those rules may determine many of the operational details that states must follow, including reporting standards, verification methodologies, data-matching processes, and the degree of flexibility states will have in defining documentation requirements and temporary hardship exemptions.

As a result, Ohio's approach may need to be adjusted once federal regulations are finalized, and partners should expect additional refinements as implementation draws closer. In fact, the state may want to think about implementation in phases, with phase one including those things that are absolutely essential and possible and a phase two where improvements can be implemented that were not possible in the initial short time frame.

Close coordination between ODM, community partners, and advocates will be essential to ensure that Ohioans maintain access to coverage and understand the new federal rules that now govern Medicaid eligibility.



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