State Advocacy Roadmap: Short-Term Hardship Exemptions from Medicaid Work Requirements

JULY 2026

The One Big Beautiful Bill Act (OBBBA, Public Law 119-21), establishes mandatory 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 several categories of people, such as medically frail individuals, and allows, but does not require, states to provide short-term hardship exemptions.

If offered by the state, the short-term hardship exemption applies when an individual receives certain inpatient, institutional, or similar acuity services; must travel outside of their community for an extended period of time to receive medical care for themselves or a dependent; lives in an area where an emergency or disaster has been declared; or lives in an area with high unemployment.

How states define and operationalize these exemptions will be essential to protecting eligible people from losing coverage. This advocacy roadmap focuses primarily on the two hardship exemptions related to medical care.

SUMMARY OF SHORT-TERM HARDSHIP EXEMPTIONS

In June 2026, CMS published an interim final rule (IFR) implementing Medicaid community engagement requirements established by OBBBA, including the optional short-term hardship exemptions. The regulations take effect on July 31, 2026.

Under OBBBA and the IFR, states may elect to deem individuals compliant with the community engagement requirement for any month in which, for part or all of a month, they:

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;
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.

A state electing the short-term hardship option may not limit its election to only some of these statutory categories. If offered, all four options must be provided. Certain categories nevertheless require additional state action. In particular, a state must request CMS approval to effectuate an unemployment-based exemption.

The two exemptions related to medical care must be affirmatively requested by the individual or someone permitted to act on the individual's behalf. If granted, an exemption applies to the month or months in which the qualifying circumstances occurred. An individual who qualifies for a short-term hardship exemption is deemed to have satisfied

© 2026 American Medical Association. All rights reserved.

the community engagement requirement for the applicable month; the exemption does not exempt the individual from community engagement requirements in future months. States must apply the emergency/disaster and high unemployment exemptions through *ex parte* processes, without requiring individual requests or documentation, once the applicable conditions and procedural requirements are satisfied.

A hardship event counts as compliance for the month in which it occurs. At application, the event must fall within the one-, two-, or three-month period immediately preceding the application month that the state has selected for assessing compliance. At renewal, or during a more frequent reverification, the event may count for a month within the applicable review period. An event outside the relevant review period cannot be used to establish compliance for the determination at issue.

Through December 31, 2027, when reliable data is unavailable, states may require documentation or accept self-attestation from the individual, another adult in the household, or an authorized representative. Beginning January 1, 2028, states must use reliable information when it is available. When reliable information is unavailable, states generally must request documentation. If documentation is not reasonably available, states must accept a reasonable explanation that includes sufficient information to be verified.

States electing the short-term hardship option must notify affected individuals that the exemptions are available and explain how the medical care-related exemptions may be requested. States must provide this information as part of their broader outreach and notice obligations relating to the community engagement requirement.

STATE FLEXIBILITY IN DESIGNING SHORT-TERM HARDSHIP EXEMPTIONS

Although OBBBA and the IFR establish a federal framework, states retain discretion to define and operationalize several terms that will determine how broadly the exemption protects patients. Medical associations should consider focusing their advocacy on the following state decisions:

Inpatient and services of similar acuity exemption

Under OBBBA, an individual qualifies for a hardship exemption if they receive inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), inpatient psychiatric hospital services, or such other services of similar acuity, including related noninstitutional care.

- ***Defining "inpatient psychiatric hospital services"***

  States may either (1) adopt their existing state-law licensure definition of a psychiatric hospital or psychiatric unit, applied regardless of Medicaid enrollment or state plan coverage status, or (2) adopt a different state-law or universal coding definition (e.g., DRG- or revenue-code-based, tied to claims data). CMS instructs states to choose whichever definition its data systems can verify with the least manual review.

- ***Defining "other services of similar acuity" in institutional settings***

  The IFR specifies that "other services of similar acuity" includes 1) inpatient services furnished in a critical access hospital; 2) inpatient services furnished in an emergency hospital recognized under the state's licensure authority; 3) inpatient services furnished in an institution for mental diseases (IMD), regardless of whether federal Medicaid matching funds are available for the stay; and 4) inpatient services furnished by other facilities not covered under Medicaid, but otherwise recognized by the state. States may also recognize other institutions they separately license, certify, or otherwise recognize as furnishing acute, sub-acute, or long-term institutional care equivalent in intensity to the statutorily defined services.

© 2026 American Medical Association. All rights reserved.

- ***Defining "other services of similar acuity" in non-institutional settings***

  The IFR specifies that "other services of similar acuity" also includes non-institutional services that, but for receipt of those services, would likely result in the individual receiving inpatient care. The rule does not establish an exhaustive list of qualifying non-institutional services. Instead, states may identify qualifying services categorically, establish a case-by-case pathway, or use both approaches.

  If the state chooses a categorical approach, it must select which non-institutional services to deem automatically qualifying. CMS offers the following examples, of which a state may select all, some, or none and may identify additional qualifying services:

  - Hospital-at-home services under a CMS-approved Acute Hospital Care at Home waiver or equivalent, where the hospital documented the individual met inpatient admission criteria when services began
  - Partial hospitalization program (PHP) or intensive outpatient program (IOP) services for a mental health or substance use disorder, where clinical documentation shows the individual met or would meet inpatient psychiatric admission criteria absent PHP/IOP enrollment
  - Intensive residential treatment, including licensed/certified residential substance use disorder treatment and residential crisis stabilization, where placement criteria are functionally equivalent to inpatient/institutional placement criteria
  - HCBS waiver or state plan HCBS services, where the individual has an active nursing-facility or ICF/IID level-of-care determination
  - PACE enrollment, consistent with the independent nursing-facility level-of-care determination required for PACE

  States may also establish a case-by-case pathway for individuals receiving non-institutional services that are not included in the state's categorical definitions. In designing this pathway, states must decide who may submit supporting documentation, such as the individual, a managed care plan, a treating clinician, or an authorized representative. States may also define the clinical documentation necessary to demonstrate that the services prevented or substituted for inpatient or institutional care.

Medical travel exemption

An individual qualifies for the medical travel exemption if the individual or their dependent must travel outside of their community for an extended period of time to receive medical services necessary to treat a serious or complex medical condition that are not available within their community of residence. For purposes of this exemption, the IFR defines a serious or complex medical condition by reference to the state's definition of medical frailty.

- ***Defining "outside the community"***

  CMS identifies two general approaches states may use to define "community": 1) a political subdivision approach, under which travel must occur outside the individual's county, municipality, school district, or other state-defined subdivision; or 2) a geographic distance approach, such as a mileage threshold, a travel-time threshold, or a requirement that travel involve an overnight stay.

  A state may not define an individual's "community" as the entire state, which would improperly limit the exemption to only those who must leave the state to obtain care.

© 2026 American Medical Association. All rights reserved.

- ***Defining "extended period of time"***

  A qualifying hardship need not span a full month, and a state may not require a full-month absence from the community. A state may, however, establish a shorter minimum duration, such as at least one overnight stay or a specified number of consecutive days, provided the standard does not functionally require a full-month absence.

- ***Defining "services not available in the community"***

  States must establish a methodology for determining when necessary medical services are unavailable within the individual's community. For example, a state could draw from standards used to determine eligibility for non-emergency medical transportation or related coverage of mileage, meals, lodging, and attendant costs.

STATE ADVOCACY OPPORTUNITIES FOR MEDICAL ASSOCIATIONS

As states develop policy and operational plans to implement community engagement requirements, state medical associations and national medical specialty societies should consider the following advocacy opportunities:

- **Encourage the state to elect the short-term hardship exemption option.**

  Because the IFR makes adoption all-or-nothing, a state that declines the option forecloses hardship protections for hospitalized patients, medically necessary travelers, disaster-affected counties, and high-unemployment counties alike. Medical associations should urge state Medicaid agencies and legislators to adopt the short-term hardship option and maintain it as part of the state plan. Declining the option should not be treated as merely an administrative decision; it would expose individuals experiencing serious but potentially temporary circumstances to otherwise avoidable coverage losses at a time when coverage is needed most.

- **Advocate for the broadest defensible definitions of qualifying care.**

  Encourage states to recognize the full range of institutional services identified by CMS and to adopt broad categorical definitions of qualifying noninstitutional care. At a minimum, these definitions should include hospital-at-home services, partial hospitalization and intensive outpatient programs, residential treatment, qualifying home- and community-based services, and PACE.

  Because no categorical list will capture every clinically comparable service, states should supplement categorical definitions with an accessible case-by-case pathway. That pathway should permit consideration of treating clinician documentation and other reliable clinical information demonstrating that the services prevented or substituted for inpatient or institutional care.

- **Push for reasonable medical travel standards.**

  Encourage states to define "community" and "extended period of time" in ways that reflect the practical burdens patients and families experience when traveling for specialized care.

  States should avoid distance or duration thresholds that exclude individuals who must devote a substantial portion of a day to travel, make repeated trips, remain away overnight, or arrange transportation and caregiving for a dependent. States should also recognize that a service may be functionally unavailable when it cannot be obtained within a clinically appropriate timeframe, even if a nominal provider of that service is located within the defined geographic area.

© 2026 American Medical Association. All rights reserved.

- **Urge minimal reliance on patient-initiated processes.**

  Although the statute requires the medical care-related exemptions to be requested by the individual or by someone acting on the individual's behalf, states should use available claims, encounter, managed care, and prior authorization data to identify potentially eligible individuals and facilitate completion of the request.

  Encourage states to work with hospitals to integrate hardship screening and assistance into hospital admission and discharge processes, as well as into eligibility-assistance programs, presumptive-eligibility workflows, applications, renewals, and change-in-circumstances reporting. Applications and renewal forms should include concise, plain-language questions that allow individuals to identify qualifying hospitalizations, high-acuity treatment, and medical travel without having to understand the legal terminology. Additionally, hospitals, clinicians, authorized representatives, and other individuals permitted to act on a beneficiary's behalf should be able to initiate or assist with a request.

- **Avoid unnecessary physician documentation and administrative burden.**

  States should not require documentation from a physician or other healthcare provider when reliable information already establishes that an individual received qualifying care or traveled for necessary medical treatment. When additional information is necessary, states should accept existing medical records, discharge documentation, treatment plans, prior-authorization records, managed care records, and documentation from an appropriate range of treating health care professionals. States should also avoid processes that depend on uncompensated, time-intensive paperwork from physician practices. Unnecessary documentation requirements may delay determinations, increase administrative burden, and prevent eligible individuals from obtaining an exemption.

- **Push for accessible request processes.**

  Encourage states to accept requests online, by telephone, by mail, and in person and through the same channels individuals use to submit Medicaid applications and renewal information. States should permit requests to be made before, during, or after the qualifying event, provided the event falls within the applicable review period. Individuals should receive adequate time and assistance to provide any necessary information.

- **Advocate for coordinated hardship exemption and medical frailty processes to reduce churn.**

  States should use available claims and encounter data to identify individuals who may qualify for a longer-term exemption rather than repeatedly routing them through short-term hardship processes. Encourage states to design the short-term hardship and medical frailty processes so that evidence of inpatient care or other high-acuity services also triggers an assessment of whether the individual qualifies for the medical frailty exclusion. States should also establish clear procedures for transitioning individuals from a short-term exemption to the medical frailty exclusion when their condition is ongoing.

- **Urge the state to monitor implementation and publicly report outcomes.**

  Encourage states to collect and publicly report data on hardship exemption requests, approvals, denials, processing times, appeals, and coverage losses. States should also monitor whether eligible individuals are failing to receive exemptions because they did not know the option was available, could not obtain required documentation, or experienced delays in claims or encounter data. Medical associations can help states identify operational problems and recommend corrective action as implementation proceeds.

© 2026 American Medical Association. All rights reserved.

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 Director in the AMA Advocacy Resource Center, at annalia.michelman@ama-assn.org for assistance with Medicaid work requirements in your state.

© 2026 American Medical Association. All rights reserved.