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# Administration's Last-Minute Restrictions Likely to Worsen Impact of Medicaid Work Requirement

The Trump Administration's final rule implementing the new Medicaid work requirement makes major, last-minute policy shifts that will likely increase the number of people who are denied or lose health coverage due to the requirement, while stymieing states' ability to implement it on time.

The work requirement as established by the 2025 reconciliation bill (H.R. 1) was harmful enough.[1] It will take away coverage from parents and childless adults who can't prove that they are participating in countable "community engagement" activities at least 80 hours per month (or have income equal to 80 hours times the federal minimum wage) or are exempt; up to 7 million people could lose coverage by 2028 due to the requirement, according to the Urban Institute.[2] And it imposes a tight implementation timeline on states, which have been rushing to carry out complex changes by the January 2027 deadline.

The new interim final rule, published June 1, compounds these problems and will make the coverage loss even higher. One example — it adds new requirements to the medically frailty exemption from the work requirement, requiring that the medical condition significantly impair a person's ability to comply with the work requirement in order to qualify them for the exemption.[3] This change will mean:

- **Fewer people will be exempted as medically frail.** The change will reduce the number of people who will qualify for the exemption, leaving more people at risk of losing Medicaid due to the work requirement even though they have a serious or complex medical condition. In addition, many people who *do* qualify under the new definition will fall through the cracks if the state can no longer automatically identify them as exempt and they can't navigate the confusing and complex policy to prove that they are.
- **State agencies will have to undertake substantial additional work.** In the short term, states will have to significantly re-work policy and systems in light of the new definition and may not be able to automatically identify individuals who qualify for the medical frailty exemption when their systems go live. Over the longer term, states will have to do much more manual work determining medical frailty exemptions, since fewer individuals will be automatically identified and much more paperwork will be required.

The final rule departs significantly from what the Centers for Medicare & Medicaid Services (CMS) has been telling states for months[4] regarding the definition of medical frailty. The changes also appear to be inconsistent with the plain language of H.R. 1, and litigation is likely. Nevertheless, with the January 2027 deadline looming, many states will likely move ahead with implementation in accordance with this new policy, even if they believe it to be unlawful.

The rule allows states, for the first year of implementation (2027), to accept self-attestation by applicants and enrollees that they have a condition that impairs their ability to comply with the requirement. But it requires documentation in 2028 and beyond in many circumstances where data aren't available to confirm the exemption. Allowing self-attestation for the first year doesn't solve the problem caused by the changed definition of medical frailty – the policy change will still significantly reduce automation, require people to navigate complex screeners, and put the health care of vulnerable people at risk. And in 2028, paperwork will increase as self-attestation is limited and individuals will have to provide doctor statements or other documentation to prove medical frailty.

The fact that these major changes came at the last minute further complicates the timeline for states and increases the risk of eligible people losing coverage. H.R. 1 required CMS to release an interim final rule with critical guidance for this new policy by June 1, 2026, just seven months ahead of the implementation date. Given the lead time necessary to implement such a significant new policy that will affect millions of people, states had to make critical design decisions for their eligibility systems, revise applications and renewal forms, and begin outreach efforts *before* the final rule was issued. States met regularly with CMS ahead of the rule's June 1 publication and received initial guidance on key issues; although the guidance was preliminary, states had no choice but to rely on it as they prepared to implement the work requirement.

The changes in the rule will force states to make time-consuming and costly changes to their eligibility system, redo notices, rescind prior communications, and prepare for eligibility workers to take on significantly more burden than anticipated. (And if the regulations are stopped by courts, they will face costly changes to undo those changes.) States implementing before January 2027 – such as Nebraska, which implemented on May 1 without full guidance from CMS[5] – will have to make even more substantial changes. As a result, many states will be unable to effectively implement the new policy by the January 2027 deadline.

The Administration or Congress should delay the effective date of the work requirement to give states the time they need to accurately implement this new policy in a way that reduces the number of people whose health coverage is taken away.

## Fewer People Will Be Exempted as Medically Frail

CMS reportedly told states prior to the rule being issued that they could define medical frailty within the parameters of H.R. 1, which lists categories of conditions that should be included under medical frailty. (These include blindness or disability; substance use disorder; disabling mental disorder, physical,

intellectual, or developmental disability that significantly impairs a person's ability to perform one or more activities of daily living; and serious or complex medical condition.) The new rule, however, adds a requirement that was not in H.R. 1: it mandates that medical frailty be limited to situations where an individual's condition impairs their ability to meet the work requirement. An individual who is meeting the work requirement cannot be considered medically frail.

This change goes against the intent of the exemption, which was to protect those at highest risk of experiencing adverse health effects from losing their health coverage due to the work requirement. And it means many people who fit the prior definition of medically frail will no longer qualify for an exemption, leaving them at serious risk of losing coverage. They include people who are able to work *because* they have consistent access to health care to manage their condition, but whose health could deteriorate to the point where they could no longer work if their health care were interrupted. (This could happen for many reasons, including a paperwork error by the Medicaid agency, a business closure, or a lack of paid sick leave.) They also include people who may be able to work 80 hours in some months but fall short in other months due to their condition.

For many people with serious health conditions such as cancer, any lapse in coverage can be life threatening. For people with such conditions, a rigid work requirement can mean that a temporary period of joblessness, regardless of the cause, can have grave implications for their health and even result in death. Given these facts, and the serious consequences of losing coverage, it makes sense that the statute exempts medically frail people from the work requirement, without further requiring that they prove they are unable to comply with the work requirement. Indeed, as Congress debated H.R. 1, supporters said repeatedly that people with serious health conditions would be exempt.[6]

Even people who do qualify under the narrower definition are at risk. Because states will be able to automatically identify fewer people as medically frail under the new policy, more people will have to navigate confusing policy and forms. Many people who should still qualify for the exemption will likely lose coverage because they are unable to navigate the complex maze to claim the exemption.

## Restricting Medical Frailty Could Lead to Coverage Losses for People With Serious Health Conditions

Consider the following hypothetical example:

**Brenda has lymphoma**, is undergoing chemotherapy, and is enrolled in Medicaid. She has a fairly flexible job and is generally able to work around her appointments and treatments, but some weeks she is too fatigued or nauseated to work very much. She can't predict on any given day if she'll be fine to work or instead will spend the day vomiting.

Under the statutory definition of medical frailty, **most states would have considered Brenda medically frail**, and she would have been automatically exempted from the work requirement. She could have been

renewed automatically (*ex parte*) without having to complete any paperwork (if other eligibility factors were able to be verified *ex parte*), ensuring she had continued access to Medicaid to cover her life-preserving treatments.

Instead, **under the overhauled definition in the new rule, Brenda's path is much more complicated**. The state may not be able to use claims data to identify her as medically frail because there might not be data indicating the severity of her condition (or the state may not be able to make the complex changes required under the rule in time).

If the state can't renew her eligibility automatically, she will be sent a renewal form to complete. Since her income is sometimes enough to deem her compliant with the work requirement, she may not qualify for the medical frailty exemption. But at her next renewal, if her health worsens and she doesn't have enough income or hours during the review month, she will have to understand that she now qualifies as medically frail since her condition is impairing her ability to work. She then must report the exemption and provide any required documentation. And **she is at risk of losing her health care** if she is unable to navigate these complexities or if her paperwork isn't submitted or processed on time.

## New Approach Will Cause Added Burden and Serious Problems for State Implementation

The complex change in approach will also wreak havoc on states' ability to implement the new policy on time and to minimize the number of people who lose coverage despite being eligible.

Relying on the preliminary information provided by CMS and the definition in the statute, states spent months working with clinicians to identify diagnostic codes (known as ICD-10 codes, from the International Classification of Diseases, 10th Revision) and other information that indicates someone is medically frail. They have begun building connections to their claims and other systems to pull this information and flag an applicant or enrollee as medically frail, which would automatically exempt them from the work requirement without further action by the individual or eligibility worker. States also developed screening questions for application and renewal forms based on their definition.

The new requirement tying medical frailty to the inability to work will make it much harder for states to automatically identify medically frail individuals using data they already have, as H.R. 1 requires them to do before requesting verification from applicants or enrollees. It upends states' plans to use information from the system that processes Medicaid claims to flag enrollees with a diagnostic code that falls under their definition of medical frailty. Under the new rule, states must not only use codes to identify a condition that could indicate medical frailty but also identify additional data that indicate severity and impact on ability to comply with the work requirement. The combination of a more restricted list of eligible codes and the difficulty in identifying data to indicate severity will mean states will be able to automatically identify many fewer people.

Individuals who can no longer be automatically identified will likely have to submit, and eligibility workers will have to review, additional documents, leading to substantially more workload for eligibility workers than anticipated.

And states will need significant time to pivot to this approach; they will be able to automatically identify only a limited number of medically frail individuals (if any) if they have to implement on January 1, 2027. This drastic change will force states to undo much of their work and start over. Among other tasks, states will have to redefine medical frailty, create a new list of diagnostic and other codes associated with symptoms that could indicate medical frailty, develop ways to determine severity of the conditions and whether someone's ability to comply with the work requirement is impaired, reprogram their eligibility and claims systems with the new information, redraft screening questions, and change outreach notices.

## States Need More Time to Implement

The 18 months from H.R. 1's enactment until implementation of the work requirement was already a tight timeframe, even if states had all the needed information from the beginning to write policy, make system changes, conduct outreach, and train staff. Even if the rule published June 1 had confirmed the preliminary guidance CMS had been giving states, they would have been hard pressed to implement the work requirement accurately – that is, with systems that produced highly reliable eligibility and compliance decisions – by January 2027.[7] The dramatic shifts to a key part of the policy in the new rule is a significant added obstacle that will make it nearly impossible to make the deadline without putting *eligible* people's health coverage at risk.

If states are forced to implement by January 2027 despite those shifts, many eligible people could face dire consequences. In states that are unable to quickly adjust their definition of medical frailty and change systems, people with serious medical needs will need to take more steps to prove their exemption and may lose the health care they depend on.

Further, if states don't have time to fully test eligibility system changes and address bugs or to conduct comprehensive communication and outreach, the burden will fall on eligibility workers. They will have to implement workarounds, answer more questions from confused community members, and process more paperwork.

State agencies already made staffing budget requests based on the preliminary guidance and didn't account for this added workload. Combined with the added burden inherent in the changes in the new rule, this will mean overstretched eligibility workers won't be able to make timely and accurate decisions and answer calls. The result will be errors and delays that could affect health coverage and care for the entire Medicaid population – including groups to whom the work requirement doesn't apply, such as children, seniors, and people with disabilities.

H.R. 1 anticipated the possibility that states wouldn't be ready and empowered the Health and Human Services Secretary to grant good-faith delays to states of up to two years. The Administration's

consequential, last-minute shifts in policy direction necessitate a delay. Congress and the Administration have options to make this happen:

- Congress could delay implementation for all states via legislation and reiterate H.R. 1's definition of medical frailty. This would increase the chances that states have systems in place so the people they promised to protect are less likely to lose access to Medicaid.
- CMS could grant a good-faith exception to all states that submit the required documentation showing that they aren't ready, delaying implementation in those states for up to two years.

Whatever the path, states need more time to ensure that the Administration's last-minute changes to the harmful work requirement do not cause even more eligible people to lose coverage. The need is urgent. Notices are already going out to individuals affected by the new policy, and system changes can't easily be turned on and off, so the sooner a change in the effective date can be made, the better. States need to know if they will be forced to push ahead with a January 2027 implementation even if they're not ready or if they will be able to take the time they need to put in place policies and systems to minimize the number of people losing coverage.

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[1] Jennifer Wagner, Symonne Singleton, and Maani Stewart, "A Guide to Reducing Coverage Losses Through Effective Implementation of Medicaid's New Work Requirement," CBPP, November 3, 2025, https://www.cbpp.org/research/health/a-guide-to-reducing-coverage-losses-through-effective-implementation-of-medicaids.

[2] Matthew Buettgens *et al.,* "Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations," Urban Institute, March 2026, https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work.

[3] Federal Register, "Medicaid Program: Community Engagement Requirement for Certain Individuals," https://www.federalregister.gov/public-inspection/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals.

[4] Margot Sanger-Katz and Sarah Kliff, "Trump Administration Announces Stricter Rules for Medicaid Work Requirement," New York Times, June 2, 2026, https://www.nytimes.com/2026/06/01/upshot/trump-medicaid-work-requirements.html.

[5] Allie Gardner, "Nebraska Launching Punitive Medicaid Work Requirements Early, Even as States Lack Information and Time," CBPP, April 29, 2026, https://www.cbpp.org/blog/nebraska-launching-punitive-medicaid-work-requirements-early-even-as-states-lack-information. Iowa and Montana also plan to implement before January 2027, and Arkansas plans an early "soft launch" of the requirement.

[6] See, for example, Senator Chuck Grassley, "Grassley Supports Common Sense Medicaid Work Requirements for Able-Bodied Adults," June 24, 2025, https://www.grassley.senate.gov/news/remarks/grassley-supports-common-sense-medicaid-work-requirements-for-able-bodied-adults; Senator Dan Sullivan, "Sullivan Shapes 'One Big Beautiful Bill' to Unleash Alaska's Economy, Create Good-Paying Jobs, Provide Historic Tax Cuts for

Working Families, and Strengthen Health Care," July 1, 2025, https://www.sullivan.senate.gov/newsroom/press-releases/sullivan-shapes-one-big-beautiful-bill-to-unleash-alaskas-economy-create-good-paying-jobs-provide-historic-tax-cuts-for-working-families-and-strengthen-health-care; Brett Guthrie, "Don't fall for the lies about the GOP's plan for Medicaid: We're actually STRENGTHENING it," New York Post, June 22, 2025, https://nypost.com/2025/06/22/opinion/dont-buy-the-lies-about-the-gops-plan-for-medicaid-were-actually-strengthening-it/; Arlt John, "How a vote for Trump's 'big beautiful bill' put Republican David Valadao in danger of losing his seat," CNN, May 15, 2026, https://edition.cnn.com/2026/05/15/politics/david-valadao-california-medicaid-cuts.

[7] Farah Erzouki, "States Need More Time to Prepare for Medicaid Work Requirement," CBPP, April 27, 2026, https://www.cbpp.org/research/health/states-need-more-time-to-prepare-for-medicaid-work-requirement.