

Mandatory Medicaid Work Reporting: Implementation Requirements and Decision Points

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While [H.R.1's](#) mandatory work reporting requirements are prescriptive, states must still make a number of policy and operational decisions that will heavily influence whether eligible individuals are able to enroll in and retain coverage. These decisions affect every stage of the enrollment and renewal process. For example, states will need to make decisions about the required period of compliance or exemption at application and renewal, how qualifying criteria and exemptions are defined within federal statute and Centers for Medicare & Medicaid Services (CMS) parameters, which data sources should be used for verification, and in which priority order, how the single streamlined application is adapted, and the timing of initial and periodic notices.

States will be required to implement these changes while also adhering to longstanding statutory and regulatory requirements that include, but are not limited to: ensuring information is provided in plain language and is accessible¹; allowing individuals to submit applications, renewal forms and supplementary documents through all modalities²; ensuring the application continues to be streamlined and integrated with other insurance affordability programs and only asks for information necessary to determine eligibility³; processing applications timely, without undue delay, and within prescribed timelines⁴; conducting renewals without requiring information from the enrollees, if able to do so based on reliable information⁵; and, except where the law requires other procedures, at state option, accepting attestation of information without requiring further information, including documentation, from the individual.⁶

¹ 42 C.F.R. § 435.905.

² 42 C.F.R. §§ 435.907, 435.916.

³ 42 C.F.R. § 435.907.

⁴ 42 C.F.R. §§ 435.911, 435.912, 435.930.

⁵ 42 C.F.R. § 435.916.

⁶ 42 C.F.R. § 435.945.

Building upon the State Health and Value Strategies’ recently released [Implementation Basics and State Decision Points](#), [Medicaid Work Reporting Requirements: Implementation Planning Milestones](#), and [Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions](#) toolkits, the following table lays out the federal requirements for various features of the mandatory work reporting requirements, outlines state policy and operational options, and provides key considerations related to maximizing efficiencies and mitigating coverage losses.

Work Reporting Requirements Feature	H.R.1 Requirement	State Options	Considerations
Application Process			
Look Back Period	States will need to evaluate compliance with, or exemption from, mandatory work reporting requirements in the month(s) preceding the month of application.	<i>Policy and Operational Options:</i> <ul style="list-style-type: none"> <i>Option 1:</i> One month preceding the month of application; or <i>Option 2:</i> Up to three consecutive months preceding the month of application. 	<ul style="list-style-type: none"> The longer the period of time the state selects, the more difficult it will be for the agency to determine eligibility and for the individual to demonstrate compliance/exemption.
Applicable Individuals	Mandatory work reporting requirements apply to: (1) individuals eligible to enroll in the Medicaid expansion eligibility group; and (2) individuals eligible to enroll in a section 1115 waiver that provides expansion-like coverage (i.e., individuals ages 19-64 who are not pregnant, not entitled to Medicare,	<i>None</i>	<ul style="list-style-type: none"> All states will need to assess whether they provide expansion-like minimum essential coverage for 19–64-year-olds through a section 1115 waiver to determine who is subject to work reporting requirements. States that have an expansion eligibility group may also have

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	and not otherwise eligible under another eligibility group under the state plan and who receive minimum essential coverage).		section 1115 waiver enrollees subject to these requirements.
Application Form	As a new condition of Medicaid eligibility, states will need to update the paper and online application to incorporate new questions related to work reporting requirements compliance, mandatory exemptions, and hardship exemptions. ⁷	<p><i>Operational Options:</i> <i>Paper Application Options:</i></p> <ul style="list-style-type: none"> • <i>Option 1:</i> Fully revise the paper application to incorporate questions into the application to assist with flow; or • <i>Option 2:</i> Create stand-alone section to be attached to paper application. <p><i>Online Application Options:</i></p> <ul style="list-style-type: none"> • How to leverage smart logic to only ask questions based on answers previously asked. For example, if an individual has attested to being an American Indian/Alaska Native, no further 	<ul style="list-style-type: none"> • States will need to obtain CMS approval for any application that deviates from a CMS-developed standard model application (which has not yet been developed).⁸

⁷ The application must continue to be a single streamlined application, and individuals must be able to submit the application and any supportive documentation through all modalities including paper, online, telephone, and in-person. The state may only require an applicant to provide the information necessary to make an eligibility determination. See 42 C.F.R. § 435.907.

⁸ 42 C.F.R. § 435.907(b).

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		questions regarding compliance with work reporting requirements should be asked.	
Exemption and Compliance Verification Processes at Application and Renewal			
Mandatory Exemptions	<ul style="list-style-type: none"> States must exempt certain individuals.⁹ States must establish <i>ex parte</i> verification processes (in accordance with CMS standards) and use reliable information available to them without requiring, where possible, the applicable individual to submit additional information. 	<p><i>Policy Options:</i></p> <ul style="list-style-type: none"> States will need to develop state-specific definitions for each mandatory exemption, within federal statutory parameters and in accordance with CMS standards (expected to be released by June 2026). States may accept attestations about whether an individual qualifies for a mandatory exception.¹⁰ 	<ul style="list-style-type: none"> <i>Eligibility group-specific exemptions:</i> States should pull out all eligibility groups that do not fall in the expansion adult category or within section 1115 waiver coverage from the work reporting requirements evaluation queue. <i>Medically frail exemptions:</i> Most states will need to establish a new data matching process where information from their Medicaid Management Information System

⁹ Individuals who must be exempt include “specified excluded individuals” defined in H.R.1, as well as individuals under 19, those enrolled in or eligible for Medicaid, eligible for Medicaid through another eligibility pathway, or inmates of a public institution. See the [Medicaid Work Requirements: Verifying Compliance and Exemptions](#) toolkit for additional information.

¹⁰ H.R.1 expressly permits states to accept attestations from individuals as to whether they qualify for a mandatory exemption. See section 1902(xx)(3)(A) of the Social Security Act (SSA) (“(A) Mandatory Exception For Certain Individuals.—The State shall deem an applicable individual to have demonstrated community engagement under paragraph (2) for a month, and may elect to not require an individual to verify information resulting in such deeming,” if the individual, for part or all of a month, was a “specified excluded individual,” under the age of 19, eligible for Medicare or another Medicaid eligibility group, or an inmate of a public institution.) It is unclear how CMS will implement this flexibility. As a general matter, under federal regulations, states are able to rely on attested information in an application when determining Medicaid eligibility unless federal law specifically requires a state to verify that information (such as for income, citizenship, or immigration status). See 42 C.F.R. § 435.945(a).

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		<p><i>Operational Options:</i></p> <ul style="list-style-type: none"> Once definitions are developed, states will need to crosswalk each mandatory exemption against available data sources and develop a plan for building new data matching processes where data matching is not yet available or not sufficiently robust. States will need to determine which state programs provide services to individuals who meet medically frail criteria [e.g., behavioral health managed care plan or intellectual and developmental disabilities (IDD) program]. States will need to develop claims and utilization codes matching process for identifying medically frail individuals via their MMIS (or other state-specific) system. 	<p>(MMIS) (or other state-specific system that holds claims/encounter information) is fed into the eligibility and enrollment system in order to identify exempt individuals. Planning for such a build should be a high priority given the time and resources required.</p> <ul style="list-style-type: none"> SNAP/TANF Data Matching: States that have integrated eligibility systems will need to program for mandatory exemptions. States that do not have integrated eligibility systems will need to establish new/expanded data matching processes.

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		<ul style="list-style-type: none"> States will need to develop an exemption verification hierarchy. States will also need to determine the role of managed care plans in identifying mandatory exemptions via utilization data and/or case management identification. 	
Short-Term Hardship Exemptions	<ul style="list-style-type: none"> States may, but are not required to, apply short-term hardship exceptions. States have the option to exempt individuals (1) who are living in a county with a high unemployment rate, (2) in the event of federally-declared emergencies or disasters, (3) who are receiving inpatient hospital care or care in a nursing facility or, intermediate care facility for individual with intellectual disabilities, inpatient hospital services, psychiatric hospital services, or such other services of similar acuity; and (4) individuals 	<p><i>Policy Options:</i></p> <ul style="list-style-type: none"> States will need to determine which short term hardship exemption(s) the state will utilize. States will then need to develop state-specific definitions for each short-term exemption, within statutory parameters and in accordance with CMS standards (expected to be released in June 2026). <p><i>Operational Options:</i></p> <ul style="list-style-type: none"> State to define the information the individual will need to 	<ul style="list-style-type: none"> For certain hardship exemptions (inpatient/institutional care and care outside a community), individuals must request the hardship exemption. Given this, the process will be largely people and paper driven.

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	<p>who must travel outside their community for an extended period of time to receive care.</p>	<p>provide and develop a process for individuals to request hardship exemptions.</p>	
<p>Compliance Activities</p>	<ul style="list-style-type: none"> Applicable individuals who are not exempt must be evaluated for compliance with work reporting activities. 	<p><i>Policy Option:</i></p> <ul style="list-style-type: none"> Develop state-specific definitions for each compliance activity, within statutory parameters and in accordance with CMS standards. <p><i>Operational Options:</i></p> <ul style="list-style-type: none"> Develop data review hierarchy for identifying compliance. (e.g., system first checks to see if income is greater than \$580/month. Systems then check to see if there is information regarding work hours.) Determine which compliance activities can be verified automatically through existing electronic data sources, and which require new systems builds. 	<ul style="list-style-type: none"> A state will want to prioritize its systems builds based on the number of people for whom it can exempt. For example, systems builds based on identifying income and work should be prioritized over systems builds identifying community service.

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		<ul style="list-style-type: none"> Establish income verification processes/waterfall (e.g., what will be the sequential order/hierarchy for verifying income). Develop consent-based verification and/or a pathway for self-employed individuals to more efficiently verify income. 	
Renewal Process			
Look Back Period	States must verify compliance with or exemption from work reporting requirements in at least one month between the individual’s prior eligibility determination and current redetermination. States may elect to verify compliance with, or exemption from, work reporting requirements for more than one month between regularly scheduled redeterminations; states cannot require such months to be consecutive. ¹¹	<p><i>Policy Options:</i></p> <ul style="list-style-type: none"> <i>Option 1:</i> Require individuals to demonstrate one month of compliance with, or exemption from, work reporting requirements; or <i>Option 2:</i> Require individuals to demonstrate more than one month (whether or not consecutive) of compliance 	<p><i>Look Back Periods:</i></p> <ul style="list-style-type: none"> Requiring more than one month of compliance/exemption is more onerous to the individual, making it more likely individuals inadvertently lose coverage. Reviewing additional months increases the administrative burden on eligibility systems and workers. <p><i>Go-Live Processes for Current Enrollees:</i></p>

¹¹ H.R.1 specifies that a state must require applicable individuals who are enrolled in the state plan or waiver to demonstrate work or community engagement “for 1 or more (as specified by the State) months, *whether or not consecutive*” during a given period. See SSA 1902(xx)(1)(B) (emphasis added). We view this as prohibiting states from requiring enrollees to demonstrate compliance across multiple consecutive months. Additionally, states continue to be required to

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		<p>with, or exemption from, work reporting requirements.</p> <p><i>Go-Live Renewal Processes for Currently Enrolled Individuals Starting January 1, 2027:</i></p> <ul style="list-style-type: none"> States will need to develop processes for how to launch renewals for currently enrolled individuals who have never been evaluated for work reporting requirements. These processes will need to account for the duration of the look back period (which per the statute could be as long as 12 months the first-time individuals come up for renewal).¹² 	<ul style="list-style-type: none"> States will need to work closely with CMS to discuss how to effectively implement work reporting requirements for current enrollees, appreciating that the rollout will be staged as different cohorts of individuals come up for renewals at different times, and that notifications may need to account for longer lookback periods compared to applicants. States will need to manage these administrative processes with limited staff resources. <p><i>Renewal Forms:</i></p> <ul style="list-style-type: none"> States can leverage smart logic in the online renewal systems to only ask questions based on answers previously provided.

conduct *ex parte* reviews of eligibility as part of the renewal process, pre-populate renewal forms for Modified Adjusted Gross Income-enrollees, and allow individuals to submit renewal forms and supplementary information through all modalities. 42 C.F.R. § 435.916.

¹² See SSA 1902(xx)(1)(B) (requiring a state to evaluate compliance with work reporting requirements “during the period between such individual’s most recent determination (or redetermination, as applicable) of eligibility and such individual’s next regularly scheduled determination of eligibility”). Prior to six-month redeterminations taking effect, this period will generally be 12 months.

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		<p><i>Paper Renewal Form Options:</i></p> <ul style="list-style-type: none"> • <i>Option 1:</i> Fully revise current renewal forms to include work reporting requirements questions; or • <i>Option 2:</i> Include a new standalone form for work reporting requirements with the renewal packet. <p><i>Online Renewal Form Options:</i></p> <ul style="list-style-type: none"> • How the state will leverage smart logic to only ask questions based on answers previously provided. 	
Frequency of verifications of compliance with work reporting requirements	States may choose to verify compliance with, or exemptions from, work reporting requirements more frequently than during regular eligibility redeterminations.	<p><i>Policy Option:</i></p> <ul style="list-style-type: none"> • Conduct more frequent checks than once every six months to verify compliance with, or exemption from, work reporting requirements. 	<ul style="list-style-type: none"> • Requiring more frequent compliance checks will be more onerous to an individual, making it more likely individuals inadvertently lose coverage. • More frequent checks significantly increases the administrative burden on eligibility systems and workers.

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Non-Compliance at Application and Renewal			
Notice of Non-Compliance	<ul style="list-style-type: none"> States must issue a notice of non-compliance if they are unable to verify compliance/exemptions; notice must include a request for information. States must provide individuals 30 days from the day the notice is received to respond to the notice and must continue to provide Medicaid to enrollees during the notice period. 	<i>None</i>	
Redetermine Eligibility on All Bases	<ul style="list-style-type: none"> If an enrollee does not demonstrate compliance/exemption after the 30-day notice period, prior to terminating Medicaid expansion coverage, the state must determine whether the individual is eligible for Medicaid under any other basis (e.g., family planning coverage) or for another insurance affordability program and issue a termination notice with fair hearing rights. 	<i>None</i>	<ul style="list-style-type: none"> States will need to track income information received as part of <i>ex parte</i> review in order to assess whether an individual was non-compliant with work reporting requirements or whether the individual is over income for the Medicaid expansion eligibility group and therefore eligible for Marketplace coverage.

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	<ul style="list-style-type: none"> The state must terminate coverage no later than the end of the month following the end of the 30-day period to demonstrate compliance. Individuals deemed ineligible for Medicaid based on non-compliance with work reporting requirements are ineligible for subsidized Marketplace coverage. Individuals continue to be eligible for a 90-day reconsideration period. 		
Go-Live Specific Notices			
Initial and Periodic Notice of New Requirement	<ul style="list-style-type: none"> States must notify applicable individuals of the following information: (1) how to comply with work reporting requirements; (2) the consequences of non-compliance; and (3) how to report an exemption. The initial notice must be sent at least three months plus the number of lookback months from December 31, 2026. For example, 	<p><i>Operational Options:</i></p> <ul style="list-style-type: none"> How will the state engage application assisters, managed care plans, providers, community-based organizations, and other ambassadors to support outreach and engagement. When will the state begin to send initial notices for: (1) all Medicaid enrollees; and (2) 	<ul style="list-style-type: none"> The number of months in the look back period impacts how far in advance the initial outreach notices will need to be sent. For example, states that choose a one month look back period must provide notice four months prior to December 31, 2026. States that choose a three-month consecutive look back period must provide notice at least six months in advance.

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	<p>if the state elects a one month look back period, the initial notice must be issued by August 31, 2026.</p> <ul style="list-style-type: none"> • Notices must be sent by: (1) regular mail (or electronic if elected by the individual); and (2) at least one other modality (e.g., telephone, text message, or internet website). • In addition to the initial notice, states must send periodic notices. 	<p>current enrollees who are up for the first cohort of renewals.</p> <ul style="list-style-type: none"> • How periodically will the state send notices (e.g., every quarter, every six months). • In what other modalities will the state send the notices. 	<ul style="list-style-type: none"> • States should look to the most effective outreach and consumer education campaigns used during unwinding to leverage for these new requirements.



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ABOUT MANATT HEALTH

This toolkit was prepared by Kinda Serafi, Lisa Sbrana and Liz Dervan. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit <https://www.manatt.com/health>.