Issue Brief: Short-Term Hardship Exemptions from Medicaid Work Requirements

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The One Big Beautiful Bill Act of 2025 (OBBBA, Public Law 119-21), establishes mandatory work and community engagement reporting activities, requiring certain Medicaid enrollees to engage in 80 hours of work per month, part-time education, or community service. The law includes mandatory exemptions for medically frail individuals (for more information, see AMA's February 2026 issue brief on Medicaid Work Requirements' Medical Frailty Exemption) and allows, but does not require, states to provide "short-term hardship exemptions" for people seeking health care treatment. Specifically, states may make short-term hardship exemptions available for individuals who:

- Receive inpatient care (or care of a similar acuity); or
- Travel outside of their community for an extended period of time to receive medical services for themselves or a dependent.

States may also make short-term hardship exemptions available for individuals who:

- Live in a county where an emergency or disaster has been declared by the President; or
- Live in a county with high unemployment.

How states define and operationalize these short-term hardship exemptions will be essential to protecting eligible people from losing coverage. Physicians and medical associations can play an important role by:

- Advocating that states take up all of the optional short-term exemptions;
- Ensuring that states adopt clinically grounded policy and operational approaches for implementation; and
- Using all available outreach and engagement strategies to ensure eligible individuals can successfully request and receive a short-term hardship exemption.

This issue brief describes how the OBBBA defines short-term hardship exemptions in statute; outlines key implementation choices facing states and the implications for physicians and patients; and identifies advocacy opportunities for medical associations to help protect coverage for eligible individuals and reduce administrative burdens on physicians and patients.

SUMMARY OF SHORT-TERM HARDSHIP EXEMPTIONS

States may, but are not required to, provide short-term hardship exemptions to work and community engagement requirements for individuals who, for part or all of a month, experience any of the following circumstances:

1. Receive inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of

similar acuity (including outpatient care relating to the above-listed services) as the Secretary of the U.S. Department of Health & Human Services (HHS) determines appropriate.

2. Must travel outside of their community for an extended period of time to receive medical services for themselves or their dependent that are necessary to treat a serious or complex medical condition that are not available in their community of residence.

3. Reside in a county or equivalent unit of local government where an emergency or disaster has been declared by the President.

4. Reside in a county or equivalent unit of local government which has an unemployment rate that is above 8 percent or below 8 percent but 1.5 times the national unemployment rate, subject to a request by the state to HHS.

The first two exemptions related to hospital or other facility stays, or traveling for care, must be affirmatively requested by the individual, and, if granted, apply only for the month to which the request applies. States can identify individuals eligible for hardship exemptions based on an emergency/disaster declaration or high unemployment during the *ex parte* process.

OBBBA requires the Center for Medicare and Medicaid Services (CMS) to release an interim final rule no later than June 1, 2026, and states must implement work and community engagement requirements by January 1, 2027. In light of the implementation timelines and absent formal guidance, states have already begun to develop eligibility workflows, verification systems, and short-term hardship exemption processes, making this a critical window for physician advocates to shape how these exemptions are defined, operationalized, and administered.

STATE ADVOCACY OPPORTUNITIES FOR MEDICAL ASSOCIATIONS

States will decide which optional exemptions to offer and, for medical care-related hardship exemptions, how to define these exemptions and the process for requesting and verifying an exemption. Ensuring that all exemptions are offered and that eligible individuals can successfully receive these exemptions will be crucial to safeguarding Medicaid coverage for eligible people. As individual states develop their policy and operational plans to implement work requirements by January 1, 2027, state medical associations and national medical specialty societies should consider the following advocacy opportunities as they engage with policymakers:

- **Encourage your state to take up all short-term hardship exemption options.**

  Providing all of the available exemptions will be essential to helping patients who face challenging circumstances successfully apply for or renew their health coverage. Because the hardship exemptions were made optional by Congress, state must affirmatively act to operationalize them. Failure to adopt these exemptions may result in individuals losing coverage when they need it the most—while they are actively seeking or receiving care. Medical associations should communicate clearly to their state Medicaid agencies and legislators that all of the optional hardship exemptions are essential to preventing coverage disruptions.

- **Help establish clinically grounded definitions.**

  Though CMS guidance has not been issued, CMS will likely set certain parameters around these exemptions. States will likely have the flexibility—within federal parameters—to define key aspects of the exemptions related to hospital or other facility stays or traveling for care. For example, states will need to define the range of inpatient and related outpatient care that would meet the hardship exemption for patients who receive inpatient services. Specifically, states are tasked with defining the types of medical treatment that would fall under the “similar acuity” definition to meet the exemption.

States will also be responsible for establishing parameters for the exemption for patients who need to travel for medical care. Specifically, states will need to define what qualifies as being "outside one's community," including setting the geographic boundary for that determination—for example, travel outside the individual's county of residence, if appropriate given the state's geographic context. States will also need to define what constitutes an "extended period of time," which could be, for example, a period longer than one week.

Without physician input, these definitions risk being drawn too narrowly, potentially excluding vulnerable patients. Medical associations should work with states to determine: (1) which services of "similar acuity" (including related outpatient care) should be considered for the inpatient exemption; and (2) what constitutes a *minimum threshold* for travel hardships (e.g., distance, frequency, necessity).

- **Advocate for streamlined exemption request processes.**

  Because exemptions for inpatient care and medical travel must be affirmatively requested by the individual, states should take steps to simplify processes to minimize the risk that some people fall through the cracks. Request processes should be embedded in existing workflows, including applications, renewal forms, and all other modalities where individuals report changes in circumstances mid-coverage year, and should employ plain-language screening questions and easy to understand examples and definitions so that individuals are able to self-identify. States should also ensure access to paper, phone, in-person and electronic submission options, and utilize brief standardized attestation forms.

  Additionally, since hospitals already conduct presumptive eligibility determinations, states should work with institutions to ensure these processes automatically screen for the inpatient hardship exemption. All individuals admitted for inpatient care automatically satisfy this short-term hardship exemption. Identifying eligible patients at the point of admission will minimize coverage disruptions.

- **Advocate against unnecessary documentation requirements for patients and physicians.**

  In general, OBBBA requires states to rely on data as much as possible when identifying and verifying exemptions before requesting individuals take any additional steps (i.e., states must use *ex parte* processes). Medical associations should hold states to that standard and advocate that data matching, such as use of Medicaid claims or encounter data to identify patients who are eligible for exemptions, be used as the primary verification took for short-term hardship exemptions when an exemption is requested.

  In situations where data are not available, such as recent inpatient care not yet reflected in claims or in instances where medically necessary travel cannot be verified through data, states should build processes that are as streamlined as possible. For 2027, CMS has indicated that states may rely on an individual's auditable self-declaration if no data are available, which will be important to reducing administrative barriers for patients. By contrast, requiring individuals to submit physician-attestation forms or medical records would create more administrative steps for patients as well as physicians, making it more likely that eligible people will lose their coverage and further strain physician workloads.

  Medical associations should advocate that individuals not be required to seek clinician certifications; doing so would add significant process hurdles for patients and add administrative burdens for physicians. Instead, simple, standardized self-attestation forms should be available when a hardship exemption cannot be verified using existing data sources. To the extent states (or CMS) require individuals to submit documentation from physicians and other healthcare professionals, medical associations should advocate for simple, accessible, and standardized attestation forms for clinicians. Unnecessary documentation diverts clinical time from patient care and can function as a barrier to access.

- **Engage on exemption renewals and transitions.**

  People who qualify as medically frail—defined as people with a substance use disorder; disabling mental

disorder; physical, intellectual, or developmental disability; serious or complex medical condition; or who are blind or meet the Social Security Administration's disability standard—are exempt from work and community engagement requirements. In some instances, people who qualify for the inpatient or medical travel hardship exemptions may also qualify as medically frail, making them statutorily exempt from work requirements.

Medical associations should work with state Medicaid agencies to define reasonable renewal standards for short-term hardships that reflect patterns of care, including recovery timelines and ongoing post-acute care. Medical associations can also advise on when individuals should transition from a short-term hardship exemption to a medical frailty exemption to prevent unnecessary coverage churn. Medical associations should encourage Medicaid agencies to use inpatient and high-acuity claims data via Medicaid Management Information Systems and Health Information Exchanges, to the extent applicable.

AMA ADVOCACY

AMA policy opposes work requirements as a criterion for Medicaid eligibility (H-290.961), and the AMA continues to make preservation of access to Medicaid a core advocacy priority at both the federal and state levels. As states prepare to implement Medicaid work requirements and associated exemption processes beginning in 2027, the AMA remains focused on minimizing coverage disruptions, reducing administrative burdens on patients and clinicians, and ensuring that exemption policies, particularly those related to medical frailty, are clinically appropriate and workable in practice.

At the federal level, the AMA has advocated to CMS for increased state flexibility in designing and administering work requirement policies, streamlined and accessible exemption processes, safeguards to prevent inappropriate coverage losses, robust data monitoring and transparency, and meaningful engagement with physicians and other stakeholders during implementation. The AMA continues to closely monitor CMS guidance and subregulatory actions related to work requirements and exemptions and to raise concerns as implementation details evolve.

The AMA Advocacy Resource Center is committed to supporting state medical associations and national medical specialty societies as states undertake OBBBA implementation. This includes sharing federal updates and analysis, elevating physician perspectives, and providing technical assistance and advocacy support related to medical frailty definitions, exemption duration, documentation standards, and beneficiary protections.

Please contact Annalia Michelman, Senior Attorney in the AMA Advocacy Resource Center, at annalia.michelman@ama-assn.org for assistance with Medicaid work requirements in your state.