Issue No. 3 | June 2026

AcademyHealth

A Decisionmaker's Guide to Competing Health Evidence

Medicaid Community Engagement (Work) Requirements

For the first time at this scale, coverage for many adults in Medicaid will be tied to documenting work or other qualifying activities. Here's what the evidence shows about the impact on coverage and employment, where the biggest uncertainties remain, and why experts disagree about what the policy will achieve.

AT A GLANCE

What it does: Requires certain adults in Medicaid's adult group and certain section 1115 demonstration populations to show 80 hours per month of work, schooling, community service, or qualifying income, or to qualify for an exception or exclusion, as a condition of eligibility.

In plain English: Certain adults will have to show they are working, studying, volunteering, or otherwise exempt for at least 80 hours a month to keep or get Medicaid.

Who this mostly affects: Adults ages 19 to 64 covered through Medicaid expansion or certain waiver coverage; not children, pregnant people, most older adults, or people enrolled in Medicare.

How big it is: Roughly 20 million people are enrolled in the adult group nationally; CMS estimates about 15 percent of adult-group enrollment could be disenrolled under the rule.

What's at stake: Coverage for millions weighed against $350.3 billion in projected federal Medicaid savings; the dispute is over how much of the coverage loss falls on people who actually qualify.

What the evidence shows: The one place this has been studied closely, Arkansas in 2018, coverage fell and employment did not rise; most who lost coverage already qualified or were exempt.

Who's Saying What

This map describes public positions of major stakeholders. It does not endorse or evaluate them.

Supporters of the rule as written

- **CMS** frames the requirement as a way to move beneficiaries toward **employment, education, and self-sufficiency**, and defends its narrower medical frailty reading as the best interpretation of the statute.
- **The HHS Office of the Assistant Secretary for Planning and Evaluation** estimates the policy could **reduce poverty by 1.6 to 2.9 million people** by drawing more people into work.
- **Paragon Health Institute** argues the rule **restores Medicaid to a targeted safety net** and praises its refusal to rely on self-attestation alone, which it views as a guard against improper enrollment.

Critics of the rule

- **The Center on Budget and Policy Priorities** argues the rule's **last-minute frailty change** departs from the statute and prior CMS guidance, and will increase coverage losses among people with serious conditions.
- **Medicaid and health-policy researchers** warn the frailty change could produce **large coverage losses among people with serious conditions** and that the documentation burden could fall on clinicians, beneficiaries, and eligibility systems.
- **Disability-rights organizations**, including the **Bazelon Center for Mental Health Law**, argue the rule **replaces categorical exemptions with case-by-case review** that they call unworkable, and warn it conflicts with disability-rights law.

Affected institutions

- The American Hospital Association and the National Association of Counties focus on the **administrative burden and uncompensated care** that fall on providers and the local agencies that run eligibility; Medicaid managed care plans will also watch churn, outreach, and rate-setting effects.

1. Why This Matters Right Now

For the first time at this scale, work is about to become a condition of Medicaid eligibility for many adults. The 2025 reconciliation law added a "community engagement" requirement to the Social Security Act, and CMS **issued an interim final rule** on June 1, 2026, published in the Federal Register on June 3, telling states how to run it. The empirical question underneath the politics is narrower than the debate suggests: when you require people to document 80 hours a month of work or a qualifying activity, who actually loses coverage, and why? People who are not currently engaged in countable work or qualifying activities, or people who already qualify but cannot get through the paperwork? The answer determines whether the policy functions mainly as a work incentive, a coverage filter, or some combination of both.

The rule lands with little room to maneuver. It is effective July 31, 2026, and states generally **must implement the new requirement no later than January 1, 2027**, unless granted a temporary good-faith exemption. **CMS's own analysis** projects enrollment falling 2.3 million in FY 2027 and 3.1 to 3.3 million in later years, with $350.3 billion in federal Medicaid savings over a decade. CBO's **October 2025 estimate for the enacted law** put the work-requirement provision's effect at 5.3 million more uninsured people in 2034; CBO's broader Medicaid estimate is larger because it includes other provisions and their interactions. The rule also makes one especially contested choice: it defines the medical frailty exclusion more narrowly, tying it to whether a condition significantly impairs a person's ability to comply with the requirement. That change, discussed throughout this guide, is where much of the dispute and likely litigation sit.

2. Why Do Smart People Disagree?

Start with what almost no one disputes. Work is good for people, on average, and the link between employment and health runs both ways. Most adults in Medicaid's expansion group already work, or would qualify for an exception if the rules reached them cleanly. And the program is a large federal commitment: expansion-group spending runs about $200 billion a year, at a federal matching rate higher than for other Medicaid groups. The fight isn't about whether work matters or whether the program is costly. It's about what a documentation requirement does once it meets a real eligibility system.

That's the heart of it. Supporters and critics are usually answering different questions, and each answer can be right on its own terms. Supporters ask whether requiring engagement will move people toward work and narrow a program they see as too broad. Critics ask whether the mechanism, verification through data matches, forms, and deadlines, will remove coverage from people who already comply or cannot navigate the process. The evidence on those two questions is not equally strong, and that asymmetry, not the politics, is what a decisionmaker should hold onto.

THE QUESTIONS BEHIND THE DEBATE

The question being asked	What It Measures	Who Tends to Ask It
Will the requirement move people into work?	Change in employment among enrollees	CMS, ASPE, Paragon
Who loses coverage, and were they already working or exempt?	Share of disenrollments among the eligible	Medicaid researchers, Urban Institute, CBPP
Does the rule protect program integrity against over-broad exemptions?	Improper or unverified enrollment averted	CMS, Paragon
Does the rule narrow a protection the statute meant to give?	Coverage loss among people with serious conditions	CBPP, Medicaid researchers, disability advocates
Can states build this accurately on the required timeline?	Implementation readiness and error rates	State agencies, NACo, AHA
What does it cost, and who bears it?	Federal savings vs. state costs and uncompensated care	CBO, CMS, hospitals, counties, plans

3. What Does the Evidence Show?

What we know:

- In the closest thing to a real-world test, coverage fell and employment did not rise, backed by the state's enrollment data and a separate national study.
- Most coverage losses fell on people who already complied or qualified for exemption.
- CMS's own analysis attributes a large share of projected losses to paperwork, not non-compliance.

What we don't know:

- How a better-designed verification system than Arkansas's would perform at steady state.
- How states will use their discretion over verification frequency, look-back months, notices, appeals, call-center capacity, and data matching, which drives both coverage loss and error rates.
- Whether the welfare-reform-era employment gains transfer to an unsupported Medicaid requirement.
- Whether the narrowed frailty definition survives the expected litigation.

The evidence is stronger on one question than the other, and the two point in opposite directions. We know a fair amount about what happens to coverage when a documentation requirement meets a real eligibility system. We know much less, and what we know isn't encouraging, about whether the requirement moves people into work.

How the requirement works

The requirement applies to nonpregnant adults ages 19 to 64 in the adult group or certain section 1115 demonstration populations, who must show 80 hours a month of work, schooling, community service, or equivalent monthly income ($580 in 2026), unless they fall into an excluded category such as the medically frail, pregnant and postpartum people, and former foster youth. **CMS requires states to attempt ex parte verification first**, using reliable information already available to the state before asking beneficiaries for more documentation. The practical question for coverage is whether those safeguards can work reliably, at scale, on the required timeline.

Evidence on coverage loss

The closest thing to a real-world test is Arkansas, which in 2018 became the first state to require work as a condition of Medicaid eligibility. Researchers tracked what happened to the people subject to it against comparable groups in Arkansas and three neighboring states. The central finding was clear: most people who lost coverage did so because of reporting and verification problems, not because they could work and chose not to. About 18,000 adults lost coverage in the first seven months, nearly one in four subject to the policy, before a court halted it. More than 95 percent of beneficiaries had already met the requirement or should have qualified for an exemption, and more than 70 percent were not sure the policy was in effect. The studies appeared in the **New England Journal of Medicine** and **Health Affairs**.

The state's own administrative data point to the same mechanism. Arkansas **automatically exempted or deemed compliant about two-thirds of the people** subject to the requirement, using data it already held; among those left to report for themselves, roughly 70 percent did not, and that is where the disenrollments came from. The dividing line was not simply whether someone worked, but whether the state could confirm work, exemption, or deemed compliance from existing data or left the burden on the individual.

Georgia offers a second, current case, and the one supporters most often cite as a model. Its Pathways to Coverage program remains the most important state demonstration because it has generated real-world administrative-cost evidence, although **CMS now reports that Nebraska began implementing** a community engagement requirement on May 1, 2026, so Georgia should not be described as the only current implementation example. Georgia has enrolled far fewer people than projected: earlier reporting put active enrollment around 7,500 against a first-year expectation of 25,000, and while it has since grown, the state's own tracker reported about 16,800 active enrollees as of April 2026, years into a program once expected to reach tens of thousands in its first year. A nonpartisan **GAO analysis** found the state spent $54.2 million on administration in the program's first four and a half years, against $26.1 million on actual medical care, with the federal government covering about 88 percent of the administrative cost. Most of that went to rebuilding the eligibility and enrollment system. GAO cautions that costs will vary by state, so Georgia is not a forecast for every state. But it is direct evidence that the build can be expensive and that a verification system can hold enrollment well below the eligible population, which is the mechanism the coverage evidence keeps pointing to.

The Arkansas study has real limits: it drew on surveys rather than enrollment records and covered a single state for less than a year, so it should not be treated as the last word. But the finding is consistent with independent sources that do not share those exact limits: Arkansas's own enrollment data, **a separate study** using national data across 27 states, and CMS's own projection below. The point is not that Arkansas forecasts every state; it is that the best direct Medicaid evidence keeps pointing to documentation failure as a major coverage-loss mechanism.

Evidence on employment

Here the record is short and points one way: it finds little to no evidence that work requirements increase employment. The Arkansas studies found no increase in employment over eighteen months. CBO, analyzing a 2023 version of a federal requirement, **found no change in employment or hours worked.** The idea behind requiring work, that many enrollees could work but choose not to, runs up against the fact that most already work, and those who do not usually face barriers a requirement does not remove. The Medicaid evidence shares the same single-state limits as the coverage evidence, so it is not airtight, but no study of an actual Medicaid work requirement has found that it raises employment.

The closest larger body of evidence comes from SNAP, the food-assistance program, which has long imposed similar work-reporting rules on able-bodied adults without dependents. The findings are not unanimous, and a few studies find small employment gains for some older workers, but the **preponderance of the high-quality research** points the same way as the Medicaid evidence: work requirements sharply reduce program participation while doing little or nothing to raise employment or earnings. One administrative-data study found they **increased program exits by 23 percentage points** with no measurable employment effect. The SNAP rules are not identical to the new Medicaid requirement, but they are the closest analog at scale, and they reinforce rather than complicate the Medicaid picture.

CMS's regulatory impact analysis draws on different evidence, worth examining because CMS leans on it. **ASPE estimates** the policy could reduce poverty by 1.6 to 2.9 million people. But its employment evidence comes from welfare-reform-era programs that paired requirements with childcare, transportation, and job training, not from Medicaid; it does not discuss Arkansas, the only place a Medicaid work requirement has been evaluated; and its estimate assumes people comply, leaving out, in ASPE's own words, the "offsetting effects from administrative burden or barriers to employment" that Arkansas identifies as the main driver of coverage loss.

ASPE is candid that its figures are "simulated calculations, not necessarily what is or will occur in the real world." But a projection that assumes people comply, and leaves out the paperwork losses, is not designed to detect the problem the real-world evidence keeps finding. It estimates what could happen if the requirement worked as intended and everyone complied, not what happens when a documentation requirement meets a real eligibility system. Economists Richard Frank and Sherry Glied make a similar point in a **June 2026 analysis**, arguing the brief's poverty reduction rests on the assumption that people subject to the requirement will find work, rather than on evidence that they do.

The medical frailty change

The rule's most contested provision concerns who counts as medically frail, and therefore is excluded from the requirement. The statute lists five categories, including, as a standalone item, anyone "with a serious or complex medical condition." The rule adds a threshold in front of all five: the condition must significantly impair the person's ability to comply with the requirement. CMS defends this as the best reading of "medically frail or otherwise has special medical needs," arguing that exemption by diagnosis alone would sweep in people whose conditions do not actually prevent engagement.

Critics read it as a limit Congress did not write. Under the rule, a person in cancer treatment who can still work some hours, or someone with well-managed HIV, may not be automatically exempt; they would have to document frailty when their hours fall short. **CBPP** and **other Medicaid researchers** argue this both shrinks the protected group and shifts it from automatic identification to individual paperwork, where the Arkansas evidence suggests the risk of eligible people falling through the cracks is highest. A **June 2026 legal analysis** led by health-law scholar Sara Rosenbaum argues the rule contravenes the statute itself, since Congress wrote "serious or complex medical condition" as a standalone category rather than one gated by ability to work. Disability-rights advocates frame the same issue in implementation terms: the Bazelon Center argues that requiring **an individualized analysis** of whether each person's condition prevents compliance, rather than exempting by category, is unworkable and will disenroll people Congress meant to protect. The practical stakes are concrete: in a **2026 KFF survey**, 30 states said they wanted to let people self-attest to frailty when verification data are not available. The rule allows broader use of self-attestation through 2027. Beginning in 2028, states generally must seek reliable data or documentation when reasonably available, though the rule still permits limited use of beneficiary statements under penalty of perjury in specified circumstances, so the burden grows over time without disappearing entirely as an option. Some states are moving faster still: North Carolina and Utah have passed laws barring self-attestation as sole evidence from the start. The American Medical Association has separately pressed CMS to keep the exemption from becoming a paperwork burden on physicians, and critics expect litigation. **Paragon** sees the same provision as a strength, arguing self-attestation alone invites improper enrollment. It is the clearest case in the rule where one provision reads as protecting integrity or narrowing protection depending on which question you start from.

The numbers

Two coverage-loss estimates circulate, and they measure different things. **CMS's projection** (about 15 percent of the adult group) scores this rule and counts Medicaid disenrollment; **CBO's estimate** that the work-requirement provision adds 5.3 million to the uninsured by 2034 counts additional uninsured people, while CBO's broader Medicaid estimate includes other provisions and interactions. The two are not contradictory. What is notable is the composition of CMS's own number: of its projected 15 percent disenrollment, CMS attributes roughly 9 percentage points to people failing to meet the requirement and about 6 to administrative or paperwork barriers. CBO reaches a similar split, attributing about 2.9 million of the 2034 coverage loss to people not meeting the requirement and about 2.8 million to the added steps in the application process. In other words, by the government's own estimates, a large share of those who lose coverage will be people who meet the requirement or qualify for an exception but do not successfully document it. That is the Arkansas finding, restated in the government's own analyses.

4. Risks and Unknowns

The estimates above are central tendencies. What happens depends on choices states haven't made yet and on how systems built in a hurry perform. These are tradeoffs to watch, not predictions.

If states implement stringently or in a hurry… watch for losses above the central estimate and errors that reach beyond the target group. The statute sets only a floor: one month of compliance, checked at renewal. States may require more months and verify quarterly rather than semi-annually, and CMS's own scenarios show that those choices can swing the disenrollment rate substantially. They must also move fast: a multi-year build compressed into roughly seven months, where Georgia spent four years and most of its program budget rebuilding eligibility systems for a single state's version. The headline numbers are a weighted average, so a more stringent state lands above it; and when systems are rushed, errors can spill into renewals for children, seniors, and others who share the infrastructure. The statute lets the HHS Secretary grant good-faith delays through December 31, 2028, so how widely that authority gets used is a key variable.

If states cannot automate the frailty exclusion in time… watch for people with serious conditions facing coverage loss first. The frailty change requires states to identify not just a qualifying diagnosis but evidence the condition significantly impairs the ability to comply with the requirement. Few systems can do that automatically on day one. Many states spent months designing frailty definitions and the business rules to apply them automatically, and would have been ready to go live in January with their existing approach; the rule's late change may leave those systems unready in time. It remains unclear how much CMS will let states keep using existing claims and utilization data to identify the frail without a separate, individualized determination. Where states cannot automate it, people who would have been excluded automatically instead get a paperwork task, and the Arkansas evidence suggests that is where eligible people fall out. The risk concentrates on the population the exclusion was meant to protect.

If few of the disenrolled find other coverage… watch for the gap between "losing Medicaid" and "becoming uninsured." CMS declined to estimate how many losing Medicaid would pick up other coverage. CBO was more direct: in a **June 2025 letter**, it concluded few of those disenrolled would have access to employer coverage, and none would qualify for ACA premium tax credits, because the law makes people who lose Medicaid for noncompliance ineligible for them. The Arkansas evidence showed little movement to other insurance. If that holds, coverage loss converts almost directly into uninsurance, the more consequential outcome for health, and the uncompensated-care cost lands on the hospitals and counties the AHA and NACo have flagged. One caution for anyone watching the data: we will know how many people lose Medicaid well before we know how many become uninsured. Medicaid disenrollment shows up in enrollment records quickly, but the move into uninsurance is captured mainly by Census surveys that lag by about a year, so early coverage-loss numbers will not yet tell the full story.

5. How to Read the Evidence Yourself

Most claims you'll hear are really claims about one of a few questions. These five let a non-expert pressure-test almost any study or talking point on work requirements.

1. **Is this measuring coverage or employment?** Different outcomes; a study strong on one may say nothing about the other. When someone cites a number, ask which outcome it measures before asking whether it's big.

2. **Among those who lost coverage, how many already qualified?** This separates a work policy from a paperwork policy. If most who lost coverage were already working or eligible for an exemption, the requirement isn't changing behavior; it's removing eligible people through process.

3. **Would this outcome have happened anyway?** Medicaid coverage churns for many reasons, and some people leave at renewal regardless of any work rule. A credible estimate separates losses caused by the requirement from baseline attrition. CMS does try to net out routine churn in its procedural estimate; ask whether the number in front of you does the same. Watch the verification frequency too: states may check at renewal or far more often, and more frequent checks mean more chances to fall out.

4. **Does the comparison fit the policy?** Evidence from one setting doesn't automatically transfer. Welfare-reform gains came from programs pairing requirements with childcare and job training; an unsupported documentation requirement is a different intervention. Ask whether the thing studied resembles the thing being implemented.

5. **Is the exemption automatic or does it require paperwork?** A protection that requires people to claim it through forms and deadlines reaches fewer people than one a state applies automatically from existing data. The same exemption can protect most of its intended group or little of it depending on how it's verified.

6. The Bottom Line

The evidence settles less than either side suggests, but it is not silent. On coverage, the record is reasonably clear: a documentation requirement can remove eligible people through process, and the losses are likely to concentrate among those who already comply or qualify for exemption. On employment, the case for the rule rests on an extrapolation from supported welfare-to-work programs to an unsupported Medicaid requirement, across a gap the evidence does not bridge. What the rule will do to coverage is better established than what it will do to work.

The tradeoff no version of this policy escapes is between integrity and access. Tighten verification, demand documentation, and gate the exemptions, and you catch more people who should not be enrolled, but you also drop more who should. Loosen verification and accept attestation, and you keep more eligible people covered, but you let more slip through who do not qualify. The two errors are not equal in size, though. The evidence to date, from Arkansas and from CMS's own projection that a large share of its coverage loss is procedural, suggests the eligible-people-dropped error is far larger than the ineligible-people-retained one. The medical frailty change is this tradeoff in miniature: CMS prioritized tighter verification; critics argue that the resulting error risk will concentrate among people with serious conditions who must now prove what used to be presumed. Reasonable people weigh those errors differently. The evidence can tell you the tradeoff exists, and roughly how large each error is likely to be; it cannot tell you which to prefer.

For decisionmakers, the asymmetry is the thing to carry. The evidence about what the program does, who is enrolled, who already works, and what happens when you require documentation is more solid than the evidence about what any particular reform will achieve. Confident claims about how this rule will change behavior, in either direction, run ahead of what is known. Be more skeptical of those than of the underlying facts about the population and the mechanism. When the gap between a policy's stated goal and its measured effect is this wide, and this consistent across the available evidence, that gap is the finding.

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