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New Medicaid Work Requirements Rule Threatens Access to Care for People with Chronic Conditions

On June 1, 2026, the Centers for Medicare and Medicaid Services (CMS) released an [Interim Final Rule \(IFR\)](#) interpreting the new Medicaid work requirement provisions required under [last year's budget reconciliation bill](#), also known as HR 1 or the One Big Beautiful Bill Act (OBBBA). This is the first time states have been required to implement work requirements in Medicaid in the program's history. The lengthy IFR covers numerous aspects of work requirements implementation, including providing details about how Medicaid enrollees can demonstrate compliance, how CMS interprets the exemptions required under HR 1, how state Medicaid agencies must educate enrollees about the new rules, and more.

Medicaid experts are still parsing the many details of the IFR, but two important takeaways are already apparent. First, in a shift from what CMS had signaled until recently, the IFR takes a restrictive approach to interpreting the work requirements exemption in HR 1 for people who are medically frail or have special medical needs. This interpretation, if implemented, would bar many people with chronic illnesses and other serious or complex conditions from accessing the exemption, threatening their access to health coverage, and putting their health at risk. Additionally, the IFR significantly limits state Medicaid agencies' ability to rely on individuals' own reports about their health to determine whether they qualify for the medically frail or special medical needs exemption. Read on for more analysis of these issues and what could happen next.

CMS's About-Face on Medical Frailty and Special Medical Needs

HR 1 required CMS to issue the IFR by June 1, 2026. However, states are required to implement the new Medicaid work requirements by January 1, 2027. This [undertaking is so significant](#)—requiring changes to state policies, eligibility assessments, IT infrastructure, and more—that implementation had to begin in the impacted states (those that have adopted Medicaid expansion) well before the IFR was published. Additionally, a handful of states [opted to implement the new work requirements early](#). The first of these, Nebraska, began applying Medicaid work requirements to new enrollees on May 1, 2026.

For states to be able to meet their statutory or self-imposed implementation deadlines, CMS needed to provide states information about what would likely be required under the IFR before it was published. For example, Nebraska stated in its recent Medicaid Advisory Committee meetings that it was [“working closely with CMS”](#) on Nebraska's work requirements implementation, since its implementation would begin before

the IFR published. Health care access advocates and other stakeholders were looking to Nebraska as a likely indicator of what CMS would allow, especially for the implementation of the medically frail or special medical needs exemption. [Nebraska adopted a straightforward interpretation](#) of this exemption that adheres closely to [the language in HR 1](#), which requires only that a person have one or more of five categories of conditions: a disability as defined in the Social Security Act; a substance use disorder; a “disabling mental disorder”; a physical, intellectual, or developmental disability that significantly impairs their ability to perform activities of daily living; or a “serious or complex condition.” Nebraska also published an extensive list of [medical diagnosis and procedure codes](#) that, if reflected in a Medicaid enrollee’s claims data, would indicate that this individual qualifies as medically frail or having special medical needs under Nebraska’s definition. An enrollee with these codes in their claims data would not need to take any further action to show that they are exempt from the work requirements. The list includes chronic conditions such as HIV and viral hepatitis that often do not impair an individual’s ability to work but do require uninterrupted access to care to maintain good health.

What is an Interim Final Rule?

Under the federal Administrative Procedures Act, when publishing regulations, a federal agency must ordinarily publish a proposed rule, accept comments on the rule, and assess the comments before publishing the final, binding rule. In limited circumstances, however, an agency may publish an Interim Final Rule, which may become effective before the agency has had a chance to solicit and review comments on a proposed rule. These are generally circumstances of urgency. Here, Congress specifically authorized CMS in HR 1 to publish an IFR, likely due to the short amount of time between HR 1’s passage and when the new work requirements take effect.

The IFR makes it more difficult for these same individuals to be exempted from work requirements because it adds a requirement that, in order for an individual to qualify as medically frail or having special medical needs, the individual must have a condition that [“significantly impairs \[their\] ability to comply”](#) with the new work requirements. This rule is *in addition to* the statutory requirement that an individual have one of the five categories of conditions listed above. The IFR includes a list of examples of conditions that could be considered “serious or complex”—including cancer, end-stage renal disease, viral hepatitis, sickle cell disease, HIV, and others—but *only* when those conditions significantly impair an individual’s ability to comply with work requirements. The IFR significantly narrows the definition of medically frail or special medical needs from the language that appears in HR 1—reducing the [number of people who will likely qualify for the exemption](#), undermining [Congress’s intent](#) to protect people who need access to care, and throwing a wrench into state Medicaid agencies’ [planning processes that were already underway](#).

The IFR’s definition of medically frail or special medical needs will also likely be unworkable. HR 1 requires that states attempt to assess a Medicaid enrollee’s compliance with work requirements on an *ex parte* basis, meaning without the enrollee having to take any action. This provision is important, as it reduces administrative barriers for enrollees that can result in coverage losses, including for people who are otherwise eligible and fully compliant with Medicaid rules. In keeping with this rule, the IFR requires states to develop lists of conditions (like Nebraska’s list) to help further define the meaning of medically frail or with special medical needs and to help identify people who may qualify. However, states will likely be unable to create comprehensive (or even near-comprehensive) lists of diagnosis and procedure codes that reflect not only

whether a person has a serious or complex condition, but also whether that condition significantly impairs their ability to work. This is because billing codes are not designed to capture this information, and a person's ability to work requires an individualized determination that may depend on individual circumstances such as the person's education and work experience. Additionally, the IFR does not define what constitutes significant impairment, leaving room for ambiguity and subjectivity in the rule's application. The result could be a lot more work for states—including revisiting work states have already done to build their lists of codes, as well as future work to process more detailed, individualized medical frailty determinations—and more work for medical providers, who may be called upon to document an individual's inability to work (as discussed below).

The IFR also includes thinly veiled warnings that CMS will be monitoring states for possible overuse of the medical needs exemption. States' code lists are required to be "auditable, justifiable, and consistent" with the IFR's definition of medical frailty. States are also reminded of their reporting obligations under the new law, and of the Secretary of Health and Human Services's authority to take "corrective action" by limiting federal Medicaid payments to states based on findings that states are not substantially in compliance with the new work requirements rules. States' reported data will be assessed for possible outliers, with "large percentages of individuals who ... meet a particular exclusion or exception" highlighted in the IFR as an example. Given the Trump Administration's demonstrated [willingness to withhold Medicaid funds to advance its policy priorities](#), the IFR may create a chilling effect that deters states from pushing the boundaries of CMS's narrow and ambiguous definition of medically frail and special medical needs.

Limited Use of Enrollee Statements to Determine Medical Frailty

The IFR also establishes strict limits on the use of Medicaid enrollees' self-assessments to determine whether an enrollee is eligible for the medically frail or special medical needs exemption. As discussed above, states will be expected to first attempt to determine whether an enrollee is eligible for the exemption based on information the state already has, including using medical diagnosis and procedure codes that appear in an enrollee's Medicaid claims history. However, it will be difficult to assess based solely on these codes whether a person is significantly impaired from working due to their condition. It is therefore likely that states will often need to rely on additional sources of information to implement the IFR's definition of medically frail.

Until January 1, 2028, the IFR permits states to either require third-party documentation (for example, medical provider records) or accept a sworn statement in order to verify that an enrollee is medically frail or has special medical needs. However, beginning January 1, 2028, the IFR allows states to accept a Medicaid enrollee's statement about their own condition only once during the individual's period of enrollment. At the individual's first eligibility redetermination (after they sought a designation that they are medically frail or have special medical needs), the state will need to be able to document their entitlement to the exemption through the state's own data (for example, new claims codes) or external documentation (provider records).

This rule will create more work for states, which will have to establish processes and tools for receiving and assessing documentation, as well as for providers, who will likely be put in the position of having to determine whether their patients are significantly impaired in their ability to comply with the Medicaid work requirements—a potentially subjective and individualized assessment. Providers will also face additional administrative burdens related to associated paperwork. Worst of all, the added documentation will generate

additional administrative hurdles to keep their coverage for people who are already facing health challenges. The result will be increased coverage losses for those who most need access to care.

What Will Happen Next, and What You Can Do

CMS will [accept comments on the IFR until July 31, 2026](#), and organizations concerned about the rule's impact should consider responding. Since this is an IFR, the final rule will take effect on July 31, 2026, before CMS has read the comments. However, commenting on the IFR is still important, because it will help build an administrative record that shows why the rules outlined above are harmful to people living with chronic illnesses and disabilities, unworkable, and contrary to Congress's intent to protect people who need access to care the most. A [recent Health Care in Motion](#) provides more information about how to comment and the role that comments play in administrative rulemaking.

Call Your Elected Officials!

In addition to writing comments explaining why the rule is harmful, advocates are urging their state governors and members of Congress to push CMS to delay implementation of the IFR, and to rewrite it so that it conforms to HR 1's definition of medically frail or having special medical needs. Check out this [AIDS United action alert](#) to lend your voice!

Given the IFR's significant flaws—especially the way its definition of medically frail or special medical needs diverges from the language in HR 1—litigation challenging the rule is likely. However, it may be some time before any lawsuit is filed, since suits filed in federal court must comply with strict rules (known as standing) that govern who can bring a suit and when.

At least some states will likely ask CMS for more time to implement Medicaid work requirements. HR 1 included a provision that allows states to request permission to delay implementation until December 31, 2028, based on a showing that they have engaged in a good faith effort to implement the work requirements on time. CMS's turnabout on the definition of medically frail or special medical needs creates more work for states to do—and to redo—providing support for such requests. However, CMS indicated in informal guidance released late last year that such requests would be granted [sparingly at best](#), and the new IFR states that initial good faith delay requests will be granted for 6 months at most. Yet even short-term delays in implementation will protect Medicaid enrollees' access to coverage temporarily, giving states more time to adequately prepare for the massive changes ahead.

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