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Medicaid Work Requirements: An Update and Look Forward

As a result of last year's [budget reconciliation bill \(H.R. 1\)](#), Medicaid agencies are gearing up to impose a new work requirement on Medicaid expansion enrollees. With a looming [implementation deadline of January 1, 2027](#) (and multiple states opting to start sooner), details of how this requirement will be operationalized are starting to emerge—but many key specifics are still unclear. Read on for an overview of what we know so far, steps states are taking ahead of this deadline, and information for advocates about what comes next.

What Do We Know So Far?

Early Implementation States

[States implementing work requirements early](#), whether through an 1115 waiver or through a state plan amendment, may provide an early window into the logistics, implementation, and impact of work requirements. Nebraska is on track to be the first state adopting these requirements, with an [implementation date of May 1, 2026](#). The January 15 and March 19, 2026, meetings of Nebraska's [Medicaid Advisory Committee \(MAC\)](#) offered insight into some of the [specifics of Nebraska's implementation](#).

Nebraska has established a clinical team to compile a list of diagnostic codes that will be used to identify people who qualify for exemption from work requirements based on [medical frailty or having special medical needs](#). If an exemption is not supported through medical claims history, Nebraska will do additional outreach to the enrollee. Additionally, Nebraska plans to adopt all [short-term hardship exemptions](#)—which are optional for states to implement—although Medicaid enrollees will need to proactively initiate a request with the state to access these exemptions. Nebraska has also said that it will only require applicants to demonstrate they have met the

MACs and BACs are Key Venues for Work Requirement State Policy Development and Public Feedback
Medicaid Advisory Committees (MACs) provide advice to state Medicaid agencies on [health and medical care services](#). They are made up of provider, consumer, and government representatives that advise their agency on policy development and program administration. 25% of MAC members must come from the BAC. MAC meetings are open to the public and include a public comment period.

Beneficiary Advisory Councils (BACs) are [advisory groups](#) composed of Medicaid beneficiaries, their families, and/or caretakers. These group create a safe and supportive environment for Medicaid members to share input. BAC meetings are not required to be open to the public unless the BAC decides otherwise.

State advocates, providers, Medicaid beneficiaries, and others concerned about a state's implementation of work requirements should review the state's MAC and BAC meeting schedule and agendas and plan to attend public meetings, if possible.

work requirements for the month immediately preceding application, which is shorter than the reconciliation law’s maximum allowed lookback period of 3 months.

Nebraska has already identified qualifying activities and exemptions for 60-72% of their expansion population based on existing Medicaid data. The remaining 28-40% of Nebraska Medicaid expansion members will be asked to provide information demonstrating qualifying activities or exemptions as part of the Medicaid renewal process. The state has already begun to [notify expansion enrollees](#) of these new requirements through mail, text, and email. Enrollee notification is expected to continue through April. In addition to continuing enrollee outreach, Nebraska will publish educational videos concerning work requirements and will begin running public service announcements in April 2026.

Since Nebraska plans to launch their system ahead of the forthcoming interim rule on work requirements that the Department of Health and Human Services (HHS) must release by [June 1, 2026](#), Nebraska Medicaid is meeting with the Centers for Medicare and Medicaid Services (CMS) on a weekly basis to confirm that Nebraska’s system will comply with the future rule. Nebraska’s [Work Requirements FAQ page](#) will be updated as they learn new information from CMS. Many [open questions](#) remain concerning Nebraska’s implementation, such as how the state will define the “serious or complex medical condition” subcategory of people with special medical needs, which makes it difficult to predict the full impact of work requirement implementation in that state.

Other states pursuing early implementation include Montana (under an [1115 waiver](#)), Ohio (also under a [1115 waiver](#)), and [more](#). Arkansas is planning a [“soft-launch” of work requirements July 1, 2025](#), in which the agency will run automated processes to determine whether Medicaid beneficiaries are exempt or in compliance with the new work requirements, and will notify beneficiaries of their status under the requirement, but will not disenroll those failing to meet the requirement until January 1, 2027.

Some states not planning to implement work requirements early have also publicly begun their planning processes. For example, California has published an [implementation plan](#). Additionally, Colorado has released [draft worksheet](#) for assessing whether individuals must comply with work requirements—though this worksheet is hopefully a work in progress, since it uses language that may be confusing or off-putting to many applicants, such as “are you medically frail” (a term most people would not use to describe themselves).

December 2025 Guidance

On December 8, 2025, the Center for Medicaid and CHIP Services (CMCS) released an [informational bulletin](#) expanding on the new community engagement requirement. Although HHS must publish its interim final rule by [June 1, 2026](#), this bulletin offered initial guidance on how states may operationalize work requirements based on the language of H.R. 1. The bulletin provides limited new details and clarification, including:

Timelines for Compliance and Outreach: As noted, states can implement work requirements on or before January 1, 2027. States are also permitted to require applicants to demonstrate one, two, or three months of compliance with the work requirement (known as the “lookback period”). As a result, in a state that is implementing work requirements effective January 1, 2027—but with a three-month lookback period—an applicant would need to be able to show compliance (i.e. work, education, or other qualifying activities) as early as *October 1, 2026*. States are required to begin their outreach to Medicaid enrollees three months before the date of earliest compliance based on the lookback period.

Compliance Verification: States are required to use reliable information from sources such as payroll data, Medicaid provider payments or encounter data, and data about higher education enrollment, job training participation, or community service. The state may not request additional information or documentation from enrollees unless it cannot establish an individual’s compliance or exemption using available reliable information.

Noncompliance Process: States must allow a 30-day cure period for the applicant to demonstrate compliance or exemption. Notices of noncompliance must explain how to demonstrate compliance or qualify for an exemption, and how to reapply for Medicaid if an applicant’s application is denied or if a beneficiary is disenrolled. If a beneficiary is disenrolled, the state must continue to provide Medicaid during the 30-day cure period. After disenrollment, if the state finds the individual has no other basis for eligibility under Medicaid or another insurance affordability program, the state must provide written notice and fair hearing rights.

Subsidized Marketplace Access: Noncompliance will bar disenrolled individuals from access to subsidized Marketplace coverage. Individuals eligible for minimum essential coverage (MEC) Medicaid are generally not eligible for advance payments of the premium tax credit (APTC) and premium tax credits (PTC) used to pay for coverage on a Health Insurance Exchange. When an individual is disenrolled from Medicaid due to work requirement noncompliance, they are still treated as “eligible” for Medicaid for purposes of Marketplace subsidy rules. Therefore, individuals unable to satisfy the work requirement or show they meet an exemption will lose Medicaid coverage and will be barred from getting subsidized coverage on the Marketplace, making it very challenging to access affordable coverage.

Implementation Choices: Policies & Logistics

Prior to implementation, all states must make important policy decisions and set up new data systems and other logistical infrastructure. Especially important discretionary decisions for states include:

- **Hours:** H.R. 1 requires a minimum of 80 hours of qualifying activities each month, but states may require more.
- **Verification Frequency:** States must verify compliance for at least one month every six months. However, states may choose which month this is, may require more frequent verifications, and may verify compliance for more than one month each period.
- **Lookback Period:** States may choose whether to require one, two, or three months of compliance prior to enrollment or renewal.
- **Key Definitions:** Many terms in H.R. 1 are not defined in the statute. The exemption based on medical frailty or special medical needs includes five groups of people who must be included, but an important group—persons with a “serious or complex medical condition”—are not defined. Additionally, the statute itself gives little context as to who should be included in that group. CMS may provide additional guidance on this and other key terms in the June 1, 2026, rulemaking, but details will likely be left to the states to determine.

- **Short-Term Hardship Exemptions:** States also have the option to recognize additional short-term hardship exemptions, enabling a temporary pass for individuals who have received inpatient care, live in an emergency or disaster area, live in a [high unemployment area](#) (as defined by the statute), or who had to travel for medical care. Some of these require HHS’s approval to implement.

In addition to answering policy questions, [states must also prepare](#) to handle the higher administrative burden these requirements will impose on their system. Some of the logistical steps states must take include developing public-facing policy guidance, developing data sharing agreements between impacted agencies, building out IT infrastructure, drafting notices and designing systems for outreach to beneficiaries, building out the appeals process, training eligibility workers, and developing workforce supports such as job training, resume building, or job search assistance.

States may apply for federal funding to support their implementation activities. Under the statute, states may also request a [good faith exemption](#) that allows them to delay implementing the work requirement for up to two years. However, the language of the [December bulletin](#) suggests that these will be rarely if ever approved—the bulletin indicates states must be “making meaningful efforts towards implementation and experience severe and/or unexpected issues that hinder their progress.”

Next Steps

Advocates should keep track of their state’s work requirements planning process and provide comments or input whenever possible.

When commenting on a state’s applicant-facing materials, it is important to emphasize that forms must be clear and consistent with statutory language. Advocates and states should also be mindful that some terms included in the bill might be vague, confusing, or stigmatizing, and should be avoided (for example, encourage the use of “special medical needs” instead of “medically frail”). [Civilla’s recommended question templates](#) may be helpful in suggesting user-friendly formatting for your state agency. Definitions of key terms may be laid out explicitly in policy or planning documents, or implicitly in the screening questions of Medicaid applications, so watch out for adverse policy decisions that are hidden or unclear.

Finally, a reminder that work requirements apply to Medicaid expansion enrollees, meaning they are not happening in states that have yet to expand their Medicaid program. Advocates in non-expansion states should monitor their own Medicaid agencies for policy changes and legislative proposals introducing work requirements independent of H.R. 1. Florida, for example, has introduced [legislation proposing work requirements that apply to non-expansion Medicaid enrollees](#). Such proposals underscore that work requirements are not about ensuring that people who can work do so—as most people in traditional Medicaid

Defining Special Medical Needs:

H.R. 1 defines “special medical needs” as someone who (a) is blind or disabled (under the Social Security definition); or (b) has a substance use disorder; or (c) has a “disabling mental disorder”; or (d) has a disability that significantly impairs their ability to perform activities of daily living; or (e) has a “serious or complex medical condition.”

While some of these categories require a degree of disability or impairment, the statute [does not require proof of disability](#) if a person has a “serious or complex medical condition” or a “substance use disorder.” These individuals are exempt from work requirements regardless of their work or disability status.

are older, have disabilities, or are pregnant or postpartum—they are about creating unnecessary barriers to coverage and care.

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