



Making Medicaid Work Requirements Work in California

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Without ensuring equitable verification of Medicaid eligibility, many of California's Expansion population are at risk of losing their health insurance. Loss of access is a loss for everyone: Individuals will experience negative health outcomes along with spiraling medical debt; healthcare providers will lose billions in revenue and incur greater write-offs of uncompensated care; and, as costs shift from the federal government to the states, California will pay a greater share of safety net costs.

HR 1, also known as the One Big Beautiful Bill Act, introduces "community engagement" (i.e., work) requirements for Medicaid "as a condition of eligibility for medical assistance" (Sec. 71119). These work requirements go into effect as of January 1, 2027 – but only for the Expansion Medicaid population, adults who qualify for Medicaid solely because their income is less than or equal to 138% of the federal poverty level. As of May 2025, the Expansion population in California included nearly 5 million adults, about [one third of the state's total 14.5 million Medicaid enrollees](#).

Individuals Demonstrate Eligibility

HR 1 outlines multiple options for individuals to demonstrate compliance with the new Medicaid work requirements. These options include engaging in a minimum of 80 hours of work, work program, educational program, community service, or some combination thereof within a month, or having a monthly income of at least \$580.

But eligibility does not depend solely on individuals' actions, e.g., whether in a given month they have worked the requisite number of hours. Eligibility also depends on how states verify that sufficient work has been performed.

[California's approach to implementing eligibility changes](#) under HR 1 aims to streamline the verification process and protect coverage stability. [AB 2161: Medi-Cal: work or community engagement](#), introduced in the California Assembly in February 2026 by Health Committee Chair Mia Bonta, supports efforts to ensure that all California's eligible Medicaid applicants and beneficiaries can obtain and maintain coverage with the least administrative burden.

California Verifies Eligibility

California's implementation plan emphasizes protecting Medicaid coverage while minimizing administrative burden. However, several important omissions in this plan, outlined below, undermine California's commitment to equitable healthcare access.

- *The state's reliance on ex parte information makes it easier to verify individuals' compliance with (or exception from) the Medicaid work requirement – but only for some, not for all*

HR 1 instructs states to use reliable *ex parte* information, such as payroll data, to reduce the amount of information that individuals must provide to demonstrate their compliance with the work requirement. According to December 2025 guidance from the Center for Medicaid and CHIP Services, the state may not request additional documentation from individuals unless it is unable to establish that the work requirement has been met using *ex parte* information.

Focusing on connecting state databases to facilitate the verification process means that some individuals are likely to fall through the cracks. Tracking compliance is more straightforward for individuals engaged in activities such as paid employment, work programs, or education that leave electronic traces (e.g., payroll transactions). In contrast, community service leaves no traces in the electronic record. Reliance on automated verification will relieve administrative burden for many, but not all, Medicaid applicants and beneficiaries. Automation, in itself, is insufficient for equitable eligibility determinations.

- *Individuals do not know whether they are in the Medicaid Expansion population*

Many individuals do not fully understand the relationship between their income and their eligibility for Medicaid, let alone the distinction between eligibility for Medicaid and Medicaid Expansion. It may also not be clear to providers at the point of service how an individual qualifies for Medicaid, and whether the individual is part of the Expansion population.

- *Notification to individuals of their work requirement is insufficient outreach*

HR 1 directs states to periodically notify applicable individuals of their work requirement, how to demonstrate compliance with this requirement, and the consequences of noncompliance. This assumes that individuals will read the notifications, understand the information they contain, and take action accordingly. In practice, many individuals may lose their Medicaid coverage without realizing it and incur enormous uncovered medical expenses as a result. Medical debt not only harms individuals and their families, but also providers and healthcare systems that have to write off uncompensated care.

Focusing solely on outreach to individuals misses the critical role of community-based organizations (CBOs) in information pathways. When individuals lose their Medicaid coverage, many turn to CBOs, navigators, or community health workers for assistance. It is therefore essential that CBOs, navigators, and community health workers be well informed about the Medicaid work requirement, verification requirements, and state procedures for granting exceptions.

- *Timelines for individual and state actions do not align*

HR 1 specifies several time frames within which Medicaid applicants or beneficiaries need to take action. For example, individuals found noncompliant with the work requirement have 30 calendar days to demonstrate either that they are compliant, or that the work requirement does not apply. Short-term hardship exceptions are granted for one month at a time. But these mandated time frames apply only to individuals; there are no similar timelines imposed on state verification processes. If the state verification processes extend beyond 30 days, individuals may still lose their coverage even if they are compliant with the work requirement or eligible for an exception.

How to Ensure Equitable Work Verification Processes for All Californians

To ensure equitable access to Medicaid and maintain a healthy California, the California Department of Health Care Services should implement the following recommendations:

- Identify documentation options for individuals demonstrating compliance through community service so that the administrative burden is no greater than for individuals demonstrating compliance through work, work programs, or education.
- Establish clear administrative timelines for determining compliance with the work requirement.
- Invest in outreach to CBOs and community-based health workers, not just IT infrastructure.
- Provide free training and resources so that CBOs and community-based health workers can best assist individuals in meeting, and appropriately documenting, the new work requirement.

As [California Assemblymember Esmeralda Soria](#) noted, the Medicaid “work requirement is going to become more of a paperwork requirement.” State verification processes play a critical role in determining Medicaid eligibility. It is essential that California take action to ensure eligible Californians do not lose access to Medicaid due to paperwork burdens or administrative delays.

Read more in Deborah Lefkowitz, “‘Doing’ eligibility through income thresholds: Organisational practices in US financial assistance programmes for women with breast cancer,” *Critical Social Policy* 45, no. 4 (2025).