STATE IMPLEMENTATION PLAYBOOK
PROTECTING HEALTHCARE IN REENTRY

An Advocate's Tool for Navigating the 2026 Medicaid Work Requirement Interim Final Rule

The Centers for Medicare & Medicaid Services (CMS) issued an Interim Final Rule (IFR) requiring 80 monthly hours of work or community engagement for Medicaid expansion recipients under H.R.1, beginning no later than January 1, 2027. **Action is required immediately within the 43 states currently implementing these policies.**

The new federal Medicaid work reporting rules present a real threat to individuals returning to our communities from incarceration. Reentry requires navigating extreme chaos: securing housing, stabilizing physical and mental health conditions, meeting parole conditions, navigating markets and finances, and overcoming systemic employer discrimination.

While the federal law mandates these requirements, state Medicaid agencies retain some administrative discretion and choice in how the rules are applied, interpreted, and verified. This guide details critical strategic "asks" local advocates can demand from state agencies to protect reentering citizens' healthcare.

The All-or-Nothing Dilemma: Short-Term Hardship Exceptions

The IFR introduces an operational catch-22 for states regarding "Short-Term Hardship Exceptions" (designed to aid in meeting work requirements during acute personal crises). CMS has decided that a state cannot select individual options; the state must choose to formally adopt ALL four federally defined hardships in its State Plan Amendment (SPA), or offer NONE of them.

Advocates' first priority must be demanding state agencies to opt in to all hardship options.
If a state opts out, caseworkers lose the policy flexibility to protect individuals during emergencies, leaving individuals experiencing serious situations vulnerable to coverage loss when they need it most.

Reentry-Specific Tactics & Interpretation Strategies

Once the state opts into the hardship framework, the strategy shifts to how the state defines and interprets the rules inside its policy manuals. Advocates must push for specific, reentry-related adaptations:

1. Enable Self-Attestation and Empower Institutional Staff and Case Managers
Securing internet access, creating online account portals, and uploading verification forms is functionally impossible for someone in their first weeks of release without a smartphone or fixed residence.

> *States must allow for self-verification in 2027 and grant expedited system access to correctional case managers, halfway house leadership, and reentry navigators. Case managers must be authorized and directed to assist reentering individuals in utilizing their initial self-reporting flexibility prior to release and before third-party documentation requirements take effect.*

2. Automate Exceptions via Corrections and Supervision Data Bridges

The federal law requires states to exempt individuals from work requirements if they meet certain “exceptions," including a baseline 3-month "recently incarcerated" window. However, relying on a newly released person to mail paper release forms to a caseworker is an operational failure.

> If an individual is released from custody or is placed on active probation/parole supervision, the state Medicaid computer system can do automated weekly electronic data-matching with the Department of Corrections. This match must automatically apply a transitional exemption on the backend, ensuring a computer-generated disenrollment notice is never sent to a transient address.

3. Consider How Community Corrections Aligns with "Qualifying Activities"

States define what activities qualify as community service within the 80-hour monthly mandate (if a person is not exempted). To force a reentering person to choose between maintaining health insurance via qualifying activity schedules and skipping mandatory parole meetings or court check-ins creates a systemic trap that actively spikes economic instability.

> *State Medicaid agencies must consider not only court-mandated community service for community engagement, but also parole/probation appointments, and state-funded, reentry-focused workforce readiness classes (e.g., DOL Pathway Home programs). Parole, probation, courts, and those they supervise must all be actively involved in helping avoid the potential conflict between community correction case plans and the availability of qualifying activities.*

4. Ensure state-licensed, county-funded and correctional-operated recovery programs are treated as functionally equivalent through broad interpretation

The statutory definition for the substance use disorder treatment exclusion relies on restrictive Food and Nutrition Act criteria. While states cannot change this definition, they can use flexibility to determine which provider types are included when individuals report on recent engagement efforts.

> States must use flexible interpretation to include court-ordered, correctional-based, and community-based SUD treatment programs—including those required as conditions of probation or parole—as qualifying treatment programs. State agencies must issue guidance or amend their plans to ensure this happens at verification.

Immediate Opportunities

Advocacy and the State Plan Amendment (SPA): Engage both your state’s **Medicaid Office** and State **Medicaid Advisory Council (MAC)** to advance the action items outlined in this memo and advocate for the optional hardship package, framing it as a fiscal necessity to avoid costly manual reviews.

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*To learn more about the sweeping changes made to Medicaid, SNAP and other assistance programs, please review our **February 2026 Brief: Navigating OBBBA Policies and Terminology.***