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New Barriers to Medicaid Eligibility and Enrollment: Work Reporting Requirements and More Frequent Eligibility Redeterminations Under H.R. 1

H.R. 1 Implementation Explainer: October 2026

The 2025 budget reconciliation law (H.R. 1) imposes major new restrictions that will make it significantly harder for eligible adults to enroll in the Affordable Care Act's (ACA's) Medicaid expansion coverage and, once enrolled, access care. Starting January 1, 2027, H.R. 1 will impose two major new enrollment hurdles on the expansion population: renewals every six months (rather than yearly) and mandatory work reporting compliance. These barriers are expected to lead to loss of coverage on top of the improper denials and disenrollments that states already produce through the ordinary eligibility process. Together, these could cost 4.9 to 10.1 million people their Medicaid access by 2028 — with the Centers for Medicare & Medicaid Services (CMS)'s more stringent implementing rules adding an additional 1.8 million people to that toll. Below is a detailed explanation of H.R. 1's new Medicaid eligibility requirements and their impact on consumers and providers, along with an examination of state implementation choices that either reduce paperwork and preserve coverage or add barriers and accelerate coverage loss. A companion explainer covers new mandatory cost sharing for expansion adults, which will sharply raise out-of-pocket costs for those who retain their coverage.

Medicaid paperwork burdens increase improper denials and disenrollments, and push eligible Americans off coverage

While Medicaid eligibility verifications are essential to program integrity, ensuring only beneficiaries who meet federal and state criteria remain enrolled, the application and renewal processes are highly error-prone. These bureaucratic barriers often deny eligible applicants or disenroll eligible beneficiaries over paperwork deficiencies rather than actual ineligibility. These procedural errors are a major driver of "churn" — when enrollees cycle on and off coverage throughout the year, often despite continued eligibility. **Medicaid churn is widespread, impacting more than 10% of enrollees annually.**[1]

Many disenrollments happen simply because eligible people never received a renewal notice, did not understand the process, or missed the response deadline.[2] During the Medicaid "unwinding" — the nationwide resumption of eligibility checks after a three-year pandemic-era pause — **69% of disenrollments nationwide were purely for procedural or paperwork reasons.**[3] State error compounds the problem: A September 2026 Government Accountability Office (GAO) report found that caseworker mistakes, IT system failures and slow processing times led to **improper-denial rates of 12% or more in five of seven states reviewed, with one state's wrongful denial/termination rate exceeding 30%.**[4] Improper

denials, disenrollments and churn — the consequences of paperwork burdens and poor state processes — disrupt care access for Medicaid-eligible populations, leading to:

- **Fewer primary and preventive care services.** Coverage lapses — even if they are short — cause people to skip high-value preventive care and screenings.[5] One study found that a Medicaid coverage disruption in the past year was associated with a 14.5-percentage-point drop in breast cancer screening.[6] Even after individuals reenroll, it may take several months to reestablish connections to health providers, showing the lingering effects of churn on health care access.[7]
- **Reduced chronic disease management and costlier care needs upon reenrollment.** Medicaid enrollees who cycle repeatedly into and out of coverage fill fewer prescriptions and have fewer health system encounters supporting chronic disease management.[8] Health needs that arise and worsen during coverage lapses can end up being more costly in the long run.[9] For example, diabetic Medicaid beneficiaries who lost coverage saw monthly clinical costs rise by $239 in the three months after reenrollment compared to the three months before the lapse.[10]
- **Increased preventable emergency department (ED) visits and hospitalizations.** According to the Medicaid and CHIP Payment and Access Commission (MACPAC), churn nearly doubles the risk of preventable ED use for common conditions, such as heart disease, respiratory diseases and diabetes.[11] Other studies show individuals who have multiple transitions into and out of Medicaid have a 17.5% increase in ED usage and a 24% increased rate of hospitalizations.[12]
- **Increased medical debt and financial instability.** Coverage loss is a well-documented driver of medical debt,[13] with Medicaid churn leaving low-income Americans temporarily uninsured precisely when medical needs arise, exposing them to unaffordable costs. Research shows Medicaid coverage reduces the share of low-income adults reporting medical debt by 13 percentage points,[14] and uninterrupted access leads to less debt in collections and better credit scores over time.[15]
- **Greater state administrative costs.** Churn not only disrupts continuity of care but generates unnecessary administrative cost burdens on state systems.[16] Disenrolling and then reenrolling just one individual costs the state an estimated $400 to $600.[17]
- **Increased uncompensated care.** Erroneous denials and disenrollments mean more low-income Americans are unnecessarily uninsured — but their health care needs do not go away. Researchers estimate that each additional uninsured person costs local hospitals about $800 per year in uncompensated care (care provided but not paid for).[18] Uncompensated care creates enormous challenges for the health care system, particularly for safety-net hospitals already at financial risk of closure, impacting access to care across the system.[19]

Past state efforts to implement work reporting requirements for adults on Medicaid only amplified procedural errors and the problems of churn. In **Arkansas**, the first state to fully implement work reporting requirements in 2018, more than 18,000 beneficiaries — one in four subject to the requirement — lost coverage within a few months,[20] despite 95% of those subject to the program meeting all requirements.[21] Many enrollees simply did not know about the requirements or missed opportunities to comply, but Arkansas' experience shows how the stressor of instituting major new eligibility requirements amplifies state errors: Arkansas suffered from faulty enrollment and IT systems along with errors in the state's data-matching processes and incorrect application of exemption requirements; these factors significantly raised rates of improper disenrollments and program churn.[22] The consequences for those who lost coverage were severe: A total of 50% reported serious problems paying off medical debt, 56% delayed care due to cost and 64% delayed medications.[23] Importantly, Arkansas' program cost millions of taxpayer dollars to implement,[24] while failing to increase employment.[25]

New eligibility and enrollment requirements compound procedural hurdles for eligible adults

H.R. 1 creates two new massive Medicaid enrollment hurdles that add red tape and paperwork and double the number of points in the year at which a paperwork lapse or state error can trigger improper loss of Medicaid coverage:

- **Six-month Medicaid renewals (§ 71107).** Beginning January 1, 2027, individuals enrolled in Medicaid expansion coverage must renew their eligibility every six months instead of annually.[26] This provision reaches only the 41 states and Washington, D.C., that cover the full expansion population — adults with incomes up to 138% FPL ($22,024 for an individual in 2026).[27] States that have a partial expansion through an § 1115 waiver, such as Wisconsin, are exempt; their partial-expansion populations remain on the annual renewal cycle.[28]
- **Medicaid work reporting ("community engagement") requirements (§ 71119).** Beginning January 1, 2027 (or earlier, at state discretion), individuals eligible for or enrolled in Medicaid expansion coverage must demonstrate 80 hours/month of work or other qualifying activity or prove an exemption. Table 1 lists a series of activities that qualify under the work requirement, along with mandatory and optional exemptions. Unlike § 71107, this provision is applicable to partial-expansion waiver states as well, and CMS has indicated that Georgia, Wisconsin and Tennessee all have populations that must comply.[29] H.R. 1 offers states some flexibilities for implementing this new eligibility requirement, including how often states will verify compliance and what level of documentation is required. Table 3 (page 16) walks through these flexibilities and individual state implementation choices to date.

Table 1: Medicaid Work Reporting Requirements — Qualifying Activities & Exemptions

Qualifying Activities

One of the following activities or any combination totaling at least 80 hours per month:

- Employment
- Community service
- Work program participation (job searching alone does not qualify, but internships, apprenticeships and on-the-job training count, along with programs that satisfy SNAP's work-program requirement)
- Educational program enrollment, at least half-time

Income-based alternative pathways (satisfy the requirement without hour-tracking):

- Monthly earned income ≥ 80 hours × federal minimum wage — currently $580 per month at the $7.25 federal minimum wage30
- Seasonal workers — may instead show average monthly income over a six-month period exceeding that same $580 threshold

Mandatory Exemptions

- Foster youth/former foster youth ≤ 26 years old
- American Indians and Alaska Natives
- Caretakers/guardians/parents of dependent children under age 13 or disabled individuals
- Disabled Veterans
- Medically frail or otherwise has special medical needs
- Meeting SNAP/TANF work requirements
- Participating in a drug addiction or alcohol treatment and rehabilitation program
- Incarcerated or released within prior three months
- Pregnant or entitled to postpartum coverage
- Entitled to Medicare Part A/enrolled in Part B

Optional Hardship Exemptions

State option to allow short-term hardship exceptions for an individual who:

- Was in an inpatient hospital, nursing facility, intermediate care facility, or inpatient psychiatric hospital
- Resided in a county with a federally declared emergency or disaster
- Resided in a county with a high unemployment rate (above 8% or 1.5x the national unemployment rate)
- Traveled outside the individual's community for an extended period for medical care for themselves or for their dependent

Shortened renewal cycles and new compliance checks increase opportunity for error

New paperwork burdens are likely to increase improper denials, erroneous disenrollments and program churn — even without any change in a person's underlying eligibility. By 2028, one year into implementation, the Congressional Budget Office (CBO) estimates that six-month redeterminations and work requirements together will cause 3.7 million people to lose Medicaid (rising to 6.0 million by 2033).[31] Other independent research estimates are much higher, estimating that **by 2028, H.R. 1's eligibility policies will cause between 4.9 and 10.1 million fewer people to be enrolled in Medicaid** in an average month, depending on state implementation choices — a 27% to 55% Medicaid expansion enrollment decline.[32] These immense coverage losses come despite the fact that the vast majority (by some estimates, more than 90%) of the people who will be subject to the new requirements are working or face barriers to work that would likely qualify them for an exemption.[33] CMS' implementation policies (discussed below) add further red tape which is likely to substantially increase coverage loss: Researchers estimate these additional paperwork hurdles will cause at least **1.8 million more people to lose Medicaid coverage each year.**[34]

H.R. 1's coverage losses stack on top of the improper denials and disenrollments states already produce through the ordinary eligibility process. As discussed above, GAO has found that some states have improper-denial rates of 12% or more.[35] Table 2 outlines the full range of eligibility requirements for adults seeking coverage through the Medicaid expansion after H.R. 1, with each requirement being a separate procedural hurdle.

Table 2: Eligibility Requirements for the Medicaid Expansion Population After H.R. 1

Text in red signals H.R. 1 changes

	REQUIREMENT	DOCUMENTATION	OCCURRENCE
CATEGORICAL	**Age:** 19–64 years.	Date of birth on record or self-attestation.[36]	At application, but not at routine renewals.[37]
	Not Medicare-entitled: Not entitled to or enrolled in Medicare Part A or B.	Federal-state data match.	Application and ***six-month*** renewal, and at least monthly.
	No other mandatory pathway: Not eligible under a different coverage group — pregnancy, Supplemental Security Income (SSI)-related disability, parent/caretaker at the state's Aid to Families with Dependent Children (AFDC)-related level, or another mandatory category.	State Medicaid agency screens all pathways.	Application and ***six-month*** renewal, or anytime a beneficiary reports a change in circumstances.

	REQUIREMENT	DOCUMENTATION	OCCURRENCE
FINANCIAL	**Income at or below 138% FPL:** Household modified adjusted gross income (MAGI) at or under 133% FPL, plus a five-point disregard — an effective ceiling of 138%. No asset or resource test applies to this group.	Electronic wage, tax and benefit data first;[38] additional paperwork only if data are unavailable or contradicted.	Application and ***six-month*** renewal, and on reported change.[39]
	Household composition: Household size determined by MAGI tax-household rules, which set the dollar value of the 138% threshold.	Self-attestation during renewals unless data conflict with electronic data sources or are deemed questionable.[40]	Application and ***six-month*** renewal, and on reported change.[41]

	REQUIREMENT	DOCUMENTATION	OCCURRENCE
STATUS	**State residency:** Resident of the state where the person applies. Enrollment in two states at once is prohibited.	Self-attestation; states check against cross-state enrollment data.[42]	Application and ***six-month*** renewal, and if individual moves across state lines.
	H.R. 1 CHANGE **Citizenship or immigration status:** Starting October 1, 2026, Medicaid restricted to U.S. citizens; lawful permanent residents; Cuban and Haitian entrants; people residing in the U.S. as citizens of the Compact of Free Association (COFA) nations; and lawfully residing children and pregnant immigrants in states that offer this coverage.[43]	Official documentation only; 90-day "reasonable opportunity period" to correct information or submit additional documentation.[44]	Application (but not typically at renewal unless status will change).
	H.R. 1 CHANGE **Work or community engagement status:** A person must demonstrate they are engaging in a qualifying activity for 80 hours per month or that they have an exemption (see Table 1).	Automated data-matching first before asking beneficiaries for paper documentation; self-attestation restricted starting 2028.	Application and six-month renewal (must meet requirement for one to three months prior); compliance check can be quarterly, at state discretion.

CMS' implementation guidance increases the harm

In June 2026, CMS released an Interim Final Rule (IFR) establishing detailed requirements for how states must implement work requirements.[45] The rule clarifies and defines qualifying activities and exemptions and outlines verification expectations, but it also introduces new requirements beyond those established in H.R. 1 that will make implementation more difficult and more likely to trigger coverage losses among eligible people:

- **More cumbersome documentation and requirements for the "medically frail" exemption:** H.R. 1 establishes several mandatory exemptions from the work requirement, including for people who are "medically frail" — a category the statute defines as anyone who is blind or disabled; has a substance use disorder; has a disabling mental disorder; has a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or has a serious or complex medical condition.[46] While the statute envisions a broad exemption capturing anyone with these qualifying conditions, the IFR narrows this exemption substantially: Beyond proving the underlying condition, CMS states that individuals must also separately show that their condition leaves them unable to work (lacking "functional capacity" to perform 80 hours per month of qualifying activities). This added burden multiplies and complicates the paperwork and processes required of patients and providers and it risks leaving vulnerable people with serious health needs unable to prove their medical frailty — and in jeopardy of losing coverage. Compounding this, CMS restricts documentation to claims or encounter data no more than 12 months old, forcing people to continually generate new documentation of their condition, even if further care is not medically necessary for their health.[47]
- **Limiting self-attestation for documenting compliance with the work requirement or proving an exemption:** Self-attestation (written or verbal statement accepted without primary paper proof) is permitted for most non-financial Medicaid eligibility criteria, including age/date of birth, household size, and state residency.[48] H.R. 1 generally requires states to verify work requirement compliance through automated state data and ex parte processes wherever possible before requesting any information from the individual. The statute allows (but does not require) states to accept self-attestation when data are unavailable[49] — for example, for new applicants without an existing claims history or when treatment does not produce a medical claim, as with community-based substance use disorder treatment.

  Despite statutory permissibility of self-attestation, the IFR significantly narrows this flexibility. States may accept self-attestation in calendar year 2027 only where reliable data sources are missing; starting January 1, 2028, states must require reasonably available paper documentation instead. The medically frail exemption carries an

additional restriction beginning in 2028: Individuals may self-attest only once per enrollment period, after which states must require documentation — such as medical records or documentation from providers of inability to work — wherever automated data are unavailable.

Legal challenges and implementation delay requests

Legal experts argue the IFR violates the law and impermissibly narrows the work requirement exclusions Congress established to protect the most vulnerable Medicaid enrollees. CMS' approach now faces two legal challenges: one filed by 26 states and Washington, D.C., and a separate action brought by Medicaid enrollees and provider advocacy groups.[50] Among other claims, both suits argue the IFR's narrowed medical frailty exemption and restricted self-attestation standards exceed statutory authority. In the state lawsuit, a court ruling on October 29, 2026 sided with the states in part and found that CMS' narrowed medically frail exemption violated the law, striking down this provision nationwide.[51] However, the court upheld the restricted self-attestation standards and the limitation that states can only use data from the previous 12 months to verify medical frailty.[52] While litigation proceeds, including potential appeals, states must still implement work requirements within the IFR's framework by January 2027, other than the IFR's narrowed definition of medical frailty.[53] Given the scale of that challenge, five governors — from **California, Maine, New Mexico, Oregon** and **Virginia** — sent HHS Secretary Kennedy a letter in October 1, 2026 asking the department to delay the compliance date and "work with states to establish a realistic implementation timeline," one that gives states time to build the necessary systems and processes while keeping eligible people covered.[54] Separately, states may individually request an extension through December 31, 2028, if they can show a "good faith" effort to comply, but are unable to meet the deadline. Of note, current legal challenges and implementation delay requests concern the work requirement *only* and do not affect state implementation of biannual Medicaid renewals.

State choices: mitigating vs. compounding coverage loss

Despite CMS' restrictive approach, states retain significant discretion in how they implement work requirements — choices that can either minimize paperwork burdens and preserve coverage for eligible applicants and beneficiaries or compound existing barriers and accelerate coverage loss.[55] Table 3 shows where states stand, as of September 2026, on key implementation choices: the compliance lookback period, verification frequency, self-attestation policy and adoption of optional short-term hardship exemptions. States also face a separate decision on how often to reverify medical frailty — every 12 months or at each six-month renewal — but none have publicly announced a choice, leaving this an open implementation question. State decisions fall in a range:

- **Pragmatic policies that minimize burdens (25 states).** Most states have made implementation choices that will make it easier for eligible people to obtain and maintain Medicaid coverage. **Nevada**, for example, has adopted a full set of mitigating policies — allowing self-attestation where possible, requiring only one month of data to show compliance, verifying compliance only at six-month renewal and permitting short-term hardship exemptions — to help protect its nearly 280,000 Medicaid expansion enrollees.[56]
- **Restrictive policies that maximize harm (2 states).** For example, **Indiana** has not adopted self-attestation, will require three months of documentation to show compliance with quarterly compliance checks (meaning enrollees must meet compliance every single month) and will not offer short-term hardship exemptions.[57] Advocates estimate the state's approach could cost an additional 500,000 Hoosiers their Medicaid coverage.[58]
- **Mixed approaches (12 states).** **Montana**, for example, has made some choices to make verification relatively easier (accepting self-attestation, verifying compliance biannually and allowing hardship exemptions) but has adopted a more restrictive lookback period (requiring only one month of compliance at application, but three months for renewing enrollees) and moved up implementation six months early (July 1, 2026), with denials and disenrollments beginning October 1, 2026.[59] Researchers estimate that one-third of Montana Medicaid expansion enrollees could lose coverage despite an estimated 93% that would meet all requirements.[60]

State implementation of six-month renewals

CMS' March 2026 guidance gives states two ways to transition to six-month renewals: either apply the change at each individual's currently scheduled renewal, or initiate renewals sooner (but not earlier than January 1, 2027).[61] According to researchers, most states plan to maintain the existing renewal cadence, the more administratively efficient option and the one likely to produce less disruption for enrollees.[62] Eventually, work requirement compliance checks will join the list of other semi-annual eligibility requirements (Table 2, page 16). However, where states choose quarterly work requirement verification (including **Indiana** and **New Hampshire**), they face the added administrative challenge of coordinating two different compliance timelines. Partial-expansion states — **Georgia, Tennessee** and **Wisconsin** — have a similar asymmetry in renewal cycles, with work requirement verifications happening every six months but redeterminations for all other eligibility factors remaining on the annual cycle.

New policies compound existing state Medicaid enrollment barriers

Indiana's choice of a paperwork-heavy approach for work requirements compounds the challenges for a state already struggling to accurately assess eligibility: In June

2026 alone, 35.1% of Indiana Medicaid recipients due for renewal were disenrolled for procedural reasons — all before the state has even implemented H.R. 1's new requirements.[63] **Nevada's** beneficiary-friendly approach today comes against a strikingly different backdrop: During the pandemic-era unwinding, Nevada had one of the nation's worst procedural disenrollment records, with 93% of all disenrollments attributed to paperwork rather than an actual finding of ineligibility.[64] RAND estimates that **given existing variation in procedural errors across states, the share of Medicaid expansion adults who may become uninsured could be as low as 17% in better-performing states (Alaska, New Hampshire, North Carolina) and up to 40% in the worst performing states (Maryland, New Mexico, Utah).[65]**

Impact on state budgets

No matter their implementation choices, H.R. 1's new eligibility requirements will be costly for every affected state. Doubling the number of redeterminations each year and adding new eligibility requirements means hiring new staff, updating IT systems and sending twice as many beneficiary notices each year. CMS estimates states will need to spend an average of $15 million each on new IT systems alone — not counting the ongoing costs of reviewing information, processing exceptions, issuing notices, resolving disputes and handling appeals.[66] Past state experience with work reporting requirements shows these systems are enormously expensive to build and put into practice and that ongoing costs can be substantial.[67] According to GAO, **Georgia** — the only state with an active work requirement ahead of H.R. 1 — has spent $54.2 million on administrative costs since 2021, more than double the $26.1 million it spent on actual medical assistance for enrollees over the same period.[68]

Many states are already feeling the budget squeeze, with one report estimating upfront administrative costs to be between $4 million and more than $30 million per state.[69] For example:

- **Ohio** and **New Mexico** estimate $28 million and $24 million, respectively, for tech upgrades, staffing and consumer outreach.[70]
- **Illinois** has allotted $55 million to hire 450 additional staff and update its enrollment and eligibility systems.[71]
- Ongoing costs are substantial too: **North Carolina** projects $31.2 million annually just to enforce the work requirement and conduct mandatory biannual eligibility checks.[72]

But the above cost estimates all predate the more restrictive and complicated IFR, and none account for its more burdensome requirements — chiefly, the individualized, applicant-by-applicant assessments that states must now conduct to determine whether someone

with a "medically frail" condition lacks the functional capacity to work. September 2026 guidance from CMS allows states to treat a small set of diagnoses — end-stage renal disease, ALS, and end-stage cancer — as automatically disqualifying, with no added documentation needed.[73] But for most people, establishing medical frailty will require supporting data or a full case-by-case review — a cost burden that will only grow once states can no longer accept self-attestation, starting in 2028. For the most part, states have not yet publicly grappled with how much costlier the IFR's narrower medical frailty standard and stricter self-attestation rules will make implementation.

Increased costs for eligibility determinations coincide with sharply reduced federal support for Medicaid: CBO estimates **H.R. 1's Medicaid provisions alone will cut federal spending by almost $900 billion over ten years (2025–2034).**[74] Two separate Families USA explainers describe the significant additional impact new restrictions on provider taxes and state-directed payments will have on state Medicaid budgets — cuts that arrive at the same moment that states must absorb the administrative costs of implementing work requirements and six-month renewals. Compounding this pressure, states are under heightened federal scrutiny to lower state error rates in Medicaid eligibility determinations[75] — meaning states must build costlier, more accurate eligibility systems with fewer federal dollars, under a stricter penalty regime for the very errors those systems are prone to produce.

Impact on Medicaid enrollees

All Medicaid expansion enrollees face greater risk of losing coverage simply from more frequent redeterminations. But H.R. 1's work requirement paperwork and CMS' strict implementation rules fall hardest on people whose circumstances — their work, their health, their access to care — do not translate cleanly into the documentation the system demands:

- **People who are compliant but cannot prove it.** Automated state verification will work well for people whose compliance is easy to check electronically — a regular pay stub, for instance. But others who meet the requirement will struggle to document it, simply because their circumstances may not show up cleanly in state data systems. For example, researchers estimate that, depending on state implementation choices, 30–73% of self-employed people and 21–56% of students could lose Medicaid, as these circumstances are not easily verified by states.[76]
- **People whose serious health conditions do not show up clearly or regularly in their medical record.** Some conditions are less visible in the medical record, especially those that do not require regular management or where care is appropriately provided outside of health care settings (for example, some community-based substance use disorder treatment or recovery supports).[77] Anyone who has not seen a doctor, filled

a prescription or been hospitalized in the past year faces a dilemma under the IFR's 12-month data-recency rule: Their record will appear blank no matter how severe their condition. Additionally, for some conditions, claims data alone are unlikely to settle a medical frailty determination — CMS' guidance cites cancer in remission and depression treated in primary care as examples.[78] The IFR's medical frailty framework turns a statutory exemption into a documentation contest — one where the burden falls hardest on people whose conditions are real but administratively invisible.[79]

- **People without consistent access to Medicaid providers.** Medically frail patients may need frequent doctor visits just to generate the claims needed to stay on Medicaid — but this depends on appointment availability that many simply do not have: Compared to other insurance types, Medicaid patients face far greater difficulty accessing primary and specialty care,[80] driven by widespread provider shortages, scarce appointments, long waiting lists, and provider refusal to accept new Medicaid patients.[81] Additionally, some states are limiting which providers can determine or document medical frailty,[82] or which treatment programs qualify for the separate exemption for people participating in substance use disorder treatment or rehabilitation programs.[83]
- **People who cannot afford cost sharing to obtain care and documentation.** Many expansion enrollees with chronic conditions or disabilities may qualify for the "medically frail" work requirement exemption — but as our companion explainer, New Expenses for Adults on Medicaid: Cost Sharing Requirements Under H.R. 1, discusses, sustaining that exemption requires frequent, extensive medical documentation. H.R. 1's added cost sharing barriers could delay or derail the very appointments needed to document medical frailty, jeopardizing access to Medicaid for the populations most in need of health coverage.
- **People aged 50–64.** In **Georgia,** older adults have struggled disproportionately to meet the state's existing work requirement,[84] consistent with the Urban Institute's national projection that 30–65% of older adults could lose Medicaid coverage once work requirements take effect, depending on state implementation choices.[85] Compared to younger adults, older workers are less likely to be employed[86] and face hiring challenges (age discrimination, etc.) that can lead to longer spells of unemployment.[87] They also have higher rates of chronic conditions[88] and caregiving responsibilities,[89] which make steady employment harder to sustain.
- **People who lack awareness of requirements or cannot get the support they need to comply.** Past state experience shows many people never learn of work requirements or what is expected of them. In **Arkansas,** nearly half the impacted population was unsure whether the requirements applied to them, and state and community resources couldn't sufficiently support those seeking help.[90] Early implementation in **Nebraska** and **Montana** is already producing similar confusion, with conflicting or overly complex

state notices, 90-minute helpline waits, and insufficient staff at both state and community-based organizations to meet demand.[91]

Impact on providers and patient care

Because automated state data will not capture every case of medical frailty, states will lean heavily on providers to document a patient's condition. However, clinicians may lack the skills to formally evaluate whether a health condition prevents someone from meeting the work requirement (particularly if they are not trained in occupational medicine),[92] and the health care system lacks valid clinical tools for making this kind of determination.[93] Assessing severity also requires understanding how a patient's circumstances and local health care access shape their ability to get appropriate care.[94] A condition normally well managed with regular treatment — asthma or diabetes, for instance — can quickly become serious without reliable access to specialists, medications or other necessary services. Symptoms also vary by patient and fluctuate over time, with some people cycling between relative health and periods of greater severity.[95] With little room for enrollees to self-attest to these circumstances, the assessment burden falls on providers.

This additional — and unprecedented — ask of the health care system may result in providers being unwilling to participate in this process or to the degree required to provide states with the level of documentation needed to determine medical frailty for millions of Medicaid beneficiaries:

- **Reimbursement realities may make it infeasible for providers to document medical frailty.** Low Medicaid reimbursement already drives providers to turn away Medicaid patients, particularly in specialty care settings.[96] If they are not paid for the additional time it takes to conduct medical frailty assessments, providers may decline to provide this documentation — or refuse the patients who need it. Worse, insurers may deny reimbursement under "medical necessity" rules when the 12-month recertification cycle pushes patients into clinically unjustified appointments — further disincentivizing providers from helping patients pursue the medical frailty exemption.[97]
- **Greater administrative demands on providers and their staff may discourage Medicaid participation.** Providers already navigate substantial administrative hurdles to Medicaid participation — complex billing, claims denials and resubmissions, and haggling with insurers over prior authorization.[98] These burdens are key drivers of physician burnout and attrition.[99] Recurring medical frailty certifications add yet another layer of non-clinical work, consuming scarce physician and staff time that could go toward diagnosis, treatment and care coordination — likely further discouraging provider participation in Medicaid networks.[100]

- **Providers may fear professional consequences.** Clinicians who attest that a patient is medically frail may worry that their judgment will be second-guessed by state or federal reviewers — and that they will face charges of fraud and professional consequences if auditors disagree — especially when the determination rests on patient-reported outcomes or clinical judgment rather than clear objective findings.[101] Practices serving a large share of Medicaid patients with significant health needs may also worry that documenting many patients as medically frail will make them stand out to auditors relative to practices with a different patient mix. Either concern could suppress medical frailty documentation even where it is warranted.

Next steps for advocates

The estimated impacts of coverage loss and health consequences are not set in stone, but depend on how federal and state governments take advantage of the flexibilities in the statute. Advocates can help prevent this harm if they can:

- **Urge states to adopt the least burdensome renewal and reporting requirements permitted under federal law.** States can and should adopt the full set of mitigating policies allowed under H.R. 1 to protect Medicaid expansion-eligible individuals from losing coverage — including allowing self-attestation where possible, requiring only one month of data to show compliance, verifying compliance only at six-month renewal and permitting short-term hardship exemptions.
- **Encourage policymakers to reduce procedural disenrollment by streamlining renewals and leveraging automated *ex parte* processes as much as possible.** CMS and independent researchers have identified numerous strategies from the Medicaid unwinding experience to boost ex parte renewals and cut administrative burden.[102] States have every incentive to adopt these strategies — not just to ease paperwork for eligible people but to lower their own administrative costs and free up capacity to absorb the new complexity of work reporting requirements.
- **Ensure states reduce other hurdles, including to Medicaid provider participation.** Medical documentation connected to work requirements will add new administrative burdens for providers and their staff. Recognizing this, states should reduce other hurdles that make it difficult for providers to participate in Medicaid, including state administrative burdens and restrictive managed care policies.[103]
- **Seek to ensure broad and simple exemption definitions, especially for medical frailty.** States are charged with operationalizing the medical frailty exemption, including by developing lists of conditions that will qualify. State decisions here will have significant implications for patient access, and advocates have an ongoing role in engaging with state decision-makers to refine this process.

- **Support clear consumer-facing information and connections to resources.** Clear, navigable state Medicaid websites — with straightforward eligibility explanations and simple paperwork submission — are critical to helping people enroll and stay covered, as is access to direct assistance and enrollment navigators. Advocates play an important role in monitoring this information to ensure consumers have what they need to apply for and renew Medicaid coverage. In addition, advocates should ensure that their states offer clear information and assistance on marketplace transitions or other coverage options for people who lose access to Medicaid. Advocates can also help states, Medicaid plans, and community partners connect people with the services that support their work or community engagement and its documentation — whether with community college and education systems, employment counseling and development agencies, community service and volunteer opportunities, and more.
- **Document the impact.** Advocates have an essential role in tracking how enrollees experience access to care once work requirements and six-month redeterminations take effect — especially for patients navigating the medical frailty documentation process. Statistics show the scale of a policy's impact, but stories show its human cost, making them essential to legal challenges and policy reform.
- **Push states to track and publicly report the costs and consequences of implementing work requirements.** States should track administrative costs related to implementing new enrollment systems, along with other issues caused by work requirements — including procedural disenrollments, administrative backlogs, enrollment shifts for key demographics (for example, people aged 50–64), changes in utilization patterns (for example, increased preventable ED visits), Medicaid provider participation rates and uninsured rates.[104] Advocates should also push states to share these data directly with CMS and ensure congressional representatives have them to drive hearings and other oversight, and federal policy change.

Table 3: State Policy Decisions on Medicaid Work Reporting Requirements (as of September 2026)

KEY

- State is electing the full set of mitigating policies that will reduce burden on applicants and enrollees (25 states)
- State has elected some consumer-friendly policies to reduce paperwork, along with other more restrictive policies (12 states)
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	(5 states)	One Month (40 states)	Two Months (1 state)	Three Months (5 states)	Biannual (41 states)	Quarterly (2 states)	Accepted (33 states)	Not Accepted (9 states)	Adopting (35 states)	Not Adopting (5 states)
AK[105]		X			X		X		X	
AL	N/A	N/A			N/A		N/A		N/A	
AR[106]	X (July 1, 2026, disenrollments begin Jan 1, 2027)	X			X			X	X	
AZ[107]		X			X		X		X	
CA[108]		X			X		X		X	
CO[109]		X			X		X		X	
CT[110]		X			X		X		X	

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DC[111]		X			X		TBD		X	
DE[112]		X			X		X		X	
FL	N/A	N/A			N/A		N/A		N/A	
GA[113]	X (Existing program)	X			X		X		X	
HI[114]		X			X			X	X	
IA[115]	X (Dec 1, 2026)	X Applicants	X Renewals		X		TBD			X
ID[116]				X	X		X Applicants	X Renewals	X	
IL[117]		X			X		X		X	
IN[118]				X		X		X		X
KS	N/A	N/A			N/A		N/A		N/A	

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KY[119]		X Applicants		X Renewals	X		X		X	
LA[120]		X			X		X		X	
MA[121]		X			X		X		TBD	
MD[122]		X			X		X		X	
ME[123]		X			X		X		X	
MI[124]		X			X		X		X	
MN[125]		X			X		X		X	
MO[126]		X			X		X			X
MS	N/A	N/A			N/A		N/A		N/A	

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MT[127]	X (July 1, 2026)	X Applicants		X Renewals	X		X	X For "medically frail" existing members	X	
NC[128]				X	X			X	X	
ND[129]		X			X		TBD		TBD	
NE[130]	X (May 1, 2026)	X			X		X		X	
NH[131]		X				X		X		X
NJ[132]		X			X		X		X	
NM[133]		X			X		X		X	

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NV[134]		X			X		X		X	
NY[135]		X			X		X		X	
OH[136]		X			X			X		X
OK[137]		X			X		X		X	
OR[138]		X			X		X		X	
PA[139]		X			X		X		X	
RI[140]		X			X		X		X	
SC	**N/A**	**N/A**			**N/A**		**N/A**		**N/A**	
SD[141]		X			X		X		X	
TN[142]										
TX	**N/A**	**N/A**			**N/A**		**N/A**		**N/A**	

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UT[143]		X			X			X	X	
VA[144]		X			X		X		X	
VT[145]		X			X		X		X	
WA[146]		X			X		X		X	
WI[147]		X			X		X		X	
WV[148]		X			X		X		TBD	
WY	N/A	N/A			N/A		N/A		N/A	

Sources: Based on official state legislation or regulation or on guidance publicly stated on state websites. Where Families USA could not confirm a state source, we relied on information reported by state officials to KFF in March 2026; this included information on self-attestation (for AR, AZ, DE, HI, NY, OK, RI and SD) and short-term hardship adoption (for LA, MD, NC and WA). See Jennifer Tolbert, Amaya Diana, Anna Mudumala, Tricia Brooks, Yuliya Yafimenka, and Antony Lin, "An Early Look at Policy Decisions as States Get Ready to Implement Work Requirements," KFF, April 30, 2026, https://www.kff.org/medicaid/an-early-look-at-policy-decisions-as-states-get-ready-to-implement-work-requirements/.

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[29] *Medicaid Program; Community Engagement Requirement for Certain Individuals,* 91 Fed. Reg. 33348 (June 3, 2026) (interim final rule with comment period), CMS-2454-IFC, codifying 42 CFR § 435.551, https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-

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[36] 42 C.F.R. § 435.956(f).

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[39] Beneficiaries are generally required to report significant income changes (such as a new job or raise) to the state Medicaid agency within 10 days of the change.

[40] 42 C.F.R. § 435.956(f) (verification of household size); 42 C.F.R. § 435.952(a), (c) (reasonable-compatibility standard); 42 C.F.R. § 435.916(b)(2) (application of verification standards at renewal).

[41] Beneficiaries are generally required to report significant changes in household composition (such as a birth, marriage, divorce, or a dependent moving out) within 10 to 30 days of the event, prompting an interim review.

[42] 42 C.F.R. § 435.956(c).

[43] Pub. L. No. 119-21 § 71109 (2025).

[44] States must verify citizenship and immigration status with the Social Security Administration and the Department of Homeland Security. If the system cannot provide real-time verification, the state must request an additional review and may request additional documentation of eligible immigration status from the applicant. Akash Pillai, Jennifer Tolbert, Samantha Artiga, and Robin Rudowitz, "How States Verify Citizenship and Immigration Status in Medicaid," KFF, March 4, 2026, https://www.kff.org/medicaid/how-states-verify-citizenship-and-immigration-status-in-medicaid/.

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