Medicaid Work Reporting Requirements: Implementation Update after CMS' Interim Final Rule

Starting January 1, 2027, the 2025 budget reconciliation law (H.R. 1) conditions Medicaid eligibility for adults in the Affordable Care Act (ACA) Medicaid expansion group on meeting work reporting ("community engagement") requirements. This requirement applies to the 41 states (including DC) that have expanded their Medicaid programs under the ACA to nearly all adults with income up to 138% FPL ($22,025 for an individual in 2026) and to other states that offer expansion-like coverage to adults. On December 8, 2025, the Centers for Medicare & Medicaid Services (CMS) issued a Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) providing initial guidance to states as they implement Medicaid work reporting requirements. On June 1, 2026, CMS issued an Interim Final Rule with Comment Period (IFC) with more detailed guidance. CMS is inviting comment on the IFC through July 31, 2026. Unlike for a proposed rule which would be finalized after CMS evaluates comments, the IFC is effective July 31, 2026.

The following chart outlines H.R. 1's statutory requirements and CMS' implementation guidance, organized by the following topics: applicable individuals and qualifying activities, mandatory and optional exceptions, demonstrating compliance, procedure after noncompliance, consumer outreach, managed care organizations, and other state requirements.

H.R. 1 Statutory Requirement	***CMS Guidance – Informational Bulletin (CIB)***	***Interim Final Rule with Comment Period (IFC)***
I. APPLICABLE INDIVIDUALS AND QUALIFYING ACTIVITIES		
Populations Subject to Medicaid Work Reporting Requirements: Applicable Individuals – 42 U.S.C. § 1396a(xx)(9)(A)(i)		
Under H.R.1, only certain Medicaid populations are subject to work reporting requirements, known in the statute as "**applicable individuals.**" These individuals and expected to prove they engage in work (or other qualifying activities) or that they qualify for one of several exemptions. An "applicable individual" is anyone who accesses Medicaid through the following pathways: (1) enrolled in or eligible for Medicaid expansion (2) through a section 1115 waiver, enrolled in or eligible to enroll in Medicaid expansion-like coverage ("coverage that is equivalent to minimum essential coverage") AND aged 19-65, not pregnant, not entitled to or enrolled in Medicare Part A or Part B	• CIB clarifies that any state that is offering "minimum essential coverage" for adults age 19-65 must adopt work reporting requirements – including some states that have not expanded Medicaid under the ACA • CMS confirmed that individuals applying for or enrolled in family-planning *only* coverage through a section 1115 waiver would not be subject to work reporting requirements, as such services do not qualify as minimum essential coverage.	***§ 435.551 Applicable Individual*** • Repeats statute and CIB guidance • The preamble makes clear that partial Medicaid expansion (in states like Wisconsin) and other 1115 waivers that offer minimum essential coverage to adults who would otherwise be expansion eligible (for example, states that offer coverage to parents and caregivers) must put in place a work requirement program: "*States that have partially expanded Medicaid through a section 1115 demonstration and additional States that have applicable individuals (defined later in this rule) eligible to enroll or enrolled in a section 1115 demonstration will also be subject to the new community engagement requirement*"

H.R. 1 Statutory Requirement	***CMS Guidance – Informational Bulletin (CIB)***	***Interim Final Rule with Comment Period (IFC)***
Work Reporting Requirement Compliance: Qualifying Activities – 42 U.S.C. § 1396a(xx)(2)		
Under H.R. 1, to demonstrate compliance with work reporting requirements, an applicable individual must meet one or more of the following qualifying activities: (A) Work for 80 hours (B) Complete 80 hours community service (C) Participate in a work program for 80 hours (D) Be enrolled in education program at least part-time (E) Any combo of (A) – (D) (F) Have a monthly income that is at least min wage x 80 hours *($7.25/hour x 80 hours = $580 per month)* (G) Be a seasonal worker and have an average monthly income over past six months that is at least min wage x 80 hours *($580 per month)* The above requirements are not applicable to individuals who meet one of the law's exceptions or exclusions (see below).	• The CIB reiterates the statutory requirements and confirms that the minimum monthly income under parts (F) and (G) would be $580 per month.	***§ 435.552 Demonstrating community engagement*** • • Describes requirements for combining different categories of community engagement (e.g. work and enrollment in an educational program). • Reiterates statutory requirements related to monthly income and seasonal employment.
Qualifying Activities: Definitions – 42 U.S.C. § 1396a(xx)(9)(B), (D)		
"Educational program" includes institution of higher education and a program of "career and technical education" "Work program" is defined under section 6(o)(1) of the Food and Nutrition Act of 2008. Here is that definition: *DEFINITION OF WORK PROGRAM.—In this subsection, the term ''work program'' means—* *(A) a program under title I of the Workforce Innovation and Opportunity Act*	• The CIB does not further define these terms.	***§ 435.552 Demonstrating community engagement*** • Defines "community service" as: "unpaid work, completed voluntarily or because of a mandate by court order, with a structured program that is completed for the direct benefit of the community under the auspices of public or nonprofit organizations." Adds that for hours to count as community service, the nonprofit organizations must provide oversight and have a process in place to track dates/hours. States

H.R. 1 Statutory Requirement	***CMS Guidance – Informational Bulletin (CIB)***	***Interim Final Rule with Comment Period (IFC)***
(B) a program under section 236 of the Trade Act of 1974 *(C) a program of employment and training operated or supervised by a State or political subdivision of a State that meets standards approved by the Governor of the State, including a program under subsection (d)(4), other than a supervised job search program or job search training program;* *(D) a program of employment and training for veterans operated by the Department of Labor or the Department of Veterans Affairs, and approved by the Secretary;* *(E) a workforce partnership under subsection (d)(4)(N)*		that public or nonprofit organizations include 501(c)(3) "and other organizations" and that the community service activity "must not serve partisan purpose." • Reiterates the statute, defining "work program" as only specific programs of employment or training offered by the government as listed in statute; does not include general job search programs or job search training programs. • States that work includes work in exchange for money, goods, or services, as well as unpaid work. • In definition of "educational program," includes high school and state approved programs of study leading to a high school equivalence. States that "enrollment in educational program" is determined by the school or institution. Clarifies that "enrollment in education program" includes time during a school break and will be based on the individual's status just prior to the school break. This ensures normal breaks in the school calendar does not jeopardize compliance.
II. MANDATORY AND OPTIONAL EXCEPTIONS		
Mandatory Exceptions to Work Reporting Requirement – 42 U.S.C. § 1396a(xx)(3)(A)		
H.R. 1 exempts certain individuals from having to demonstrate compliance with work reporting requirements. States must deem an individual as having satisfied the work reporting requirement if, at some point in a given month, the individual falls in one of the following mandatory exception categories:	• CIB confirms that if someone falls into one of the exception categories for "part or all of a relevant month," they do not have to demonstrate compliance with work reporting requirements. This suggests that if someone falls into one of these categories for even just	***§ 435.553 Mandatory exceptions for certain applicable individuals*** • Restates statute and CIB guidance: if someone falls into one of the exception categories for "part or all of a relevant month," they do not have to demonstrate compliance with work reporting requirements.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*

• A "**specified excluded individual**" (see below, (xx)(9)(A)(ii));
• Under age 19;
• Entitled to Medicare Part A or Part B;
• Entitled to Medicaid via other Medicaid pathways <u>outside</u> of Medicaid expansion (Group VIII), including:
  • Aged (over 65), blind or disabled with limited income
  • Individuals receiving Supplemental Security Income (SSI)
  • Children under age 19 (who meet income levels)
  • Pregnant women, during pregnancy and during the 60-day period beginning on the last day of the pregnancy (who meet income levels)
  • Qualify for Temporary Assistance for Needy Families (TANF) (in states that have rules that allow certain families that receive TANF to qualify for Medicaid)
  • Other qualified pregnant women and children (pregnant women who meet TANF requirements and children under age 19 who meet income requirements of TANF)
  • Children with Title IV-E adoption assistance, foster care or guardianship care
• An inmate of a public institution (at any point during the three months prior to a compliance check)
 	
The statute further states that states "may elect to not require" an individual to verify information that they fall into the above categories.
	one day in a month, they are exempt for the entirety of that month.	

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
Mandatory Exceptions to Work Reporting Requirement: Definition of Specified Excluded Individual – 42 U.S.C. § 1396a(9)(A)(ii)		

"**Specified excluded individuals"** are not subject to work reporting requirements. States must deem an individual as having satisfied the work reporting requirement if, at some point in a given month, the individual falls in one of the following categories:
(I) Foster youth under age 26 who were Medicaid-enrolled at age 18 (or higher age, depending on state coverage for this group), as under 42 USC 1396a(a)(10)(A)(i)(IX)
(II) Indian, Urban Indian, California Indian, otherwise determined eligible as Indian for the Indian Health Service
(III) Parent, guardian, caretaker, relative, or family caregiver of: a dependent child 13 years of age and under OR a disabled individual
(IV) Disabled veteran status under 38 U.S. Code § 1155
(V) "Medically frail or otherwise has special medical needs," (see below)
(VI) In compliance with work participation standards for TANF recipients under Sec 407, OR is a member of a household that receives Supplemental Nutrition Assistance Program (SNAP) benefits and is not exempt from a work requirement (list of SNAP work exemptions here)
(VII) Participates in a drug addiction or alcoholic treatment and rehab program as defined under F&N Act of 2008: *"Drug addiction or alcoholic treatment and rehabilitation program'' means any such program conducted by a private nonprofit organization or institution, or a publicly operated community mental health center,*
	• The CIB reiterates these categories and states that "specified excluded individuals" are excluded from the "applicable individual" definition altogether.	***§ 435.554(a)-(c) Specified excluded individuals***
		• Reiterates statute and CIB guidance
		• Clarifies that anyone who meets criteria as "specified excluded individual" does not have to meet community engagement requirements: "*Community engagement is not a condition of eligibility for specified excluded individuals.*"
		  • Specified excluded individuals do not have to meet other aspects of community engagement (lookback period, etc.)
		• "**Caretaker relative**" means a relative of a dependent child or a disabled individual by blood, adoption, or marriage with whom the child or disabled individual is living, who assumes primary responsibility for the dependent child's or disabled individual's care.
		  • IFC provides a long list of specific relations in its definition of caretaker relative (parent, stepparent, grandparent, etc.). States also have the option to include another relative, the domestic partner of the parent or other caretaker relative, or an adult in the same household who assumes primary responsibility for the child/disabled individual.
		• "**Dependent child**" means a child 13 years of age or under who relies on another individual for care.
		• "**Disabled individual**" means an individual who meets the Americans with Disabilities Act definition of disability. CMS clarifies that an individual does not have to be eligible for

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.) to provide treatment that can lead to the rehabilitation of drug addicts or alcoholics" (VIII) An inmate of a public institution (IX) Is pregnant or entitled to postpartum medical assistance for 60-days OR up to 12-months postpartum (if state has chosen that option)		Medicaid or other Federal programs on the basis of a disability to be considered a disabled individual for the purposes of work reporting requirements. • "**Family caregiver**" means an adult family member or other individual who has a significant relationship with, and who provides care within a broad range of assistance to, a dependent child or a disabled individual as both terms are defined in this section. • "**Guardian**" means an adult appointed by a court to care for and make personal decisions for a dependent child or disabled individual, as defined in this section, who cannot care for themselves, in accordance with applicable State law. • "**Parent**" means an individual with the legal status of a mother or father, including by adoption, in accordance with applicable State law, who provides some level of care to a dependent child or disabled individual, as defined in this section.
Mandatory Exceptions to Work Reporting Requirement: Medical Frailty – 42 U.S.C. § 1396a(9)(A)(ii)		
"Medically frail or otherwise has special medical needs" is one category of "specified excluded individuals" that are not subject to work reporting requirements. The statute defines medical frailty to include: • *Blind or disabled under Section 1614* • *Substance use disorder* • *Disabling mental disorder* • *Physical, intellectual or developmental disability that significantly impairs their*	• The CIB reiterates these categories and states that "specified excluded individuals" are excluded from the "applicable individual" definition altogether.	***§ 435.554(c) Specified excluded individuals*** • "An individual who is medically frail or otherwise has special medical needs is defined as an individual whose physical, mental, or behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement" and is an individual that falls into one of the medical frailty categories identified in the statute. • The IFC does not define "significantly impairs," but the term is mentioned in the preamble.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
ability to perform 1 or more activities of daily living • *Serious or complex medical condition*		• CMS declined to specify additional conditions that count as **medically frail**, stating "*we have not identified any other populations that we believe could reasonably be considered medically frail*" outside of the five categories descried under the statute • Definition of **serious or complex medical condition**: "*a medical condition that is life threatening, seriously disabling without necessarily being life threatening, causing significant pain or discomfort that can cause serious interruptions to life activities, requiring a major time or effort commitment from caregivers for a substantial period of time, requiring frequent monitoring, associated with severe consequences or negative consequences for someone else, affecting multiple organ systems, requiring management to tight physiological parameters, requiring coordination of multiple specialties, requiring treatment that carries a risk of serious complications, or requiring adjustment in non-medical environments.*" • States must develop an auditable list of diseases, diagnoses, disorders, or other health conditions to identify individuals who meet medical frailty criteria; and states must revise list on a regular basis. • Where an individual's condition is not on the list, states must provide individuals with ability to request consideration of their condition • States may not add any additional categories beyond the five categories in the statute: "*For example, we do not believe it would be reasonable for States to consider an individual who is homeless as medically frail solely on the*

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		basis that the individual is homeless, as that circumstance is not a medical condition" **State Implementation Notes:** • At least 22 states have their own medical frailty definitions in place already connected to other Medicaid requirements outside of H.R. 1. Whether any of these survive is a matter of whether the existing definitions go beyond the five categories in the statute • States have begun to define medical frailty for the purposes of work reporting requirements. For example, Nebraska has amassed a list of hundreds of diagnosis codes that could qualify someone as "medically frail" in their state. It would seem that these lists remain viable, so long the state is not pushing medical frailty beyond the statute • CMS would allow states to develop their own list of "diseases, diagnoses, disorders, or other health conditions" that fall under medical frailty, so long as the state is not in any way adding to the statutory definition of medical frailty categories. While this gives states discretion to operate their programs, different state definitions could mean people with the same health circumstances can receive an exception in one state, but not another.
Medical Frailty & Ability to Work		
The statute defines medical frailty to include: • *Blind or disabled under Section 1614* • *Substance use disorder* • *Disabling mental disorder* • *Physical, intellectual or developmental disability that significantly impairs their*	• CIB does not address this issue.	The preamble adds a twist to the medical frailty definition, that an individual must not only demonstrate a medically frail condition but also demonstrate that condition impairs their ability to work: • *"The phrase 'medically frail or who otherwise has special medical needs' connotes*

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
ability to perform 1 or more activities of daily living • *Serious or complex medical condition* H.R. 1 does not link medical frailty to ability to work.		*diminished functional capacity that significantly impairs an individual's ability to meet ordinary demands. In this context, the relevant demand is meeting the community engagement requirement. Accordingly, we interpret the statute to require consideration of the severity of an individual's condition as relevant to whether that individual is capable of meeting the community engagement requirement.* ***An individual who lacks the capacity to meet the community engagement requirement may properly be determined to be medically frail or otherwise to have special medical needs. But, if a person is able to demonstrate community engagement by performing 80 hours per month of qualifying community engagement activities, notwithstanding their physical, mental, or other behavioral health condition, they would not qualify as medically frail and would not be a specified excluded individual****.* • *"The best reading of the statutory phrase "medically frail or otherwise has special medical needs" is one that considers not only the presence of a particular diagnosis or condition, but also the extent to which the condition impairs an individual's ability to engage in community engagement activities…* ***Reading the statute to require automatic classification as medically frail or otherwise having special medical needs based solely on diagnosis or condition would risk sweeping in individuals whose conditions do not significantly impair their functional capacity, meaning that they are able to perform 80 hours per month of qualifying activities, and thus would fail to give full meaning to the***

H.R. 1 Statutory Requirement	***CMS Guidance – Informational Bulletin (CIB)***	***Interim Final Rule with Comment Period (IFC)***
		term "medically frail or who otherwise has special medical needs."
Optional Exception for Short-Term Hardship Events – 42 U.S.C. § 1396a(XX)(3)(B)		
States have the option to allow for certain additional short-term hardship exceptions, exempting individuals from the work reporting requirement who, for all or part or of a month— (I) Received inpatient hospital services, nursing facility services, services at an intermediate care facility, inpatient psychiatric services, or "other services of similar acuity," and applies for an exception; (II) Lived in a county with a: • Federally-declared emergency or disaster; • High unemployment rate (unemployment rate was at or above the lesser of 8% OR 1.5 times the national unemployment rate); (III) Had to travel outside their community for an "extended period of time" to seek medical care (for themselves or their dependent) to treat "a serious or complex medical condition" [defined under (xx)(9)(A)(ii)(V)(ee)], and apples for an exception.	• The CIB reiterates that states have the option to put optional hardship exemptions in place. • The CIB emphasizes the statutory requirement that an individual must *apply* for short-term exemptions if related to their medical care (categories (I) and (III)).	***§ 435.555 Optional exception for short-term hardship events*** • Restates statutory provisions. • Sets requirements for states to notify individuals of availability of short-term hardship exceptions and how to request an exception. • *§ 435.557 Verifying compliance* -- state must automatically give the exemption in cases of disaster/emergency or high unemployment (without requesting any information from individuals). • Defines "**other services of similar acuity**:" (A) Inpatient services furnished in a critical access hospital consistent; (B) Inpatient services furnished in an emergency hospital; (C) Inpatient services furnished in an institution for mental diseases; (D) Inpatient services furnished by other facilities that are not covered under Medicaid but are otherwise recognized by the State; and, (E) Noninstitutional services that an applicable individual receives that, but for the receipt of such services, would likely result in the applicable individual receiving inpatient services. • When individuals have to travel outside their community for care (for themselves or a dependent), CMS offers flexibility to the term **"extended period of time" --** could be for "part or all of a month or longer"; CMS does not set a minimum number of days.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		• For the hardship exception to apply, the individual, or their dependent must be traveling to receive medical services necessary to treat a "serious or complex medical condition" (same definition as applied to medical frailty), that are not available within their "community of residence." • CMS would allow caregivers to show they have to take leave from employment or other community engagement activities for reasons related their dependent's travel (for example, to help their dependent get to local medical appointments in preparation for medical travel). **Remaining Questions:** • The IFC does not define what it means to travel "outside" of one's community to seek medical care. **State Implementation Notes:** • It is not yet known how many states will grant short-term hardship exceptions for people subject to the work reporting requirement. • According to a KFF survey, Indiana and Iowa do not plan to adopt *any* hardship exceptions. New Hampshire has also passed legislation preventing the state's Department of Health and Human Services from seeking any short-term hardship exceptions without express legislative approval. According to KFF, other states have decided to adopt only some exceptions (for example, Missouri is not adopting the exception for residents of counties with high unemployment and New York is not adopting the exception for

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		individuals traveling outside their community for medical care).
III. DEMONSTRATING COMPLIANCE		
"Lookback" Period at Initial Application & Redetermination – 42 U.S.C. § 1396a(xx)(1)(A)-(B)		
Medicaid populations subject to this requirement must prove their eligibility with work reporting requirements (either that they participate in a "qualifying activity" or meet one of the laws exclusions or exemptions) in the month(s) preceding application or renewal. However, the law gives states discretion to set the length of the this "lookback" period: • New applicants: must demonstrate meeting requirements for at least one but for up to three consecutive months immediately preceding application (at state discretion) • Current enrollees at redetermination: must demonstrate meeting requirements for at least one but up to three months "whether or not consecutive" during the period between determinations (at state discretion)	• Demonstrating compliance at application: The CIB confirms that compliance must be in the month(s) immediately preceding application. • Demonstrating compliance at redetermination: The CIB clarifies that while states can require up to three months of compliance, the state cannot dictate the specific month(s) in which an individual must demonstrate compliance and cannot require compliant months to be consecutive. This means, for example, that if a person must prove two months of compliance every six months, the individual can choose any two months in that six-month timeframe as the months that will demonstrate their compliance.	***§ 435.556 Assessing compliance with the community engagement requirement*** • Restates CIB guidance and statute that lookback period is between one and three months, at state discretion. • Clarifies that the state may not apply the lookback period to "specified excluded individuals" (meaning people who have medical frailty exception, for example, do not have to provide documentation of their condition during the timeframe of any lookback period – other rules allow for documenting medical frailty would allow claims data from the preceding 12 months). **State Implementation Notes:** • According to KFF, most states are planning for a one-month lookback period for both application and renewal. • However, we note that some states have already determined they will implement the *maximum* lookback period, including Indiana and Idaho which will both require all new applicants to show compliance for three consecutive months prior to their application, and Kentucky which will require all current enrollees to demonstrate three months compliance between eligibility determinations.
Option for More Frequent Compliance Verifications – 42 U.S.C. § 1396a(xx)(4)		

H.R. 1 Statutory Requirement	***CMS Guidance – Informational Bulletin (CIB)***	***Interim Final Rule with Comment Period (IFC)***
Frequency of Medicaid Redeterminations: • H.R. 1 (under § 71107) requires people enrolled in the Medicaid expansion to undergo more frequent redeterminations, now every six months. In addition to the usual verification requirements (income, household size, and residency requirements), Medicaid expansion individuals will also have to demonstrate their compliance with work reporting requirements. • CMS' March 2026 guidance on redeterminations makes clear that people enrolled in expansion-like coverage (Georgia and Wisconsin) are also subject to more frequent eligibility determinations (every six months). H.R. 1 gives states the option to check compliance with work reporting requirements "more frequently" than just at redetermination.	• Confirms that at redetermination, applicable individuals must demonstrate compliance with work reporting requirements in addition to verifying other usual eligibility factors. • Reiterates that states may verify compliance with work reporting requirements "more frequently."	***§ 435.557(d) State option to conduct more frequent verifications*** • Reiterates that states may verify compliance with work reporting requirement more frequently than just at six-month redeterminations (for example, a state could verify monthly). • But, if in previous determination someone meets the definition of "specified excluded individual," then state cannot reverify their compliance more frequently than the regularly scheduled redetermination (once every six months). • Each time the state conducts a more frequent verification it must recheck all reliable information available to the state to determine whether someone newly qualifies for exclusion status or whether they do not, but continue to meet community engagement requirements. **State Implementation Notes:** • According to KFF, most states are planning to verify work requirement compliance only every six months. • Some states have already determined they will require more frequent compliance checks. For example, Indiana and New Hampshire have both passed legislation to require compliance quarterly (every three months). For a state like Indiana that is also requiring three months of compliance between checks, individuals will effectively have to prove their compliance in every single month.
Ex Parte (Automatic) Verifications – 42 U.S.C. § 1396a(xx)(5)		

H.R. 1 Statutory Requirement	***CMS Guidance – Informational Bulletin (CIB)***	***Interim Final Rule with Comment Period (IFC)***

Where possible, H.R. 1 requires states to use an automated (*ex parte*) process to verify an individual's compliance with work reporting requirements or exceptions.
 	
H.R. 1 requires states to: "*establish processes and use reliable information available to the State…without requiring, where possible, the applicable individual to submit additional information*."
• Provision mentions a few data sources as examples (but does not require that these be used), including payroll data, payments data and encounter data.
	• CIB restates requirement that states use *ex parte* processes wherever possible.
	• CIB explicitly reminds states that they must first attempt to verify compliance or exemptions using "reliable information" available to the state before requesting any additional information or documentation from Medicaid applicants or beneficiaries. This *ex parte* process is required at application, redetermination (every six months) and at any additional compliance check (for example, if the state has elected to verify compliance quarterly).
	• CMS adds to a list of possible data sources that could serve as "reliable information:" payroll data, Medicaid provider payments, or encounter data, and data sources about higher education enrollment, job training participation, or community service.
		§ 435.557 Verifying compliance
		• Restates the expectation that states will use "reliable information available to the State" to verify compliance or verify that someone is a "specified excluded individual" before requesting any additional information from the applicant/beneficiary.
		• Sets an obligation for states to continue to check all of its sources of information "until the agency verifies" compliance or verifies that someone does not have to comply b/c they are a specified excluded individual.
		• Adds to the list of possible data sources that could serve as reliable information, offering a broader timeframe for information to show medical frailty than just the dates of the lookback period:
		  • Claim(s) that have been adjudicated in the preceding 12 months "including those that have been paid, pended or denied."
		  • Encounter date for the preceding 12 months.
		• Gives states discretion to determine data sources it will use, but state must document verification plan and its data sources.

Verifications & Self-Attestation (in All Cases Except Medical Frailty)		
H.R. 1 does not specify whether individuals may be allowed to self-attest to medical frailty or other conditions where there is no documentation available; however the statute does not disallow self-attestation.	• The CIB does not clarify whether and when self-attestation might be allowed where *ex parte* efforts fall short.	***§ 435.557(f) Verifying compliance*** **Verifications *except for verifying medical frailty*:** • Allows for self-attestation (as defined under § 435.952(c)) before January 1, 2028 "when there is no reliable information available to the State."

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		• Existing § 435.952(c) is a general regulation applicable whenever a state Medicaid agency needs to verify an applicant's or beneficiary's eligibility details (like income or assets). Here, self-attestation is permitted for most Medicaid/CHIP eligibility criteria, provided the information aligns "reasonably" with electronic data sources. Where state and individual information do not align, state must give individual an opportunity to explain the discrepancy through a statement or other documentation. • Beginning on January 1, 2028, states "*must require documentation whenever documentation is reasonably available*." However, if there is no reasonably available documentation, then state may accept "information other than documentation" (which, presumably could include self-attestation). • The state may not deny or terminate Medicaid solely because someone could not produce documentation where none exists or is reasonably available, but state may require individuals to provide "specific information considered sufficient" to verify compliance in the absence of documentation. • State must provide individuals with opportunity to supply information to show their compliance; state must accept information from individuals via modalities described in § 435.907(a): internet, phone, mail, in person or "other commonly available electronic means".
Medical Frailty Verifications & Self-Attestation		

H.R. 1 Statutory Requirement	***CMS Guidance – Informational Bulletin (CIB)***	***Interim Final Rule with Comment Period (IFC)***

H.R. 1 does not specify whether individuals may be allowed to self-attest to medical frailty or other conditions where there is no documentation available; however the statute does not disallow self-attestation.	• The CIB does not state whether and when self-attestation might be allowed where *ex parte* efforts fall short	***§ 435.557(f) Verification of medical frailty and privacy requirements for certain populations***
		
		Verification of medical frailty:
		• States must attempt to verify medical frailty using reliable information available to the State, "including claim(s) relevant to the individual that have been adjudicated in the preceding 12 months, including those that have been paid, pended or denied, and encounter data, as relevant to the individual."
		  • Before January 1, 2028, states may accept self-attestation or other documentation when there is no reliable information otherwise available to the state.
		  • Beginning on January 1, 2028, states may accept self-attestation when no other reliable information is available, but then at the individual's next redetermination, state must verify medical frailty with documentation (either using information available to the state or requesting documentation from the individual).
		  • States must reverify medical frailty status "at least every 12 months" (meaning, no option for a person to gain long-term medical frailty status).
		
		State Implementation Notes:
		• According to KFF, most states (29) report wanting to allow for self-attestation, but are waiting on federal rules to clarify whether and when self-attestation is permissible; 30 states indicated wanting to develop a process to obtain verification from a treating provider. Other states are designing "health screeners" to verify medically frail status when *ex parte*

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		data is unavailable. Some of these efforts may still be permissible, but only in the short term through 2027. • We note that some states have put laws in place that limit the use of self-attestation, including bills passed in Indiana, New Hampshire and Utah which state that self-attestation alone is insufficient for compliance. As CMS allows, but does not require states to use self-attestation, these state laws are likely permissible.
Short-Term Hardship Verifications		
		§ 435.557(g)(2) Verification of optional exemptions • Verification requirements for **short-term hardships** are similar to the other verification requirements (e.g., that state must attempt to verify with all reliable information first before requiring documentation). • Clarifies that states must automatically give the exemption in cases of disaster/emergency or high unemployment (without requesting any information from individuals). **Remaining Questions:** • Unclear whether self-attestations are allowed for short-term hardship verifications (most documentation related to these would likely be in the medical record, but some aspects may be harder to document, for example, a caregiver proving they had to take leave from employment to assist in care related to their dependent's medical travel).

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
Requirement to Determine an Individual as a "Specified Excluded Individual"		
		§ 435.557(c)(2) Requirement to apply exclusions • Whenever a state has sufficient information to determine someone is a "specified excluded individual," then state must give an individual that determination even if that individual also demonstrates they meet other community engagement requirements. • For example, if the state determines someone is a caretaker of a dependent child under age 13, this person can qualify as an excluded individual even if they are also working (getting a determination as a specified excluded individual will mean they have to verify their compliance and show paperwork fewer times, so the distinction is meaningful to the individual).
Requirement to Verify Potential Exclusions Post-Enrollment		
		§ 435.557(c)(3) Requirement to enroll eligible individuals and verify potential exclusion post-enrollment. • Whenever a state has sufficient information that someone meets community engagement requirements, the state must enroll the individual promptly. • If a state is still trying to verify an exclusion, it can do that post-enrollment and recategorize someone later.
Requirement to Inform Individuals of State's Eligibility Determination		
		§ 435.556(d) Assessing compliance with the community engagement requirement.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		• A state must inform applicants and beneficiaries of the State's eligibility determination, specifying whether the applicant/beneficiary: (1) meets criteria as a "specified excluded individual" (and, therefore, not subject to the work reporting requirement); OR (2) is an "applicable individual" subject to the work reporting requirement, and whether the state has determined the individual to have demonstrated compliance with community engagement. **Remaining Questions:** • The IFC does not provide clarity regarding what amount of notice or due process an individual must receive regarding the state's determination. For example, while the state is required to provide notice regarding what information the applicant needs to provide and how to provide that information, the IFC appears to allow the state to issue a notice of eligibility determination without explaining the specific basis for its determination.
Policy on In-Person Interviews		
		§ 435.907(d) Application • States may NOT require in-person interviews for a determination of eligibility using MAGI-based income. • However, nothing prohibits a state from offering an individual the opportunity to meet in person to provide information regarding their application.
Timely Determination of Eligibility		

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*

		§ 435.912 Timely determination of eligibility
		• States must adopt timeliness and performance standards for determining Medicaid eligibility.
		• Timeliness standards refer to the maximum period of time in which every applicant is entitled to a determination of eligibility.
		  • Determination of eligibility for any applicant may not exceed:
		  • 90 days for applicants who apply for Medicaid on the basis of disability; or
		  • 45 days for all other applicants.
		• Performance standards are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

Periodic Renewal of Medicaid Eligibility		
		§ 435.916 Periodic renewal of Medicaid eligibility • Modified adjusted gross income methods (MAGI) -- The eligibility of individuals whose Medicaid eligibility is based on MAGI must be renewed once every 12 months, and **no more frequently than once every 12 months.** • Eligibility for non-MAGI: redeterminations "at least" every 12 months. • **Non-MAGI, longer-term exemptions:** • (1) States may consider blindness as continuing until the reviewing physician determines that a beneficiary's vision has improved beyond the definition of blindness.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		• (2) States may consider disability as continuing until the review team determines that a beneficiary's disability no longer meets the definition of disability. • Sunset date. October 1, 2034. CMS will follow applicable rulemaking procedures to ensure that policies governing the periodic renewals of Medicaid eligibility and redeterminations based on changes in circumstances are implemented and effective on October 1, 2034, replacing the policies scheduled to sunset on that date.
IV. NONCOMPLIANCE: PROCEDURE AND PENALTIES		
Procedure for Noncompliance – 42 U.S.C. § 1396a(xx)(6)(A)(i)-(ii)		
If state cannot use *ex parte* verification to determine compliance with work reporting requirement (or exceptions), then state must: • provide the individual with notice of noncompliance (see below) • give 30 days (from date notice of noncompliance received) for the individual to make a "satisfactory showing" of compliance • provide individual with Medicaid coverage during this 30-day grace period (assuming the individual was already enrolled and this is a redetermination; no Medicaid coverage given in this window for initial applicants).	• The CIB restates the statutory requirement and offers no additional information.	***§ 435.558 Noncompliance procedures*** • Restates statutory requirements and reiterates that states must continue to provide medical assistance until the individual is determined ineligible.
Notice of Noncompliance – 42 U.S.C. § 1396a(xx)(6)(B)		
Notice of noncompliance must include information on: • How the individual can make a "satisfactory showing" of (1) compliance with work	• The CIB restates the statutory requirement and offers no additional information.	***§ 435.558(c) Content and form of noncompliance notice*** Notice of noncompliance must contain clear statements of the following:

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
reporting requirement and (2) meeting the various exceptions under the law. • How the individual may reapply for Medicaid in the case of denial/disenrollment.		• How to make a satisfactory showing of compliance with the community engagement requirement, including: (A) which month(s) will be assessed by state; (B) how to demonstrate community engagement; and (C) how to show the individual should be deemed to have demonstrated community engagement. • How to make a satisfactory showing of meeting criteria as a "specified excluded individual." • The deadline for providing information and ways/modalities to respond. • A description of the consequences of noncompliance with the community engagement requirement and failure to respond to the notice of noncompliance for Medicaid eligibility and eligibility for advance payments of the premium tax credit (APTC) and the premium tax credit (PTC) used to pay for coverage through a Health Insurance Exchange. • How to reapply for Medicaid if denied or disenrolled. • Information about short-term hardship exceptions, where applicable. The notice is considered to be "received" by the individual 5 days after the date on the notice (but applicant/beneficiary is allowed to show they did not receive notice) **<u>Remaining Questions:</u>** • Again, while the notice requirements cover how to submit additional required documentation, the IFC appears to lack clarity regarding how much specificity the state must

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		provide regarding the basis for its determination. • CMS has not set requirements for how notices should be written (for example, grade level, languages) and what obligations the state has for providing people with assistance if they have questions about notice received (a state call center etc.).
Procedure for Noncompliance: Denial or Disenrollment – 42 U.S.C. § 1396a(xx)(6)(A)(iii)		

If individual cannot make a "satisfactory showing" of compliance AND the individual is not a "specified excluded individual," then state must deny application or disenroll them "*not later than the end of the month <u>following</u> the month in which the 30-calendar-day period ends.*"
 	
But, before denial/disenrollment, state must:
• First determine whether the individual meets any other Medicaid eligibility category; and
• Provide individual with written notice and grant them opportunity for fair hearing (see below).
	• The CIB restates the statutory requirement and offers no additional information.	***§ 435.558(d) State responsibilities in the event of no satisfactory showing***
		
		• If after 30-day period, an individual does not satisfactorily show that they meet community engagement or exclusions, then the state <u>must first</u> consider all other avenues for Medicaid enrollment, and, if none are found:
		  • Deny application (provide written notice and opportunity for a fair hearing); OR
		  • Disenroll the individual "*not later than the end of the month following the month in which the 30 calendar day period…ends and after the provision of advance written notice and fair hearing rights.*"
		• In denying or disenrolling, state must include a clear statement of the specific reasons for denial/disenrollment.
		
		<u>Remaining Questions:</u>
		• The law states that if an individual is a "specified excluded individual," then they cannot be denied Medicaid or be disenrolled even if they do not make a "satisfactory showing" of compliance. Some individuals may be put in a tough spot here, as they meet the

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		medically frail category but do not have documentation and cannot make a "satisfactory showing" (say, because their condition is one that does not come with a medical claim, such as treatment for substance use). The statute would seem to allow them to obtain and maintain Medicaid coverage, but practically, how can a state operationalize this without any information to verify?
Prohibition on Restrictions to Re-Applying for Coverage		
		§ 435.558(e) Prohibition on restrictions to re-applying for coverage • A state "must not impose any restriction on an applicable individual's ability to re-apply for coverage or their ability to receive coverage if determined eligible upon reapplication based on a prior denial of eligibility or disenrollment for noncompliance under this section."
Noncompliance and Premium Tax Credit Eligibility – 42 U.S.C. § 1396a(xx)(7)(B)		
H.R. 1 prohibits individuals' access to premium tax credits through the Marketplaces if they do not demonstrate compliance with work reporting requirements.	• The CIB reconfirms this penalty reminding readers of the general rule that an individual who is eligible for Medicaid coverage that provides minimum essential coverage (MEC) is not eligible premium tax credits. CMS will consider an individual to be "deemed to be eligible for MEC if the individual would have been eligible for Medicaid but for their failure to meet community engagement requirements." • For this reason, anyone who fails to demonstrate compliance with work reporting requirements or exceptions will be ineligible for premium tax credits.	• The IFC states that information about the penalty on the ability to receive premium tax credits must be available in outreach notices and notices of noncompliance.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
V. CONSUMER OUTREACH		
Outreach – 42 U.S.C. § 1396a(xx)(8)		

H.R.1 requires states to send outreach notices to applicable individuals enrolled in their Medicaid programs to inform them about the work reporting requirement.
 	
• Notice must include: how to comply, explanation of the exceptions, the definition of "applicable individual," the consequences of noncompliance and how to report any change in circumstances to the state that could result in a change in eligibility.
• Notice must be delivered by regular mail (or individual can elect to have email), AND must be given in one or more additional forms of communication, including telephone, text message, an internet website and "such other forms as the Secretary determines appropriate."
• State must give notices "periodically" thereafter.
 	
In general, these outreach notices must go out by summer of 2026 to meet a January 1, 2027 start date. The specific deadline for sending notices depends on the length of the state's lookback period: If state elects to have a one-month look back period, then notice needs to be given four months in advance of an individual having to comply (five months in advance if state requires two-month lookback; six months in advance if state requires three-month lookback).
	• CIB expands on statutory language of what outreach notice has to include about a change in status: "outreach notice must include…how to report a change in status that could result in the individual qualifying as a specified excluded individual, meeting an exception, or being subject to the community engagement requirement after an exclusion or exception ends."
	• CIB defines "periodically" to mean outreach notices sent to applicable individuals at least once every six months.
		§ 435.561 State requirements for outreach
		• Restates statute and prior guidance, adding more to the definition of "periodically" that in addition to outreach every six months ahead of redetermination, states must provide outreach when the state elects a short-term hardship exception and on each occasion that a short-term hardship becomes applicable (for example, the unemployment rate rises above 8% or there is a federally-declared disaster).
		• CMS may require states to conduct more frequent outreach if state-reported monitoring data or other information indicates a need for state to conduct more frequent outreach.
		• Outreach notice must include:
		  • How to comply with the requirement to demonstrate community engagement.
		  • An explanation of the exceptions, including short-term hardship exceptions.
		  • Who is an applicable individual.
		  • The number of months an applicable individual is required to demonstrate community engagement at renewal.
		  • How often the State will verify compliance.
		  • The consequences of noncompliance (impact on Medicaid eligibility and eligibility for advance payments of the premium tax credit (APTC) and the premium tax credit (PTC) used to pay for coverage through a Health Insurance Exchange).

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		• How to report change in status to state. • States must send outreach via mail or email AND one additional method (individual's electronic account, telephone; text message; or other commonly available electronic means). **Remaining Questions:** • CMS has not set requirements for how notices should be written (for example, grade level, languages) and what obligations the state has for providing people with assistance if they have questions about notice received (a state call center etc.). • CMS does not detail any additional places where consumer information might be appropriate, such as Medicaid department websites, health care clinics, health fairs. **State Implementation Notes:** • We note that Nebraska has already sent more than 70,000 outreach notices to impacted individuals in advance of their work reporting requirement stating in May 2026. Montana sent out notices in March 2026 in advance of a July program launch. Other states are populating their websites with information for impacted consumers. According to one review of state webpages, consumer facing information varies greatly by state. • It is unclear whether states like Nebraska and Montana will be required to resend notices if their initial communications were not in compliance.
VI. MANAGED CARE ORGANIZATIONS		

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
Role of Managed Care Plans: Prohibiting Conflicts of Interest – H.R. 1 § 71119(c)		
• As Medicaid managed care plans and other similar organizations have a vested interest in making sure their current beneficiaries remain enrolled and making sure they have new covered lives coming into their plans…there may be a conflict of interest. • H.R.1 restricts states from using Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, or other contractors with direct or indirect financial relationships to plans, to determine individuals' compliance with work reporting requirements.	• CIB clarifies that while these entities cannot verify compliance, states can choose to delegate other "support activities" to managed care plans to support successful implementation. • CIB states: "*CMS expects to issue further guidance on the potential role that managed care plans can appropriately play in activities that are not related to determining beneficiary compliance*."	***§ 438.58 Conflict of interest safeguards*** • Restates the statutory requirements. • CMS requires states to have in place safeguards that protect against conflicts of interest. **Remaining Questions:** • In the past, states have relied on managed care plans to conduct outreach and assist their members in submitting requested information at renewal. It is possible that plans could play a similar role here: for example, proactively reaching out to their members who might meet the medical frailty exception and proactively providing them with documentation that could prove their compliance. • States need further guidance on what managed care "support activities" will be permissible in the context of work reporting requirements.
VII. STATE COMPLIANCE & FUNDING		
State Implementation Deadline – 42 U.S.C. § 1396a(xx)(1)		
• H.R.1 requires states to adopt Medicaid work reporting requirements by January 1, 2027, but states may begin earlier.	• The CIB confirms that Medicaid work reporting requirements must begin January 1, 2027, unless a state opts to implement it sooner through a section 1115 demonstration or a state plan amendment.	***§ 435.559 Implementation timing for the community engagement requirement*** • Reiterates requirement to start program on or before January 1, 2027. • Clarifies that for a current Medicaid beneficiary, the agency must verify compliance with the community engagement requirement at the applicable individual's first renewal initiated on or after the implementation date.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
		State Implementation Notes: • On May 1, 2026, Nebraska was the first state to implement work reporting requirements under H.R. 1. Other states are planning to start early, including Arkansas and Montana, which are each planning to commence work reporting requirements on July 1, 2026. • It remains to be seen whether other states will implement early or whether CMS' IFC requirements will deter states from this path.
Good Faith Exemption – 42 U.S.C. § 1396a(xx)(11)		
• All states are required to implement work reporting requirements by January 1, 2027, but H.R.1 allows states to request a "good faith" exemption from the Secretary of Health and Human Services (HHS Secretary) to ask to delay implementation. • HHS Secretary may grant this exemption and allow a state to delay implementation for up to two years (until December 31, 2028) if the state can demonstrate it made a good faith effort at compliance, but has met "*significant barriers to or challenges in meeting such requirements including related to funding, design, development, procurement, or installation of necessary systems or resources*."	• CMS explains in the CIB that it anticipates good faith approvals will be limited to states that are making meaningful efforts towards implementation, but "experience severe and/or unexpected issues that hinder their progress."	***§ 435.560 Good faith effort exemption*** • Restates the statutory requirements, with some additional guidance on reporting requirements for states that have been granted a good faith exemption. **Remaining Questions:** • Since H.R. 1's passage, state Medicaid Departments have been in regular contact with CMS as the agency sets a pathway forward for work requirement implementation. In preparation for a 2027 launch, many states have already designed and built enrollment systems and other program features based on CMS feedback. If the IFC puts regulations in place that diverge from CMS' prior guidance to states, could this be grounds for states applying for a good faith exemption? If states have built systems in good faith based on prior communication with CMS and the IFC would mean a rebuild of systems, states may have trouble meeting the 2027 implementation deadline and a legitimate argument for delay.

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
State Requirements to Submit Data to CMS		
		§ 435.562 Requirements for States to submit data for monitoring community engagement States must submit data to CMS for the following categories: • Enrollment totals of individuals receiving medical assistance. • Application and renewal processing and timeliness, including information, if relevant, about pending applications and renewals that exceed the timeliness standards. • Outcomes of determinations and redeterminations of eligibility. • Population counts of individuals subject to and their compliance with the requirements, including their manner of compliance. • Any other data specified by CMS to monitor State implementation.
Work Reporting Requirement Provisions not Waivable – 42 U.S.C. § 1396a(xx)(10)		
• States cannot seek section 1115 demonstration waivers to alter their implementation of H.R. 1's work reporting requirements: "Notwithstanding section 1115(a), the ***provisions of this subsection may not be waived.***" • While this statutory provision means states cannot pursue waivers to lessen the impact of the law (for example, to reduce requirement to just 40 hours/month), this also means states cannot use the waiver process to put in place requirements that are *harsher* than H.R. 1 (for	• The CIB confirms that work reporting requirement provisions cannot be waived under Section 1115 demonstration authority.	***§ 435.563 Prohibition of waivers of the community engagement requirement*** • Restates the statute: "CMS will not approve a section 1115 demonstration project that waives, in whole or in part, the community engagement provisions of section 1902(xx) of the Act." **<u>Remaining Questions:</u>** • It remains to be seen whether states will seek waivers to attempt to change their work

H.R. 1 Statutory Requirement	*CMS Guidance – Informational Bulletin (CIB)*	*Interim Final Rule with Comment Period (IFC)*
example, states cannot seek a waiver to require 100 hours of work/month or cut back on the categories of exclusion).		reporting program outside of federal statutory and regulatory requirements. • We note that Arkansas has recently submitted a waiver to CMS asking to include "success coaching" services to their work requirement program by July 1, 2028. It is unknown whether CMS will approve of this waiver or any others related to work reporting requirements and how the agency will interpret its ability to grant waivers in light of H.R. 1's waiver restriction.
Grants to States: Funding for Information Technology (IT) Systems – H.R. 1 § 71119(e)		
• To assist states in carrying out the provisions of this section that "pertain to conducting eligibility determinations or redeterminations," HHS must grant an award to EACH state and "distribute an equal amount" across states. • $100M for FY 2026 to be granted to EACH state based on a ratio of the number of applicable individuals residing in the state compared to the total number applicable individuals residing nationally (as of March 31, 2025). • $100M for FY 2026 to be distributed in equal amounts to all states that are carrying out provisions of this section.	• CIB reiterates statutory funding requirements. • Acknowledging that implementing work reporting requirements will require significant changes to Medicaid IT systems, the CIB reminds states that enhanced federal funding is available for certain efforts related to their systems, including a 90% federal match for design, development, and implementation activities and a 75% federal match for maintenance and operations.	