



Potential Impact of HR1 Cuts to Medicaid on Ending the Epidemic Efforts

Ginny Shubert, Senior Advisor, Policy & Research
Housing Works

g.shubert@housingworks.org



Devastating \$1 Trillion cut to Medicaid over 10 years to help offset tax cuts

- HR1, passed in July 2025, now referred to by the Centers for Medicare & Medicaid Services (CMS) as the “Working Families Tax Cut (WFTC) Legislation,” made a number of cuts to Medicaid to help pay for tax cuts primarily benefiting high earners.
- This presentation will focus primarily on the “community engagement” requirement imposed on the Medicaid expansion population – adults age 19-64.
- Other provisions harmful to enrollees include:
 - Recertification required for expansion adults every 6 months or more frequently at state discretion, with look-back of 1 to 3 months
 - For expansion adults, retroactive Medicaid coverage drops from 90 days to 1 month starting January 1, 2027
 - On October 1, 2026, immigrant eligibility restrictions take effect – certain lawfully present immigrants lose federally funded Medicaid eligibility
 - New address verification requirements that potentially threaten Medicaid coverage for **all** enrollees
- Of 20M expansion adults nationwide, the Congressional Budget Office (CBO) estimated 5.5M to 6.3M will lose Medicaid due to work requirements alone, many simply through failure to navigate bureaucratic requirements.
- In New York State, it is estimated that 61% of the 2 million Medicaid expansion population will be subject to the work requirements.



We Know What To Expect

- Between 2017 and 2021, CMS approved section 1115 projects that included work requirements.
- Five states with approved Medicaid work requirements as section 1115 CMS approved demonstration projects – Arkansas, Indiana, Kentucky, Michigan, and New Hampshire – proceeded far enough in their demonstrations to obtain early data on potential enrollment effects.
- In 2021, the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE) reviewed the evidence from these projects and found that “[m]ultiple studies indicate that Medicaid work requirements...can lead to significant coverage losses and worse access to care, without improvements in employment, job training, or other related activities.”
- Only Arkansas proceeded far enough in its implementation to disenroll any beneficiaries due to noncompliance – in many cases simply because enrollees did not provide documentation.
- Arkansas’ work requirement policy was in effect from June 2018 until March 2019, when a federal court halted it. During this period:
 - 18,000 of these Medicaid enrollees lost coverage due to noncompliance – a 25% reduction among those subject to the requirement
 - 95% of those who lost coverage either met the requirement or were exempt
 - There was no increase in employment or community engagement activities
 - Adults with chronic conditions were more likely to lose coverage, despite broadly allowed self-attestation for all exemptions
 - Even temporary loss of coverage caused harm, including medical debt, delayed care, and missed medications due to cost



Medicaid and HIV Prevention and Care

- Medicaid plays a critical role in the United States HIV response, covering HIV screening, prevention including HIV pre-exposure prophylaxis (PrEP), and antiretroviral treatment that sustains health and stops ongoing transmission.
- Nationwide, Medicaid is the largest payer of HIV care, covering 40% of people with HIV at any given time, according to the Kaiser Family Foundation (KFF).
- Yet, while Medicaid accounts for an estimated 45% of all federal spending on HIV care, in 2022 CMS estimated that federal Medicaid spending on HIV represented less than 2% of total federal Medicaid spending.
- In New York State, almost half of all people living with HIV—an estimated 55,000 to 57,000 individuals—depend on Medicaid for their healthcare coverage.
- While we are unaware of the percentage of New Yorkers with HIV who rely on Medicaid are part of the expansion population, we do know that a high percentage are adults without dependent children.
- We do know that in 2024, some 13,480 New Yorkers who rely on Medicaid coverage filled a PrEP prescription.



HR1: Medicaid Work Requirements

- For the 1st time in history of the Medicaid program, from January 1, 2027, expansion adults 19-64 must show 80 hours/month of “community engagement.”
 - **Demonstrated income of \$580/month**—80 hours at the federal minimum wage, or 36.3 hours at the NYS minimum wage (states may allow seasonal workers to average income over 6 months), or income divided into hours at the federal minimum wage of \$7.25/hour and combined with any of the following activities.
- OR
- **Demonstrate 80 or more hours or more per month of the following activities:**
 - **Work:** Paid work, work in exchange for goods or services, or certain unpaid work (outside of “community service”)
 - **Participation in a work program:** Certain federally or state recognized employment and training programs
 - **Enrollment in an educational program:** At least half-time enrollment in an institution of higher education, a career and technical education program, a high school, or a high school equivalency program.
 - **Community service:** Unpaid work for community benefit that takes place within a structured program overseen by a public or nonprofit organization.
 - **Some combination of these activities** that totals 80 hours/month.
- All members of a household can meet the requirements based on the hours or pay of one family member.



Some Definitions Related to Work Requirements

- **Applicable individuals subject to work requirements** are adults enrolled under the Affordable Care Act's Medicaid expansion to cover individuals who fall between a state's traditional Medicaid income eligibility threshold and 138 percent of the Federal Poverty Level, or through a waiver program that provides minimum essential coverage. As of July 2025, 41 states have adopted Medicaid expansion, with over 20 million adults currently receiving benefits as part of the expansion population.
- **Mandatory exceptions** and **short-term hardship exceptions** set out in HR1 apply to applicable individuals and satisfy compliance with work requirements, as detailed below.
- **Specified excluded individuals** refers to nine categories of people who are not subject to work requirements, as detailed further below. Specified excluded individuals are not considered "applicable individuals." Work requirements are not a condition of specified excluded individuals' eligibility for Medicaid and states are prohibited from assessing whether these individuals meet work requirements.



Mandatory and Short-Term Exceptions Under HR1

- **Mandatory exceptions:**
 - Under the age 19
 - Entitled to, or enrolled in benefits under Medicare part A, or enrolled in benefits under Medicare part B
 - Specified excluded individuals; AND/OR
 - Individuals incarcerated in the prior three months.
- **Short-Term exceptions:** States may optionally allow exceptions for all or none of these extenuating circumstances:
 - Individuals receiving care in hospitals, nursing facilities, psychiatric facilities, or other intensive care settings
 - Individuals in a federally declared disaster area
 - Individuals living in counties with unemployment rates higher than eight percent, or 1.5 times the national unemployment rate (pending permission from HHS Secretary)
 - Individuals or their dependents who are required to travel outside their home for medical care for an extended time



Specified Excluded Individuals Under HR1

- **Former foster care youth:** Individuals under age 26 who were in foster care until they aged out, and were enrolled in Medicaid while in foster care.
- **Indian Health Service members:** Individuals recognized as American Indians or Alaska Natives and eligible for health services through the Indian Health Service.
- **Caregivers:** Defined as “parent, guardian, caretaker relative, or family caregiver of a dependent child 13 years of age and under or a disabled individual,” defined by CMS as providing regular assistance within a “significant relationship,” such as co-residence, familial relationship, or at least 80 hours of care/month.
- **Disabled veterans:** Defined as a veteran “with a disability rated as total under Section 1155 of Title 38, United States Code.”
- **Individuals already subject to work requirements:** Those meeting Temporary Assistance for Needy Families (TANF) work requirements or subject to the Supplemental Nutrition Assistance Program (SNAP) work requirements.
- **Individuals participating in a qualifying substance use disorder (SUD) treatment program:** Defined as SUD programs that meet SNAP-related federal requirements, run by nonprofit organizations or public community mental health centers.
- **Incarcerated:** Individuals who are currently incarcerated.
- **Pregnant and postpartum individuals:** Defined as “pregnant or entitled to postpartum medical assistance under paragraph (5) or (16) of subsection (e)” (the 12-month Medicaid continuous postpartum extension).
- **Medically frail individuals:** Who meet one of the following five categories: are blind or disabled, have a substance use disorder, a disabling mental disorder, a physical, intellectual, or developmental disability, or have a serious or complex medical condition.

Medical Frailty

- The record indicates that Congress included “medical frailty” exemptions to protect the most vulnerable from loss of continuous coverage, including those with “serious or complex” medical conditions like HIV or cancer.
- H.R.1 specifically excluded from the “community engagement” requirement any individual “who is medically frail or otherwise has special medical needs.” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). Although Congress afforded the agency discretion to define this term, H.R.1 specifies that the definition must include[e] an individual” with one of five types of clinical conditions:
 - those who are blind or disabled
 - have a substance use disorder
 - have a disabling mental disorder
 - have a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
 - have a serious or complex medical condition.



Medical Frailty: Impact of the CMS Interim Final Rule

- The interim final rule (IFR) issued June 1, 2026, by HHS and CMS to guide implementation of the new Medicaid work requirements, significantly narrowed these categorical medical frailty exclusions from the work requirement.
- The IFR adds a new requirement—one that appears nowhere in the statutory language of H.R.1—that individuals who otherwise would be classified as medically frail ***must also demonstrate that their condition “significantly impairs” their ability to comply with the work requirements.***
- This new requirement sharply limits the medical frailty exemption and requires states to verify not just that someone has a serious condition, but also that their condition significantly impairs their ability to work or engage in other community engagement activities.
- **Notably, the IFR fails to define or provide any guidance or criteria on determining the “significantly impairs” requirement.**



Implementation Concerns

- HR1 and the IFR emphasize the importance of employing “ex parte” data that does not require seeking additional information from enrollees to establish eligibility and compliance or exemption from work requirements - important ways to limit administrative barriers for enrollees.
- The IFR includes a list of examples of conditions that could be considered “serious or complex”—including cancer, end-stage renal disease, viral hepatitis, sickle cell disease, HIV, and others—but only when those conditions significantly impair an individual’s ability to comply with work requirements.
- Early sub-regulatory CMS guidance indicated that states could look to patients’ diagnosis codes to determine medically frailty, but the additional “significantly impairs” requirement will be difficult or impossible to establish using diagnosis codes or utilization data.
- Billing codes are not designed to capture this information, and a person’s ability to work requires an individualized determination that may depend on a person’s circumstances such as education and work experience.



Implementation Concerns

- The IFR also severely limits self-attestation under penalty of perjury that a Medicaid enrollee is unable to work. Self-attestation is allowed during 2027, but beginning in 2028, individuals who are medically frail will only be able to attest to this once during an enrollment period.
- At the individual's first eligibility redetermination (after they sought a designation that they are medically frail or have special medical needs), the state must be able to document their entitlement to the exemption through the state's own data (for example, new claims codes) or external documentation (provider records).
- Completing work assessments is a special skill for which most U.S. physicians are not trained. Although many physicians complete routine forms documenting the need to miss work or school due to an appointment, injury or illness, few are trained to make vocational capacity assessments.

Additional Limitations on Medical Exemptions

- An additional concern is the IFR 12-month limit on look-back data to establish medical frailty. The twelve-month limit is arbitrary and inconsistent with clinical experience that for many conditions, where reliable records establish that an individual has a permanent, irreversible, or progressive condition satisfying the medical frailty exclusion, the individual should be excluded from work requirements—even if these records are more than twelve months old at the time of the eligibility assessment. Nor does the 12-month limit on the lookback period account for known lags in claims submission and processing.
- HR1's unqualified exemption for people with substance use disorder is also severely limited by the IFR exclusion from this group of any Medicaid enrollee that is “in stable recovery (in recovery for 5 or more years).” Substance use disorders are chronic, relapsing medical conditions that are treatable and manageable, but not curable in the traditional sense, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR).
- In the IFR, CMS declines to define an individual “with a disabling mental disorder,” instead directing states “to consider whether the...disorder significantly impairs an individual’s ability to comply” with the work requirement. Many mental disorders are chronic conditions, with episodic onsets, that are treatable but not curable.
- In the IFR, CMS is silent as to what impact loss of health coverage would have on these groups.

Administrative Burdens

- The “significantly impairs” requirement will create operational challenges for enrollees, providers, and state eligibility and enrollment staff, as many individuals will need to get their health care provider to evaluate their ability to work—a task that is not a routine part of medical care—and submit their determination for documentation purposes.
- Given the short timeframe for implementation, states had relied upon sub-regulatory guidance from CMS over the course of 2025-2026 that indicated approval of the use of diagnostic codes to determine medical frailty exemptions.
- The new “significantly impairs” criteria will require costly and difficult adjustments to preparations for the initiation of the “community engagement” requirements.
- Meanwhile, the stakes are high. The IFR also includes warnings that CMS will be monitoring states for possible overuse of the medical frailty exemption. CMS has explicitly threatened states with significant financial penalties for any noncompliance with the IFR if they are later found to have determined individuals to be “medically frail in a manner inconsistent” with the IFR’s new, unlawful definition.

Anticipated Impact

- The IFR itself estimates that that the regulation will lead to seven percent of applicable individuals“ los[ing] coverage due to administrative or procedural reasons” like “not responding to verification requests or submitting insufficient documentation.”
- Manatt Health estimates that the IFR implementation approach would increase average annual Medicaid coverage losses by 1.8 million people, from 6.4 million to 8.2 million between FFY 2027–2034—nearly 1 in 10 Medicaid enrollees nationwide.
- It is sobering to consider that nationally, 13.5% of Supplemental Nutrition Assistance Program (SNAP) recipients had lost their benefits as of June 2026 due to work requirements, including a 53% loss of SNAP benefits in Arizona.
- Because HR1 does not include homelessness as a medical frailty on its own, many of the most vulnerable to loss of Medicaid coverage will face significant challenges with compliance.
- When uninsured individuals inevitably have a medical emergency or require essential ongoing care, safety net providers—whom federal law requires to treat patients regardless of ability to pay—will be forced to absorb the costs of uncompensated care.
- Declines in compensated care will increase fiscal burden on already-stretched safety net providers and systems, including community health centers and public hospitals, inevitably eroding our individual and public health workforce and capacity.

Anticipated Impact on EtE Efforts

- All people with HIV have a lifelong serious and complex medical condition for which uninterrupted access to HIV treatment is required to suppress viral load to an undetectable level that sustains optimal health and prevents transmission of the virus to others.
- For these individuals, continuity of care is not optional; it is essential.
- Any interruption in treatment leads to worsened health outcomes, new HIV infections, and significantly higher long-term costs to the healthcare system.
- A prolonged loss of care results in progression to AIDS and premature death.
- The over half of people with HIV between the ages of 50 and 64 face a heightened risk of losing Medicaid coverage for not meeting the new work requirements, as age and HIV stigma pose particular challenges trying to reenter the workforce or navigating complicated exemption requirements.
- It is also important to note that Medicaid coverage has been shown to support participation in the workforce, enabling people to work.
- From an individual, public health, and fiscal perspective, policies that create barriers to continuous coverage HIV care are inefficient, counterproductive, and undermine EtE efforts.



Legal Challenge to the IFR

- On July 29th, 25 States and the District of Columbia, including New York State, sued CMS Administrator Dr. Mehmet Oz and HHS Secretary Robert F. Kennedy, Jr. in Federal District Court in Massachusetts, under the Administrative Procedure Act (APA), challenging several provisions of the IFR, including the “significantly impairs” condition on medical frailty.
- The lawsuit asserts that CMS exceeded its statutory authority by including requirements not supported by the language of HR1 and that are contrary to its intent.
- Indeed, as an Amicus Brief filed by the American Medical Association notes, House Energy & Commerce Chairman Guthrie wrote after the bill passed that, “This policy applies only to able-bodied, unemployed adults . . . Our bill couldn’t be clearer about that . . . You’re exempt if you’re medically frail, which includes anyone who’s blind, disabled, battling a chronic substance-use disorder or living with a serious and complex medical condition like cancer.”
- The states also challenge the IFR limitation on self-attestation as exceeding CMS authority under HR1, provisions governing the optional short-term hardship exceptions, and the 12-month lookback.
- The lawsuit also argued that the IFR provisions should be enjoined as they contradict sub-regulatory guidance from the federal government states relied on to build implementation plans.

Legal Challenge to the IFR

- On July 30, 2026, the District Court denied the States' motion for a preliminary injunction, without prejudice, holding that the states had not demonstrated sufficient irreparable harm, since the federal government had previously represented to the states that it would reimburse 90% of the states' expenses in designing, developing, and installing state eligibility systems to implement the rule.
- In denying the motion, the court clarified that its decision was not a reflection or anticipation of its ultimate views on the merits of the underlying litigation, as the case presents **“difficult issues regarding the scope of Congress's delegation of interpretative authority to the Secretary and the faithfulness to Congressional intent with which the Secretary performed his task”** more appropriate for consideration on a motion for summary judgement.
- The Court indicated its intent to decide summary judgment before the January 1, 2027, implementation of the IRF, noting that if briefing extends past December 31, 2026, and is not accompanied by a discretionary deferral of implementation deadline by the Government, the States remain free to renew their request for injunctive relief (or to file a new request for emergency relief).
- Arguments on Summary Judgment are scheduled for October 20, 2026.



Mitigation

- I will not attempt an exhaustive list of mitigation efforts underway, just a few I am aware of.
- The Community Health Care Association of New York State (CHCANYS) has taken a very proactive approach to assist Federally Qualified Health Centers (FQHCs) and other community health centers with planning the staffing, policies and procedures, and best practices to protect patients from coverage loss.
- The New York City Health Department is launching a Health and Affordability Resource Team (HART) to engage in public information campaigns, grassroots efforts, and individual assistance aimed at mitigating coverage loss among New York City Medicaid enrollees subject to the work requirements.
- I am sure we will hear from the New York State Department of Health on the notices, assistors, and other efforts the State will put in place.
- And of course, I am sure of the commitment of everyone in this room and the organizations you represent to make every effort to ensure that New Yorkers living with HIV and those vulnerable to HIV who rely on Medicaid will have the support they need to retain that vital coverage.



Additional Challenge: Address Verification for All Medicaid Enrollees

- HR1 also imposes new address verification requirements that potentially threaten Medicaid coverage for all enrollees:
 - January 1, 2027: states must have a CMS-approved process to regularly obtain address information for all Medicaid participants
 - October 1, 2029: states must submit addresses & other info such as Social Security numbers to CMS monthly
 - Ostensibly to prevent duplicate Medicaid enrollment in more than one state
- Populations at high risk of Medicaid loss:
 - People experiencing homelessness or housing instability
 - Youth transitioning from foster care
 - People leaving incarceration
 - The half of Medicaid recipients who live in unaffordable housing, resulting in instability & frequent moves
- What can help to inform state implementation:
 - Cross-agency working groups
 - Participation by advocates for vulnerable populations
 - Adequate training of application assistors/navigators

HOUSING WORKS





Thank You!