

Medicaid Work Requirements

State Options and Implications for the Direct Care Workforce

INTRODUCTION

Direct care workers, including personal care aides, home health aides, and nursing assistants, are the backbone of our long-term services and supports (LTSS) system. Despite their central role in supporting the health and well-being of others, low wages and limited access to employer-sponsored insurance mean that approximately [one-third](#) of the nation's 5.4 million direct care workers must rely on Medicaid for their own health coverage.

The budget reconciliation act of 2025 ([HR 1](#)) mandated that all states which have [expanded Medicaid](#) impose “community engagement requirements” (more commonly known as “work requirements”) as a condition of Medicaid coverage for the Medicaid expansion population. By January 1, 2027, systems must be in place to verify that these Medicaid enrollees are completing at least 80 hours per month of paid work, education or training, or community service. Individuals who are deemed to fall short of the requirements will be denied Medicaid coverage and also prohibited from receiving [premium tax credits](#) to purchase alternate coverage through the health insurance marketplace.

Due to the nature of direct care jobs, these requirements will likely compromise access to health coverage for many direct care workers and, in turn, worsen existing workforce shortages—leading to care gaps and unmet needs among LTSS consumers. As states proceed with

planning and implementing this requirement, mitigating unintended impacts on the direct care workforce will be imperative to avoid further destabilizing LTSS and driving up overall costs of care.

This brief offers a set of recommendations for state leaders and advocates on how to reduce unnecessary coverage loss among direct care workers—along with other low-wage workers—while complying with federal work requirements. Strategies include maximizing exclusions, adopting streamlined reporting systems that leverage existing data sources, and investing in targeted outreach and support.

Why Consider Direct Care Workers?

Direct care workers comprise the **largest single workforce in 24 states**, outnumbering every other occupational group—and are among the top five occupations in 41 states. Destabilizing this workforce by rolling back essential health care coverage will have ripple effects across the long-term services and supports system, the broader health care system, the labor market, and state economies overall.

THE CHALLENGE OF COMPLIANCE

Because of the unique characteristics of their jobs, direct care workers will likely face heightened barriers to comply with or prove their compliance with (or exclusion/exemption from) the 80-hour requirements. Key factors include:

- › **Variable Hours:** Inconsistent schedules are common in direct care, especially for home care workers (the largest segment of this workforce), because hours can fluctuate widely in response to client needs. For this and other reasons, nearly two in five direct care workers [work part-time](#).
- › **Employment Disruptions:** Home care workers are also vulnerable to sudden employment gaps, for example when a client is hospitalized or passes away—and all direct care workers are at [heightened risk of occupational injuries](#) that may require recovery time away from work. These employment gaps can be impossible to plan for or immediately rectify.
- › **Verification Challenges:** Direct care workers often work [multiple jobs](#), turnover is high in this workforce, and the work is decentralized (particularly for home care workers). All of these factors can make it difficult for direct care workers to consistently document their hours, even when they are meeting or exceeding the minimum threshold.
- › **Family Caregiving Responsibilities:** Twenty-five percent of direct care workers provide [unpaid care](#) to older adults, compared to 19 percent of the total U.S. labor force, and 29 percent have children at home. Ensuring that direct care workers who are also providing essential unpaid care are categorically excluded from the work requirements may be more or less difficult

depending on state program design choices, as discussed below.

Evidence from previous [work requirement demonstrations](#) indicates that compliance with these requirements may also be hindered by inadequate information and guidance, limited technological access and/or literacy among workers, and insufficient time to comply. Individually and together, these factors will put many direct care workers at risk of losing health coverage—harming their health, financial stability, and ability to remain in the workforce, and impeding access to care for countless older adults and people with disabilities across the country.

STATE POLICY LEVERS

Although HR 1 established broad work requirements, states hold significant ownership over program design and implementation—meaning that states can make choices that meet the federal requirements while also minimizing unnecessary coverage losses and meeting other policy goals, such as program alignment.

The following recommendations highlight practical strategies to promote continuity of coverage while meeting statutory obligations.

OVERALL CONSIDERATIONS

States must grapple with a range of difficult policy and operational decisions in meeting the requirements of HR 1. The following overall considerations will help ensure that these decisions lead to coverage continuity and systemic efficiencies to the extent possible.

Set a Shared Policy Goal

Implementing work requirements will be a complex task, especially amidst competing state priorities and obligations. Establishing a shared vision across leadership and relevant state

agencies will help guide this process and keep it on track throughout the numerous decision points along the way. One strategy is for the state governor to issue an executive order asserting that the state's implementation of work requirements should seek to maximize continuity of Medicaid coverage among eligible individuals and minimize coverage losses due to administrative barriers. A clearly articulated vision from leadership will serve to align implementation efforts across relevant agencies and their staff.

Engage Executive-Level Leadership Across Agencies

Relatedly, securing buy-in and active participation from key agency leaders will help ensure that implementation is adequately resourced, operational challenges are quickly addressed, and coordination across agencies is sustained. An important approach is to establish an inter-agency leadership team, ideally under a directive from the governor, that is led by the state Medicaid agency and that includes representation from relevant agencies and departments, including but not limited to labor, health, human services, and information technology agencies. The inter-agency team can then align staff around the shared vision and priorities for implementation and ensure that work proceeds efficiently, on schedule, and in the right direction.

KEY DECISION POINTS

The following recommendations center on specific decisions that states can make about work requirements to mitigate harmful loss of coverage for the direct care workforce, among other Medicaid enrollees.

¹[Guidance from the Center for Medicaid & CHIP Services \(CMCS\)](#) indicates that further clarification on this group is forthcoming.

Apply Categorical Exclusions Automatically

The work requirements in HR 1 pertain to adults ages 19 to 64 applying for or enrolled through Medicaid expansion or minimum essential coverage under Section 1115 demonstration waivers (as in Wisconsin and Georgia). Mandatory exclusions from the requirements include parents and family caregivers of individuals with disabilities or children under 14; medically frail individuals and those with special needs (including those who are defined as blind or disabled according to Social Security criteria); and those who are already subject to work requirements under the Temporary Assistance for Needy Families (TANF) program or Supplemental Nutrition Assistance Program (SNAP)¹; among others. Approximately half of states have TANF and SNAP integrated into their Medicaid eligibility determination systems, creating a foundation for automatically identifying those who are categorically excluded. The remaining states should strive to set up automatic identification in other ways, thereby eliminating or minimizing administrative burden on individuals and state systems as much as possible.

As one example of the implications for the direct care workforce, one in every 10 direct care workers is [age 65 or above](#) and should be automatically identified as *not* subject to the work requirements, rather than being asked to prove compliance.

- › **Use existing program data to identify Medicaid enrollees who are categorically excluded from work requirements, with robust data quality assurances in place.** HR 1 requires states to use *ex parte* processes, i.e. leverage existing data sources, to verify exclusion or compliance to the

extent possible. [Ex parte sources](#) include Medicaid claims and payment data, SNAP and TANF program data, and state wage and unemployment data. For direct care workers, additional relevant sources include electronic visit verification (EVV) data, Medicaid-participating agency payroll data, and fiscal intermediary data. Each of these data sources has limitations, however, and safeguards must be put in place to ensure that [accurate, reliable, and up-to-date](#) assessments are achieved.

- › **Ensure that individuals who are employed can still qualify for exclusion.** Employment and exclusion status should not be considered mutually exclusive. States should not require Medicaid enrollees to demonstrate that they are not working or unable to work in order to qualify for exclusion, nor should recent or ongoing employment be used to deny exclusion eligibility. For example, an individual may serve as a family caregiver *and* work part-time as a direct care worker—and in that case should be automatically excluded from the work requirements, not required to comply.
- › **Simplify and streamline documentation requirements for the caregiver exclusion.** [Guidance](#) from the Center for Medicaid & CHIP Services (CMCS) clarifies that family caregivers should be excluded from work requirements using the definition established under the [Raise Family Caregivers Act](#) (see box). States should simplify and streamline documentation requirements for family caregivers by accepting verification through self-declaration or from health care providers. Given that one in four direct care workers are [family caregivers](#), honoring and simplifying this categorical exclusion is critical to protecting states' caregiving infrastructure.

Defining Family Caregivers

States should ensure that any Medicaid enrollee who can attest to meeting the following definition of a family caregiver is excluded from work requirements: “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.”

This definition was established at the federal level through the [RAISE Family Caregivers Act of 2017](#).

Base the Work Requirements Standard on Income

HR 1 lays out a number of pathways for individuals to comply with the work requirements in a given month, including through demonstrating at least 80 hours worked/served or through reporting an equivalent monthly income. States should offer the monthly income option using the federal minimum wage calculation for those who are employed.

- › **Use the federal minimum wage to establish the income threshold for compliance.** Work requirements should use the federal minimum wage to translate earnings into hours, as outlined in the CMCS guidance cited above. This approach establishes \$580 per month as the income threshold for eligibility (e.g., $\$7.25 \times 80 = \580 per month). Taking this approach will ensure that scheduling and earnings variability does not undermine direct care workers' ability to demonstrate compliance with the requirements.

Minimize Administrative Burden and Costs

As noted, states are required to use ex parte processes to streamline verification of categorical exclusion or compliance. When existing data sources are insufficient, however, states should take further steps to ensure that arduous reporting expectations do not cause individuals to lose critical coverage. Minimizing reporting burden saves time and money for the state while also protecting individual enrollees, such as direct care workers, who may be juggling multiple paid jobs with family caregiving and other responsibilities.

- › **Limit the employment verification lookback period to one month.** According to HR 1, states must require individuals applying for Medicaid coverage to demonstrate that they have met the work requirement criteria for at least one month but up to three months prior to enrollment. States must also require individuals who are already covered by Medicaid to demonstrate compliance for one or more months between regular renewal processes. While most states appear to be limiting the “lookback period” to [only one month](#) in each case (application and renewal), which will ease the administrative burden and reduce the risk that eligible individuals lose coverage due to errors in reporting or data-matching, others are using a longer lookback period or have yet to decide. Limiting the verification requirement will be important for direct care workers, who, as noted, may have variable hours and employers from month to month, making consistent monthly documentation difficult.
- › **Align existing data sources to verify compliance with work requirements.** For many states, integrating different data systems will pose significant operational challenges. However, effective use and

integration of available data, with safeguards in place to ensure accuracy and confidentiality, is crucial for minimizing the documentation burden on individuals. Data integration is particularly important for ensuring ex parte verification for direct care workers, more than a quarter of whom are [enrolled in SNAP](#), for example. Almost 20 states plan to [access new data sources](#) to document compliance with work requirements, while others either do not plan to use new sources or have not made a determination.

Design Inclusive and Targeted Enrollee Engagement Strategies

Prior to initial implementation and periodically thereafter, states are required to give notice to Medicaid enrollees about the work requirements and guidance on how to comply. Going beyond the basic requirements, states should take proactive steps to educate existing and prospective Medicaid enrollees about the work requirements, adapting outreach to appropriate literacy and English-language levels and disseminating information through appropriate partners and platforms.

- › **Design outreach to reach specific audiences, including direct care workers.** Nationally, 29 percent of direct care workers are [immigrants](#), and nearly one in five (17 percent) report limited or no English proficiency. The median age is [44 years](#) and about half the workforce has a [high school diploma/equivalent](#) or less. While these proportions vary from state to state (higher or lower), the overall implication is that cultural and linguistic competence must be built into all communications efforts. Outreach should be conducted in multiple languages and led by trusted sources including employers, unions, and other community-based organizations. Digital and

non-digital formats, including flyers and other hard copy materials, should be used.

- › **Tailor self-reporting mechanisms to diverse needs and abilities.** The reporting channels for documenting exclusion or compliance should also be designed with end users in mind, including direct care workers. As noted above, strategies should include using multiple languages, offering both digital and non-digital methods, and engaging trusted sources to help workers understand, access, and navigate the documentation requirements and processes.

CONCLUSION

As states face ongoing and growing pressure on their long-term care systems, recruiting and retaining a strong direct care workforce is essential. Given that nearly one-third of this workforce relies on Medicaid for their own health insurance—and more than 10 percent [lack any form of health insurance](#)—streamlining access to Medicaid and minimizing the risk of coverage loss must be a priority. This brief has laid out key opportunities for states to comply with new work requirements in Medicaid while protecting coverage for direct care workers, among other enrollees. PHI stands ready as a trusted resource to support states in navigating these complex challenges and designing policies that work effectively for direct care workers and those they support.

For more than three decades, PHI has provided evidence-based, non-partisan technical assistance to states on the most pressing issues impacting the direct care workforce. With our expertise in research and evaluation, policy advocacy, and workforce innovations, we stand as a trusted resource to support states in

navigating complex challenges and designing solutions that work effectively for direct care workers and those they support. Examples of PHI assistance related to implementing HR 1 requirements include:

- › Advising state leaders on key decision points and potential impacts on the direct care workforce;
- › Assisting with the design of data collection frameworks to track the impact of work requirements on the direct care workforce;
- › Supporting employer engagement strategies to streamline employment reporting for direct care workers; and
- › Collaborating on an outreach and communications strategy to build awareness of administrative requirements among direct care workers.

Please reach out to [Amy Robins, Senior Director of Policy](#), to explore how PHI can partner with your state to strengthen and grow your direct care workforce.

About This Brief

The information about work requirements contained in this brief is drawn from [HR 1](#) and from the [Informational Bulletin](#) released by the Center for Medicaid & CHIP Services (CMCS) on December 8, 2025, which served as the first round of implementation guidance to states. More guidance is expected from CMCS prior to the implementation deadline, which is January 1, 2027.

As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.

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