Designing Effective Verification Pathways for Exempt Populations at Heightened Risk of Coverage Loss Under Mandatory Work Reporting Requirements

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Introduction

H.R.1 fundamentally restructures Medicaid by conditioning eligibility for expansion adults on compliance with new work reporting requirements—typically 80 hours per month of qualifying activities.[1] At the same time, Congress explicitly exempted certain groups that face additional barriers to work and are at greater risk for adverse health outcomes if they experience disruptions in Medicaid coverage from these requirements.

States face the challenge of operationalizing these exemptions at scale and in a way that minimizes coverage loss for eligible individuals. H.R.1 requires states to attempt to verify medical frailty and other exemptions *ex parte*, using data already available to the state to confirm the exemption wherever possible before requesting additional information from individuals.[2] Unless states have a deliberate, robust, and data-enabled strategy to verify exemptions, certain populations risk losing Medicaid coverage despite meeting exemption criteria, undermining their access to critical physical and behavioral healthcare and supports that help them stay healthy and live successfully in the community.[3] Getting exemptions "right" helps states comply with statutory protections, reduce administrative churn, and preserve continuity of care for eligible individuals whose health and functioning depend on stable Medicaid coverage.

As states prepare to implement exemption verification pathways for medical frailty, engaging people with lived experience is essential. In doing so, it is important to recognize that people in exempt populations may have reasons for not wanting to identify as medically frail, or feel hesitant to engage with the healthcare system broadly. These reasons can include experiences

[1] H.R.1, One Big Beautiful Bill Act, 119th Congress. (2025–2026), §§3xxx–3yyy (Medicaid work reporting provisions).
[2] K. Serafi, P. Boozang, and J. Frohlich, "Operationalizing the Medical Frailty Exemption: A Step-by-Step Implementation Toolkit for States," State Health and Value Strategies, (November 2025).
[3] L. Cuello, Georgetown University McCourt School of Public Policy Center for Children and Families, "How Do We Know Congress's Work Requirements in Medicaid Will Fail? They Already Have," (May 12, 2025).

of discrimination, stigmatization, criminalization, and institutionalization. [4,5,6,7,8,9] Such experiences can reinforce feelings of mistrust of government and the healthcare system and remind people of negative interactions with government or healthcare systems. This toolkit explores parameters for creating effective verification pathways for medical frailty and in doing so, identifies opportunities for states and other stakeholders to consider the previous experience of applicants, enrollees and their caregivers in designing those pathways.

This toolkit offers a high-level roadmap for how states can plan to identify and protect three exempt populations. While there are other groups of Medicaid enrollees who may be exempt from work reporting requirements and at-risk of inappropriately losing coverage, this toolkit focuses on the following three groups of exempt populations; SHVS may address other groups in future toolkits.

- **Exempt Population #1:** Individuals with behavioral health needs, including those related to both mental health and substance-use disorder (SUD);
- **Exempt Population #2**: Individuals with intellectual or developmental disabilities (I/DD); and
- **Exempt Population #3**: Individuals who are incarcerated or have been released from a carceral facility within the past 90 days.

Four Pillars for Exemption Design

Across all populations that are exempt from work reporting requirements, states are encouraged to consider designing coordinated strategies around four complementary pillars:

> **Pillar #1: Targeted outreach and education** that help people and their caregivers understand both their obligations and exemptions, using tailored messages and trusted messengers for each population.[10]

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[4] J. Cook, "Employment Barriers for Persons with Psychiatric Disabilities: Update of a Report for the President's Commission," Psychiatric Services, (October 2006).
[5] J. Gasper et al., "Survey of Employer Policies on the Employment of People with Disabilities," Westat, (June 2020).
[6] Rosino ML, Hughey MW. The War on Drugs, Racial Meanings, and Structural Racism: A Holistic and Reproductive Approach. Am J Econ Sociol.
[7] Misra S, Etkins OS, Yang LH, Williams DR. Structural Racism and Inequities in Incidence, Course of Illness, and Treatment of Psychotic Disorders Among Black Americans. *Am J Public Health*.
[8] Shim RS. Dismantling Structural Racism in Psychiatry: A Path to Mental Health Equity. *Am J Psychiatry*. 2021;178(7):592-598.
[9] Martin K, Taylor A, Howell B, Fox A. Does criminal justice stigma affect health and health care utilization? A systematic review of public health and medical literature. Int J Prison Health. 2020 Jul 15;16(3):263-279.
[10] Engaging Medicaid managed care plans to support special populations will also be a critical strategy. See SHVS' expert perspective, E. Montz, K. Serafi, and M. Savuto, "Leveraging Managed Care Plans to Support Implementation of Medicaid Work Reporting Requirements," (October 24, 2025).

Pillar #2: Medical frailty screener at application that equips individuals (and, where appropriate, family members and caregivers) to determine if they should be exempt based on their health status and other factors at the point of application; (1) with a SUD; (2) with a disabling mental disorder; (3) with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; (4) with a serious or complex medical condition; or (5) who are blind or disabled.[11]

Because states will often have limited or no programmatic data available on an individual prior to enrollment in Medicaid, a well-designed medical frailty screener at the point of application is a critical tool for ensuring that eligible individuals can be identified and provided with statutorily mandated exemptions from work reporting requirements from day one of their enrollment.

Pillar #3: Data-driven identification of exempt individuals, leveraging Medicaid and non-Medicaid data sources to identify exempt individuals *ex parte* and provide validation of individuals' medical frailty status. For all populations, states should use linked data across state programs and agencies to batch-identify individuals who should be exempt and flag their records in the eligibility system, minimizing the need for individuals to manually provide this information and states to process it when they already can be determined to meet medical frailty standards.[12] States should also establish processes for ongoing data exchange to keep exemption flags current as individuals obtain new diagnoses and newly become eligible for and use services or programs that would qualify them for an exemption.

Pillar #4: Hands-on assistance to individuals with providing information or documentation, as needed, when *ex parte* verification methods are insufficient, including support from: community-based organizations (CBOs), health plans, providers, or state care managers, community health workers, peer support specialists, family members and caregivers, other providers, justice partners, and disability service systems. These partners can help individuals provide needed information or documentation, when requested, to substantiate their eligibility for an exemption. When collecting information, rather than require an individual to obtain and submit medical records that create administrative burden for the eligibility workforce to process, states should develop a standardized form that allows providers, CBOs,

[11] The terms used in this document are those from the statutory language of H.R.1.

[12] See SHVS Toolkit, K. Serafi, P. Boozang, and J. Frohlich, "Operationalizing the Medical Frailty Exemption: A Step-by-Step Implementation Toolkit for States," (November 2025).

managed care plans and other approved partners to verify that a person meets exemption criteria.

Engaging People With Lived Experience in Design

Engaging individuals with lived experience is essential to designing exemption strategies across each of these four pillars that are tested and will work in practice. States can and should involve individuals with lived experience—as well as family members and caregivers—throughout every phase of work reporting requirements exemption planning and implementation. This may include, but is not limited to, co-designing and testing medical frailty screeners and notices to ensure language is accessible and in plain language and shaping outreach and education campaigns.[13,14] Meaningful engagement goes beyond one-time listening sessions[15] and includes compensating participants for their time,[16] partnering with trusted community organizations and peer-run programs, and building formal feedback loops to refine policies over time. This type of co-design helps ensure that exemption pathways are understandable and usable, surface unintended consequences early, and reflect the experiences of those most likely to be affected by coverage loss and administrative barriers.

Central to building a foundation for effective engagement is acknowledging and validating the distrust and mistrust that individuals and communities may hold as a critical first step in meeting individuals at high risk for coverage loss where they are. States should develop clear messaging and communication language about data and privacy protections and the state's commitment to protecting them. Additionally, clinicians, social workers, community health workers, and other advocates should be prepared to support enrollees and engage in open discussions about these considerations.

Exempt Population #1: Individuals With Behavioral Health Needs

H.R.1 exempts adults with an SUD, individuals who are "participating in a drug addiction or alcoholic treatment and rehabilitation program (as defined in section 3(h) of the Food and Nutrition Act of 2008)," and individuals who have a "disabling mental disorder" from work

[13] The 80 Million, "How States Can Incorporate Human-Centered Design in Medicaid Work Reporting Requirement Systems," (November 13. 2025).
[14] J. McLean, "Human-Centered Principles for States Evaluating Vendor Solutions to Implement H.R.1 Work Reporting Requirements," State Health and Value Strategies, (October 28, 2025).
[15] T. Dwan Everette, D. Sathasivam, and K. Siegel, "Transformational Community Engagement to Advance Health Equity," State Health and Value Strategies, (January 30, 2023).
[16] Please refer to SHVS' issue brief, L. Sbrana, K. O'Connor, M. Cooper, and P. Boozang, "State Strategies to Compensate Beneficiary Advisory Council Members," (November 22, 2024).

reporting requirements under the medical frailty exemption framework.[17] By definition, certain mental health conditions and SUD are associated with impairments, such as challenges with executive function, that make it more difficult to work as well as more challenging to complete paperwork necessary to obtain an exemption under work reporting requirements.[18] Research shows that during the COVID-19 "unwinding," people with mental health conditions and SUD were more likely to lose Medicaid coverage than the general population, in addition to being more likely to be disenrolled for procedural reasons (i.e., failure to return paperwork).[19] As a result, it is critical that states design comprehensive strategies to ensure that individuals with a qualifying behavioral health condition are identified as exempt.

Pillar #1: Targeted Outreach and Education

Many individuals with behavioral health conditions experience stigma and mistrust of government and employment systems and may be reluctant to self-identify an SUD or disabling mental disorder even when doing so would qualify them for an exemption.[20] In addition, approximately 20% of adults experiencing homelessness have a serious mental illness or chronic SUD, which requires more intentional and creative outreach strategies to engage these individuals.[21] State strategies for outreach and education should include the following:

- Partner with organizations that have existing relationships with individuals with behavioral health conditions, such as behavioral health providers (e.g., outpatient clinics, crisis services), clubhouses, peer support programs, care managers, CBOs (e.g., shelters, food banks, soup kitchens), managed care plans, and other people and organizations that may have frequent touchpoints with applicants or enrollees with behavioral health needs to deliver trusted messaging about work reporting requirements and exemptions and provide input to states on effective outreach strategies.

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[17] In addition, at their option, states can exempt individuals due to a "short-term hardship event," which includes receiving "inpatient psychiatric hospital services" or "other such services of similar acuity," including related outpatient services.

[18] Substance Abuse and Mental Health Services Administration, "Co-Occurring Disorders and Other Health Conditions," (March 29, 2024); R.G. Frank, The Commonwealth Fund, "Work Requirements and Medicaid: What Will Happen to Beneficiaries with Mental Illnesses or Substance Use Disorders?," (May 2, 2018); N. Counts, The Commonwealth Fund, "Medicaid's Role in Mental Health and Substance Use Care," (May 7, 2025).

[19] W.P. Bensken, S.M. Koroukian, B.M McGrath *et al.*, "Unwinding of Continuous Medicaid Coverage Among Patients at Community Health Centers." *JAMA Health Forum.* (January 5, 2024); A. Soni, J. Blackburn, "Health Characteristics of Adults Unable to Complete Medicaid Renewal During the Unwinding Period." *JAMA Health Forum*. (March 21, 2025).

[20] H. Saunders, A. Diana, E. Hinton, and R. Rudowitz, Kaiser Family Foundation, "Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders," (June 23, 2025).

[21] A. Pillai, H. Saunders, R. Rudowitz, Kaiser Family Foundation, "Five Key Facts About People Experiencing Homelessness," (September 9, 2025).

- Support individuals in enrolling in disability-based Medicaid eligibility groups (rather than in the expansion eligibility group) if they are eligible.
- Educate healthcare professionals and the public about the importance of having behavioral health conditions formally diagnosed, both for purposes of treatment, but also to help ensure that exempt individuals are not subject to work reporting requirements.[22] This education can be conducted through provider bulletins, convenings with providers, and coordinated efforts through managed care plans and provider associations.
- Develop accessible, plain language materials in multiple formats explaining who is and is not subject to work reporting requirements, which mental health and SUD conditions may qualify an individual for an exemption, and where to reach out for assistance or questions. Such materials should include clear language about how to submit information to the state Medicaid agency about your exemption.
- Engage individuals with lived experience to ensure language is plain, destigmatizing, and action-oriented.

Pillar #2: Medical Frailty Screener at Application

States should embed behavioral health-specific questions in the single, streamlined Medicaid application's medical frailty screener using plain language to allow individuals to self-identify that they have a disabling mental disorder or a SUD. The screening questions, co-designed and tested with individuals with lived experience and reviewed by front line providers, should be accompanied by examples of the types of conditions and services that would meet the definition of a disabling mental disorder or SUD, (e.g., schizophrenia, bipolar disorder, opioid-use disorder; psychiatric hospitalizations; methadone or buprenorphine treatment), and states should clarify that these examples are not exhaustive.

Pillar #3: Data-Driven Identification of Exempt Individuals

States have access to rich behavioral health data across Medicaid and non-Medicaid systems, creating a strong foundation for proactively identifying exempt individuals *ex parte*. By investing in cross-agency data governance, robust data-use agreements, and technical infrastructure to link behavioral health utilization and Medicaid eligibility systems, states can transform these diverse data sources into a powerful tool for accurately flagging individuals with a SUD or a disabling mental disorder.

[22] E.C. Williams, O.V. Fletcher, M.C. Frost *et al.,* "Comparison of Substance Use Disorder Diagnosis Rates From Electronic Health Record Data With Substance Use Disorder Prevalence Rates Reported in Surveys Across Sociodemographic Groups in the Veterans Health Administration," *JAMA Network,* (June 30, 2022); A. Bradford, A.N.D. Meyer, S. Khan, T.D. Giardina, and H. Singh, "Diagnostic error in mental health: a review," (April 4, 2024).

While for SUD, H.R.1 makes clear that either a diagnosis or utilization is sufficient for a person to qualify as exempt, states will need to develop a definition of a "disabling mental disorder" to identify people with a functional impairment associated with a mental health condition. For some conditions, diagnosis alone is likely a sufficient indication of impairment, while for other conditions, utilization provides evidence of disability. States should consider the following scenarios in developing their definitions:

- **Diagnosis alone** is a strong indicator of a disabling mental disorder. For example, conditions like schizophrenia and major depressive disorder have low rates of recovery, indicating that functional impairment associated with the mental health condition is likely to persist.[23]
- **Utilization data plus diagnosis indicate disabling mental disorder.** For less acute diagnoses, utilization of intensive treatment services provides evidence of functional impairment. For example, a diagnosis of generalized anxiety disorder paired with utilization of an intensive outpatient program, a partial hospitalization program, or attendance at a clubhouse would indicate that a person has significant functional impairment.
- **Utilization data can indicate disability without a diagnosis.** For example, a person may use crisis services before they have been diagnosed with a mental health disorder or have multiple emergency department visits for psychiatric reasons or due to SUD.

Across each of these scenarios, state strategies to use data to identify exempt individuals should include the following:

- Identify relevant diagnoses, utilization, and enrollment data to be used to identify exemptions, including:
    - Diagnoses that meet the state's definition of SUD or a disabling medical disorder, ideally using the Diagnostic Statistical Manual 5th edition and/or International Classification of Diseases (ICD-10) code sets. States should consider using the list of diagnoses that may qualify a person as having a mental disorder required for a disability evaluation under Social Security as a "floor" for a "disabling mental disorder."
    - Claims or encounter data for any SUD treatment services, including outpatient, intensive outpatient, residential, drug or alcohol treatment program, withdrawal management, and medications for opioid or alcohol use disorder.
    - Claims or encounter data for services that provide evidence of a disabling mental disorder, including claims for intensive mental health treatment outside of typical outpatient therapy (e.g., assertive community treatment, partial hospitalization, psychiatric hospitalization, clubhouse services, mobile crisis, and crisis service encounters).

[23] E. Zylla and E. Lukanen, "The Disability Gap in Medicaid: Implications for the Federal Work Requirement Proposal," State Health and Value Strategies, (June 20, 2025).

  - Specialty behavioral health managed care plan enrollment or utilization of "carved out" behavioral health services provided by an administrative services organization or specialized behavioral health provider that serves only those individuals with significant behavioral health conditions.
- Conduct a cross-agency data landscape assessment to identify non-Medicaid data that could support exemptions, such as:
  - State mental health authority and SUD agency datasets.
  - State-funded grant programs (e.g., block grant-funded crisis or recovery services).
  - Supplemental Nutrition Assistance Program (SNAP) records indicating a "mental limitation" that precludes work.
- Develop and maintain data use agreements and privacy-compliant workflows to navigate confidentiality constraints, including explicit treatment of SUD data governed by 42 CFR Part 2.
- Establish rules for exemption duration and look-back periods, as permitted under federal guidance, to avoid repeated churn for individuals with lifelong or long-duration conditions.

Pillar #4: Hands on Assistance

Even with strong *ex parte* processes and clear screener tools, some individuals will need help navigating exemptions and responding to requests for information. State strategies for providing hands on help include the following:

- Distribute materials to Medicaid-enrolled behavioral health providers, care managers, community health workers, peer specialists, and CBOs to help individuals understand the consequences of non-compliance; complete applications and medical frailty screeners; and respond to requests for information (including explanation for how data will or will not be used).

Develop a strategy and form for providers or state-approved mental health or SUD-related CBOs (e.g. recovery community organization, shelter, harm reduction organization, clubhouse, homeless outreach team, hospitals, mobile crisis teams) to submit documentation on a person's behalf to demonstrate that the person meets medical frailty exemption criteria.

Exempt Population #2: Individuals With Intellectual and Developmental Disabilities

Only about 10% of individuals with disabilities enrolled in Medicaid qualify through disability-based (non-Modified Adjusted Gross Income) eligibility pathways, and these individuals are not subject to work-reporting requirements.[24] Those who qualify through the Medicaid expansion

[24] "R. Euhus, A. Burns, and R. Rudowitz, Kaiser Family Foundation, "5 Key Facts About Medicaid Eligibility for Seniors and People with Disabilities," (February 7, 2025).

eligibility group will face new risks under H.R.1.[25] In particular, lower rates of employment among individuals with I/DD further place them at risk for losing coverage if they are unable to demonstrate that they qualify for an exemption.[26] Many individuals with an I/DD will likely qualify for one or more exemptions defined in H.R.1—including having a significant physical, intellectual or developmental disability or being a caretaker of a disabled individual—underscoring the importance of state efforts to align outreach and engagement efforts to these populations.

Pillar #1: Outreach and Education

Many individuals with I/DD require information in plain language, alternative formats (such as infographics or videos), and/or need communication supports. They often rely on family members, caregivers, and service coordinators to help them navigate Medicaid eligibility. These supporters play a central role in interpreting and responding to notices and requirements, as well as gathering and submitting required documentation, but they may lack detailed knowledge of work reporting rules and exemption pathways. Therefore, it is critical to provide supporters, in addition to Medicaid enrollees, with clear, accessible communication and targeted education. State strategies can include the following:

- Develop accessible, plain language materials in multiple formats, co-designed with and tested by individuals with lived experience (which in this instance would include family members, caregivers and services coordinators), explaining: who is and is not subject to work reporting requirements, which I/DD-related conditions may qualify an individual for a disability-based exemption, and who can assist or answer questions, including service coordinators or state staff.
- Partner with home and community-based services (HCBS) providers and advocacy organizations to disseminate information through existing meetings and communication channels.
- Coordinate timelines so work reporting notices and renewal reminders are synchronized with known I/DD program touchpoints (e.g., intake, monitoring, needs assessment meetings, regular person-centered planning meetings).

Pillar #2: Medical Frailty Screener at Application

I/DD is typically defined by lifelong conditions and functional limitations,[27] not simply a diagnosis code, and many individuals with I/DD in the expansion group may not be clearly flagged as disabled in the eligibility system even if they meet disability standards or are already receiving

[25] The 80 Million, "H.R.1 Threatens Access to Care for Individuals with Intellectual and Developmental Disabilities," (August 13, 2025).
[26] U.S. Department of Labor Bureau of Labor Statistics News Release, "Persons With A Disability: Labor Force Characteristics – 2024," (February 25, 2025).
[27] U.S. Department of Health and Human Services, Eunice Kennedy Shriver National Institute of Child Health and Human Development, "About Intellectual and Developmental Disabilities."

HCBS—making it especially important to build alternative pathways to identify them and provide support to protect their access to services. State strategies can include the following:

- Ensure the screener, co-designed with and tested by individuals with lived experience, includes functional questions tied to activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
- Align screener questions with the H.R.1 definition of medical frailty to ensure that the screener identifies individuals who may be exempt from work reporting requirements even if they are not currently receiving HCBS and/or do not meet higher eligibility thresholds that may be in place for state-run I/DD programs.

Pillar #3: Data-Driven Identification of Exempt Individuals

States often have robust data on people with I/DD through their developmental disability programs and HCBS waiver enrollment, as well as through state systems outside of Medicaid, such as vocational rehabilitation agencies and education departments, which are not routinely linked to Medicaid eligibility. Diagnostic and service-related information available through Medicaid data may also help identify individuals who have conditions that may qualify them for exemptions, even if they do not meet a higher eligibility threshold for state-run I/DD programs. Because H.R.1 explicitly requires states to leverage available data *ex parte* to document exemptions, these existing I/DD data sources represent an important opportunity to proactively identify individuals who should be exempt from work reporting requirements. State strategies can include the following:

- Map and link core I/DD datasets, such as:
    - Enrollment in I/DD 1915(c) waiver or state-funded programs, or utilization of HCBS offered through 1915(i), 1915(j), 1915(k) or section 1115 demonstrations.
    - Enrollment lists and/or service utilization data from state developmental disability agencies, vocational rehabilitation agencies, and departments of education.
    - Indicators of disability or medical frailty support needs (e.g. accessing state plan personal care services).
- Leverage claims and encounter data that includes I/DD diagnosis codes.

Pillar #4: Hands on Assistance

For individuals with I/DD, even the most well-designed exemption pathways will fall short without hands on assistance from the people and organizations that support them every day. States can strengthen these pathways by clearly defining and resourcing the role of I/DD service coordinators and providers in helping individuals understand their options, complete exemption processes, and navigate work reporting requirements when exemptions do not apply. State strategies can include the following:

- Clarify the role of I/DD service coordinators in helping individuals obtain and maintain Medicaid eligibility, including information on who is impacted by work reporting

requirements, exemption information, and reinforce that role through resources, measures, contracts, or guidance. This should include clear expectations for how service coordinators should interface with state Medicaid eligibility teams and Medicaid managed care plans, if applicable, and expectations for helping individuals collect information to substantiate an exemption (e.g., Individual Program Plans, needs assessments).

- Provide training and tools (e.g., checklists, scripts, sample forms) for I/DD service coordinators and service providers so they can help individuals, families, and caregivers complete exemption screeners; and explain work reporting requirements in accessible terms when individuals do not qualify for an exemption.

Exempt Population #3: Justice-Involved Individuals

H.R.1 explicitly exempts individuals who are currently incarcerated and those within 90 days post-release from Medicaid work reporting requirements. It also recognizes additional exemptions relevant to justice-involved people, including SUD, disabling mental disorders, and complex medical conditions. These protections are critical given the high prevalence of chronic conditions, mental illness, and SUD[28] among justice-involved individuals and the dramatically elevated risk of overdose, hospitalization, and death in the immediate post-release period.[29,30]

Pillar #1: Outreach and Education

People leaving incarceration often experience housing instability, employment barriers,[31] and acute health needs,[32] so providing information about work reporting exemptions may be a lower priority concern.[33] Many individuals may not realize they are not only exempt for the 90 days after release but that other exemptions, such as SUD or a disabling mental disorder, may apply beyond that window. State strategies can include the following:

- Integrate Medicaid work reporting education into pre-release planning, leveraging reentry planning processes already under development in many states through section 1115 reentry

[28] L.M. Maruschak, M. Berzofsky, & J. Unangst, "Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12," U.S. Department of Justice, Office of Justice Programs, Bureau of Labor Statistics, (February 2015).
[29] J.W. Frank, J.A. Linder, W.C. Becker *et al.*, "Increased Hospital and Emergency Department Utilization by Individuals with Recent Criminal Justice Involvement: Results of a National Survey," *Journal of General Internal Medicine,* (May 10, 2014).
[30] E.A. Wang, Y. Wang, & H.M. Krumholz, "A High Risk of Hospitalization Following Release From Correctional Facilities in Medicare Beneficiaries: A Retrospective Matched Cohort Study, 2002 to 2010," *JAMA Internal Medicine,* (September 23, 2013).
[31] S. Ferguson Melhorn, M. Hoover, I. Lucy, U.S. Chamber of Commerce, "The Workforce Impact of Second Chance Hiring," (September 18, 2024).
[32] National Conference of State Legislatures, "Connecting Recently Released Prisoners to Health Care—How to Leverage Medicaid," (January 16, 2023).
[33] L. Couloute, Prison Policy Initiative, "Nowhere to Go: Homelessness among formerly incarcerated people," (August 2018).

demonstrations and implementation of Consolidated Appropriations Act (CAA)-required services for youth where applicable.[34]

- Use pre- and post-release case managers, reentry navigators, community health workers, and peer mentors to provide simple, repeated messages about: the 90-day post-release exemption; additional exemption pathways (e.g., SUD, disabling mental disorder, complex medical conditions); and what individuals need to do once the 90-day period ends.
- Coordinate messaging across correctional facilities, probation/parole offices, Medicaid managed care plans, and providers serving justice-involved populations so individuals receive consistent information throughout reentry.[35]
- Engage individuals with lived experience to ensure language is plain, destigmatizing, and action-oriented.

Pillar #2: Medical Frailty Screener at Application

Given the prevalence of chronic conditions among justice-involved individuals,[36] many will qualify for one or more medical frailty exemptions defined under H.R.1. These exemptions are especially critical for maintaining coverage more than 90 days after the individual's release from a carceral facility. The pre-release window is a particularly opportune window to screen individuals for medical frailty exemptions that can be documented to maintain exemptions after 90 days post-release. State strategies can include the following:

- Incorporate the completion of medical frailty screener into pre-release Medicaid application processes with clear assurances about how information will and will not be used (e.g., information will not be shared with probation/parole officers).
- Train correctional health staff, reentry case managers, and community providers to coach individuals through the provision of exemption information and to identify those who may qualify for behavioral health or complex medical condition-based exemptions once the 90-day incarceration-based exemption ends.

Pillar #3: Data-Driven Identification of Exempt Individuals

As states continue to implement section 1115 reentry demonstrations and CAA-requirements, state Medicaid agencies have or will have information on an individual's incarceration status when they suspend coverage. State strategies can include the following:

[34] See SHVS' expert perspective, K. Serafi, P. Boozang, and G. Morgan, "CMS Issues Guidance on Section 1115 Demonstration Opportunity to Support Reentry for Justice-Involved Populations," (April 19, 2023).
[35] See SHVS' expert perspective, K. Serafi, J. Frohlich, C. Cantrell and A. Leiter, "Information Sharing Considerations for Implementing the Consolidated Appropriations Act's Requirements for Justice-Involved Children and Youth, " (November 22, 2024).
[36] MACPAC, "Access in Brief: Health Care Needs of Adults Involved with the Criminal Justice System," (August 2021).

- *For individuals who are currently incarcerated*: Implement and fully operationalize coverage suspension policies, ensuring that incarceration status is accurately flagged in eligibility systems and used to automatically document exemptions.
- *For individuals within 90 days post-release*: Establish real or near- real time data feeds from carceral facilities with release dates and use them to generate automatic 90-day work-reporting exemptions and minimize lag between release and exemption flagging.
- *For individuals beyond the 90 days post-release*: (1) link to section 1115 demonstration qualifying condition eligibility information, if applicable and tracked in the state;[37] (2) leverage information obtained from medical frailty screening activities as described above; and (3) leverage claims and encounter data as described above.

Pillar #4: Hands on Assistance

For justice-involved individuals, assistance with reporting exemptions is often the difference between maintaining coverage and falling through the cracks. People cycling in and out of carceral settings may have unstable housing, limited access to phones or the internet, and fragmented care relationships, making it unrealistic to expect them to navigate exemption requirements on their own.[38] State strategies can include the following:

- Use pre- and post-release case managers, reentry navigators, probation/parole officers, peer supports, and CBOs as key partners in collecting and transmitting information when *ex parte* processes are insufficient (e.g., reentry care plans, carceral health records); and
- Train correctional facilities, probation/parole, and community providers on Medicaid work reporting requirements and their role in assisting individuals.

Conclusion

H.R.1's Medicaid work reporting requirements introduce significant new risks of coverage loss for adults with behavioral health needs, individuals with I/DD, and justice-involved people. For these populations, Medicaid coverage is a lifeline. Congress created important statutory exemptions intended to protect individuals who may be disproportionately impacted by administrative complexity due to behavioral, cognitive, or functional limitations or who would be at risk of unmet health needs if coverage was disrupted. Whether these protections operate as intended will depend on how successfully states design their identification and mitigation strategies.

[37] Some states require individuals to meet certain clinical criteria to be eligible for the Section 1115 Demonstration, such as individuals with an SUD, complex mental disorder, or complex medical condition.
[38] D.E. Keene *et al.*, "Stigma, housing and identity after prison," *The Sociological Review,* (2018).

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