DOCTORS FOR AMERICA

Implementing New Medicaid Work Requirements

A Doctors for America Resource

What are the new federal Medicaid Work Requirements?

The so-called One Big Beautiful Bill Act (HR1, 2025) makes Medicaid Eligibility contingent upon meeting work requirements for certain patients. According to the Congressional Budget Office, by 2034 the number of uninsured Americans will rise by 5.3 million as a result of this law. DFA strongly opposes these burdensome Medicaid work requirements. Though states must enact work requirements by January 1, 2027, states have flexibility in how they implement them. Several steps can still be taken to protect patient access to care.

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Overview of the Work Requirements

Who has to meet work requirements?

Any person who is eligible for Medicaid through the Affordable Care Act (ACA) Medicaid expansion group and enrollees in partial expansion waiver programs (Georgia and Wisconsin). For the majority of states (41 states + DC), this includes *nearly all adults with income up to 138% FPL* ($22,024 for an individual in 2026).

Who is exempt?

- Pregnant / postpartum, parents / guardians of children under 13, those meeting SNAP / TANF work requirements, participating in substance use treatment program, incarcerated or recent release from incarceration.
- Medically Frail Patients. CMS issued a rule in June 2026 that created a shockingly narrow definition of medical frailty, requiring patients to be both medically frail and unable to meet the work requirements because of their medical condition. Five subcategories of medical frailty include substance use disorder; disabling mental disorder; physical, intellectual or developmental disability; serious or complex medical condition; and blind or otherwise meet the Social Security Administration's disability standard.
- States also have the option to implement optional Hardship Exceptions.

How does verification work?

- At application, and every 6 months at renewal. States will need to "look back" and review a period of at least the previous one month, and up to three months, to determine whether a patient met the work requirements at the time of application and renewal.

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Key points on the likely impact of work requirements:

Medicaid programs should minimize administrative burden to ensure eligible patients are able to get coverage, and to control costs.

In Georgia, the only state with work requirements at present, administrative burdens account for nearly 70% of total costs. More than one-fifth of patients were denied coverage for administrative reasons - even if they might have been eligible.

Reporting requirements particularly threaten access in rural areas, which have a high number of Medicaid enrollees under expansion.

In states that have expanded Medicaid, 30% of Medicaid enrollees in rural areas are eligible for Medicaid because of expansion. This is same population who now will face work requirements and the red tape associated with them.

If patients lose Medicaid coverage because of work reporting requirements, rural hospitals will provide more uncompensated care to uninsured patients. Rural safety-net hospitals could see operating margins drop by as much as 28%, threatening their ability to stay open and provide essential care to rural America.

Concrete strategies to suggest to legislators to minimize the burden on patients of work reporting requirements

1. **Automate reminders** for deadlines through text, email, and mail to ensure patients stay enrolled. Technical glitches in Georgia led to missed deadlines.
2. **Streamline and automate work status verification** using existing sources like SNAP, school enrollment, consent-based verification of W2, gig-work platforms.
3. **Don't require patients to do additional work of uploading documents.** Putting this burden on patients poses a significant health equity concern. Non-native English speakers and rural patients face additional barriers to verification.
4. **Provide targeted support to non-native English speakers** who already face substantial barriers in applying for Medicaid.

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Concrete strategies to suggest to legislators to minimize the impact of this legislation on patients continued...

5. **Keep frequency of work verification to the required 6 months.** Minimize the "look back" period for work requirements to just one month. Arkansas, Idaho, Indiana, and New Hampshire currently plan to adopt more restrictive compliance verification policies than required by law. Indiana and New Hampshire plan to conduct more frequent (quarterly) compliance checks than required by law.
6. **Implement transparent and robust hardship exemptions.** States can adopt hardship exemptions to temporarily waive work reporting requirements under the following conditions: inpatient hospitalization; residence in a county with a federally-declared emergency; residence in a county with high unemployment (>8%); or extended travel for medical care. Indiana and Iowa do not plan to allow any hardship exemptions; several states are still debating exemption policy. Encouraging all states to allow robust hardship exemptions is critical to ensuring patients do not lose access to healthcare when they need it the most.
7. **Maintain as broad a definition of Medical Frailty as possible**. The medical frailty exemption will be critical to ensuring that the most vulnerable Medicaid patients maintain access to care. Because CMS has established a narrow definition requiring consideration of both the severity of health conditions and healthcare utilization—not simply ICD-10 codes—physicians from multiple specialties should help develop standardized criteria for identifying eligible patients. The process should also include a simple, patient-friendly self-attestation option to minimize barriers to obtaining the exemption.
8. **Allow Self-Attestation and Physician Certification of Medical Frailty.** Patient self-attestation of medical frailty should be sufficient for reporting purposes. At the same time, however, self-attestation should not require that patients submit complicated and personal medical docuements. In addtion, states should allow standardized physician certification of medical frailty and inability to meet work requirements while minimizing administrative burdens and avoiding the ethical concerns inherent in asking physicians to make subjective judgments about patients' ability to work. Note: self-attestation will be allowed in 2027, but beginning in 2028, states must verify medical frailty or require annual documentation. DFA finds this burdensome and unnecessary.