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WORK REPORTING REQUIREMENTS AND MENTAL HEALTH

Recommendations to Protect Individuals with Mental Health Conditions from Losing Medicaid

NAMI
National Alliance on Mental Illness

LAC LEGAL ACTION CENTER

WORK REPORTING REQUIREMENTS AND MENTAL HEALTH

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About NAMI

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

www.nami.org

About Legal Action Center

Legal Action Center (LAC) is a non-profit organization that uses legal and policy strategies to fight discrimination, build health equity, and restore opportunities for people with substance use disorders and mental health conditions, people with arrest and conviction records, and people living with HIV and AIDS.

www.lac.org

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We are deeply grateful to grassroots advocates from across the country who shared their stories with federal legislators during the debate over adding work reporting requirements to Medicaid as part of H.R. 1. We hope this resource will be helpful in their continued work to ensure people with mental health conditions can access health coverage through Medicaid.

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INTRODUCTION

In 2025, Congress enacted Public Law 119-21 (H.R. 1), which made sweeping changes to the Medicaid program, including its eligibility, enrollment, and financing. Among these provisions is a new requirement for individuals ages 19 to 64 who receive their health coverage through the Medicaid expansion[1] to comply with work reporting ("community engagement") requirements.[2] Starting in 2027, many of the impacted individuals will have to participate in 80 hours a month of some combination of work, job training, education, or community service. Not only do most individuals need to participate in these activities, they may need to report these hours to the state before they can enroll in Medicaid, and again at least every six months so they can keep their Medicaid coverage.[3]

Recognizing that work reporting requirements are not appropriate for all populations, the law created a number of exemptions so that people in certain circumstances will be deemed compliant whether or not they can prove they are participating in 80 hours per month of community engagement activities.[4] The most relevant exemption for people with mental health conditions is the one for an individual who is "medically frail or otherwise has special medical needs," which specifically includes an individual "with a disabling mental disorder."[5] However, there are a number of other exemptions that may apply to individuals with mental health conditions and their families. For example, there are other health conditions like substance use disorders and physical, intellectual, or developmental disabilities that fall under the "medically frail" category. Additionally, people with mental health conditions may be exempt through other exemption categories not related to health, such as American Indian/Alaska Native individuals; veterans with total disability ratings; parents, guardians, and caregivers of dependent children 13 years old and under or of disabled individuals; and individuals who are currently or were incarcerated at any point during the previous three months. See page 5 for a full list of exemptions.

Importantly, many individuals with mental health conditions — as well as people who meet other exemptions — can and do work or participate in other community engagement activities. There are also requirements under the Americans with Disabilities Act (ADA) for workplaces to make reasonable accommodations for these individuals as needed.[6] But the requirement to report community engagement hours on a regular basis is projected to lead to millions of people losing their health insurance due to administrative burdens and red tape. As such, the best way to prevent individuals from losing their Medicaid is by ensuring they can be deemed compliant by fitting into one of these exemptions, even when they can and do work, and by reducing the burden for them to be classified as exempt by the state. This is particularly critical for people with mental health conditions, who may experience different intensity of symptoms over time, changing how it may impact their ability to work.

Accordingly, this issue brief offers recommendations to advocates and policymakers to protect individuals with mental health conditions from losing Medicaid coverage under these new work reporting requirements.[7]

Recommendations to Protect Coverage for People with Mental Health Conditions

1. Maximize identification of people eligible for exemptions,
2. Minimize the burdens, and
3. Advance inclusive policies that improve access to coverage and care.

Work Reporting Requirement Exemptions

States are required to exclude certain individuals from the work reporting requirements, including:

- Foster care youth under age 26;
- American Indians/Alaska Natives;
- Parent, guardian, caretaker relative, or family caregiver of a dependent child 13 years of age and under or a disabled individual;
- Veterans with a total disability rating;
- Medically frail individuals, including people with a substance use disorder, a "disabling mental disorder," a physical, intellectual, or developmental disability, or "a serious or complex medical condition," as well as individuals who are "blind or disabled" according to the Social Security Administration's definition;
- Individuals already meeting work requirements under Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program (SNAP);
- Individuals participating in a qualifying substance use disorder (SUD) treatment program;
- Individuals who are also enrolled in Medicare;
- Incarcerated or recently incarcerated individuals who were incarcerated at any point within the prior three months; and
- People who are pregnant or receiving postpartum coverage.

MAXIMIZE THE EXEMPTIONS

KEY RECOMMENDATIONS

- Adopt the broadest definitions possible to capture all individuals who should be eligible for exemptions.
  - "Disabling mental disorder" should be defined as an individual who has a diagnosis of, or who needs services or supports for, any mental health condition that could be disabling at some point.
- Apply the longest lasting exemption to individuals who are eligible for multiple exemptions.

Exemptions for Individuals Who Are Medically Frail or Otherwise Have Special Medical Needs

Congress created an exemption to the work reporting requirements for an individual "who is medically frail or otherwise has special medical needs (as defined by the Secretary)."[8] At a minimum, H.R. 1 specifies that this category must include:

- An individual who is blind or disabled, using the Social Security Administration definition;
- An individual with a substance use disorder;
- An individual with a disabling mental disorder;
- An individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
- An individual with a serious or complex medical condition.

Individuals with mental health conditions in the Medicaid expansion population may fall into one or more of these classifications such that they would be qualified for this "medically frail" exemption. For example, if the individual's mental health (or any other health) condition prevents them from working for a year or longer, then they may be eligible for this exemption because they could be considered "blind or disabled." Many individuals with mental health conditions have other co-occurring health conditions — including substance use disorders;[9] physical, intellectual, and developmental disabilities; and serious or complex medical conditions — such that they may be considered "medically frail" regardless of whether they also have a mental health condition.

It is likely that many individuals with mental health conditions will fall into this exemption under the category of "disabling mental disorder." However, this term is not defined anywhere in the law. The U.S. Department of Health & Human Services (HHS) is required to publish interim final rules on the work reporting requirements by June 1, 2026.[10] These rules may include more guidance on what this term means, as well as the broader category of "medically frail or otherwise has special medical needs,"[11] but it also may be left up to the states to interpret.

Federal and state policymakers must ensure that any definition of "disabling mental disorder" they adopt accounts for several key features, which are discussed in greater detail below:

- It cannot be limited to people who are considered or determined to have a mental disability;
- It should include people who have a diagnosis but not be limited to people who do; and
- It should recognize that mental health conditions are chronic health conditions that fluctuate in terms of severity and functional limitations, and it should strive to ensure that people with these disorders have access to the health care services they need to prevent their conditions from becoming more acute or making them unable to work.

In order to understand what "disabling mental disorder" means, it must be compared to the other exemptions included in H.R. 1 because this term was intentionally listed separately and therefore cannot have the same meaning as any other exemption. For example, there is a separate exemption under the medically frail category for individuals who are "blind or disabled" under the Social Security Administration's (SSA) definition.[12] SSA identifies people as "blind or disabled" if their condition makes them "unable to engage in any substantial gainful activity" and has lasted or can be expected to last for no less than 12 months.[13] As previously noted, some individuals with mental health conditions will fall under this "blind or disabled" exemption if they are not able to work because of their condition or because of any co-occurring conditions. In fact, some of the most frequent disability determinations made by the SSA include common mental health conditions.[14] According to the SSA, virtually all "mental disorders" can be disabling, but, notably, not all of these disorders require functional limitations for a disability determination — several categories require only that the condition be "severe and persistent."[15] However, since the "blind or disabled" Medicaid work reporting requirement exemption is listed separately from "disabling mental disorder," the latter cannot be limited only to individuals who are unable to work and/or have a disability determination by the SSA, or else it would not be needed in the statute.

The Americans with Disabilities Act (ADA) also covers individuals with mental health conditions, though the functional limitations are broader than ability to work. Individuals are protected if their health condition "substantially limits one or more major life activities," which includes, but is not limited to, "caring for oneself, … eating, sleeping, learning, reading, concentrating, thinking, communicating, working …" as well as "major bodily functions" including neurological and brain functioning.[16] However, since Congress did not use the same language as that used for SSA or in the ADA (i.e., "an individual with a mental disability," or "an individual whose mental impairment substantially limits one or more major life activities"), the new category of "disabling mental disorders" must have been intended to encompass additional individuals not already captured under the other definitions.

To that end, the best interpretation of the statute would be to exempt individuals with any of the mental disorders that can be "disabling" (i.e., according to SSA or ADA) from the work reporting requirements. It would be impractical, if not impossible, for the state to actually require and review the medical documentation for each applicant, so it cannot be limited to people who meet the medical, functional, and/or historical criteria for that condition. Rather, since these work requirement exemptions are related to health insurance coverage and ensuring that these individuals can start or continue to get the health care services they need through Medicaid, "an individual with a disabling mental disorder" should be operationalized to include any individual who has a diagnosis of, or who may need services and supports for, a mental disorder.

THE BEST INTERPRETATION OF THE STATUTE WOULD BE TO EXEMPT INDIVIDUALS WITH ANY OF THE MENTAL DISORDERS THAT CAN BE "DISABLING" (I.E., ACCORDING TO SSA OR ADA) FROM THE WORK REPORTING REQUIREMENTS.

Importantly, Congress could have limited this exemption to people who have a "serious mental illness" (SMI) but chose not to do so. The term "SMI" is already defined and used in other federal statutes under the same title,[17] when "disabling mental disorder" is not. As such, it would be an overly limited reading of H.R. 1 to only include individuals who have an SMI under the definition of "disabling mental disorder."

There is another federal law related to Medicaid expansion that includes a reference to "medically frail," prohibiting states from requiring "an individual [who] is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary)" to enroll in benchmark or benchmark-equivalent plans.[18] As of 2019, only a dozen states needed to identify "medically frail" individuals because the rest of the states did not have a separate benefit plan for Medicaid expansion enrollees such that this law and subsequent regulations would apply.[19]

Notably, the majority of these states not only allow an individual to self-attest to being medically frail, but they also allow that self-attestation to be sufficient for verifying that the individual is medically frail without needing additional documentation or information,[20] which will be discussed further in the next section on minimizing the burden.

Leveraging self-attestations is consistent with the Centers for Medicare & Medicaid Services' (CMS) recommendation that states use the enrollment process to identify individuals who meet the criteria of statutory exemptions, including medical frailty, such as through screening where the individual identifies themselves as meeting the exemption criteria.[21] Doing so is often necessary because the state — and the individual — would be unlikely to have historic encounter data, documentation, or other information to determine that someone has a "disabling mental disorder" when the individual first applies.[22] This is not unique to new applicants, as only about half of Americans with mental health conditions receive treatment for their condition (52.1%)[23] that would result in having treatment records or even an appropriate diagnosis. Thus, this legislative and regulatory history suggests that having the condition alone should be sufficient to fall into this category, without the need for a functional or disability-related assessment or determination.

IT IS IMPORTANT THAT THE "DISABLING MENTAL DISORDER" EXEMPTION NOT BE LIMITED ONLY TO PEOPLE WHO HAVE A DIAGNOSIS.

For similar reasons, it is important that this exemption not be limited only to people who have a diagnosis, because individuals initially applying to Medicaid may not be able to get a diagnosis, treatment, or other documentation of their mental health condition without Medicaid coverage.[24] That is, there will be many individuals with a qualifying disabling mental disorder whose condition is undiagnosed and who are in need of treatment. They may not be able to work due to the lack of treatment and severity of symptoms, but they were intended to be exempt so that they could get the diagnosis and treatment that they are not only entitled to, but that would also prevent their condition from becoming more acute. Without the exemption, they may not be able to fulfill the work requirement and would lose coverage, which would be contrary to the intent.

Accordingly, states should use a flexible definition of "disabling mental disorder" that includes people who would need services and supports for a mental health condition, as determined by self-attestation or other appropriate means, which is described further in the next section. And, if the federal government or a state does require individualized functional or time-based criteria to be met, beyond simply having the mental health condition that can be disabling, then the identification and verification of such criteria must not require additional documentation beyond attestation.

Notably, for the states whose medical frailty criteria (for prohibiting automatic enrollment in benchmark or benchmark-equivalent plans) are available, they seem to only require the attestation of the mental health diagnoses/conditions, rather than any additional information or assessment.[25]

Finally, not only is a broad definition of "disabling mental disorder" necessary from a legal perspective, but it is also an important way to implement H.R. 1 from a fiscal and public health perspective. If people only have access to mental health care and affordable insurance when their condition becomes so acute that they are unable to work and need intensive treatment, that will be more costly to the state. In reality, mental illnesses are chronic and/or episodic health conditions that fluctuate in severity and functional ability over time. They can be disabling one month but not the next, and it would be impractical and unduly burdensome for individuals to report these fluctuations when they are applying for or renewing their Medicaid. Importantly, mental health conditions are treatable, just like any other health condition, and preserving access to that treatment must be paramount for positive long-term outcomes.

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These various statutes and regulations, as well as their interpretation over the years, suggest that "disabling mental disorder" must be defined broadly to include individuals who have a mental health condition that could be disabling at some point, regardless of current functional impairment or whether or not they have a diagnosis, so that they are able to get the services and supports they need.

Utilizing Other Exemptions That May Apply

If the federal government, or a state, defines "disabling mental disorders" or the broader category of medical frailty in an overly limiting way, then another important way to protect individuals with mental health conditions from losing Medicaid is to ensure that they get classified into another exemption, if applicable. Similarly, some of these exemptions may be important for the family members, caregivers, and loved ones of individuals with mental health conditions. A key priority should be to ensure that the longest lasting — and thus the most protective — exemption is used for individuals so that they are less likely to lose their insurance. This approach is already required in the Supplemental Nutrition Assistance Program (SNAP) work reporting requirements,[26] and it should be used for these new Medicaid work reporting requirements as well. The following is not an exhaustive list of exemptions, which can be found in the H.R. 1 text and on page 5.[27]

Parent/caregiver: H.R. 1 exempts an individual "who is the parent, guardian, caretaker relative, or family caregiver (as defined in section 2 of the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act) of a dependent child 13 years of age and under or a disabled individual."[28] Importantly, the term "family caregiver" is defined quite broadly in the RAISE Family Caregivers Act as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."[29]

Pregnant or postpartum: Another group of people who are exempt from the work reporting requirements are individuals who are pregnant or entitled to postpartum medical assistance. Depending on what the specific state covers for postpartum assistance, this period could either go through the end of the month in which the 60-day period after the last day of a pregnancy ends, or through the end of the month in which the 12-month period after the last day of a pregnancy ends.

Dually eligible: Individuals are also exempt from the work reporting requirements if they are entitled to or enrolled in Medicare Part A or if they are enrolled in Medicare Part B.[30] This means that any individuals who are dually eligible for Medicare and Medicaid are exempt from work reporting requirements activities.

Incarcerated or recently incarcerated: The new Medicaid work reporting requirements also exempt individuals who are an "inmate of a public institution"[31] as well as people who were an inmate at any point in the prior three months.[32] This exemption recognizes the unique challenges facing people who are transitioning back to the community after incarceration. However, this exemption should only be used if no other ones apply, because it is time-limited and puts an additional burden on the individual to identify a different exemption or come into compliance with the community engagement activity requirements only a few months after reentering the community. For example, someone leaving incarceration might qualify under the medically frail exemption, which would not expire in three months. However, if another longer-term exemption is not identified or applicable, this exemption should still be leveraged to help get individuals who are released from incarceration to appointments where they can be screened and appropriately linked to other exemptions, if applicable.[33]

MINIMIZE THE BURDENS

KEY RECOMMENDATIONS

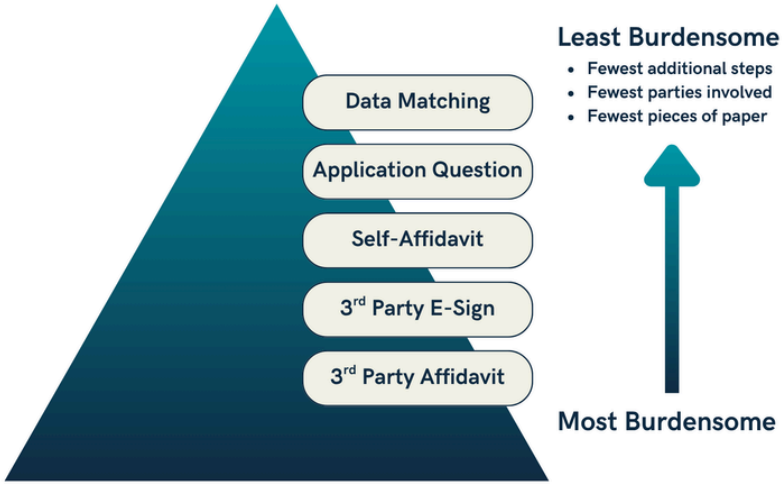
- **Preserve flexibility in how states can identify and deem individuals eligible for an exemption to the work reporting requirements.**
- **Establish systems, processes, and procedures to identify and deem individuals eligible for exemptions without imposing additional burdens on beneficiaries, providers, or the state.**

There is no statutory requirement for individuals to demonstrate or states to verify the exemptions to the work reporting requirements. Instead, the statute explicitly allows the state to elect to not verify the information that would result in an individual being deemed exempt.[34] As such, federal policymakers must maintain this flexibility, consistent with the statute. State policymakers should adopt the approach of deeming people eligible for exemptions through automatic processes, not requiring additional paperwork for individuals to verify their exemption(s).

If states choose to require additional paperwork, they should impose the least possible burden on beneficiaries. The law requires states to "establish processes and use reliable information available to the State […] without requiring, where possible, the applicable individual to submit additional information" for determining an individual is in compliance with or exempt from the work reporting requirements.[35] This is necessary because "research shows that additional reporting or administrative burdens can create barriers to eligible people retaining coverage."[36] Every step, entity, 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. Therefore, policymakers should utilize a framework in which they prioritize the least burdensome options for determining eligibility and compliance — and for verifying exemptions for states that choose to do so.

To be consistent with the statutory intent, states should require only the minimum additional actions, documentation, and number of involved parties that are necessary, as outlined in the below recommended framework.[37] Data matching, the first option, represents the least burdensome tactic — and is required by H.R. 1.[38] However, data matching has proven insufficient in states that have previously implemented work reporting requirements.[39]

As such, the subsequent tactics in this framework may be necessary, but should only be implemented for each individual when the preceding tactic does not work:



Data Matching

At a minimum, states should be identifying individuals who have a mental health diagnosis that can be disabling and, as a result, eligible for an exemption through existing Medicaid claims and encounter data. States should also identify individuals that are receiving or have received medications, services, and supports for disabling mental health conditions. This should include at a minimum:

- Psychiatric medications
- Outpatient mental health therapy or counseling
- Intensive outpatient or partial hospitalization programs
- Mobile crisis services or crisis stabilization services
- Assertive community treatment
- Nutritional counseling for eating disorders
- Applied behavioral analysis therapy
- Peer support services

However, recognizing that having a diagnosis or receiving such services will not capture all individuals eligible for an exemption, states should also identify individuals who are receiving services and supports at settings for the treatment of disabling mental health conditions, such as community mental health centers, Certified Community Behavioral Health Clinics, residential treatment centers, and inpatient psychiatric facilities.

Given the sensitive nature of this information, it is imperative for states to ensure that this data is merely matched, rather than shared. All data matching efforts must prioritize confidentiality and abide by the privacy protections set forth in HIPAA and state-specific laws that govern the confidentiality of mental health records and psychotherapy notes. Data matching, however, will not work for everyone — there will be inconsistencies and gaps. This is especially true for people with mental health conditions because such a low percentage of individuals with these conditions receive treatment, so many people would not even have relevant claims and encounter data.[40] As a result, states still must ensure that there are other pathways for individuals to be identified as exempt when applicable.

Self-Identification

For individuals not identified through data matching described above, states should allow individuals to appropriately identify themselves through a simple screening process in the application itself. This would be consistent with HHS's recommended approach for the implementation of the "medically frail" exemption for benchmark and benchmark-equivalent plan automatic enrollment.[41] As HHS identified in that context, this is especially important because not all individuals will have data that can be matched to reflect their condition,[42] especially for people who have never had Medicaid or have never received treatment before. In order to reduce burdens, these screening questions should be integrated into the application directly so the individual does not need to submit — and the state does not need to process, review, and securely maintain — any additional forms or documents. States should not require a separate form or affidavit unless required by federal regulations or state law. Further, as previously noted, exemption information verification is not required by statute, so states should deem a self-attestation that is integrated into the application to be sufficient.

As previously discussed, this approach is also consistent with how most states who use benchmark and benchmark-equivalent plans have made "medically frail" determinations to comply with the requirement that such individuals are not automatically enrolled, as many states allow self-attestation for identification, determination, and/or verification.[43] Moreover, there is already a model in the SNAP work requirements for screening individuals for exemptions at certification and recertification.[44] Policymakers should take the same approach when implementing these new Medicaid work reporting requirements.

Requiring too many questions or too much personal health information may inadvertently lead to fewer individuals reporting that they are medically frail and are thus entitled to an exemption. People can be fearful of identifying such personal health information because that has historically led to stigmatization and discrimination — including employment discrimination[45] which, although illegal,[46] may nonetheless be one of the reasons why individuals in this population cannot comply with the H.R. 1 work reporting requirements.

Accordingly, it is best to only require the individual to identify that they fit into the "medically frail" category, while still identifying all of the conditions and circumstances that would make someone qualify as medically frail so that they know to answer the question or check the appropriate box correctly but do not fear the consequences of sharing this information. If this must be a separate form or affidavit, the state should ensure that all exemptions are listed in one place to reduce stigma, reduce the burden for individuals who may fit into more than one exemption category, and ensure that individuals can then be matched under the exemption that will last the longest.

Recognizing that many individuals who are eligible for this exemption may not have or know their specific mental health diagnosis, states may consider adopting a screening tool that could be used to identify individuals who qualify for an exemption without needing a diagnosis. States can partner with mental health providers and people with lived experience to develop appropriate screening questions that capture the required information in language that can be understood by the broadest possible audience without reinforcing stigma or prejudice. This type of screening can help identify an individual who has functional impairments but may not have enough information to attest to having a "disabling mental disorder."

Third Party Verification

The statute does not require any sort of verification or additional information for determining exemptions from work reporting requirements, and the addition of such requirements would unduly burden individuals, the state, and third parties. However, in the event that forthcoming federal regulations (due no later than June 1, 2026) or state laws require third party verification, it should be fully integrated into the application itself such that the applicant can include the contact information for someone who can confirm their exemption status and the state can initiate the verification. For example, if the third party has an email address, then the individual should be able to provide that contact information, and a simple form can be sent to that individual to electronically sign and submit. Ideally, the state should incorporate all methods of communication that are deemed acceptable forms of outreach for this new work reporting requirement.[47]

THE STATUTE DOES NOT REQUIRE ANY SORT OF VERIFICATION OR ADDITIONAL INFORMATION FOR DETERMINING EXEMPTIONS FROM WORK REPORTING REQUIREMENTS, AND THE ADDITION OF SUCH REQUIREMENTS WOULD UNDULY BURDEN INDIVIDUALS, THE STATE, AND THIRD PARTIES.

The least desirable and most burdensome option would be requiring a third party to submit additional verification, such as a letter or form. This would be the most burdensome option because it requires additional forms, steps, and administrative burden on the patient and provider, which — if any steps are not followed — could result in a person inappropriately losing coverage. However, if this is the strategy a state chooses, then the state should make a short and simple template readily available and accept it as sufficient proof. There should be as few limitations as possible on who can verify this information. For example, while health care providers are certainly qualified to make this determination, many individuals do not seek treatment such that they would have a practitioner who could verify this information for them. In addition to health care providers, states should ensure that peer support specialists, community health workers, case managers, rehabilitation counselors, jail and prison administrators, parole and probation officers, and others can complete any of these third-party verification requirements, if needed.

Redetermination

Regardless of how a state chooses to identify individuals who are exempt, including if the state elects to require any sort of verification (despite not being required to do so), individuals who have a disabling mental disorder should not need to submit any additional information at their eligibility redetermination. Most mental health conditions are chronic, if not lifelong,[48] and there is little likelihood that there would be a change in this status at redeterminations. Therefore, requiring additional information on whether someone still has a mental health condition every six months or every year is neither an appropriate reading of the statute nor an appropriate clinical understanding of these conditions.

Instead, states should allow individuals who have previously been identified as exempt to confirm (for example, by checking a box) that they have no changes to their exemption status. Half of the states who make "medically frail" determinations (related to not automatically enrolling individuals in benchmark or benchmark-equivalent plans) already use this approach — only reviewing medical frailty status when there is a service need or change in circumstances, rather than annually.[49] At the same time, states should still ensure that screenings are available as part of the redetermination process to help identify individuals who may be newly exempt.

ADVANCE INCLUSIVE POLICIES THAT IMPROVE ACCESS TO COVERAGE AND CARE

KEY RECOMMENDATIONS

- Proactively screen for exemptions, eligibility pathways, and other benefits.
- Expand coverage for services provided by peer support specialists.
- Expand access to integrated care.
- Promote universal mental health screenings across health care and community settings.
- Ensure adequate community-based services.
- Strengthen and enforce protections that limit discrimination against people with mental illness.

Policymakers have an important opportunity, even before H.R. 1 provisions go into effect, to advance policies that will improve and maintain access to mental health care for people with mental health conditions.

Proactively Screen for Exemptions, Eligibility Pathways, and Other Benefits

States should proactively screen Medicaid expansion enrollees for exemptions to the work reporting requirements, other Medicaid eligibility pathways, and other coverage and benefits. There are many ways that people with mental health conditions might qualify for Medicaid coverage. For example, a person might be enrolled via Medicaid expansion even when they are also eligible for Medicaid through a traditional eligibility pathway. With the implementation of work reporting requirements for the Medicaid expansion population, it highlights an opportunity to identify if an individual could be enrolled through a traditional eligibility pathway.

Before a state can determine that an individual has not complied with the work reporting requirements, there is a statutory requirement that 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.[50]

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.

Expand Coverage for Services Provided by Peer Support Specialists

Across the U.S., there is a growing demand for mental health and substance use disorder care. At the same time, there is a significant shortage of mental health providers. Peer support workers are an important option that can help address this shortage, as well as help individuals navigate a complex health care system. Peer support workers (PSWs, or peer support specialists) are generally defined as individuals with lived experience of recovery from a mental health condition, substance use disorder, or both, and are trained to support other individuals and their families in recovery. These professionals play a vital role in connecting individuals with mental health conditions with health care services and recovery supports, addressing upstream drivers of health, and building skills and community.[51]

Peers can build on the trust they have developed within their communities to share resources and educate people about these new policies. They can also help individuals navigate this new process while ensuring they have access to the most comprehensive coverage, services, and supports they need. As such, peer services and their work must be meaningfully covered by the state's Medicaid program.

Promote Universal Mental Health Screenings Across Health Care and Community Settings

Universal screenings are an important component of preventative health and early intervention services. If people lose Medicaid coverage, and along with the loss of coverage, access to affordable treatment, it will be critical to ensure universal screening for mental health and other chronic health conditions at key intercept points in health care and community settings. This can include places where individuals will continue to go without insurance coverage, such as safety net programs, crisis services, emergency departments, schools, and throughout the criminal legal system. Greater uptake of universal mental health screenings will help more individuals qualify for the "medically frail" exemption, enabling them to enroll in and retain their Medicaid coverage and access to affordable treatment services, improving their health outcomes. Screening should be paired with meaningful access to treatment, including facilitated referrals or warm hand-offs, so that people who are screened positively are immediately connected to services and supports that they need.

Expand Access to Integrated Care

States can play a central role in advancing integrated care models that coordinate physical and behavioral health services. Millions of people enrolled in Medicaid live with both a mental health or substance use condition and a chronic physical health condition.[52] Yet care often remains fragmented, leading to poorer outcomes, higher costs, and avoidable hospitalizations. Integrated care models that bring together primary care, behavioral health, and social supports can improve access to treatment, promote recovery, and address upstream drivers of health.

Integrated care also creates opportunities for earlier identification and treatment of mental health needs. When mental health screening and brief interventions are built into primary care settings, more people with symptoms can be identified and connected to care sooner, often before a crisis occurs.[53] This approach helps reduce stigma, normalizes mental health care, and ensures that both physical and behavioral health needs are addressed together. States should promote and build on existing Medicaid initiatives such as Health Homes, Certified Community Behavioral Health Clinics (CCBHCs), and Collaborative Care Models (CoCM) to expand integrated care. These programs show that when care teams coordinate across settings, people are more likely to receive timely, appropriate treatment for both physical and mental health needs.[54] States should ensure that these models are adequately funded, sustained through Medicaid reimbursement, and accessible to all people covered by Medicaid, including people who may be impacted by policy changes under H.R. 1.

Ensure Adequate Community-Based Services

States across the U.S. have ramped up efforts to address mental health[55] in meaningful ways over recent years. To protect these gains, states should be thinking about how to protect and maintain access to vital community-based treatment and supports. Recognizing that Medicaid is the single largest payer of behavioral health services in the nation,[56] and many of these providers and programs are primarily sustained by Medicaid reimbursement, state Medicaid programs play a uniquely important role.

It is imperative that states do not pass budget cuts onto mental health or substance use disorder treatment providers. Instead, states 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, protecting the progress made to address the ongoing mental health, suicide, and overdose crises. There is a significant cost to other systems if states don’t invest in these services, resulting in worse access to care and more untreated conditions that can often result in increased rates of hospitalization or emergency department visits, interactions with law enforcement, and homelessness.

Strengthen and Enforce Protections That Limit Discrimination Against People with Mental Illness

Medicaid managed care organizations, Medicaid alternative benefit plans, 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 of 2008, which requires non-discriminatory coverage of mental health and substance use disorder benefits as compared to medical and surgical benefits.[57] Improving enforcement of parity laws will help ensure that people are not subject to greater burdens and barriers when accessing mental health and substance use disorder care than for other types of health care. This is particularly important for protecting access to Medicaid and ensuring meaningful access to care for people who are exempt from work reporting requirements due to being "medically frail" or participating in substance use disorder treatment.

While enforcing parity requirements undeniably helps individuals access care, it also can help states financially. Taking compliance action against commercial insurance companies and managed care organizations who fail to comply with parity rules not only helps states provide their residents with the care to which they are entitled, but it also can provide financial resources that allow states to invest in their behavioral health infrastructure.

CONCLUSION

Many millions of people who are eligible for Medicaid are expected to lose their Medicaid 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 minimize coverage losses for people with mental health conditions. By maximizing the use of exemptions, minimizing the burdens on individuals and providers, and advancing policies that improve access to coverage and care, policymakers can mitigate harm to public health and better protect people with mental health conditions.

CITATIONS

[1] The Medicaid expansion population refers to individuals who became eligible for Medicaid as a result of the Affordable Care Act's provision extending Medicaid eligibility to people who are low-income up to 138% of the Federal Poverty Level, regardless of whether or not they have dependents. The majority, but not all, of states have taken up this option. *See* "Status of State Medicaid Expansion Decisions," KFF (Updated Sept. 12, 2025), https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/.
[2] An Act, Pub. L. 119-21, § 71119, 139 Stat. 306-15 (2025).
[3] Not all individuals will need to actively report their hours, because there is a requirement that states use "ex parte verifications" — data matching — to see if someone is meeting the 80-hour requirement and then the individual would not need to submit additional information. *Id.* at § 71119(a) (codified at 42 U.S.C. § 1396a(xx)(5)).
[4] *Id.* (codified at 42 U.S.C. § 1396a(xx)(3), (9)).
[5] *Id.* (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(cc)).
[6] *See* https://www.ada.gov/.
[7] For more information and details on this framework, *see* Deborah Steinberg, "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 (Sept. 3, 2025), https://www.lac.org/resource/protecting-people-with-suds-and-formerly-incarcerated-individuals-from-losing-medicaid-coverage-recs-on-implementing-hr1-work-reporting-requirements.
[8] Pub. L. 119-21, § 71119(a), 139 Stat. 312 (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)).
[9] See Deborah Steinberg, "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 (Sept. 3, 2025), https://www.lac.org/resource/protecting-people-with-suds-and-formerly-incarcerated-individuals-from-losing-medicaid-coverage-recs-on-implementing-hr1-work-reporting-requirements.
[10] Pub. L. 119-21, § 71119(d), 139 Stat. 314.
[11] *Id.* § 711119(a), 139 Stat. 312 (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)).
[12] *Id.* (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa)).
[13] 42 U.S.C. § 1382c(a)(3).
[14] *See*, e.g., "Most Common Disabling Medical Conditions," Quikaid (accessed Sept. 29, 2025), https://www.quikaid.com/article/most-common-disabilities.
[15] SSA lists 11 categories of mental disorders including: neurocognitive disorders; schizophrenia spectrum and other psychotic disorders; depressive, bipolar and related disorders; intellectual disorder; anxiety and obsessive-compulsive disorders; somatic symptom and related disorders; personality and impulse-control disorders; autism spectrum disorder; neurodevelopmental disorders; eating disorders; and trauma- and stressor-related disorder. For five of these categories, it is not necessary for individuals to meet the functional criteria for a disability determination if they are considered "severe and persistent" — that is, if there is a medically documented history of the disorder over a period of at least two years combined with several other criteria related to how the individual has responded to treatment. See "Disability Evaluation Under Social Security: 12.00 Mental Disorders — Adult," Social Security Administration (accessed Sept. 29, 2025), https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm.

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[16] 42 U.S.C. §§ 12102(1), (2).
[17] *See*, e.g., 42 U.S.C. §§ 290aa-0b; 11360(25).
[18] 42 U.S.C. § 1396u-7(a)(2)(B)(ii)
[19] MaryBeth Musumeci, Priya Chidambaram, & Molly O'Malley Watts, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," KFF (June 2019), https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medical-Frailty-Determinations-for-Medicaid-Expansion-Adults.
[20] *Id*. at 10.
[21] Centers for Medicare & Medicaid Services, 78 Fed. Reg. 42160, 42231 (July 15, 2013).
[22] *Id*. at 42230-31.
[23] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health, SAMHSA 50 (July 2025), https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf.
[24] For a new applicant, an individual is required to demonstrate compliance with the community engagement requirements for one or more (but no more than three) consecutive months immediately preceding their application. Pub. L. 119-21, § 71119(a), 139 Stat. 307 (codified at 42 U.S.C. § 1396a(xx)(1)(A)). That is, compliance must be determined retrospectively, not just prospectively. As such, **one additional way states can protect access to Medicaid for more individuals is to adopt the 1-month lookback period, as this is the most minimal period permissible under the federal law**. Similarly, states can look at one or more months (whether or not consecutive) in between eligibility redeterminations for individuals who are renewing their Medicaid. *Id*. **So the most protective option for states to adopt would be only one month, and not require that it be the month immediately preceding the redetermination** — that is, allow the individual to show that they complied with the community engagement hours in any one of the months in between redeterminations.
[25] For example, Michigan has a lengthy list of mental health diagnosis codes (F codes) that can count for "disabling mental disorder" and can be identified by the state through self-identification, claims analysis, or provider referral: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder65/Folder2/Folder165/Folder1/Folder265/Attachment_D_-_Medically_Frail_Process.pdf?rev=941dade01fab49ff961a0e089ec89838. Iowa uses a more limited set of diagnoses (only 7) but still does not require any functional limitations or additional criteria, and offers the option for an individual to self-identify as medically frail through a screening tool, as well as a provider referral form: https://hhs.iowa.gov/media/6738/download. Indiana's criteria are not transparent: https://provider.indianamedicaid.com/ihcp/StatePlan/Suffix/ABP/ABP1-2c.pdf. Instead, they report using the Milliman Underwriting Guidelines, which as far as we can tell still only necessitate a diagnosis (in order to score 75 points, which is the threshold for mental health conditions) based on this slide deck: https://nationaldisabilitynavigator.org/wp-content/uploads/state-resources/NCBH_Medically-Frail_Oct-27-2015.pdf.

CITATIONS

[26] 7 C.F.R. § 273.7(b)(3).
[27] Pub. L. 119-21, § 71119(a), 139 Stat. 312 (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)).
[28] *Id*. (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(III)).
[29] Pub. L. 115-119 § 2(2), 132 Stat. 23 (Jan. 22, 2018).
[30] Pub. L. 119-21, § 71119(a), 139 Stat. 308 (codified at 42 U.S.C. § 1396a(xx)(3)(A)(i)(II)(B)).
[31] *Id*. at 312 (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(VIII)).
[32] *Id*. at 308 (codified at 42 U.S.C. § 1396a(xx)(3)(A)(ii)).
[33] *See* Deborah Steinberg, "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 (Sept. 3, 2025), https://www.lac.org/resource/protecting-people-with-suds-and-formerly-incarcerated-individuals-from-losing-medicaid-coverage-recs-on-implementing-hr1-work-reporting-requirements.
[34] Pub. L. 119-21, § 71119(a), 139 Stat. 307-08 (codified at 42 U.S.C. § 1396a(xx)(3)(A).
[35] *Id*. at 309 (codified at 42 U.S.C. § 1396a(xx)(5)).
[36] MaryBeth Musumeci, Priya Chidambaram, & Molly O'Malley Watts, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," KFF (June 2019), https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medical-Frailty-Determinations-for-Medicaid-Expansion-Adults.
[37] For a more detailed overview of this framework, see Deborah Steinberg, "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 (Sept. 3, 2025), https://www.lac.org/resource/protecting-people-with-suds-and-formerly-incarcerated-individuals-from-losing-medicaid-coverage-recs-on-implementing-hr1-work-reporting-requirements. The appendix to the report also includes a sample self-affidavit and a sample third-party verification letter as detailed in this section.
[38] Pub. L. 119-21, § 71119(a), 139 Stat. 309 (codified at 42 U.S.C. § 1396a(xx)(5)).
[39] *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.
[40] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health, SAMHSA 50 (July 2025), https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf.
[41] Centers for Medicare & Medicaid Services, 78 Fed. Reg. 42160, 42231 (July 15, 2013).
[42] *Id*. at 42230-31.
[43] MaryBeth Musumeci, Priya Chidambaram, & Molly O'Malley Watts, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," KFF (June 2019), https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medical-Frailty-Determinations-for-Medicaid-Expansion-Adults.
[44] 7 C.F.R. § 273.7(b)(3).

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[45] *See*, e.g., "Stigma, Prejudice and Discrimination Against People with Mental Illness," American Psychiatric Association (Mar. 2024), https://www.psychiatry.org/patients-families/stigma-and-discrimination.
[46] *See*, e.g., Paul S. Appelbaum, "Workplace Discrimination Against People with Mental Disorders and the ADA," Psychiatric Services 73(10), (Oct. 1, 2022), https://psychiatryonline.org/doi/full/10.1176/appi.ps.20220379.
[47] Pub. L. 119-21, § 71119(a), 139 Stat. 311 (codified at 42 U.S.C. § 1396a(xx)(8)(B)).
[48] *See*, e.g., National Institute of Mental Health. (2025). Bipolar disorder. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/publications/bipolar-disorder; Cleveland Clinic. (2022, June 26). Paranoid schizophrenia: What it is, symptoms & treatment. https://my.clevelandclinic.org/health/diseases/23348-paranoid-schizophrenia; Harvard Health Publishing. (2025, July 7). Generalized anxiety disorder (GAD). Harvard Medical School. https://www.health.harvard.edu/mind-and-mood/generalized-anxiety-disorder-a-to-z.
[49] MaryBeth Musumeci, Priya Chidambaram, & Molly O'Malley Watts, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," KFF (June 2019), https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medical-Frailty-Determinations-for-Medicaid-Expansion-Adults.
[50] Pub. L. No. 119-21 § 71119(a), 139 Stat. 310 (to be codified at 42 U.S.C. 1396a(xx)(6)(A)(iii)(I)).
[51] "Peer Support Workers for Those in Recovery," SAMHSA (Updated Nov. 5, 2024), https://www.samhsa.gov/technical-assistance/brss-tacs/peer-support-workers.
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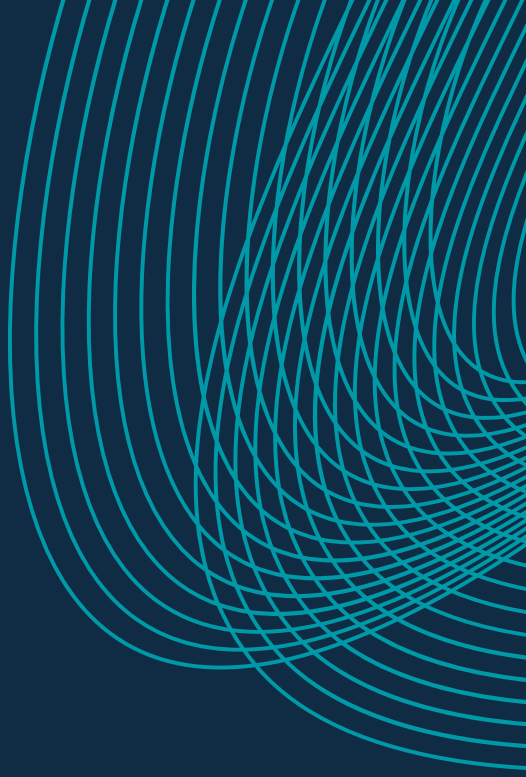
[55] For more information, *see* https://www.nami.org/support-education/publications-reports/public-policy-reports/
[56] "Behavioral Health Services," Medicaid.gov (accessed Sept. 18, 2025), https://www.medicaid.gov/medicaid/benefits/behavioral-health-services.
[57] For more information, *see* https://www.nami.org/advocacy/policy-priorities/improving-health/mental-health-parity/

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