H.R.1

AND THE IMPACT OF MEDICAID WORK REQUIREMENTS

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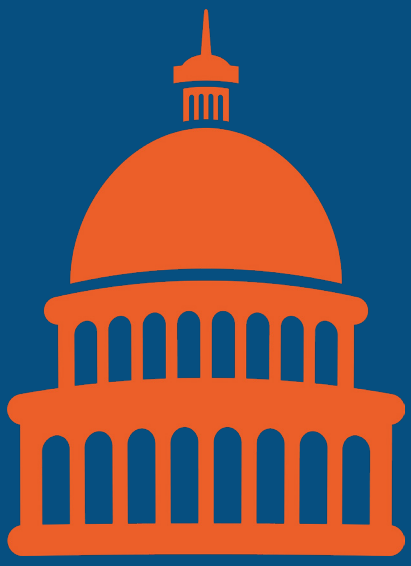

NATIONAL COUNCIL
for Mental Wellbeing®

The National Council for Mental Wellbeing has developed the following white paper focusing on the upcoming work requirements under the Medicaid program. It provides background on the passage of the 2025 landmark legislation H.R.1 (the "One Big Beautiful Bill Act") and the updated work requirements guidance issued since the bill's passage, and highlights state examples and developments around work requirement implementation. Finally, it offers recommendations from the National Council for Mental Wellbeing to the Centers for Medicare and Medicaid Services (CMS) and to provider organizations for implementing these requirements.

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Section I: Background on H.R.1 and Updated Guidance

Background

On July 4, 2025, President Donald J. Trump signed H.R.1 into law. The "One Big Beautiful Bill Act," includes significant changes to Medicaid,[1] such as new community engagement requirements (more commonly referred to as "work requirements") for members of the Medicaid expansion population.[2]

Specifically, the bill requires expansion enrollees to complete at least 80 hours of work or qualifying activities each month.[3] In addition to work, such activities can include community service, educational programs, or a combination of these activities. Individuals may also be eligible if their monthly earnings (average monthly earnings over a six-month period for seasonal workers), are equal to or greater than the amount calculated by multiplying the minimum wage by 80 hours.[4] The work requirements provision becomes effective Jan. 1, 2027.

H.R.1 includes exceptions to work requirements for individuals with a substance use disorder or "disabling mental disorder;" individuals in a "drug addiction or alcoholic treatment or rehabilitation program;" American Indians, Alaska Natives and California Indians; parents, guardians or caregivers of dependent children 13 years or younger or disabled individuals; veterans with total disability ratings; and former foster care youth under age 26, among others.[5] CMS, and states to varying extents, will likely determine specific definitions for several potentially ambiguous terms listed as exceptions (e.g., "disabling mental disorder") through rulemaking.

H.R.1 directs CMS to issue an interim final rule for the purposes of assisting with implementation of the work requirement provision no later than June 1, 2026.[6] H.R.1 also requires states to verify that an enrollee has met the work requirements during regularly scheduled eligibility redeterminations or more often at a state's choosing.[7] Currently, Medicaid eligibility redeterminations must be conducted at least annually; however H.R.1 requires states to increase the frequency of redeterminations for expansion enrollees to at least once every six months.[8] States will also be required to use existing state data sources to verify compliance (a process known as ex parte verification).[9]

December 2025 CMS Guidance

On Dec. 8, 2025,CMS released initial guidance clarifying how states should implement the new Medicaid community engagement requirements. The guidance largely restates information contained within H.R.1, reiterating who is considered an "applicable individual," detailing the requirements, listing exceptions and

exclusions, and outlining how states should document and verify compliance.[10] While largely aligned with existing directives in the law, the guidance offers some new insights, including CMS's interpretations on verification processes, what may constitute "reliable information," and the role managed care organizations (MCOs) can potentially play in implementation.[11]

Specifically, the guidance explains that work requirements do not apply in states that (1) have not adopted Medicaid expansion and (2) do not operate a Section 1115 demonstration that provides minimum essential coverage to applicable individuals.[12]

Notably, the CMS guidance clarifies that a beneficiary will be deemed compliant if they show engagement at any point during the eligibility period for a number of months specified by the state.[13] CMS further clarifies that states may not require engagement in particular months or mandate that the required months be consecutive when more than one month of compliance is required. Additionally, CMS highlights H.R.1's modification to Medicaid eligibility redetermination requirements, which mandates that states conduct redeterminations every six months for expansion enrollees. The guidance provides that individuals subject to both the work requirement and eligibility redetermination provisions must demonstrate compliance semiannually.[14]

The guidance elaborates on potential sources of reliable information for verifying compliance, recommending that states consider data on higher education enrollment and participation in job training programs or community service in addition to the statute's examples, such as payroll records, Medicaid provider payment and encounter data.[15] States may not ask individuals to submit additional information or documentation unless compliance cannot be verified using these data sources, whether at initial application or renewal.[16] The guidance also clarifies that states may not allow Medicaid MCOs to determine whether beneficiaries are complying with community engagement requirements, although the MCOs may carry out supportive tasks.[17] With respect to "good faith effort" exceptions, CMS indicates requests will be evaluated on a case-by-case basis. The agency adds that it expects approvals to be limited to states making meaningful progress toward implementation but facing severe or unforeseen challenges slowing that progress.[18]

CMS has created an online hub for H.R.1 implementation with a dedicated page to community engagement requirements.

Congressional Budget Office Analysis

The Congressional Budget Office (CBO) predicts that of all the Medicaid provisions within H.R.1, the work requirements provision will have the greatest impact on federal spending and enrollee coverage.[19]

According to KFF, CBO also "projects indirect effects from the work requirement provision will decrease federal revenues by $8.65 billion over a decade."[21] Overall, CBO estimates that H.R.1 will lead to approximately $911 billion in total Medicaid reductions.[22]

CBO anticipates federal Medicaid spending will be reduced by approximately $326 billion over 10 years, with most of the savings generated by coverage losses (an estimated increase of roughly 5.3 million uninsured people across the country).[20]

Section II: State Examples and Developments

Work Requirements: Historical Impacts and the Arkansas Experience

In 2018, for the first time in the history of the Medicaid program, states were given the option to impose work requirements as a condition of enrollment.[23] CMS approved 11 state proposals for implementing waiver-based demonstration programs between 2017 and 2021.[24] Most of these proposals faced legal challenges and were never fully implemented before being rescinded entirely in 2021.

An analysis found that compared to individuals in states without work requirements, work requirements failed to increase employment among 30- to 49-year-old Arkansans (the group targeted by the policy) and resulted in significant coverage losses while they were in effect.[28]

As part of its proposed waiver-based programs, in 2018 Arkansas implemented a Medicaid work requirement for a nine-month period.[25] During this time, more than 18,000 Medicaid enrollees lost coverage.[26] Roughly one-third of Arkansan enrollees reported being unaware of the requirement.[27]

Pathways to Coverage: Georgia's Experience with Work Requirements

Similarly, Georgia's work requirement for certain individuals not otherwise eligible for traditional Medicaid (offered through the Georgia Pathways to Coverage program[29]) has fallen short of initial expectations. In October 2020, Georgia received approval for its demonstration to require certain adult Medicaid beneficiaries to meet work or other activity requirements as an eligibility condition.[30] To date, Georgia is the only state that has implemented work requirements on eligible individuals with incomes up to 100% of the federal poverty level as a condition of receiving Medicaid.[31]

Enrollment began in July 2023 after a two-year delay due to litigation. Implementation of work requirements required significant changes to Georgia's eligibility and enrollment systems, outreach and communications efforts, staffing and contractor support, and other administrative functions.[32] The state reported that in the first year of the program, more than 40% of Georgia's counties still had fewer than 10 enrollees.

Despite the state having one of the highest percentages of uninsured populations in the nation, there was a total of 4,231 individuals enrolled, well below the state's first-year projection of approximately 100,000 new enrollees.[33]

The Government Accountability Office Report on Georgia's Work Requirement Efforts

In September 2025, following a request from several members of Congress,[34] the Government Accountability Office (GAO) published a report on administrative spending related to Georgia Pathways to Coverage.[35]

The GAO report found the Georgia Pathways to Coverage program had not met its enrollment targets and was over budget primarily because of administrative expenses .[39] These weaknesses align with concerns GAO raised in 2019 about oversight of administrative spending in Medicaid demonstrations.[40]

According to GAO, Georgia reported approximately $80.3 million in total spending on the demonstration between October 2020 and March 2025.[36] Of that amount, about $54.2 million was spent on administrative activities,[37] and out of that about $47.4 million (roughly 88%) was funded by the federal government through federal matching funds.[38]

Nebraska Work Requirement Implementation

On Dec. 17, 2025, Nebraska Governor Jim Pillen was joined by CMS Administrator Mehmet Oz, MD, to announce the state's early start to work requirement implementation.[41] Pillen announced that Nebraska plans to begin implementation on May 1, 2026.[42] As with other states, the requirements will apply to "able-bodied" adults ages 19-64 enrolled in Medicaid expansion, and such individuals "will be required to participate in work, approved work programs, community service or educational activities for at least 80 hours per month, unless they qualify for an exemption."[43] Nebraska Medicaid will verify compliance at application and renewal using available data sources. When verification cannot be completed through these sources, beneficiaries will be required to submit supporting documentation. Individuals determined to be noncompliant will receive notice and have 30 days to either come into compliance or attest to an exemption before coverage is denied or terminated.[44]

The press release announcing the start of implementation lists several exemption categories for expansion enrollees within the state, including "people receiving treatment for a substance use disorder," medically frail individuals, disabled individuals, those in foster care, and people who are or have been incarcerated within the last 90 days.[45] A related FAQ document disseminated by the state clarifies that these exemptions specifically include, "people who are participating in a drug addiction or alcoholic treatment program," an exemption consistent with the statutory requirements of H.R.1.[46] The FAQ also specifies that the "medically frail" exemption category will include individuals who have one or more of the following conditions:

- Blindness or disability
- Substance use disorder
- Disabling mental disorder
- Other significant physical, intellectual or developmental disabilities[47]

The FAQ does not offer further details on what may constitute a "disabling mental disorder" or a "substance use disorder."

The FAQ states that to verify compliance, Nebraska Medicaid will first review available information to determine whether an individual has met the work requirements or qualifies for an exemption.[48] If additional information is needed, Nebraska Medicaid will request it directly. Individuals may submit the required information in person, online, by phone or by mail. Nebraska Medicaid will provide a form outlining the specific information needed and instructions for submission. Once completed, the form will serve as official documentation that the individual meets the work requirements for a given reporting period.[49]

KFF Survey of States Identifies Potential Challenges

In late 2025, KFF and several partner organizations conducted an annual budget survey of Medicaid officials in each state and the District of Columbia with specific questions about actions they planned to take to prepare for implementation of H.R.1 work requirements.[50] The organizations received responses from 42 of the 43 states where work requirements will be implemented — all Medicaid expansion states, the District of Columbia, plus Georgia and Wisconsin, which have not expanded Medicaid through traditional means but have waivers in place that cover the expansion population. [51]

States surveyed identified a number of potential challenges related to implementation. Among the survey responses, many states noted that eligibility/claims/data-matching infrastructure currently is limited, and building interfaces across agencies and programs will take time. Some states are already engaged in multi-year IT system modernization projects, and adding the infrastructure needed to implement work requirements will likely prove burdensome.[52] Some states also voiced concerns regarding the need to make significant system changes in a limited amount of time before the requirements begin in 2027, noting the "long lead times typically needed to design, procure and build new systems."[53] Further, states anticipate needing additional staff or reallocating existing staff to handle verification, appeals, outreach, training and increased questions from enrollees. Overall, the survey suggests that states expect substantial operational obstacles in implementing Medicaid work requirements, driven in large part by system redesign, data sharing needs, compressed timelines, staff/workforce constraints and cost pressures.[54]

Under H.R.1, states will have an opportunity to apply for good faith waivers that will allow for a delay in implementation of work requirements through Dec. 31, 2028. While this may provide states with some of the additional time that may be needed to achieve a smoother implementation, it is currently unclear what the process for applying for these exceptions will entail. H.R.1 also does not require CMS to grant any such requests, and it is possible that the agency will choose not to do so.

These findings suggest that when work requirements are layered onto existing programs like Medicaid, the administrative burdens and unintended consequences (such as increased disenrollment) may be significant without proper safeguards in place.

Section III: Work Requirement Implementation Recommendations

Implementation Recommendations for CMS

Given the challenges faced by states that previously attempted implementation of work requirements, the National Council for Mental Wellbeing encourages CMS to consider the following recommendations, which seek to smooth implementation of this new mandate.

RECOMMENDATION 1:

Establish clear guidelines, while providing states with flexibility to tailor solutions, definitions and processes to the people they serve.

The National Council supports the inclusion of community engagement exemptions specifically for people living with mental health and substance use disorder challenges within H.R.1. Challenges with mental health and substance use are complex and dynamic, and impact all facets of a person's life; this can often make an otherwise straightforward procedural request difficult or even impossible for individuals to navigate while they seek treatment, care and recovery. As aligned with statutory requirements set forth under H.R.1, CMS should establish clear guidelines that provide states with the flexibility to tailor solutions, definitions, and processes to the people they serve.

Providing guidance, implementation support, and a "policy floor" will support states in establishing their operating definitions and processes to implement community engagement requirements. For example, the statutory language included in H.R.1 for the term "disabling mental disorder" under "medically frail" recognizes Congress's intent to provide states flexibility to best serve their populations.

RECOMMENDATION 2:

Create pathways for states to leverage existing claims and pharmacy data.

H.R.1 requires ex parte verification for work requirements. To this end, creating a pathway for states to leverage their claims data will likely facilitate a streamlined approach to evaluate community engagement

exemptions and align with Congressional intent. However, it will be essential to identify and mitigate any potential lags in data sharing as well as ensure any individual who rises to the level of needing an exemption is able to secure one.

Effective use of ex parte verification will enable states to identify individuals eligible for community engagement exemptions, minimizing unnecessary redeterminations and avoiding coverage losses that could interrupt access to care, which could in turn become more costly for states and local communities down the road.

Any known existing lags in data sharing should be recognized, addressed and mitigated to deter any interruption to an individual accessing needed care.

Integrated technology systems will be essential to reducing both patient and provider administrative burden, while also ensuring any third-party technology complies with all data privacy requirements for patients. Using existing claims data effectively and efficiently leverages existing resources.

RECOMMENDATION 3:

Establish simple processes for clinicians to certify community engagement exemptions as part of medical provider decision-making, while also allowing state flexibility.

Given the mental health and substance use workforce shortages across the country, particularly in rural communities, people can face significant delays in getting the care they need. As a result, an individual may not receive a diagnosis, and new beneficiaries who need an exemption may not have yet gotten appropriate treatment necessary for them to qualify for an exemption to their state's community engagement requirements based on claims data or other criteria.

CMS should allow providers flexibility to use their medical decision-making expertise and discretion to certify, in the least administratively burdensome manner, that someone has met the requirements for an exemption in their state.

Implementation Recommendations for Clinics and Providers

In addition to federal policy suggestions, The National Council proposes the following clinic-level recommendations, which may help ease the administrative burden faced by both providers and patients as they seek to comply with H.R.1's work requirements.

RECOMMENDATION 1:

Strengthen eligibility navigation and reporting support.

As work requirements take effect, organizations should consider prioritizing eligibility navigation and reporting support for clients. Even modest investments in navigation capacity can help prevent coverage losses and reduce care disruptions. Clinics may wish to consider identifying someone within the organization to be responsible for Medicaid eligibility navigation. This person may be responsible for activities such as monitoring eligibility and reporting deadlines, serving as a point of contact for client questions, coordinating with external navigators or enrollment assisters, and tracking coverage-related issues and escalations.

RECOMMENDATION 2:

Partner with state and local workforce and social services early.

To minimize coverage disruptions and administrative burden, organizations should seek to align with the public systems responsible for administering qualifying community engagement activities. Early coordination can help ensure clients are referred quickly into allowable activities while accounting for relevant needs. Clinics may want to establish Memorandums of Understanding with local workforce development boards, community colleges and adult education providers, and local volunteer and community service organizations. These agreements can help to clarify referral processes and expectations around documentation of participation, ultimately reducing delays for clients in demonstrating compliance.

RECOMMENDATION 3:

Offer on-site or virtual "reporting days" with staff assistance.

Clinics may also consider hosting periodic on-site or virtual "reporting days" where clients receive hands-on assistance completing required Medicaid reporting tasks. Structured support sessions can help address common technology and administrative impediments that sometimes disproportionately affect individuals experiencing mental health and substance use challenges. Clinics may wish to consider designating specific days where staff or volunteers help clients submit hours, upload documents or request exemptions. This can help reduce missed deadlines caused by technology or other impediments. Clinics may be able to maximize the impact of this practice by using standardized checklists to confirm tasks completed during the session and documenting assistance provided in an electronic health record (EHR) or care management system.

RECOMMENDATION 4:

Track and report coverage loss impacts to state Medicaid agencies.

As changes are implemented, organizations can play a critical role in documenting real-world impacts of coverage loss and administrative churn. Even limited, targeted data collection can help state Medicaid agencies understand unintended consequences and inform future policy choices. Clinics may wish to track a list of indicators that are most directly tied to coverage loss.

This may include:

- Missed or cancelled appointments following disenrollment.
- Interruptions in medication access or treatment continuity.
- Increased use of crisis services, emergency departments or inpatient care.
- Growth in uncompensated or charity care.
- Delays in re-enrollment or repeated churn.

RECOMMENDATION 5:

Develop written internal policies and protocols.

Clinics should consider adopting a set of written policies that describe how staff will identify patients subject to work requirements, assess exemptions, document functional limitations, assist with reporting, and respond to coverage risk. Clear protocols can reduce staff confusion and ensure consistent support across different programs and sites.

RECOMMENDATION 6:

Use AI-assisted documentation to help capture exemptions.

AI-enabled note generation tools can help to detect clinically relevant criteria that support exemptions. If a clinician documents a condition that qualifies an individual for an exemption, an AI documentation tool can potentially auto-tag that information in the record, generate a summary of exemption-related documentation, and push alerts to care managers when verification may be needed. Clinics should consider adding exemption keywords to templates so AI documentation tools pick them up consistently, configuring EHR systems to automatically route flagged notes to the eligibility or financial services team, and use AI to generate standardized letters or verification forms for patients who need proof of a condition to claim an exemption.

RECOMMENDATION 7:

Use evidence-based approaches to help patients stabilize and achieve compliance.

Untreated mental health and substance use conditions can make compliance with work requirements difficult to achieve. Clinics may wish to consider positioning evidence-based options to stabilize patients, such as the Common Elements Treatment Approach (CETA), to improve functional capacity and readiness for employment or other qualifying activities. This system can also help alleviate workforce concerns for clinics that may arise as a result of work requirement implementation.

Final Considerations

H.R.1's work requirements introduce complex operational and clinical challenges for states. Implementation choices at the federal, state and clinic levels will determine whether the policy helps participants enter or remain in the workforce or whether it causes individuals to lose coverage. Practices like minimizing administrative burden, investing in community partners, and building strong data and monitoring systems can help states and clinics to meet statutory requirements while preserving care continuity for people experiencing mental health and substance use challenges. The National Council stands ready to partner with CMS, states, providers and communities to assist in achieving these outcomes.

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