Protecting People with Substance Use Disorders and Formerly Incarcerated Individuals from Losing Medicaid Coverage:

Recommendations on Implementing the H.R. 1 Work Reporting Requirements

LEGAL ACTION CENTER

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Introduction

In July 2025, Congress passed and the President signed into law H.R. 1 (Public Law 119-21) to effectuate the largest cuts to Medicaid in the history of the program – nearly $1 trillion. As a result, the federal government expects at least 10 million individuals across the country to lose their Medicaid coverage and access to health care.[1]

Medicaid is the nation's single largest payer of mental health and substance use disorder services.[2] Over 20% of U.S. adults with any substance use disorder are covered by Medicaid,[3] underscoring the program's crucial role in addressing the continuing overdose crisis. Medicaid is also a critical resource for the millions of people leaving incarceration each year. These individuals, who experience disproportionately higher rates of chronic physical health conditions as well as mental health and/or substance use disorders compared to the general public,[4] face a significantly heightened risk of death post-release.[5] Medicaid expansion has proven particularly vital for these vulnerable populations. For instance, 60% of Medicaid enrollees with an opioid use disorder qualify for Medicaid through the expansion,[6] while up to 90% of formerly incarcerated individuals are likely eligible for coverage due to this provision.[7]

One of the single largest projected sources of coverage loss from H.R. 1 is the new work reporting requirements for the Medicaid expansion population.[8] This "community engagement" provision requires individuals ages 19-64 in the Medicaid expansion population to be working or participating in education, training, or community service activities (or some combination of those) for at least 80 hours each month. Individuals will need to demonstrate they already meet these requirements *prior* to enrolling in Medicaid, and again, at least every six months, upon eligibility redetermination.[9]

Congress established a number of exemptions to the 80-hour work requirement. However, people who meet one or more of these exemptions may still be required to comply with the *reporting* requirements and thus may need to demonstrate that they meet an exemption when renewing their Medicaid twice a year. This report does not address all of the exemptions but highlights three that may be most directly relevant for individuals who have a substance use disorder and/or arrest and conviction records:

- An individual with a substance use disorder ("medically frail");
- An individual who is participating in a drug or alcohol addiction treatment and rehabilitation program (for a subset of treatment programs); and
- Incarcerated individuals and individuals who were incarcerated at any point in the previous three months.

There are other exemptions that may overlap with or separately apply to these same populations that deserve additional attention.[10] Some of these – including the other health conditions that count as "medically frail" – are discussed briefly throughout this report, and the full list is included in Appendix B.

Data shows that at least 92% of adult Medicaid enrollees already meet either the "community engagement" requirements or one of the exemptions.[11] However, the Congressional Budget Office (CBO) estimates that far more than 8% of Medicaid expansion enrollees will lose their coverage under H.R. 1's new requirements due to bureaucratic red tape. Even with these statutory changes, Medicaid is still an entitlement program,[12] and people who are entitled to receive Medicaid should not be effectively barred from doing so because of overly narrow definitions or burdensome reporting and verification processes.

While many people with substance use disorders and/or arrest and conviction records are fully able to and do work and participate in the other types of "community engagement" activities in H.R. 1, pervasive stigma and discrimination often makes it harder for them to initially find and maintain employment and comply with these requirements.[13] Work, education, training, and community service can be helpful for wellness and reentry, and many treatment and reentry programs help to facilitate access to these opportunities, but these populations face many unique barriers, including, for example, mandatory background checks or treatment schedule conflicts. This, on top of the standard barriers people already face in meeting reporting requirements, such as transportation and internet, can thwart access to Medicaid coverage and vital, affordable health care for those with substance use disorders and/or prior incarceration.

As such, this report focuses on the exemptions, rather than the "community engagement" activities, because qualifying for exemptions will reduce coverage losses and the administrative burdens on both the individual and the state. However, the guiding principles and framework can also apply to the "community engagement" activities and the populations who are required to regularly report their compliance.

The goal of this report is to ensure that people with substance use disorders and formerly incarcerated individuals do not fall through the cracks and have their health insurance terminated as H.R. 1 goes into effect. Thus, this report identifies options that policymakers can pursue to implement these new requirements in a way that is the least burdensome and most inclusive of these populations – and others – so they can afford their health care and live their lives with dignity.

Recommendations: Guiding Principles and Framework

As the federal government and states consider how to implement the work requirements set forth in H.R. 1, they should strive to

1. **Maximize the exemptions;**
2. **Minimize the burdens; and**
3. **Advance policies that help more people access coverage and care.**

Importantly, these guiding principles apply to all populations, not just individuals with substance use disorders and/or arrest and conviction records, and the framework can easily be adapted.

1. Maximize the Exemptions

Members of one or more of the populations that Congress has exempted are going to struggle to stay covered, even and especially if they are working or participating in other "community engagement" activities. Individuals whose incomes are low enough to qualify for Medicaid often do not have control over their work hours (due, for example, to just-in-time scheduling and work within the gig economy), may not have the appropriate documentation to reflect their time – particularly for workers in hospitality or service – or may be working multiple jobs such that compiling the necessary documentation is an additional burden.[14] These requirements also do not account for monthly variations, such as when schools go on vacation or businesses are closed for the holidays. The populations that are statutorily exempt often face additional barriers that compound these challenges, or have heightened health care needs that make it critical that they not lose their coverage and care. For example, individuals who participate in certain types of substance use disorder treatment (such as regularly attending opioid treatment programs) or are responsible for childcare on top of working are going to have a harder time consistently meeting the 80 hours per month, not to mention finding the time to collect and upload documentation. Individuals with substance use disorders and those who were recently formerly incarcerated face unique barriers to employment and may also have significant or special medical needs. For these and many other reasons, **adopting the broadest possible definitions for each of the exemptions protects vulnerable populations** – including those with substance use disorders and/or arrest and conviction records – from losing their health coverage amid circumstances beyond their control.

Additionally, some exemptions are time-limited, while others describe more static situations or chronic conditions and thus are less likely to lead to churn and coverage loss. As such, maximizing the exemptions not only includes capturing as many people as possible, but also identifying and developing policies to **facilitate categorizing individuals in the longest lasting, most protective exemption(s)**, so they are less likely to lose their coverage. Both of these principles are consistent with existing Medicaid regulations, which require the state Medicaid agency to allow an individual who would be eligible under more than one category to have their eligibility determined under the category they select.[15] In fact, there is already a model in the Supplemental Nutrition Assistance Program (SNAP) work requirements for screening individuals at certification and recertification for exemptions, and applying the one that will be in effect the longest when the individual qualifies for more than one.[16] Policymakers should take the same approach when implementing these new Medicaid work reporting requirements.

Furthermore, Medicaid is integral to prosperous state and local economies by ensuring a health workforce, to hospitals keeping their doors open – particularly in rural communities – as a result of offset payments and disproportionate share payments, and so many other things beyond directly covering the cost of health care for low-income individuals.[17] Accordingly, by capturing more people in these exemptions and limiting the number of individuals who get terminated from Medicaid, states can also help to mitigate the most severe potential harms of H.R. 1 to communities' economic wellbeing and rural hospitals.

One of the defining aspects of the Medicaid program is its flexibility – it is a partnership with the federal government in which states have significant leeway to make decisions that will best meet the needs of their residents, their workforces, and their economies. As such, even if the federal government declines to maximize the exemptions under the statute in its forthcoming interim final rules (to be released no later than June 1, 2026), it is crucial that they prioritize maintaining as much of this flexibility as possible in how states can interpret the exemptions for their residents. And, regardless of how the federal government implements H.R. 1, states should still optimize these exemptions to promote access to and continuity of health care coverage.

2. Minimize the Burdens

Importantly, there is no requirement in H.R. 1 for individuals to demonstrate or states to verify the exemptions. Instead, the law includes explicit permission for states to elect not to do so. The statutory language only requires "applicable individuals" to regularly verify their compliance, whereas individuals who meet the exemptions are deemed compliant, and the state may elect not to verify the information resulting in such deeming.[18] **Federal policymakers must maintain this flexibility, consistent with the statute, and state policymakers should adopt the approach of not requiring individuals to verify their exemption(s)**.

In order to identify individuals who are exempt, as well as individuals who are complying with the work requirements, H.R. 1 instructs states to prioritize data matching ("ex parte verification") and not require individuals to submit more information:

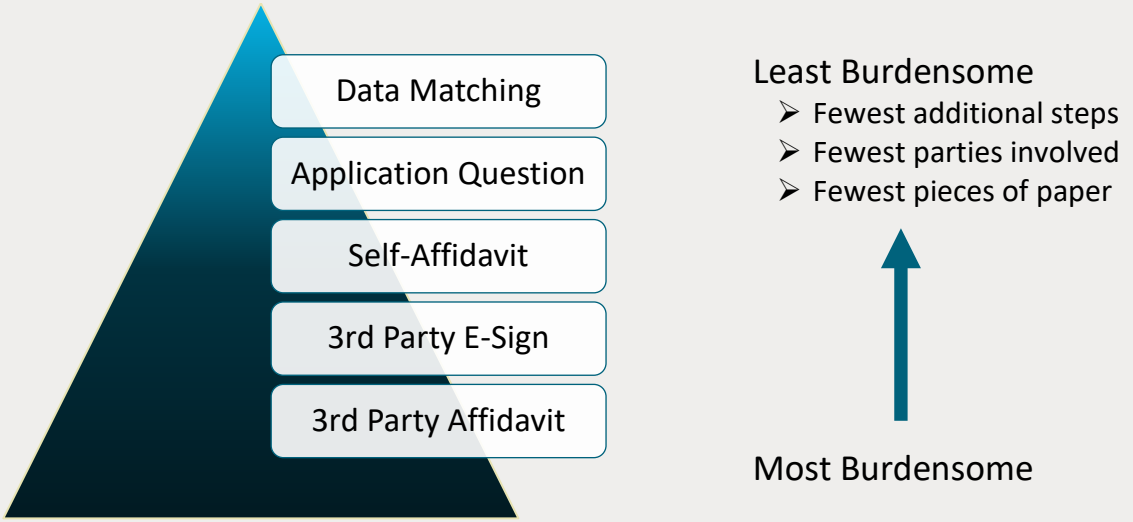
> [T]he State shall, in accordance with standards established by the Secretary, establish processes and use reliable information available to the State (such as payroll data or payments or encounter data under this title for individuals and data on payments to such individuals for the provision of services covered under this title) without requiring, where possible, the applicable individual to submit additional information.[19]

Not only do these new statutory provisions emphasize minimizing burdens – both for the state and the individual – but long-standing Medicaid regulations do as well. One such regulation regarding Medicaid eligibility and enrollment states, "The agency's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the best interests of the applicant or beneficiary."[20]

Because every step, party, and piece of paper added to the application or eligibility determination process is another point where someone could – and often does – drop off and lose access to the care to which they are entitled, policymakers should utilize a framework in which they prioritize the least burdensome options for determining eligibility and compliance — and for verifying exemptions if state chooses to do so. To be consistent with the statutory intent, only the minimum additional actions, documentation, and number of involved parties deemed necessary should be required, as outlined in the below recommended framework.

Data matching, the first option, represents the least burdensome tactic; each subsequent tactic should only be implemented when completely necessary – such as, if the preceding tactic is precluded or unavailable to the individual:

1. First, data matching ("ex parte verification") should be implemented with all relevant agencies and third party sources, maintaining strong privacy and confidentiality protections.
2. If data matching is inconclusive, self-attestation should then be considered sufficient and fully integrated into the application and redetermination processes, in a way that further preserves privacy and dignity.
3. If standalone documentation is needed beyond the application, then a standardized affidavit should be readily accessible to substantiate the self-attestation.
4. If third party confirmation is needed, then an "e-form" should be integrated into the application (or otherwise readily available) that can be electronically shared with, signed, and submitted by any third party who can attest to individuals' "community engagement" activity hours or exemption(s).
5. If fully integrated electronic verification by a third party is not possible, then a standardized affidavit or letter should be accepted as sufficient proof, with the fewest limitations on which third parties can complete and submit them.



Data Matching: **Data matching across agencies, to the extent feasible, must be the first strategy for determining compliance with the work requirements or whether an individual meets an exemption, as required by statute.** There are many federal, state, and county/local agencies that have data that can demonstrate income, education and training program enrollment, community service hours, and many of the exemptions. All of these must be leveraged rather than forcing individuals to report this information multiple times to multiple agencies. However, it is important to note that data matching alone is not and cannot be wholly sufficient to identify all those who are complying or exempt, as not all individuals will be adequately captured in the data while others may be tied to incorrect data.

Application Question: Because there will likely be gaps or inaccuracies with data matching, **policymakers should enable individuals to self-attest to complying with or being exempt from the federal work requirements directly in their application or eligibility redetermination form**. Applicants and enrollees are already required to submit accurate and true information to the best of their knowledge and ability — requiring additional paperwork for further proof only adds unnecessary burden for both the individual and the state. Self-attestation fully integrated into the application eliminates the need for additional documentation as well as state collection and maintenance of personal health information, further reducing costs and overall burden. To the extent that exemptions may be stigmatizing, it is imperative that policymakers prioritize the dignity and privacy of individuals by limiting the amount of information that must be disclosed and recorded. As previously noted, exemption verification is not required by the statute, so states should deem an integrated self-attestation as sufficient.

Self-Affidavit: In situations where the federal government or the state deems further documentation or verification necessary, a **standardized affidavit in which an individual can attest to "community engagement" hours or exemption status should be developed, made widely available, and accepted as proof**. Ideally the affidavit is a simple document with check boxes that can be easily completed by the individual and easily processed by the state, many of which are already used for health insurance exchanges.[21] This type of affidavit is already permissible for demonstrating certain other requirements for the Medicaid application,[22] and thus it would be reasonable to extend such a provision to community engagement hours or exemption status when data matching falls short. By streamlining the attestations and reporting as much as possible into a single form, policymakers can reduce confusion among and burden on people who may fall into multiple categories or who may be exempt but not realize. Doing so will also allow eligibility reviewers to apply the most longest lasting or most protective exemption. As before, privacy and dignity should be central to how the affidavit is developed and used.

3rd Party E-Sign**:** If the federal government or state decides to require some form of third party verification, then the application – or at least the state's website – should **integrate an entirely electronic form that can be shared directly with, signed, and submitted by a third party who can confirm the community engagement hours or exemption status**.[23] Requiring third party verification is inevitably more onerous for all involved parties, but ensuring all steps to do so can be done electronically would help to minimize the overall burden, especially since H.R. 1 already requires states to conduct electronic outreach on these work requirements.[24] **Individuals who are unable or choose not to complete an online application should still have the option to provide an email address for their third party contact such that the state can send the electronic verification form on their behalf. States should also ensure this type of verification can occur by phone and all other methods that H.R. 1 has authorized for outreach**,[25] particularly in rural areas where there may be limited or inconsistent internet access. In addition, policymakers should ensure the greatest flexibility and fewest limitations possible on what third party can attest to the "community engagement" hours or exemption(s).
3rd Party Affidavit**:** If a state lacks the capabilities or technology to integrate an electronic third party verification process, then **a template letter or standardized affidavit completed by the third party must be deemed sufficient proof**. Again, the affidavit should be as simple as

possible, collecting the minimum amount of information necessary, so as to reduce the burden on all parties involved.[26] As before, the state should place the fewest limitations possible on who can complete and sign the letter or affidavit, recognizing the many types of individuals and organizations who can adequately attest to participation in "community engagement" hours or exemption(s). If an individual is unable or does not wish to involve a third party, guidance should be developed that includes other examples of acceptable documentation to show their work or exemption status (such as court dockets in lieu of a letter from a jail to verify a person was recently released; or a copy of a prescription for medication for opioid use disorder in lieu of a physician completing an affidavit to verify an individual has a substance use disorder).

Redetermination**:** Importantly, **enrollees who are going through the redetermination process should not need to submit any new or additional information to demonstrate that they still meet an exemption**. The vast majority of the exemptions are static situations or chronic conditions that will not change in six months or less – and some are lifelong by definition. As such, during any redeterminations, states should first employ data matching, and if inconclusive, allow individuals who meet an exemption to self-attest – integrated into the application – that they have no changes to their exemption status. For time-limited exemptions (such as the 3-month period for formerly incarcerated individuals and the caregiver of a child age 13 or younger) states should provide additional outreach, as well as information in the redetermination form, to help the individual understand if they may qualify for another exemption moving forward.

Recommendations for Specific Populations and Exemptions

Consistent with the overarching principles and framework, this section discusses how exemptions can be maximized and burdens minimized specifically for individuals with substance use disorders and/or formerly incarcerated individuals. However, as previously noted, the principles and framework can and should be applied to as many populations as possible to minimize coverage loss and harmful impacts to state budgets and communities.

Individuals with Substance Use Disorders ("Medically Frail")

H.R. 1 exempts any individual "who is medically frail or otherwise has special medical needs" from participating in the 80 hours of work and/or community engagement activities required each month.[27] The federal government has authority to further define who fits into this category, but it must include individuals "with a substance use disorder."[28] This category also includes individuals who are blind and disabled,[29] have a disabling mental disorder, have a serious or complex medical condition, and have a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living.

Maximizing the Exemption

Policymakers should – in law, regulation, or guidance – define an individual with a substance use disorder for this purpose as: "an individual who had, has, or would be classified as having any substance use-related condition under the most recent edition of the DSM or ICD."

The best interpretation of the statutory language would be to define an individual with a substance use disorder as **inclusive of all substances** – alcohol and drugs, regardless of whether they are illicit – **and all levels of severity**, consistent with the most recent editions of the Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD). If Congress intended to limit the definition to specific substances or severity levels, it would have done so in the statute, as it did for other health conditions within the "medically frail" category, or it would have excluded this exemption for its redundancy.

The exemption should be defined to capture all individuals who *would be classified* as having a substance use disorder**, even if they have not received a formal diagnosis by a medical provider.** If Congress had intended to limit this provision to those who have a substance use disorder *diagnosis*, it would have done so in the statute.[30] Additionally, it would be redundant to do so, as diagnoses are usually related to treatment, and there is a separate exemption for those participating in addiction treatment, discussed in the next section. This is particularly important because the vast majority of individuals who have, or would be classified as having, a substance use disorder do not receive treatment and thus are unlikely to have a recorded diagnosis.[31] Especially because there may be stigma and fear associated with participating in formal treatment, these individuals may opt to instead participate in anonymous treatment or mutual aid programs, or even use a mobile phone application to reduce or address their substance use. Ultimately, any substance use-related services and supports that would reflect a person's condition should be sufficient to demonstrate that they do in fact have a substance use disorder and thus are eligible for this exemption. As a related example, receipt of homelessness-related services can typically be used to show someone is unhoused and thus entitled to certain homelessness-related benefits or documents (such as an identification card) that they otherwise could not obtain.[32] In this context, federal agencies have already set a precedent for recognizing individuals who would be classified as having a substance use disorder via data collection such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH) — not just those who have a diagnosis.[33] Including these individuals in this exemption is particularly important as part of the public health response to the overdose crisis, so these individuals can access formal treatment if and when they need it.

Substance use disorders are typically chronic, lifelong health conditions.[34] Many individuals will be in treatment, including taking medications for treating their substance use disorder, or receiving supports and recovery services, for the rest of their lives. Additionally, the rate of recurrence (relapse) is similar to that for other common chronic health conditions.[35] As such, it is not only the most accurate interpretation of the statute to include all individuals who have ever had a substance use disorder, but it is also imperative – as a public health matter, in the

midst of the ongoing opioid epidemic – to ensure these individuals have low-barrier access to evidence-based treatment to prevent overdose and death by maintaining their access to Medicaid. Furthermore, many people who are "in recovery" still face the same stigma-based and discriminatory barriers to employment and community engagement activities as those who are in an acute stage of their condition. Thus, it is vital for policymakers to recognize that **all individuals who have ever had a substance use disorder, are in recovery or remission, and/or have finished their treatment** should be included in the definition of this exemption.

Additionally, policymakers should include in this category **individuals who have experienced discriminatory adverse actions because of their substance use**, as this too would be reflective of having a substance use disorder. For example, if an individual has been fired from their job, lost custody of children, or been dis-enrolled from school because of their substance use, they should be considered as meeting the definition of having a substance use disorder for the purposes of being exempt from the work requirement so they can access vital treatment, if needed. This is especially important because these types of adverse actions frequently coincide with the loss of other types of health insurance, leaving individuals without coverage alternatives if they cannot qualify for Medicaid.

As a final note, some people who use drugs may have a substance use disorder, but not all do. Regardless, because of the high rates of co-morbidity with several other chronic health conditions, it is likely that many individuals who use drugs have other health conditions that would allow them to meet the "medically frail" exemption, or others. To ensure as many people have access to treatment as soon as possible if and when they decide they need it, policymakers should ensure that as many of the serious or complex medical conditions that are often related to or exacerbated by drug use (such as HIV or AIDS, HCV, and other infectious diseases) are explicitly captured in the "medically frail" exemption.

Minimizing the Burden

Data Matching

If the state is able to determine through ex parte verification (data matching) that an individual applying for or renewing their Medicaid has a substance use disorder, then additional attestation or confirmation is not necessary to meet the exemption, consistent with the federal statute. If the individual has a substance use disorder diagnosis on record or has previously received substance use disorder care, then insurance claims and encounter data will be a useful source of data matching, as identified in H.R. 1. The state should ensure that the Medicaid eligibility determination system is able to communicate with its claims and payment system to account for individuals who have had a substance use disorder diagnosis on their claims at any time while being enrolled in Medicaid. Any type of substance use disorder treatment, including prescriptions or claims for medications for opioid use disorder or alcohol use disorder, should be a presumptive showing of eligibility for this exemption. Any claims in which a substance use

disorder is listed as a primary or secondary diagnosis, such as for a hospital visit or emergency services, would likewise clearly demonstrate the individual meets this exemption.

As mentioned above, because substance use disorders are chronic and often lifelong conditions, the state should recognize all prior claims with a substance use disorder diagnosis or with substance use-related care or treatment as confirmation of this exemption, rather than limit its search to a specific look-back window. To the extent that the state has a database that captures all claims (i.e., an all payer claims database) with personally identifiable information, it should be using claims data from any prior insurance coverage as well, not just Medicaid.

Importantly, all data matching must continue to protect patient privacy, as well as comply with any federal and state privacy and confidentiality laws and regulations, including HIPAA and 42 C.F.R. Part 2. Protecting patient privacy is especially important for individuals with a substance use disorder as stigma and discrimination based on the condition and its treatment are all too pervasive. For example, records disclosed, with patient consent, for the purpose of payment could be used for such data matching per HIPAA's statutory definition of "payment," which is also used for 42 C.F.R. Part 2.[36] Medical records, on the other hand, should not be required or collected by the state. To ensure burdens are minimized and patient privacy protected, the state should be accessing the least amount of information necessary to data match on this exemption.

In addition to claims data, there will be other records and documentation that are collected by safety net programs and local, county, or state health departments where other substance use-related services are provided. To the extent these programs or departments are collecting personally identifiable information but not submitting claims – for example, if the person did not have health insurance while receiving services – they should work to make this information available to the state Medicaid agency for data matching if it can confirm exemption status, such as a substance use disorder diagnosis, while still protecting patient privacy to the greatest extent possible.

Due to persistent "War on Drugs" era policies and the ongoing criminalization of people with substance use disorders, at least 60% of the incarcerated population has a substance use disorder.[37] This presents additional opportunities for data matching with records from the criminal legal system. For example, if an individual was screened for and shown to have a substance use disorder or received treatment while incarcerated, the state should be able to capture this through data matching. Thus, states should prioritize partnerships with their Departments of Corrections as well as their local jails so this data can be seamlessly communicated and matched, particularly when an individual is being released and likely applying for or restarting their Medicaid coverage. In states that are utilizing Section 1115 waivers to connect soon to be released individuals to care covered by Medicaid ("reentry waivers"), the agency should already have these claims and be able to easily match them. Moreover, the state would work to ensure that all individuals who are receiving any substance use disorder services while incarcerated – Including through, but not limited to, the Section 1115 reentry waiver – are not only automatically enrolled in Medicaid but also deemed exempt from work reporting requirements without the need for any further documentation.

Self-Attestation

Second to data matching, self-attestation is the optimal way for demonstrating the "medically frail" exemption, especially for individuals with a substance use disorder, as it protects the privacy of individuals' personal health information and puts the least amount of burden on the state to collect, review, and maintain such sensitive documentation. Consistent with the requirements of the statute – as states are not mandated to verify exemption(s) – and the framework for minimizing the burden, states should integrate the self-attestation in which the individual confirms their exemption directly in the application or eligibility redetermination. If such integration is not possible, or if it is determined that a separate affidavit is necessary, then states should streamline the self-attestation affidavit to include as many exemptions as possible in one document to help ensure the most people possible can easily identify their exemption(s).

Especially for substance use disorders, the model standard for self-attestation – whether integrated into the application or in a separate affidavit, although the former is preferable as it is the less burdensome option – would be to **have an individual check off or attest that they fit into the broader category of being "medically frail." Doing so would allow them to identify that they are exempt from the 80-hour "community engagement" requirement without needing to specifically disclose that they have a substance use disorder or for the state to keep a record of the condition**. The stigma and discrimination against people who use drugs and/or have a substance use disorder is pervasive, and states should prioritize allowing these individuals to attest simply to being "medically frail." However, it will be important for the application (or affidavit) to list all of the conditions and situations that would meet this definition, so that individuals can easily recognize themselves in and appropriately select this broader category. For substance use disorders in particular, policymakers should partner with people with lived experience to determine the most comprehensible and inclusive language to which this population can relate.

Additionally, some individuals who have a substance use disorder or who use drugs, regardless of whether they use this terminology, may qualify for other exemptions – including those within the "medically frail" category. There is a high co-morbidity rate between substance use disorders and disabling mental health conditions, HIV/AIDS, and other serious or complex medical conditions.[38] Accordingly, to capture as many people with a substance use disorder or who use drugs but do not recognize or use these terms, as well as to reduce confusion among people who have multiple chronic health conditions, it will be paramount to streamline the self-attestation of the "medically frail" exemption, if not all exemptions.

If the federal government or state determines it is necessary for the individual to clarify which condition makes them "medically frail," then the state should still streamline this process by having all of the conditions listed in the same part of the application or in the same affidavit, rather than a separate questionnaire or document just for substance use disorders. Doing so would reduce the burden for the state to process these documents, and would simultaneously reduce some of the stigma for the individual who is disclosing this information. It would also reduce confusion and the amount of documentation necessary to submit if the individual is

eligible for multiple exemptions. However, it will be the least burdensome for both the individual and the state if disclosing the specific condition is not required.

Third Party Verification

If the data matching is inconclusive and the federal government or state determines that self-attestation is insufficient for demonstrating that an individual has a substance use disorder, then the agency should ensure that a simple, standardized affidavit or letter from a third party is sufficient. It is important to recognize that Congress specifically included a separate exemption for people who are participating in substance use disorder treatment in H.R. 1. Thus, it would be an irrational reading of the statute to suggest that only treatment-related documentation would be acceptable for this exemption, as that would be redundant.

Accordingly, **the state should develop, make widely available, and accept as sufficient proof a simple, standardized affidavit or template letter signed by a third party who can reasonably confirm that the individual has a substance use disorder**. As before, it would be the least burdensome – for the state and third party – and most protective of the individual's privacy to **have a broad, streamlined letter that includes all exemptions, rather than a separate one for substance use disorders**. Ideally, the state would make this an electronic form that could be shared with, completed, and submitted by the third party. If the state is unable to adopt this relatively simple technology, and recognizing that not all third parties have access to reliable internet, it should also develop the simplest analog process possible for the third party to obtain, sign, and submit the affidavit.

An appropriate third party for this exemption would certainly include a medical, mental health, or substance use disorder treatment providers or their staff, including safety net or other programs that do not bill Medicaid or other insurance. It should also be interpreted to include any substance use disorder treatment provider or program for which the individual is on a waitlist.[39] That is, if an individual cannot get a diagnosis or treatment because of lack of availability, they should not be deprived of Medicaid, especially because inclusion on the waitlist clearly reflects the individual's substance use disorder. **In addition to health care providers, third parties who can confirm the individual has a substance use disorder should also include any other individuals or entities who provide or can attest to the use of substance use-related services and supports** (i.e., peer recovery specialists; recovery community organizations; harm reduction and overdose prevention programs; law enforcement and courts, including drug and mental health courts; parole and probation officers; and residences such as halfway houses, sober living facilities, and recovery homes). Individuals who do not directly provide the supports or services but can attest to the individual's participation, such as a faith leader or staff member at a place of worship where a mutual aid or recovery meeting takes place, should also be an acceptable third party.

Although documents or other proof should not be required or necessary, **a state should also allow an individual to submit documents that demonstrate they meet the exemption if that is easiest for them or if they are unable or unwilling to contact a third party who can verify the**

information. For example, an individual should be able to show a medical record, claim, receipt, or prescription that reflects a substance use disorder diagnosis or use of treatment services or medications. This should not be limited to substance use disorder treatment, but may also include a discharge summary from a substance use-related emergency department visit or documentation that reflects an individual's participation in substance use- or recovery-related services or supports. However, as previously recommended, to minimize the burden and ensure compliance with federal and state privacy protections, policymakers should not be retaining these or any other documents that reflect an individual's substance use disorder.

Lastly, the state should also accept as proof of an individual's substance use disorder any instances of discrimination or punishment against the person because of their condition. For example, courts may revoke custody from parents with substance use disorders, students get expelled from school, individuals get removed from public housing, and employees can lose their jobs. Some of these devastating situations can cause individuals to lose access to other health insurance, often making them eligible for Medicaid. Accordingly, to the extent that any such documentation is available, or someone from one of these entities can provide verification either through an e-form or a letter, it should be sufficient to demonstrate the person has a substance use disorder for the purposes of meeting the work reporting requirement exemption.

An Individual Who is "Participating in a Drug Addiction or Alcoholic Treatment and Rehabilitation Program"

H.R. 1 also exempts individuals who are participating in "drug addiction or alcoholic treatment and rehabilitation programs" from the required 80 hours of "community engagement" activities each month. Notably, it does not apply to all settings of substance use disorder treatment. The definition for these programs is the same that is used for SNAP:

> ''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, 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.[40]

Although the SNAP regulations are not binding on this new work reporting requirement in Medicaid, they further clarify: "Under part B of title XIX of the Public Health Service Act is defined as meeting the criteria which would make it eligible to receive funds, even if it does not actually receive funding under part B of title XIX."[41] That is, the programs would not need to be receiving mental health or substance use disorder block grants to qualify as an acceptable treatment program for the purposes of this exemption, just meet the eligibility criteria to do so.

Maximizing the Exemption

The vast majority of individuals with substance use disorders do not receive treatment in any given year, and approximately half of substance use treatment facilities across the country will not qualify under this definition.[42] While the exemption for "an individual with a substance use disorder" is broader, longer term, and should be used whenever possible, this participation in a treatment program exemption should still be interpreted as generously as possible to capture all who should be eligible. Being overly inclusive is of paramount importance for this exemption because Medicaid's payment for this treatment may be the only way an individual can pursue or stay in such a program, as it would generally be unaffordable otherwise.

As noted above, this treatment exemption was lifted directly from the SNAP work reporting requirements, and thus policymakers should be informed by existing best practices in implementing this exemption for Medicaid work reporting requirements. Although the statute sets limits on the settings for substance use disorder treatment, there are no minimum hour requirements for treatment nor specifications regarding types of treatment. As such, the vast majority of states do not impose any minimum treatment participation hours for this exemption in SNAP, and explicitly state that treatment can be residential or non-residential.[43] Moreover, it is clear that Congress is capable of setting minimum hour requirements, as it has done so for this work reporting requirement in general, and elected not to do so here. Accordingly, policymakers must ensure that **all individuals who are participating in a substance use disorder treatment program for any amount of time each month – and regardless of whether such participation interferes with their ability to meet the "community engagement hours"** – be included under this exemption.

Importantly, the referenced language in the statute includes "community mental health centers" as a treatment setting, not just facilities that primarily treat substance use disorders. The fact that community mental health centers are only required by law to provide outpatient services and day treatment reinforces the reading that **both residential and non-residential treatment programs are acceptable to meet this exemption**.[44] The additional reference to part B of title XIX of the Public Health Service Act includes block grants regarding *both* mental health and substance use. Accordingly, states should ensure that **programs and facilities that offer treatment for co-occurring mental health and substance use** are also included in this definition. In so doing, states will minimize their burden in identifying many individuals who are exempt because they have a "disabling mental illness" under the "medically frail" exemption as well.

However, it is also very important for the federal government – and states – to recognize that not all states license or certify "community mental health centers" by this name, and it would be an illogical interpretation of the statute to limit it in this way. For example, some states only recognize "community behavioral health centers" or other similar publicly operated settings that would meet the same requirements as those of a "community mental health center." As such, the federal government and/or state should clarify the definition of a "community mental health center" for the purposes of this exemption so as to be as inclusive as possible of all states. The most logical interpretation of "community mental health center" that would be

consistent with the intent of statute and existing SNAP regulations is: “any publically operated entity that provides substance use disorder and/or mental health treatment that would be eligible to receive funding under part B of title XIX of the Public Health Service Act.”

Notably, this exemption is time-limited by definition, applicable only to those who are actively participating in treatment. This is especially problematic because many individuals who start treatment do not complete it,[45] and the recurrence (relapse) rate in the first year following treatment is incredibly high.[46] That is, during this period of time, it is critical that individuals do not lose their health insurance so they can access treatment again if they need it. Evidence further suggests that recurrence is still common for a number of years following treatment,[47] not just the first year, underscoring the deficiency of such a time-limited exemption. It is also likely that these individuals have other co-occurring conditions that also need to be treated.

With all of this in mind, individuals who would meet this participation in treatment exemption would almost certainly fit into “medically frail” exemption as well due to their substance use disorder. To minimize disruptions to care or coverage, policymakers and eligibility reviewers should **categorize people who are participating in this type of treatment under the “medically frail” substance use disorder exemption** instead to avoid the additional burdens and paperwork of switching the enrollee after they complete a treatment program. It would also be easier for the state to implement, as otherwise the state would have to verify that the setting of treatment fits under the SNAP definition. Doing so would likewise be consistent with work requirement exemption policies for other public benefits in which the “agency must apply the exemption that will be in effect the longest when an individual qualifies for more than one exemption.”[48] If the federal government or state determines this is not feasible, then they should ensure that there is an automatic way to seamlessly transition an individual who has completed treatment into the “medically frail” substance use disorder exemption without requiring a new eligibility determination or additional documentation.

Minimizing the Burden

As discussed above, one of the most important ways to minimize the burden on individuals with respect to the participating in treatment exemption is to ensure they are instead classified under a longer-term exemption, such as the “medically frail” category — or at the very least, automatically transitioned to the “medically frail” exemption once they complete treatment. Thus, while the framework is adapted below for this exemption, the most expansive, least burdensome exemption that will best ensure an individual’s coverage is not disrupted or terminated is the “medically frail” exemption.

Data Matching

If the state is able to determine that an individual is participating in substance use disorder treatment through ex parte verification (data matching), then additional attestation or verification is not necessary to meet the exemption, consistent with the federal statute. To the

extent that a state already has an appropriately broad definition and is already using data matching for this exemption in SNAP work reporting requirements, states should be able to do the same for Medicaid. States should review their policies and practices for how they interpret the participating in treatment exemption for the SNAP work reporting requirements to ensure that is not overly burdensome or restrictive, given the additional changes to SNAP in H.R. 1. However, in this context, individuals in the Medicaid expansion population will not be eligible for coverage unless they have met the work reporting requirements or exemptions for the month(s) (no more than three) preceding enrollment,[49] thus complicating uninsured individuals' access to the treatment necessary to meet the exemption in the first place.

Also, as previously noted, to minimize the burden and cost to states to comply with federal and state privacy and confidentiality protections, policymakers should not be requiring or retaining any medical records. States should be accessing the least amount of information necessary to data match on this exemption, and they should consult with substance use disorder treatment providers in their state on best practices to minimize the burdens on both parties while ensuring patient privacy.

Self-Attestation

Out of concerns for privacy and confidentiality, as well as complying with relevant laws mandating such protections, policymakers should enable self-attestation when data matching is inconclusive. Moreover, it is important for states to realize that data matching for this exemption is not going to be wholly sufficient because individuals' treatment will not have been covered by Medicaid – and thus available for ex parte verification in Medicaid claims and encounter data – when they are first applying. Accordingly, self-attestation will be the most feasible and efficient way to account for discrepancies or gaps in the data matching and allow this exemption to be identified, without imposing additional burdens on the state, the individual, or the substance use disorder treatment programs.

As previously noted, states are not required to verify exemption(s), and thus self-attestation should be deemed sufficient for identifying an individual meets the participating in treatment exemption. Furthermore, for the SNAP work requirements, "The State agency is not required to verify an exemption or exception unless it determines the information is questionable or verification is otherwise required by program rules, for example, disability status."[50] A number of states have explicitly adopted this latitude not to require verification of the participating in treatment exemption,[51] among others, thus demonstrating that it can be accomplished in Medicaid as well.

Consistent with the framework for minimizing burdens, policymakers should integrate the self-attestation directly into the application if feasible. A separate affidavit should only be used if deemed necessary and is preferable over requiring third party verification. As discussed above, a single, streamlined affidavit should be used to identify all of the exemptions, rather than separate documents for each category. This will make it easier for states to categorize individuals under

the longest term exemption possible, as well as reduce the stigma and potential for discrimination that may be associated with disclosing participation in substance use disorder treatment.

Third Party Verification

Nonetheless, if third party verification is required, it is again important for policymakers to prioritize entirely electronic verification processes by which a provider or their staff can confirm the individual's participation in a substance use disorder treatment program. If necessary, the next best option would be a brief, standardized template letter from the treatment program, so any staff member at the program can confirm the individual's participation without needing to submit any records. Again, it is paramount that the state protects the individual's privacy, and develop clear guidance for treatment providers to ensure that any requirements for third party confirmation comply with HIPAA, 42 C.F.R. Part 2, and any state privacy and confidentiality requirements.

An Individual Who Currently Is or Was an "Inmate of a Public Institution" at Any Point Within the Prior 3-Month Period

The H.R. 1 work reporting requirements exempt individuals who are currently in jail or prison, as well as for the three months following their release. In the statute, these are two exemptions, worded as an individual who is "an inmate of a public institution," or an individual who was "an inmate of a public institution" at any point during the previous three months. For Medicaid purposes, a public institution is one "that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control," not including medical institutions, intermediate care facilities, publicly operated community residences for up to 16 residents, and childcare institutions.[52] An "inmate" in this context is someone living in such an institution, unless they are in a public educational or vocational training institution, or unless they are only residing at the public institution for a temporary period pending other appropriate arrangements. The Centers for Medicare & Medicaid Services (CMS) released guidance in 2016 with further clarifications on when someone is considered an "inmate," as federal Medicaid dollars generally are not available to cover individuals in these circumstances.[53] However, 19 states have been granted Section 1115 waivers to cover eligible individuals who are incarcerated up to 90 days prior to their release,[54] and per H.R. 1, would be exempt from the work reporting requirements as well.

Maximizing the Exemption

Formerly incarcerated individuals face significant barriers to gainful employment. More than 60% of those who are actively seeking work cannot find a job a year post-release.[55] Approximately 33% of those released from incarceration are unable to find any jobs in the first four years following their release, and more than 60% of this population are unemployed at any given time in the four years post-release.[56] Those that do find employment opportunities have an average of 3.4 jobs in those four years and have significantly lower earnings than the general population.[57] These economic factors make this population much more likely to be eligible for

Medicaid through the expansion, yet simultaneously make it harder for them to comply with the work reporting requirements. In addition, most formerly incarcerated individuals face significant health needs, making access to health coverage and care even more critical.

As such, the most important way to maximize exemptions for this population is to **identify other, longer-term exemptions for which they can qualify, because the 3-month period post-release will not be sufficient** for many of these individuals to secure employment and thus maintain affordable coverage. Approximately 60% of the incarcerated population has a substance use disorder,[58] and about 38% of people in state and federal prisons have at least one disability, which is almost 2.5 times that of the general population.[59] People also leave incarceration with higher rates of mental health conditions, chronic illness, and other serious and complex health medical conditions, potentially qualifying many of them for the "medically frail" work requirement exemption.[60] To maximize continuity of coverage and care, **policymakers and correctional systems should develop policies and procedures to ensure they are appropriately screening and documenting the health conditions and medical needs of those who are in jail and prison for any amount of time**. Such screening should be coupled with appropriate diagnosis and treatment, both behind bars and upon release, for which continuity of Medicaid coverage and eligibility for longer-term exemptions from the work reporting requirements will be instrumental.

For those who are not eligible for another exemption – as well as for those who should be eligible but were not screened, diagnosed, or treated for a "medically frail" condition while incarcerated – policymakers can still maximize these two exemptions by **ensuring that an individual who was in the "inmate" exemption is automatically transitioned into the 3-month formerly incarcerated exemption upon their release** without requiring a new eligibility determination or additional documentation. That is, as soon as an individual's Medicaid is activated or reinstated following time in jail or prison, they should automatically be categorized under the formerly incarcerated exemption without having to submit any additional information. This is especially important when recognizing the reality that many of these individuals may not be screened, diagnosed, and/or treated while incarcerated. Automating their seamless transition into the formerly incarcerated exemption will enable these individuals to address ongoing health conditions and give them time to obtain any verification necessary to facilitate access to an applicable longer-term exemption, particularly those for disabilities, substance use disorders, mental health conditions, or serious complex medical conditions.

Minimizing the Burden

As previously noted, one of the most important ways to minimize the burden on individuals with respect to the incarcerated and formerly incarcerated exemptions is to prioritize their classification under a longer-term exemption, such as the "medically frail" category, as this would reduce the additional paperwork or changes they have to make to comply with these work reporting requirements after the 3-month post-release period.

Data Matching

If the state is able to determine through ex parte verification (data matching) that an individual applying for or renewing their Medicaid is an "inmate of a public institution" or was an "inmate" at any point in the preceding three months, then additional attestation or confirmation should not be necessary to meet the exemption, consistent with the federal statute. For states that have been granted Section 1115 reentry waivers, they should already be enrolling eligible individuals in and submitting claims to Medicaid that could be easily matched for these purposes. For other states, as well as those whose reentry waiver does not extend to all correctional facilities in the state or all populations that may be eligible for Medicaid (for example, only certain health conditions or demographics), they will need to take additional steps to improve data collection and matching to enroll in or reactivate Medicaid coverage for as many people as possible.

Federal and state policymakers should be leveraging the provision in and grant funding from the Consolidated Appropriations Act (CAA) of 2024 that requires all states to suspend, rather than terminate, Medicaid coverage upon incarceration – effective January 1, 2026 – to facilitate faster reinstatement upon release.[61] That is, they should **develop policies and practices that identify someone as an "inmate of a public institution" when suspending coverage upon incarceration, and then identify someone as exempt for the following three months upon their reinstatement**, consistent with these new laws. Even if this requires action on behalf of the corrections facility, rather than automatic data sharing due to a lack of technological capabilities, this would be the most effective and efficient way to implement both the CAA, 2024 statutory requirement to only suspend Medicaid and to implement the new H.R. 1 work requirements. More specifically, there should be a requirement for corrections facilities to make a deliberate and proactive effort to help an individual who is being released from incarceration to not just enroll in or reactivate their Medicaid coverage, but also to help demonstrate the formerly incarcerated exemption status.

Moreover, **if claims and encounter or any other matched data from the criminal legal system reveal that an individual may be eligible for a longer-term exemption, that one should be applied**. For example, if the individual is an American Indian or Alaska Native, a former foster youth, a veteran with total disability, dually eligible for Medicare…etc., then that exemption should be used by the state instead of the 3-month exemption for formerly incarcerated individuals. Or, if the individual was screened and diagnosed with – or received medications, services, or supports for – a substance use disorder during or prior to incarceration, the data matching or other communications between the correctional facility and the state Medicaid agency should facilitate categorizing that person under the "medically frail" exemption. Thus, states should prioritize partnerships with their Departments of Corrections as well as their local jails so this data can be seamlessly communicated and matched during the reentry process, without the need for any further self-attestation or documentation.

Self-Attestation

Even with robust data collection and matching, and any other facilitated communication between corrections facilities and state Medicaid agencies, there will inevitably be individuals whose data is not appropriately captured or who are not immediately enrolled or reinstated in Medicaid. In these particular circumstances, it is also incredibly unlikely that the individual would have access to any documentation that would reflect their release date or contacts at the jail or prison who could verify their exemption status as a formerly incarcerated individual. In fact, most individuals do not receive any such documentation upon their release, nor are they provided appropriate contacts at the jail or prison where they were detained. For these practical reasons, as well as the statutory language enabling states to elect not to require an individual to verify this information, **an individual should be able to self-attest to having been an "inmate of a public institution" during the preceding three months to meet this exemption**, ideally as a single question integrated into the application. If it cannot be fully integrated into the application, it should be a straightforward and simple affidavit that the state develops, makes widely available, and accepts without further verification. The affidavit should be streamlined to include all exemptions in one document to reduce the stigma and protect the privacy of the enrollee, while enabling the state to identify applicable longer term exemptions.

Third Party Verification

If, for whatever reason, the state determines that third party verification is needed to confirm an individual was incarcerated in the preceding three months, then **the state should automate such verification to the greatest extent possible**. It would be impractical and unduly burdensome for most individuals to return to the jail or prison to pick up documentation or get a letter signed. If the exemption status cannot be determined via data matching or self-attestation, the state should take any additional steps it determines necessary to verify that information itself, such as contacting any relevant parties that could confirm the exemption: jail or prison staff, parole or probation officers, courthouse staff, attorneys, or any other individuals who work in the criminal legal system that would have knowledge of the person's date of release from incarceration.

Nonetheless, **states should also ensure that correctional facilities give individuals all of the information and documentation that they may need upon their release to facilitate access to coverage and care**, including confirmation of their release date and any medical records from their time spent behind bars. This will ensure that individuals have the documents they need not only to prove their exemption(s), but also to facilitate better coordination of care when they return to their communities. Reentry documents should also include information about eligibility and enrollment in Medicaid, opportunities to comply with the work reporting requirements such as employment and training programs, and the exemptions, as well as information about patient rights and protections associated with Medicaid coverage.[62] Additionally, facilities should not charge individuals for these documents or hold them past their release date to make documents available. Rather, facilities should proactively coordinate with individuals soon to be released so that their documents are available upon release.

3. Advance Policies that Help More People Access Coverage and Care

Federal, state, and local policy- and decision-makers should be proactive and creative in expanding access to care and coverage. Not only are millions of eligible individuals projected to lose Medicaid due to the administrative burdens and other barriers associated with work reporting requirements, but millions more are projected to lose coverage as a result of other provisions in H.R. 1 as well. To that end, there are many policies and practices that can be enacted that would simultaneously help more people who fit into these work requirement exemption categories maintain coverage and also strengthen access to care more broadly. For example, policymakers can implement initiatives to:

1. Proactively screen Medicaid expansion enrollees for exemptions, other pathways to Medicaid eligibility, and other coverage and benefits as these new work reporting requirements only apply to individuals in the expansion population. There is a statutory requirement that, if the state determines an individual has not complied with the work reporting requirements, then the state must first determine whether there is any other basis for Medicaid eligibility or another insurance affordability program before terminating the individual's coverage.[63] Instead of waiting for the individual to fail at meeting the required "community engagement" activity reporting, states should proactively assist Medicaid expansion enrollees to help determine if they meet an exemption or if there are other eligibility pathways through which they can enroll in Medicaid or other health coverage (for example, if the individual is dually eligible for Medicare, they are exempt from these work requirements). States should also consider providing individuals with additional assistance to identify other public benefits for which they may be eligible, such as disability benefits. States may wish to conduct additional outreach in particularly vulnerable communities, such as those with higher uninsured rates or lower treatment rates, to increase access to health coverage and care.

Based on quantitative and qualitative data from states that have implemented Section 1115 work reporting requirement waivers in Medicaid like those in H.R. 1, individuals are going to struggle to meet these reporting requirements and to understand the exemptions even when they are eligible.[64] Policymakers should ensure there is sustainable funding to support insurance navigators and assisters, including consumer assistance programs and organizations that support individuals reentering the community from incarceration, to help enrollees understand and navigate the work reporting requirements and exemptions.

Jails and prisons, as well as the broader criminal legal system, should also be responsible for screening individuals for exemptions, other eligibility pathways, and other coverage and benefits as part of their reentry planning and processes. States that are planning and/or implementing Section 1115 reentry waivers should incorporate these screenings into their demonstrations to ensure they can occur as early as possible, as well as other best practices to facilitate access to community-based care and successful reentry.[65] States that are not using

reentry waivers should still implement such screenings and directly facilitate enrollment, including meeting exemption(s). At the very least, all correctional systems should ensure that information about Medicaid, including these work requirements and exemptions, is made available in written form to individuals as part of their release from incarceration, and that they are collaborating with the state Medicaid agencies to minimize the burdens on formerly incarcerated individuals.

2. Promote universal screening for substance use disorders (and other conditions that qualify for the "medically frail" exemption), especially at key intercept points. Particularly as people lose their Medicaid, and with it, access to affordable treatment, it will be critical to ensure universal screening for substance use disorders and other chronic health conditions at key intercept points where individuals will continue to go even and especially without insurance coverage, such as safety net programs, emergency departments,[66] and schools. As discussed above, many incarcerated people have poorly or unaddressed substance use and other health conditions that could mean that they will qualify for the "medically frail" exemption to the work requirements upon reentry. Documentation of these health conditions should occur as people receive screenings during their incarceration and as a part of reentry planning.

Greater uptake of universal screening will help more individuals qualify for the "medically frail" exemption, enabling them to enroll in and retain their Medicaid coverage such that they can also access affordable treatment services, improving their health outcomes. It is imperative though that screening is paired with meaningful access to substance use disorder and other treatment, including facilitated referrals or warm hand-offs, so that people who are screened positively are immediately connected to the care or other services and supports they need.

3. Ensure adequate and sustainable funding for community-based substance use and mental health treatment providers and support services, including through reimbursement rates and grant funding. States should be thinking about how to protect and maintain access to substance use disorder and mental health treatment and supports, recognizing that Medicaid is the single largest payer of behavioral health services in the nation, and many of these providers and programs are primarily sustained by Medicaid reimbursement. It is imperative that states do not pass budget cuts onto substance use or mental health treatment providers. Instead, they must ensure that providers have continued access to adequate Medicaid reimbursement, so they can continue to serve the community. At the same time, with the significant cuts to Medicaid in H.R. 1, grant funding is more important than ever to help fill gaps left by inadequate reimbursement and protect access to affordable mental health and substance use-related services and supports, especially so the progress made to address the ongoing overdose crisis is not lost.

Moreover, as states continue to propose and/or implement Section 1115 reentry waivers, especially in light of other federal actions that limit grant funding and prioritize involuntary treatment, they should ensure that Medicaid dollars go towards culturally effective community-based providers. States operating reentry demonstrations should be funding substance use disorder – and other – treatment providers (particularly those embedded within reentry

organizations) and peer support specialists to do in-reach into jails and prisons to ensure that individuals who are returning to the community have high quality care and can make the health-related connections they need to facilitate their reentry *before* they are released. At the same time, this will help to ensure that community-based providers and peers are adequately supported, including with employment opportunities, and that jails and prisons do not become the default or only location for treatment.

By maintaining a strong base of mental health and substance use disorder treatment providers and supports in the community, more individuals will have access not only to the care they need but also to exemption opportunities from the work requirements. Many individuals in the expansion population will face a Catch-22 where they cannot enroll in Medicaid until they know they have a condition that would make them exempt from the work requirements, yet they cannot afford to go to a provider to confirm or get treatment for the condition without Medicaid coverage. This particular issue will also affect the reentry population, as many incarcerated individuals cannot access the diagnosis or care they need while in jail or prison such that they would qualify for an exemption lasting longer than the 3-month one for formerly incarcerated individuals, let alone the appropriate treatment for their condition. Especially if federal or state regulations require individuals to have a diagnosis or to verify the longer term "medically frail" exemption status, it is vital to ensure low-barrier access to substance use and mental health care in the community, including services and supports for people who use drugs, or else such exemptions are effectively meaningless. The full range of community-based and safety net providers will be critical to ensuring people can access lifesaving care.

4. Strengthen and enforce anti-discrimination protections in health insurance. Medicaid managed care organizations, alternative benefit plans (Medicaid expansion), and the Children's Health Insurance Program (CHIP) – in addition to most private insurance plans – are all subject to the Mental Health Parity and Addiction Equity Act, which requires non-discriminatory coverage of mental health and substance use disorder benefits as compared to medical benefits and surgical procedures. Improving enforcement of parity laws will help ensure that people are not subject to greater burdens and barriers when accessing substance use disorder and mental health care, which is also important for ensuring meaningful access to the "medically frail" and participation in substance use disorder treatment exemptions. But more than that, states could be saving a lot of money and investing in their behavioral health infrastructure if they hold commercial insurance companies and managed care organizations accountable for failing to comply with the Parity Act and provide their residents with the care to which they are entitled.

Another important anti-discrimination protection is to prohibit artificial intelligence (AI) systems from making coverage or care denials. While AI can and should be helpful in streamlining and speeding up coverage and care approvals, it is deeply problematic to rely on AI exclusively for individualized adverse determinations as such can result in eligible individuals being deprived of or denied benefits to which they are entitled.[67] Moreover, the lack of transparency into these algorithms prevents policymakers from understanding whether discriminatory biases and practices are baked into the models, exacerbating health disparities.

Thus, as states consider how to make their eligibility determinations and benefit coverage decisions more efficient, they must ensure that a human being meaningfully reviews any denials or terminations before they are issued.

States should also end policies that punish pregnant or parenting people that use substances since these policies could also result in people losing their health coverage. Policies that remove babies and children from parents who use substances or that subject the pregnant or parenting individual to punishment for such use not only lack evidence and deter help-seeking behavior, but they could also lead to an individual losing their Medicaid via post-partum or parent eligibility pathways. In non-expansion states, this may mean a complete loss of access to health coverage. Now, in expansion states, this could mean being subject to the onerous work reporting requirements that indirectly result in the loss of access to health coverage. States should instead adopt priority treatment policies, and allocate additional resources for such treatment and childcare, to ensure that pregnant and parenting individuals seeking substance use disorder treatment have timely access to care.[68]

5. Improve employment and training programs serving Medicaid and SNAP enrollees.
Everyone deserves meaningful and substantive opportunities to provide for their families. H.R. 1 effectuated the most significant funding cuts to both Medicaid and SNAP in the history of these programs, including through the new and expanded work reporting requirements. Yet these new requirements are not expected to improve economic mobility for people served by these programs. Most Medicaid and SNAP beneficiaries want effective job and career training and meaningful employment, but most state Medicaid and SNAP programs do not offer robust employment and training services to meet the needs of the population they serve, and existing programs fall short.[69] Nor do most states recognize or plan for the often overlooked barriers to accessing employment or training for people with conviction histories, thus perpetuating a no-win situation where individuals are required to work to access basic needs yet are excluded from employment opportunities based on their former incarceration.[70] This can, and often does, have the adverse impact of threatening the lives and livelihoods of individuals and their families. Medicaid and SNAP enrollees will face dire consequences if they fail to meet these work reporting requirements, making it more important than ever for states to improve employment and training programs and help individuals with arrest and conviction histories address barriers to employment, obtain needed education or training, and connect to stable, living-wage employment.

Conclusion

Absent full repeal of these new provisions in H.R. 1, many eligible individuals are going to lose their health coverage due to the extra paperwork, time, and effort necessary to verify compliance with the work reporting requirements or meet an exemption. However, federal, state, and local policymakers have opportunities to reduce coverage loss and mitigate the harm to public health by maximizing the exemptions, minimizing the burdens, and advancing policies that improve access to coverage and care.

Appendix A: One-Page Summary of How Best to Implement Medicaid Work Reporting Requirements While Protecting Individuals with Substance Use Disorders & Formerly Incarcerated Individuals from Losing Vital Coverage

1. **Maximize the Exemptions**
    a. Adopt the broadest definitions possible.
        i. Define "an individual with a substance use disorder" as: "an individual who had, has, or would be classified as having any substance use-related condition under the most recent edition of the DSM or ICD."
        ii. Include as many health conditions under "medically frail" as possible, with enough flexibility to be responsive to emerging public health crises.
        iii. Do not impose any limitations on the time or intensity of treatment for the participating in substance use disorder treatment exemption.
    b. Apply the longest term exemption to individuals who are eligible for multiple.
        i. Automatically classify people who are participating in substance use disorder treatment under the "medically frail" exemption for having a substance use disorder.
        ii. Automatically classify individuals being released from jail or prison under a longer term exemption than the 3-month post-release exemption if applicable.
2. **Minimize the Burdens**
    a. Partner with community-based organizations and people with lived experience to identify appropriate sources of data matching while preserving privacy.
    b. Elect not to require individuals to submit any documentation or proof to verify that they meet an exemption.
        i. Enable simple self-attestations to identify the exemption(s), fully integrated into the application, to the extent possible.
        ii. Self-attestations should require the least amount of self-disclosed personal health information necessary (i.e., one check box for all conditions that qualify as "medically frail," listing all the applicable conditions and definitions so individuals can easily recognize themselves in this category, without having to identify their specific condition).
    c. If verification is needed, standardized template affidavits should be developed by the state, made broadly accessible, and accepted as sufficient proof.
        i. Self- and third-party affidavits should be as simple as possible and again, only require the minimum personal health information necessary.
        ii. All affidavits should be available electronically (for signing and submission) and through all other formats required for outreach, and integrated into the application where possible.
        iii. Jails and prisons should facilitate enrollment in or reactivation of Medicaid upon reentry, including any information necessary to apply relevant exemption(s). If not feasible, then the state Medicaid agency should communicate and verify information with the criminal legal system to minimize the burden on formerly incarcerated individuals.

d. States should not require compliance more frequently than at the redetermination, and individuals should only need to certify that they have no changes to their exemption at that time.
    i. No additional documentation or verification should be required.
    ii. States should conduct additional outreach, and provide information in the redetermination, to assist individuals for whom a time-limited exemption is ending to determine if another exemption applies.
e. Automate transitions between exemptions when relevant.
    i. Automatically switch an individual from "inmate" to the 3-month post-release exemption when reactivating their Medicaid upon reentry, unless a longer term exemption can be applied.
    ii. Automatically switch an individual from "participating in substance use disorder treatment" to "medically frail" (with a substance use disorder) when their treatment concludes.

3. Advance Policies that Improve Access to Coverage and Care

a. Proactively screen Medicaid expansion enrollees for exemptions, other Medicaid eligibility pathways, and other coverage and benefits.
    i. Increase funding for health insurance navigators and assisters, including consumer assistance programs and reentry organizations, who can contribute to such efforts.
b. Expand universal screenings for substance use disorders (and other chronic health conditions that meet the definition for "medically frail") at key intercept points, including safety net programs, emergency departments, schools, and throughout the criminal legal system.
c. Ensure sustainable funding for community-based substance use and mental health treatment providers and support services.
d. Strengthen and enforce anti-discrimination protections.
    i. Improve oversight and enforcement of the Mental Health Parity and Addiction Equity Act.
    ii. Prohibit artificial intelligence from making coverage and care denials.
e. Improve employment and training programs for Medicaid and SNAP enrollees.

Appendix B: Sample Self-Affidavit for Attesting to Community Engagement Exemption(s)

To Whom It May Concern:

This statement is for declaring that, for the purposes of accessing Medicaid [insert state program name if different] health care coverage, I am exempt from participating in work, education, training, or community service (community engagement activities) for 80 hours a month based on the below information. I understand that this information will be kept private and will not be used for any other purposes.

I, [NAME], swear or affirm that I do not need to report community engagement activities to retain my Medicaid coverage for the following reason(s). Select all that apply.

- ❑ I am under 26 years old and I was in foster care when I turned 18.
- ❑ I am an American Indian or Alaska Native (including Urban Indian, California Indian, or determined eligible for services from the Indian Health Service).
- ❑ I am the parent, guardian, or related caregiver for either a child who is under 14 years old or a disabled individual of any age.
- ❑ I am a veteran with a total disability.
- ❑ I have one (or more) of the following medical conditions or special needs (Note: you do not need to identify which):
    - Blindness;
    - Disability ([reference more information with definition]);
    - Substance use disorder (this includes if I use/have ever used alcohol or drugs (legal or illegal) in a way that has made it difficult to stop or has interfered with my life);
    - Mental health condition that makes it difficult for me to do certain things;
    - A physical, developmental, or intellectual disability that makes it difficult for me to do any of the following: eating, getting dressed, moving or walking, getting in and out of bed or a chair, going to the bathroom, or grooming; and/or
    - A serious or complex medical condition (this includes [insert ALL conditions in federal or state guidance]).
- ❑ I am participating in an addiction or substance use treatment or rehabilitation program.
- ❑ I am pregnant or had a baby within the past [insert state requirement] days.
- ❑ I am already complying with the work requirements for TANF [insert state program name if different] and/or SNAP [insert state program name if different].
- ❑ I am entitled to or enrolled in Medicare Part A and/or enrolled in Medicare Part B.
- ❑ I am currently in jail or prison.
- ❑ I was in a jail or prison at any point during the previous three (3) months.

I hereby certify that the statements provided in this affidavit are true and accurate to the best of my knowledge.

Sincerely,

[INSERT FULL PRINTED NAME, SIGNATURE, AND DATE]

Notes:

- The list of exemptions in this letter should also be used in the integrated application question, and should be paired with a comprehensive reference list of all the exemptions and their definitions.
- States should partner with community-based organizations and people with lived experience to identify the most accessible and inclusive language.
- If using a standalone affidavit, states may wish to streamline reporting by including questions and options for determining compliance with "community engagement" activities for the situations in which data matching is unlikely to be successful, such as self-employment and community service hours.

Appendix C: Sample Third Party Letter for Verifying an Individual's Community Engagement Exemption(s)

To Whom It May Concern:

[APPLICANT/BENEFICIARY NAME] has presented themselves as an individual who [EXEMPTION LANGUAGE i.e. "is medically frail"] to [THIRD PARTY NAME].

If you have any questions, please contact us at [PHONE NUMBER, E-MAIL ADDRESS, and/or MAILING ADDRESS].

Sincerely,

[INSERT FULL PRINTED NAME AND SIGNATURE OF AUTHORIZED REPRESENTATIVE AND DATE]

Notes:

- If other information from a third party is determined necessary, then it should be as brief and streamlined as possible.
- This letter, as well as the self-affidavit in Appendix B, should be paired with a comprehensive reference list of all the exemptions and their definitions.
- States should partner with community-based organizations and people with lived experience to identify the most accessible and inclusive language.
- States may wish to streamline reporting by including questions and options for verifying compliance with "community engagement" activities for the situations in which data matching is unlikely to be successful, such as self-employment and community service hours.

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[10] Pub. L. No. 119-21, § 71119(a), 139 Stat. 308-13 (to be codified at 42 U.S.C. 1396a(xx)(3), (9)). *See also* Appendix B.

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[15] 42 C.F.R. § 435.404.

[16] 7 C.F.R. § 273.7(b)(3).

[17] *See, e.g.*, Leighton Ku et al., "How National Medicaid Work Requirements Would Lead to Large-Scale Job Losses, Harm State Economies, and Strain Budgets," The Commonwealth Fund (May 1, 2025), https://www.commonwealthfund.org/publications/issue-briefs/2025/may/medicaid-work-requirements-job-losses-harm-states; Madeline Morcelle, "Medicaid Work Requirements Would Gut State and Local Economies," National Health Law Program (Mar. 13, 2025), https://healthlaw.org/resource/medicaid-work-requirements-would-gut-state-and-local-economies/; Emma Parker-Newton, "Medicaid Work Requirements Undermine Rural Healthcare," National Health Law Program (Apr. 7, 2025), https://healthlaw.org/resource/medicaid-work-requirements-undermine-rural-healthcare/.

[18] Pub. L. No. 119-21 § 71119(a), 139 Stat. 307-08 (to be codified at 42 U.S.C. 1396a(xx)(3)(a)).

[19] *Id.* at 139 Stat. 309 (to be codified at 42 U.S.C. 1396a(xx)(5)).
[20] 42 C.F.R. § 435.902.
[21] For example, Maryland has a number of affidavits available on its state benefit exchange website: https://www.marylandhealthconnection.gov/after-you-enroll/submit-documents/. The "Affidavit of No Current Income" offers a valuable template that could be adapted for demonstrating community engagement hours or exemption status. https://www.marylandhealthconnection.gov/wp-content/uploads/2020/11/MHC-Affidavit-of-No-Current-Income.pdf. Healthcare.gov also has a number of template letters that can be used for resolving inconsistencies with data matching: https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/. For example, there is a single form that can be used for confirming various types of income that otherwise might not be captured in other documentation, including self-employment income, unearned income, or any other income that might be different from what the data matching says. "Annual Income Letter of Explanation," Healthcare.gov https://www.healthcare.gov/downloads/annual-income-letter-explanation.pdf.
[22] 42 C.F.R. §§ 435.407(b)(16); 435.407(c)(3).
[23] For example, Massachusetts has an entirely electronic Authorized Representative Designation Form that is available on mass.gov. https://www.mass.gov/lists/authorized-representative-designation-form.
[24] Pub. L. No. 119-21 § 71119(a), 139 Stat. 311 (to be codified at 42 U.S.C. 1396a(xx)(8)(B)(i)).
[25] *Id.* (to be codified at 42 U.S.C. 1396a(xx)(8)(B)).
[26] *See, e.g.*, New York State Dep't of Health, "Provider Attestation Form: New York State (NYS) Social Care Networks (SCN)" https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/provider_attestation_form.pdf.
[27] Pub. L. No. 119-21 § 71119(a), 139 Stat. 312 (to be codified at 42 U.S.C. 1396a(xx)(9)(A)(ii)(V)).
[28] *Id.* (to be codified at 42 U.S.C. 1396a(xx)(9)(A)(ii)(V)(bb)).
[29] The definition for "blind or disabled" references the definition used for Supplemental Security Income (SSI) at 42 U.S.C. 1382c. Pub. L. No. 119-21 § 71119(a), 139 Stat. 312 (to be codified at 42 U.S.C. 1396a(xx)(9)(A)(ii)(V)(aa)).
[30] For example, the federal statutory definition under Medicaid for a residential pediatric recovery center is "a center or facility that furnishes items and services for which medical assistance is available under the State plan to infants *with the diagnosis of* neonatal abstinence syndrome without any other significant medical risk factors." 42 U.S.C. 1396a(pp)(1) (emphasis added).
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[32] *See, e.g.*, South Dakota, "Affidavit of Homeless Status for Certified Copy of Birth Certificate" (rev. June 2025), https://doh.sd.gov/media/ibdj0frw/homeless-waiver-affidavit.pdf; DC Healthcare Alliance, "Proof of Residency Form," Section C (2009) https://dhs.dc.gov/sites/default/files/dc/sites/dhs/publication/attachments/final_proof_of_dc_residency_form.pdf
[33] *See, e.g.*, SAMHSA, "2023 National Survey on Drug Use and Health (NSDUH) Methodological Summary and Definitions" (July 2024), https://www.samhsa.gov/data/sites/default/files/reports/rpt47098/Methodological%20Summary%20and%20Definitions/2023-nsduh-method-summary-defs.pdf.
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[40] 7 U.S.C. 2012(h).

[41] 7 C.F.R. § 271.2.

[42] *See* SAMHSA, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health" 44 (July 2024), https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf; SAMHSA, "National Substance Use and Mental Health Services Survey (N-SUMHSS) 2023: Data on Substance Use and Mental Health Facilities," 4 (2024), https://www.samhsa.gov/data/sites/default/files/reports/rpt53012/2023-nsumhss-annual-report.pdf ("private non-profit organizations operated 48% (N=6,962) of [substance use] facilities," only a small minority of facilities are publicly operated by local, state, federal, or tribal governments, and these numbers do not include all substance use disorder treatment that would occur in general medical or non-facility based settings).

[43] Based on our review of state SNAP manuals, there were only four (4) states that States that have more stringent language than is statutorily required – i.e. a minimum number of hours in treatment or the requirement that participating in treatment actually interfere with the individual's ability to work. States that do impose any additional limitations on meeting the SNAP exemption for participating in a substance use disorder treatment program should strongly consider removing those limitations, especially recognizing the changes in H.R. 1 that will hurt SNAP recipients and state budgets as well.

[44] 42 C.F.R. § 410.2.

[45] Jessica Miller, "Addiction Recovery Statistics," Addictionhelp.com (July 30, 2025), https://www.addictionhelp.com/recovery/statistics/.

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[48] 7 C.F.R. § 273.7(b)(3).

[49] In H.R. 1, states have the option to require individuals to demonstrate compliance for one to three consecutive months prior to the month in which they are applying for Medicaid through the expansion eligibility pathway, and one or more months for subsequent redeterminations. Pub. L. No. 119-21 § 71119(a), 139 Stat. 307 (to be codified at 42 U.S.C. 1396a(xx)(1). Consistent with the framework for minimizing burdens, the shortest lookback window should be selected so as to limit the amount of information the individual needs to submit and the state needs to review, which will further reduce costs and save time for the state.

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[51] *See, e.g.*, Virginia Department of Social Services, "SNAP Manual" 143 (updated Oct. 2024), https://www.dss.virginia.gov/files/division/bp/fs/manual/Entire_Manual_01272025.pdf.
[52] 42 C.F.R. § 435.1010.
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[61] Consolidated Appropriations Act of 2024, Pub. L. 118-42 sec. 205 (2024).
[62] *See* "2022 Medicaid Reentry Recommendations," Legal Action Center (2022), https://www.lac.org/assets/files/september-2022-LAC-Medicaid-reentry-recommendations.pdf.
[63] Pub. L. No. 119-21 § 71119(a), 139 Stat. 310 (to be codified at 42 U.S.C. 1396a(xx)(6)(A)(iii)(I)).
[64] *See, e.g.*, Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," Center on Budget and Policy Priorities (Aug. 8, 2023), https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.
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