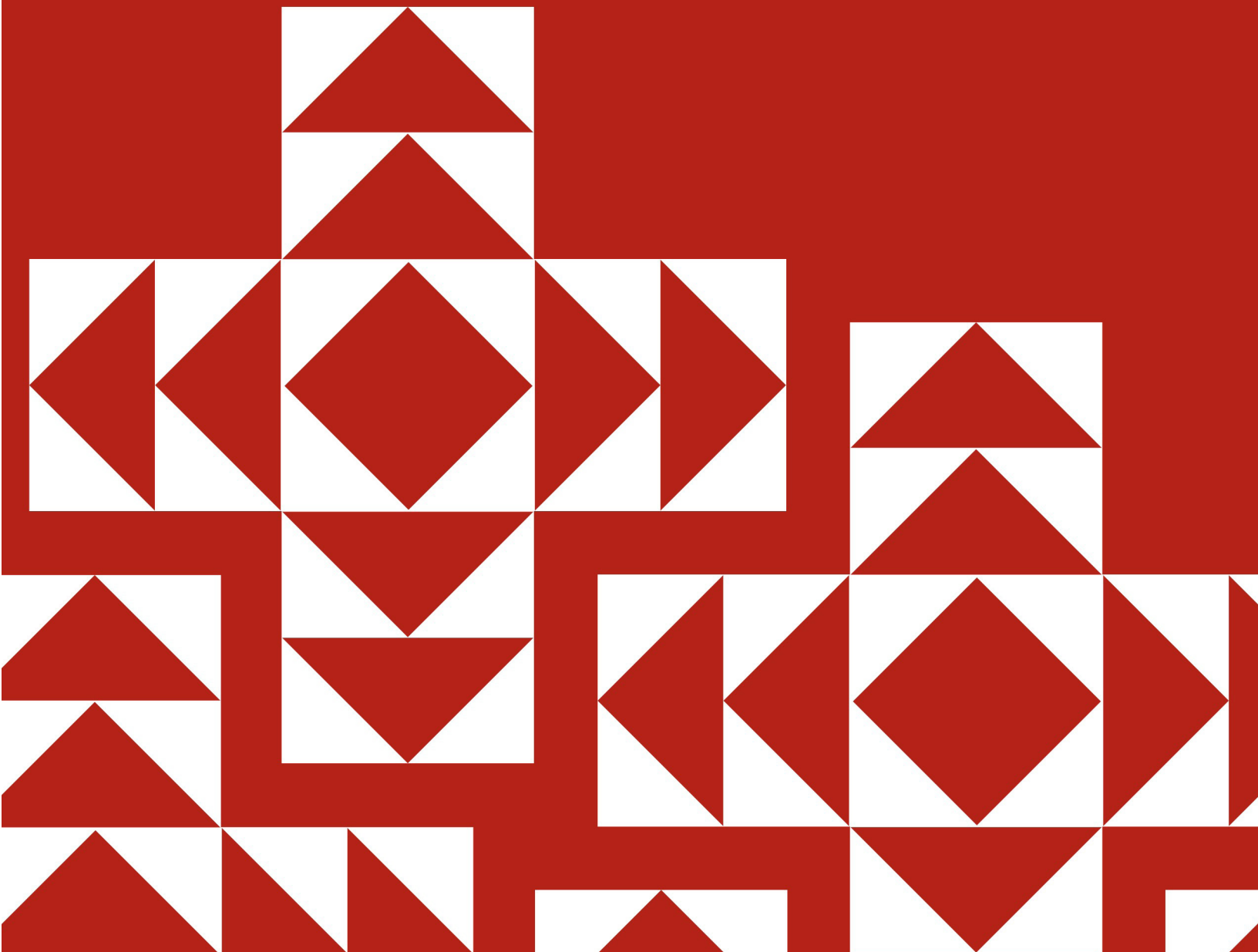


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***A Toolkit to Help Direct Care Workers  
Serving People with Disabilities Understand  
New Medicaid Requirements***



# *A Toolkit To Help Direct Care Workers Serving People With Disabilities Understand New Medicaid Requirements*

This toolkit is designed for direct care workers who provide services to people with disabilities and will need to know about Medicaid work requirements and other barriers to care created by H.R. 1 (the “One Big Beautiful Bill Act” or “OBBBA”). It identifies questions that direct care workers need to understand as they help people apply for Medicaid, navigate Medicaid eligibility redeterminations, and meet the work requirements if they are applicable.

While each state is setting up its own system to comply with the new Medicaid requirements in H.R. 1 and can make its own choices in several areas, the law spells out certain requirements clearly and direct care workers can be prepared for those. The toolkit provides a variety of questions that direct care workers (such as case managers and peer support specialists) as well as family and friends can use to help people with disabilities navigate these new requirements in their states.

### **What are the key provisions that direct care workers should understand?**

Congress recently enacted major changes to the Medicaid program as part of the so-called “One Big Beautiful Bill Act” (OBBBA). Direct care workers should understand the changes highlighted below, as they raise particular concerns for people with disabilities:

- The law requires people enrolled in or apply-

ing for Medicaid through the “Medicaid expansion,” many of whom have disabilities, to work or participate in “community engagement activities” (such as community service, a work program, an educational program, or a combination of those) for at least 80 hours per month.

- The law exempts people who qualify as “medically frail” or have “special medical needs” from these requirements. This exemption is particularly important for people with disabilities, and this toolkit includes key questions related to this exemption. These work requirements go into effect on January 1, 2027.
- The law requires states to redetermine eligibility for people enrolled through the Medicaid expansion every six months, rather than every year. This change begins on January 1, 2027.
- The law allows states to impose cost sharing of up to \$35 for each service for adults enrolled in the Medicaid expansion, with an annual cap of up to 5% of family income. These new provisions become effective October 1, 2028.

### **Why is this important?**

People with disabilities are at serious risk of losing health coverage as a result of these changes. The new Medicaid work requirements and more frequent eligibility redeterminations are likely to

result in inappropriate denials or disenrollment from Medicaid coverage.

Many people who are eligible for Medicaid and are actually meeting or are exempt from the work requirements are expected to lose or be denied coverage because of difficulties providing required documentation and information. Those same difficulties may cause many to lose or be denied coverage when their eligibility is redetermined (either because of the work requirement or because of other documentation requirements).

Direct care workers often play a key role in assisting people with disabilities in applying for Medicaid, assisting them through the process of eligibility redeterminations, and/or helping them navigate cost-sharing for Medicaid services. Thus, each of these requirements will be important for direct care workers to understand so that they can help prevent people with disabilities from losing access to care.

This toolkit provides guidance on what direct care workers should know when these requirements go into effect and how they can prepare themselves in advance of those deadlines. Each state will have its own processes for maintaining coverage, but the information below will help direct care staff across all states ask a series of critical questions that need to be answered in their state to help people maintain Medicaid health insurance coverage.

## **What Can You Do Before Your State Releases Details On How They Will Implement The New Requirements?**

The Centers for Medicare and Medicaid Services (“CMS”) released an interim final rule on June 1, 2026. This toolkit takes into account the require-

ments of that rule. While we do not yet have full information about how the federal government will enforce its rule, nor how each state will interpret certain aspects of work requirements, states are beginning to develop their implementation plans and direct care workers can still prepare themselves by knowing what questions to ask and what steps to take.

## I. WORK REQUIREMENTS

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To show that someone has met Medicaid “community engagement” (work) requirements, direct care workers should know:

- How does your state communicate with enrolled and eligible Medicaid program participants to inform them of changes and requirements around the law?
- What counts as work in your state?
- What counts as a work program in your state?
- What counts as an educational program in your state?
- What counts as community service in your state?

CMS’s interim final rule provides definitions and guidelines for what states may count as work, work programs, educational programs, and community service. States will still need to design their own definitions and processes within those parameters.

- Does your state require people to provide documentation showing that they meet the work requirements?
- If so, what kinds of documents are accepted by your state to show that someone is fulfilling any of these types of “community engagement?” How are those documents shared with state eligibility workers?
- How far back does your state look in deter-

mining whether someone meets the work requirements?

- Who in your state is considered to be “medically frail” and thus exempt from work requirements?
- How does your state interpret these categories and do the people you work with fit within any of them?

As noted above, the law exempts people who are “medically frail” or have “special medical needs.” People who are “medically frail” include the following:

- People with a “disabling mental disorder”
- People with a “substance use disorder”
- People with a “serious or complex medical condition”
- People with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living

Some of these categories—particularly “disabling mental disorders” and “serious or complex medical conditions”—may be interpreted in different ways. The rule requires each state to develop a list of health conditions that are covered and to identify individuals who meet the criteria and may be exempted, as well as a process by which to make those determinations. The rule requires states to determine whether a per-

son has a covered condition and whether it substantially impairs the person from meeting the community engagement requirement.

- Does your state require people to provide documentation showing they meet the “medically frail” exemption?
- If so, what kinds of documents can be used to show that someone meets this exemption?
- The law also contains other exemptions, such as exemptions for certain veterans with disabilities, Native Americans, people enrolled in substance use disorder treatment, and caregivers for a person with a disability. How does your state plan to define these exemptions and do the people you work with fall within any of those?
- The law also provides a “short-term hardship” exception to work requirements. How does your state plan to define that exception?

For example, Georgia, Kentucky, Iowa, Montana, and Utah have requested that homelessness be considered a short-term hardship, and that people experiencing homelessness should therefore be exempt from work requirements.

CMS’s interim final rule appears to limit this exception to people receiving inpatient services or non-institutional services that avoid the need for inpatient services, but these states’ requests have not yet been resolved.

- If you believe someone you are working with qualifies for an exemption, how do you assist

them in proving this to the state, so that coverage is maintained?

- What steps can you take to influence how your state defines medically frail?

States may choose to define who is medically frail through legislation, through state Medicaid office regulations, or through less formal guidance. Manatt Health has created an [Implementation Toolkit for States](#) and a [Medical Frailty Project Workplan](#) that states may use to guide their process. This process includes critical feedback from People with Lived Expertise (PLE) who are current or past Medicaid Beneficiaries.

- For clients who are not exempt from work requirements, how does your state classify supported employment services when determining compliance?

## Helping Clients With Documentation

The interim final rule requires states to first use reliable information available to the state to verify that a person is complying with or exempt from the requirements. If such information is not available, states may choose to require documentation or, before January 1, 2028, to accept other information (to show that a person is medically frail, that may be in the form of a statement). Beginning on January 1, 2028, states must require people to show compliance with the work requirement by submitting documentation if it is reasonably available. Also beginning on January 1, 2028, states may allow a person to show they are medically frail and thus exempt

from the work requirement by submitting a statement, but they may only do that one time. After that, states must require individuals to submit documentation. This appears to contradict what the law itself says and the differences may be resolved by the courts.

Clients need to document these activities for the appropriate state systems and authorities. Systems are being set up quickly, and we can expect challenges in implementation. Being persistent in working through or alerting state authorities to these challenges can often make a critical difference.

- Does your state or community have an online documents hub that allows these documents to be stored securely “in the cloud?”

For example, Minnesota’s [Disability Hub MN](#) - Home includes an online document hub.

- What client documentation does your provider organization have that may be important for showing that a client has met or is exempt from the work requirements? E.g. proof of employment, pay stubs related to income or rental calculations or, for exemption, documentation related to the provider’s services, such as mental health treatment records.
- Can your organization maintain and store additional documentation that is important for clients to show that they are meeting or exempt from work requirements?
- Can your organization keep this information after a client loses Medicaid coverage, as it may

be essential to help that person get re-enrolled?

## Knowing the timelines for compliance

H.R. 1 dictates certain timelines for state implementation. Understanding the timelines for your state can help your agency determine what efforts to take to support residents, train staff, and otherwise help people protect their health care coverage.

- How frequently do your clients need to show that they are meeting or exempt from work requirements? CMS has stated an exemption must be reverified every 12 months, but a state could choose to do so more frequently.
- What timelines and state systems have been put in place to:
  - Inform beneficiaries of new requirements?
  - Gather information to prove compliance with requirements?
  - Inform beneficiaries of decisions and rights to appeal?

## Helping clients switch from the Medicaid expansion to traditional Medicaid

Clients enrolled in traditional Medicaid, rather than Medicaid expansion, are exempt from work requirements, more frequent eligibility determinations, and cost sharing. If clients qualify for traditional Medicaid, even if they are currently enrolled instead in the expansion, assisting them through the qualification and enrollment process for traditional Medicaid can protect their health insurance coverage.

- Can you provide counseling and support for clients who are eligible for traditional Medicaid to help them enroll? This involves helping them apply for SSI/SSDI benefits and, in some states, a separate Medicaid application is also required. Individuals enrolled in traditional Medicaid are not subject to the work requirements.
- Is the person eligible for a [SSI/SSDI Outreach, Assistance and Recovery \(“SOAR”\) program](#) in your community? Who leads the local SOAR program in your community?

agencies to ensure that they receive reasonable modifications such as extra help in the process of showing they meet or are exempt from work requirements, and that communication happens in plain language or in an accessible format where needed?

- What resources or agencies are available in your community to assist people with disabilities?

## **Advocating for your clients’ rights under disability rights laws to help them keep coverage**

States must ensure equal opportunity for those with disabilities.<sup>1</sup> This may mean providing additional support or time for people with disabilities to comply. Knowing a person’s rights and assisting them to advocate can mean the difference between having and losing coverage and services. Your state Protection & Advocacy organization may also be able to assist your clients.

Federal disability rights laws like the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act give people with disabilities the right to equal opportunity in public programs, services, and activities, to reasonable modifications needed as a result of their disability, and to effective communication.

- Are you familiar with these rights?<sup>2</sup>
- Are you able to help clients with disabilities advocate with state and local government

## II. ELIGIBILITY REDETERMINATIONS

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### Who is able to assist?

- Who is responsible for helping your clients with eligibility redeterminations? Sometimes there is confusion between whose role this is, particularly when there is a separate care management entity.
- Does your state have individuals and/or services to help your clients with eligibility redeterminations?

States may choose to have a role called “Application Assister,” “Health Care Navigator,” or a similar name who has training access and support to help people with enrollment and eligibility redeterminations stay enrolled in health coverage.

States may provide application assisters with expanded access to help others maintain their coverage. Assisters may be authorized to:

- Receive notices about actions required to maintain coverage
- Support the person to perform the actions as required
- Educate the person around new requirements and advise on steps to take to maintain coverage (job placement assistance, volunteer efforts if allowed, educational support, etc.)
- Access an online account

- Upload documents
- File grievances and appeals if a person believes they have been wrongly terminated from coverage

### Helping clients with documentation

Current and potential beneficiaries may need assistance navigating new or adapted Medicaid enrollment compliance systems. Other community-based organizations, especially organizations that provide housing and homelessness services, may already have electronic copies of required paperwork including identification, pay stubs, benefits information, or medical records. These could minimize burdens on the beneficiary to demonstrate compliance.

States may have online document hubs, where copies of critical documents can be stored. Those experiencing homelessness and housing instability will especially benefit from these hubs, as keeping track of critical documents can be very hard for those without safe, stable, long-term places to store those documents.

- Can your organization maintain and store additional documentation that is important for clients for eligibility redeterminations?
- Can your organization keep this information after a client loses Medicaid coverage, as it may be essential to help that person get re-enrolled?
- Does your state have an on-line document hub?

## **Knowing the timelines**

The law specifies timelines required for eligibility redetermination. Those redeterminations must happen every six months, although a state may impose more frequent redeterminations with approval from CMS. Timelines impact when people will be notified whether they are still eligible for health insurance and when they may lose coverage. Agencies assisting beneficiaries need to know these timelines and help people meet requirements within the timelines.

- When are your clients due for eligibility redeterminations? These will now happen at least every six months.

## **Advocating for your clients' rights**

States must ensure equal opportunity for people with disabilities. This may mean providing additional support or time for people with disabilities to comply with the new requirements. Knowing a person's rights and assisting them to advocate can mean the difference between having and losing coverage and services. Your state Protection & Advocacy organization may also be able to assist your clients.

- Are you familiar with the rights of people with disabilities under federal disability rights laws?
- Are you able to help clients with disabilities advocate with state and local government agencies to ensure that they receive reasonable modifications such as extra help in navigating the eligibility redetermination process or acceptance of alternative documentation such as identification other than a driver's license for someone who does not drive due to a

disability, and that communication happens in plain language or in an accessible format where needed?

### *III. COST SHARING*

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States are now required to implement cost sharing for enrollees in the Medicaid expansion populations. Cost sharing can be a co-pay (collected at time of service), a deductible (amount paid annually before insurance begins to pay), or a premium (collected monthly to ensure health coverage). States must implement their cost sharing programs by October 1, 2028. Cost sharing payment cannot be over \$35 per service, and total cost sharing cannot be more than 5% of a person's income.

- How is your state implementing cost sharing? Premiums? Copays? Deductibles?
- Is anyone exempt from cost sharing?
- Who can assist the person to pay?
- If a person needs care, but is not able to pay the cost sharing requirements, what happens?

## *CONCLUSION*

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This toolkit outlines many of the critical questions that direct service workers (including case managers, outreach and navigation staff, health care provider staff, and resident services coordinators) will have to navigate as their states implement H.R. 1. While answers will differ state by state, knowing the question to ask in your state will help you be a more effective advocate for yourself, the people you serve, and your community.

## Endnotes

1 Bazelon Center for Mental Health Law & Corporation for Supportive Housing, Preserving Medicaid Coverage for People with Disabilities: What Federal Disability Rights Laws Require of States.

2 Id.