H.R.1 Community Engagement Requirements: Fact Sheet and Recommendations

What's Changing?

Beginning Jan. 1, 2027, members of the Medicaid expansion population will need to **complete 80 hours per month of qualifying activities** to maintain coverage. Although this is an interim final rule, the Centers for Medicare and Medicaid Services (CMS) may take submitted comments into consideration if the agency determines it needs to alter any parts of the rule. States must implement the requirements beginning **Jan. 1, 2027.** States may elect an earlier implementation date, as Nebraska, Montana and Iowa have done. Based on CMS' individual evaluation of each request, a state may also receive a temporary good faith effort exemption extending its implementation deadline to no later than **Dec. 31, 2028.**

Who Is Subject to the Requirements?

The requirements apply to non-pregnant adults ages 19 to 64 who are not entitled to or enrolled in Medicare and are eligible for or enrolled in the state plan Medicaid adult (expansion) group or in certain Section 1115 demonstrations providing minimum essential coverage to adult beneficiaries. The IFC refers to these individuals as "applicable individuals." Currently, 43 states and the District of Columbia cover these populations and will be required to implement the requirements. Certain individuals, including some people with mental health and substance use conditions, are excluded and do not have to meet the requirements.

Qualifying Activities

Each month, an applicable individual must satisfy one of the following:

- Work at least 80 hours;
- Complete at least 80 hours of community service;
- Participate in a work program for at least 80 hours;
- Be enrolled at least half time in an educational program;
- Complete any combination of these activities totaling at least 80 hours (though at-least-half-time educational enrollment cannot be combined with another activity);
- Have a monthly income of at least $580; or be a seasonal worker with an average monthly income of at least $580 over the preceding six months.

Exceptions and Exclusions for People with Mental Health and Substance Use Conditions

On June 1, 2026, CMS released an interim final rule with comment period (IFC) that provides further guidance on qualifying activities, exemptions, and state verification processes.

The IFC excludes several categories of individuals ("specified excluded individuals") from the requirements. States determine this status at application, renewal, or if the state elects, at more

frequent verifications. Two exclusion pathways are most relevant to people with mental health and substance use conditions:

- **Medical Frailty:** Under the IFC, ***medical frailty*** includes, among others, individuals with a disabling mental disorder or substance use disorder (SUD). To claim this exemption, enrollees must not only have a qualifying medical condition ***but must also*** demonstrate that the condition substantially impairs their ability to satisfy community engagement requirements. CMS defers to states to develop lists of qualifying conditions for the medically frail categories of 'disabling mental disorder' and SUD. ***Individuals with a SUD who have been in recovery for five or more years are not eligible for this exclusion.*** Medically frail status must be reverified at least every 12 months, but states may not reverify excluded status between regularly scheduled renewals as part of any more frequent verification process unless they have information indicating the individual's status has changed.
- **Participation in a drug addiction or alcoholic treatment and rehabilitation program:** Individuals participating in a qualifying SUD treatment program are excluded from the requirement. Participation in a for-profit program will not qualify, and states can determine whether individuals must be in treatment for a given length of time in order to qualify for this exclusion. The IFC clarifies that this exclusion is ***separate from medical frailty.***

Verification and Self-Attestation

States must first attempt to verify exclusion status using reliable available data. Where data are unavailable, for 2027, states ***may*** accept self-attestation (an auditable self-declaration under penalty of perjury) to confirm medical frailty status. Beginning Jan. 1, 2028, when states cannot verify compliance using reliable available information, they must require documentation when it is reasonably available and establish a process to accept other information when it is not.

Short-Term Hardship Exceptions

Short-term hardship exceptions are optional for states. A person experiencing a qualifying hardship is treated as having met the requirement for that month. Importantly, this section does not apply to specified excluded individuals — people who are already fully exempt from the requirement don't need a hardship exception. Individuals would need to self-declare these exceptions. ***States must allow individuals to claim any of the following four short-term hardship exceptions or none at all.***

- Receiving inpatient or institutional care (or services that would require inpatient care if not received).
- Travel for medical care

- High unemployment counties
- Federally declared emergency or disaster areas

What Can I Do Now to Prepare?: The following are high-level recommendations designed to help with implementation of these changes.

→ **Document All Instances of Substance Use Relapse in Clinical Notes**

For individuals deemed medically frail with a substance use disorder, clinicians should document each occurrence of a relapse. This is because medically frail individuals could include those with an SUD who are in recovery for less than five years, meaning a relapse could potentially reset this critical time period and qualify such individuals for medical frailty status for longer.

→ **Work with your State to Ensure the Use of an Accepted and Efficient Functional Assessment Screening Tool that Minimizes Burden on both Providers and Patients**

States will likely decide whether specific functional assessment tools are acceptable. A state that accepts documentation CMS later deems insufficient may face payment error findings, which could lead to states being conservative and tightening retroactively if their initial approach is deemed unacceptable. States will therefore need to consider the potential effects of Payment Error Rate Measurement (PERM) audits and any compliance monitoring CMS builds around community engagement requirements. For example, a clinic whose assessment tool was accepted by the state one year could see the same tool invalidated the next year after an audit cycle. With this in mind, engage your state Medicaid agency and/or state association while this determination is still being made to attempt to get specific instruments named or approved. Ideally, these would be instruments clinics already administer, so exclusion tracking processes correspond to existing clinical workflows and reduce administrative burden for staff.

→ **Monitor State Implementation of Choices that will Affect Clients (Review Period at Application, Frequency of Verification, Short-Term Hardship Exceptions, and Qualifying Conditions and Diagnosis Codes)**

As noted above, it will be important for providers to regularly engage with their state Medicaid agency and/or their state association while states are making decisions related to community engagement implementation.

It will be important to know the following:

- How many months of compliance review will be required for those applying for Medicaid?
- How frequently will states verify compliance with community engagement requirements?

- Will states allow for short-term hardship exceptions?
- How will states define 'disabling mental disorder' and substance use disorder for purposes of determining medical frailty, including qualifying conditions and diagnosis codes?

→ **Prioritize Exemption Screening at all Clinical Touch Points**

Exemption screening at every feasible clinical touchpoint is critical and involves embedding standard questions into existing patient encounters. This may include intake, routine visits, case management contacts, and discharges, among others. This will help ensure that exclusion status is established and documented as a result of processes that are currently taking place.

→ **Develop Written Internal Policies and Protocols.**

Clinics should consider adopting a set of written policies that describe how staff will identify patients subject to work requirements, assess exemptions, document functional limitations, assist with reporting, and respond to potential coverage loss or interruption. Clear protocols can reduce staff confusion and ensure consistent support across different programs and sites.

Next Steps: The National Council for Mental Wellbeing is closely monitoring implementation and will share additional guidance and recommendations on this and other H.R. 1 provisions as new developments arise.