Preparing for Medicaid Work Requirements: Strategies for Supportive Housing Providers Questions and Answers (Q&A)

February 26, 2026

1. ***Are there options for states to file waivers to delay implementation of community engagement rules to 2028?***

Response: States can delay implementation but only under specific conditions set in H.R.1. (Public Law 119-21) Under section 71119, states must implement Medicaid community engagement (work requirements) by January 1, 2027, unless they request an exemption and receive federal approval to delay no later than December 31, 2028.

To receive an extension beyond the 2027 deadline, a state must demonstrate a "good faith effort" toward compliance and provide:

- Actions already taken
- Documented significant barriers
- A detailed implementation plan and timeline, and
- Routine progress reports

Bottom line – States may delay implementation of work or community engagement requirements but only if they secure an HHS-approved exemption, and delays cannot extend beyond December 31, 2028.

2. ***As written, do the changes in H.R.1. only affect people who fall under the new requirements (for example, non-disabled individual adults would not be currently receiving Medicaid in non-expansion state), or will this change result in criteria differences between expansion and non-expansion states?***

Response: The new federal requirements apply primarily to the Medicaid expansion population, and H.R.1 does *not* require non-expansion states to adopt expansion or newly cover adults who are currently ineligible. However, differences *will* exist between expansion and non-expansion states, because expansion states must impose the new requirements on their expansion populations, while non-expansion states only apply them if they cover a similar population through another state specific pathway.

States that have *not* expanded Medicaid **are not required** to implement community engagement requirements **unless they offer coverage to the "expansion like"**

population through another pathway (e.g., Georgia or Wisconsin, which cover certain adults up to 100% FPL even without ACA expansion).

Bottom line – These changes do create new differences between expansion and non-expansion states because the law mandates requirements only where relevant eligibility groups already exist.

Expansion states:

- Must enforce work requirements for all eligible expansion adults (age 19–64).
- These states will see large operational and eligibility changes affecting a substantial portion of their adult population.

Non-expansion states:

- Do **not** have to adopt the new requirements unless they have an alternate coverage pathway that includes this adult population.
- In traditional non-expansion states, many nondisabled childless adults simply remain ineligible, meaning the new federal requirement does not introduce new obligations or populations.

3. Will there be any "wiggle" room for households who may struggle for one month to meet the new requirements? Or is it "don't meet requirements" one month and they are off Medicaid the next? How long until they can reapply?

Response: Yes — but flexibility is limited and depends on whether the person is a *new applicant* or an *existing enrollee*. The law does not immediately terminate Medicaid for a single missed month in all cases, but it also does not allow unlimited flexibility. States can terminate as soon as 30 days after a deadline, but they must reach out to beneficiaries and explain to them how they must comply.

- Existing Medicaid enrollees must meet the requirement at least one month in each 6-month redetermination period.

  Beginning January 2027, expansion of population enrollees must satisfy the work or community engagement requirement for at least one month within each 6-month eligibility period.

  States *may choose* to be stricter. States are allowed to require individuals to meet the requirement more frequently than once every six months — including every single month — but this is optional.

- New Medicaid applicants must show they met the work or community engagement requirement for 1 to 3 consecutive months before applying, with the exact number of months (between 1 and 3 months) chosen by the state.

  Depending upon what the state decides, a household trying to newly enroll may

need to demonstrate up to three consecutive months of compliance before gaining eligibility.

4. ***What happens if someone fails to meet the requirements? When can they reapply? The federal statute requires that eligibility be conditioned on satisfying the community engagement requirements, but the precise "penalty" mechanics (e.g., grace periods; suspension vs. disenrollment) are to be finalized in Centers for Medicare & Medicaid Services (CMS) regulation.***

   If disenrolled for failure to meet requirements, individuals may reapply as soon as they can meet the preapplication requirement, which is 1–3 consecutive months of community engagement activities, depending on the state.

   For example:
   - If a state requires 2 consecutive months for new applicants,
   - and a beneficiary is disenrolled for noncompliance,
   - They must complete 2 compliant months before their application is approved.

   There is no federally mandated waiting period beyond this required demonstration of compliance.

5. ***What do you mean by $580 or less per month?***

Response: The $580 per month figure comes directly from the statute (H.R.1. / Public Law 11921) — in Section 71119. This reflects how the law defines one of the ways a Medicaid enrollee can satisfy the work requirement without documenting hours: If someone earns at least $580 in a month, that income is treated as equivalent to working 80 hours at the federal minimum wage amount.

6. ***What monthly income is considered? Does SSI or other federal/state funding count as monthly income?***

Response: Most people receiving Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Temporary Assistance for Needy Families (TANF) would *not* be in the expansion group and therefore would *not* be subject to the new work or community engagement requirements. Supplemental Nutrition Assistance Program (SNAP) participation does not affect Medicaid eligibility group, so SNAP recipients *may or may not* be in the expansion group depending on their state's rules and their personal situation.

In terms of other funding sources, the statute (HR 1 or Public Law 119-21) does not define income. CMS has stated that additional definitions and operational standards will come via regulation (the interim final rule due by June 2026). The safest interpretation is that it is tied to earned income, but this is *not* confirmed in law or guidance.

7. ***Is a care giver for a child under age 5 count?***

Response: Yes, caregivers — including those caring for a child under 5 — are exempt from the Medicaid work or community engagement requirements under H.R.1. CMS December 2025 guidance (summarizing how states must implement the new law) also lists caregiving as one of the exemptions.

Although H.R.1. and the CMS December guidance does not specify an age cutoff (e.g., under age 5), it does confirm that caregivers — including parents caring for dependent children — are exempt from the work requirement. States do *not* have the discretion to override federal exemptions, meaning caregivers must be excluded from the community engagement requirement.

8. What happens if someone is in the process of applying for MCD (Medicaid), are they exempt?

Response: If they are applying right now and are in a state that has not opted to start their community engagement requirements early, then they are most likely not required to fulfill the requirement. States are required to provide advance notification to affected individuals before community engagement requirements begin. This is not part of H.R.1. or Public Law 119-21 but was in CMS guidance from December 8, 2025.

9. What does rating of total mean?

Response: The rating of total comes from the exemption for certain veterans. In the CMS December 8, 2025, Information Bulletin or guidance, the list of exclusions from the Medicaid community engagement or work requirements includes: "*A veteran with a disability rated as total under* 38 U.S.C. § 1155." There is a schedule of ratings for disabilities based on the average impairments of earning capacity resulting from specific injuries or combinations of injuries.

A veteran with a total disability rating (100% schedular or Total Disability based on Individual Unemployability) is completely exempt from all Medicaid community engagement or work requirements. States cannot require them to complete, report, or verify work hours, community service, or any other engagement activities.

A disability "rated as total" means: the veteran has a VA disability rating of 100%. This includes any of the following:

- 100% schedular rating

The VA has determined that the veteran's service-connected condition(s) meets the criteria for a full 100% rating.

- Total Disability based on Individual Unemployability (TDIU)

Even if schedular ratings add up to less than 100%, VA may grant *"total"* disability if the veteran cannot maintain substantial gainful employment because of service-connected conditions.

Both count as “rated as total” for exemption purposes.

10. Does SSI also include SSDI?

Response: Hopefully this answers your question. SSI eligibility and SSDI eligibility are *not* treated the same for traditional (or “classic”) Medicaid. If a person receives SSI, they are considered *categorically eligible* for Medicaid in the majority of states. A small number of states use more restrictive Medicaid eligibility rules for “aged, blind, or disabled individuals” than the federal SSI program uses. In those states, people who receive SSI are not automatically eligible for Medicaid and must go through a separate disability-based Medicaid determination under that state’s more restrictive rules. Those states include Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia.

People receiving SSDI are considered disabled for Social Security purposes, but SSDI does not automatically qualify someone for Medicaid. For Medicaid, SSDI recipients must still meet the state's Medicaid disability category + income and resource limits.

11. Can you talk more about the drug treatment program?

Response: Both the statute and CMS Guidance Dec 8 2025 confirm that substance use disorder (SUD) treatment is an explicit exemption from the community engagement/work requirements. CMS guidance from December 8, 2025 outlines in more detail exclusions and exceptions to the work requirement. If someone is currently enrolled in a state licensed and recognized SUD treatment program, they are exempt from the Medicaid community engagement requirement.

Neither the statute nor the December 2025 CMS bulletin provides a formal definition of:

- What qualifies as a “SUD treatment program”
- Whether peer recovery services qualify
- Whether harm reduction participation (e.g., syringe services) counts
- How states must verify participation

These specifics are expected to be defined in the Interim Final Rule due June 2026, which CMS is required to issue.

12. What if someone is currently homeless? Are they unable to work because of that?

Response: Homelessness is not listed as an explicit statutory exemption. We are aware of one state that has requested CMS to consider homelessness as a short-term hardship exemption. As of this writing, a decision on whether CMS will accept this is unknown. This could be considered part of an advocacy agenda in your state.

13. Is there clarity on who is included in 'complex medical conditions'? For example, would this include persons living with HIV?

Response: The term medically frail is defined in H.R.1./Public Law 119-21 and in the December CMS guidance as an exclusion to the community engagement requirement.

An individual who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual: who is blind or disabled (as defined in section 1614 of the Act); with a substance use disorder; with a disabling mental disorder; with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition;

Further clarification, if any, is expected to be released by CMS via regulation (the interim final rule due by June 2026). CSH is holding a webinar on March 26, 2026, on how states can use the medically frail designation to help people retain coverage.

14. Do states decide what documentation is accepted to determine medically frail, or is the documentation laid out by CMS, etc.?

Response: States decide what documentation is acceptable. The statute does not prescribe a specific documentation list for determining medical frailty, nor does the December CMS guidance. CMS guidance only requires states to verify exemptions and create communication processes. States determine how to operationalize the exemption.

There is a requirement for states to use ex parte verification to identify medically frail individuals before requesting documentation from a member. Ex parte verification is when states use existing data sources to verify Medicaid eligibility without requiring documentation from individuals or members. For example, states could use their Medicaid claims systems and other data systems to ensure that people with relevant diagnoses are not deemed ineligible for Medicaid. This requirement comes directly from HR 1/Public Law 119-21. CMS has *not yet* released its detailed operational rules, but the statute mandates that ex parte must be used.

15. Does the drug treatment program have to be inpatient, or can it be outpatient?

Response: Please see the response to question 10 above.

16. "A disabling mental health disorder" - do they have to be on SSDI or are there eligible diagnoses?

Response: Please see the response to question 12 above.

17. Is this being in rehab or enrolled in ongoing outpatient programs like the Medication Assisted Treatment (MAT) program?

Response: Please see the response to question 10 above.

18. ***How is "serious or complex medical condition" defined?***

Response: "A serious or complex medical condition" is part of the medically frail description in H.R.1./Public Law 119-21. However, the statute does not provide a definition, criteria, or operational meaning for what counts as "serious" or "complex." Even in other Medicaid regulations (42 CFR 440.315(f)) where the same terms are used, there is no diagnosis list or technical definition. This leaves states responsible for applying it and perhaps with considerable flexibility in defining medical frailty operationally. If you work with people with a particular diagnosis, such as HIV, you may want to advocate with the state to have this diagnosis qualify as a "serious or complex medical condition" and qualify people for an exemption.

19. ***Are work requirements for SNAP different from Medicaid? Where can we find more information on SNAP requirements?***

Response: The Center for Health Care Strategies has a useful brief that includes a nice table, comparing the community engagement/work requirements between SNAP and Medicaid.

20. ***We will likely discuss how to show the state that someone meets the exemption for individuals with SUD / mental health conditions.***

Response: Consider joining us in March and April for more webinars on H.R.1. implementation.

- Register for March 26 Webinar on Strategies to limit health insurance coverage losses- Medically Frail and SOAR
- Register for April 22 Webinar on HR1 and Immigration Restrictions on Medicaid Coverage

21. ***To be clear, is this for the overall work requirements for health benefits? I was aware and working with folks for SNAP requirements, exemptions, etc., is this the rest that is being rolled out for everyone on Medicaid benefits, not just food stamps?***

Response: Yes, this is for Medicaid benefits. States must verify compliance with work requirements at both the initial application and at a six-month redetermination for continued Medicaid coverage.

22. ***How are consumers supposed to substantiate volunteer hours? Signed letter from an organization?***

Response: This is an area still to be determined by each state.

23. If someone has EAEDC from their state, does that qualify as a disability like SSI/SSDI?

Response: EAEDC (Emergency Aid to the Elderly, Disabled, and Children) is a Massachusetts state-funded program that provides cash assistance and Medicaid coverage to certain low-income residents who do not qualify for SSI and are unable to work due to a disability (lasting at least 60 days). This is state-specific and state funded, and as of this date, there is no information found on what changes, if any, the State of Massachusetts is planning for this program.

24. And this is true - I have a client that makes $579 income and was told to get more hours or find a second job, and she did.

Response: The statute states that an individual meets the community engagement requirements if they have "a monthly income of no less than $580 per month, which is the monthly income equivalent to at least minimum wage for 80 hours." However, income is only one of the ways to meet the requirements. An individual earning $579 per month could still qualify by meeting one of the other community engagement criteria, such as

- Working, in total, at least 80 hours per month
- Participating in a work program or job training
- Being in an educational program at least half-time
- Participating in community service

These are the minimum levels allowed. States may choose to go higher (more than 80 hours per month), but they won't be able to go lower. It is good to always check what your state will require.

25. What does look back mean?

Response: In the context of Medicaid's work requirements, *look back* refers to a period of past months during which applicants must prove they already met the work requirements before they can enroll in Medicaid or continue in Medicaid if they are already enrolled.

26. Housing Related Social Needs programs (FCS in Washington State) codify client's disabling conditions during the approval process. Would this documentation that is kept by the state Health Care Authority exempt clients from work requirements?

Response: This will be up to the Washington State HealthCare Authority. States determine specific documentation that they will use to verify exemptions and eligibility criteria. There is a requirement for states to use ex parte verification to identify medically frail individuals (where the disabling condition falls) before requesting documentation from a member. This requirement comes directly from HR 1/Public Law 119-21. CMS has *not yet* released detailed operational rules, but the statute already mandates that states must use ex parte for verification, meaning they are required to use existing data sources to verify Medicaid eligibility without requiring documentation from individuals or Medicaid members.

27. If someone is homeless, are they exempt?

Response: Please see the response to question 11 above.

28. If someone is in the early stages of applying for SSI, will that suffice for the disability exemption, or do they need to be approved for the program before their work requirements are waived?

Response: Based on what we know at this time, the law and CMS guidance define exemptions based on an established disability status, not based on pending SSI applications. Depending upon the individual and the decision tree introduced during the webinar, it may very well be good to seek a disability by the state Medicaid agency under the work requirement exemptions like medically frail while at the same time applying for SSI.

29. Is the $580 earned income or any income?

Response: Please see the responses to questions 4 and 5 above.

30. Can you recommend any 1115 waiver training courses or tutorials specific to my state (IL)?

Response: The Autistic Self Advocacy Network has an excellent Medicaid 1115 Waiver Advocacy Toolkit. While the toolkit is geared towards services needed by people who are autistic, the toolkit can be helpful to other advocates who may be concerned with others services but need to learn about 1115 waivers.

Illinois' 1115 waiver page is also a good resource.

31. Can you share how new regulations or requirements will affect HASA clients?

Response: Please see the response to question 12 above.

32. Is there any guidance on documentation for exemptions that can be shared more broadly?

Response: Please see the response to question 13 above.

33. Can you say more about the look back period. I heard that it would look back a month and no more than 3 months. But also, I believe y'all said that there is a look back for 6 months?

Response: The look back period is the amount of past time during which individuals must prove they already met Medicaid's new community engagement (work requirement) rules before getting or keeping coverage. It applies for individuals in the expansion group who are newly applying for Medicaid and for individuals in the expansion group who are renewing their eligibility, but the rules differ slightly for each group.

Once the community engagement requirement is in effect:

- New Medicaid applicants will have to demonstrate that they have satisfied the community engagement requirements for *one to three consecutive months* immediately preceding the month in which they are applying for Medicaid. The exact number of past months (one to three months) is at the state's discretion. Each state may have a different number of months that they look back to qualify the applicant. The statute says *one to three months* which means states cannot require more than three months.

- Existing Medicaid members must satisfy the community engagement requirement for at least one month during each period between eligibility redeterminations, which will be every six months for members in the expansion group. Medicaid members must show they met work requirements in at least *one month of the past 6-month period* for them to continue their coverage. States may choose stricter versions, requiring multiple complaint months within the 6-month window or verifying compliance every month of rants than every 6 months.

34. How do you know when your state will be going live?

Response: States must implement community engagement requirements no later than January 1, 2027, though they may begin earlier. This deadline triggers multiple notice obligations, because states cannot begin enforcing the requirements without informing affected enrollees in advance.

CMS Guidance Dec 8 2025 requires states to notify members before the requirements begin. This means people in every affected state will receive advance, formal notice through their state's Medicaid agencies before going live.

35. Will individuals who have been deemed work exempt for TANF-related benefit programs automatically be deemed exempt for Medicaid work requirements? Or would separate paperwork have to be submitted?

Response: It is good to check with your state to be sure. Individuals who are work-exempt under TANF-related benefit programs are not automatically exempt from Medicaid community engagement (work) requirements under H.R.1./ PL 119-21. They may be exempt if they independently fit into a Medicaid exclusion category, but TANF status does not transfer automatically. States *may* use TANF data to streamline verification, but separate Medicaid-specific verification will still be required unless the state intentionally builds automated alignment.

36. Did states hire an additional amount of Medicaid staff clinical or non-clinical to coordinate this? Answer phones?

Response: There are Governments Efficiency Grants specifically created to help states implement the new Medicaid community engagement requirements. The purpose of this funding is to help states adapt eligibility systems, verification processes, caseworker training, and reporting functions required under Section 71119 of PL 11921. It is one-time funding, not an ongoing funding stream. It is also unknown whether the amount fully covers what states need to implement these changes.

37. Will there be training or seminars for Medicaid participants to discuss this information and their options?

Response: This also is a state-by-state decision. CSH is supporting SH residents who are also Medicaid enrollees to comment on this process, particularly in CA. If you are interested in collaborating with CSH on this type of project, please reach out to Health@csh.org.

Homebase (Accessing and Maintaining Medicaid — Homebase) and National Health Care for the Homeless Council (H.R. 1 Implementation) also both have great materials on this topic.

38. You mentioned that Georgia is "going live" sooner than required. But since Georgia has not accepted expanded Medicaid coverage, how would that work? I thought that meant Georgia was a "non-expansion" state and thus would not have the work requirement for Medicaid.

Response: Georgia has utilized the Section 1115 waiver authority to provide Medicaid coverage to adults above the mandatory eligibility levels, thereby "expanding" their Medicaid population. Under H.R.1., any state covering adults 19-64 through an expansion-like pathway, even if not ACA expansion must apply the federal community engagement/work requirements to those individuals. Section 71119 of HR 1 explains that the community engagement requirements apply to ACA expansion adults and "*adults covered under Section 1115 demonstration that provides minimum essential coverage.*"

See Georgia in this resource that further explains more about their 1115 waiver.

39. Can the 80 hours be a combo of all the above?

Response: Yes. The 80-hour monthly requirement *can* be met through any combination of the qualifying community engagement activities — and this is clearly stated in the H.R. 1 statutory summaries and CMS-related guidance.

40. Will there be documentation that is required re: identifying as Alaskan Native or American Indian other than self-disclosure?

Response: Yes, but it is not clear what documentation will be required. Neither H.R.1. nor the CMS December 2025 guidance include instructions on how the AI/AN identity must be documented. There could be more guidance coming from CMS, or it could be left to each state to determine what documentation required.

States do have to verify exemptions, which means they will need some documentation. Given past practices (which may or may not work now), self-attestation is commonly used by states, i.e., a question on Medicaid applications, or verifications, or verification through Indian Health Service eligibility rules which themselves permit multiple verification pathways.

41. So, do I understand this, are all Native American's are exempt from work participation?

Response: Yes, the AI/AN exemption appears in the Medicaid community engagement (work requirement) provisions contained in Section 71119 of Public Law 119-21. It is federally mandated and specifically states that "specified excluded individuals" include:

- Indians and Urban Indians as defined in the Indian Health Care Improvement Act (IHCIA)
- California Indians (Section 809(a))
- Individuals determined eligible as an Indian for the Indian Health Service under federal regulation

42. What risk do individuals have if they live in a state with strict restrictions around abortion or lost pregnancies, and they report they are pregnant, but unfortunately lose their pregnancy?

Response: Across the governing statue (PL 119-21), the underlying bill (H.R.1.), and CMS' December 8, 2025, guidance, the rules are consistent: "A woman who is pregnant or entitled to postpartum medical assistance" is automatically exempt from community engagement/work requirements. They are not considered "applicable individuals" that therefore do not have to meet community engagement/work requirements.

43. Is terminal illness or chronic illness an exemption reason?

Response: CMS' December 8, 2025, guidance lists "*medically frail or otherwise has special medical needs*" individuals as specified excluded individuals who are not subject to community engagement requirements. (Please see the response to question 13.) A person with a terminal illness or a chronic illness severe enough to substantially limit daily functioning could be considered medically frail under the definition from CMS. This could be considered under "serious or complex medical conditions." However, the best action here is to inquire into or check with your state's Medicaid agency to confirm their interpretation.

44. What is the go live date?

Response: Please see the response to question 34.

45. Where can we access updates on federal regulations?

Response: One of the best sites for updates on CMS is the CMS Medicaid & CHIP Services – Federal Policy Guidance Page. All community engagement requirement updates, including the December 8, 2025, Informational Bulletin, are posted here. New documents (IFRs, FAQs, bulletins) related to H.R.1. implementation will be published on this page as CMS releases them.

46. What does the exemption for American Indian / Alaskan Natives look like?

Response: Please see the responses for questions 40 and 41.

47. If someone has no work credits to qualify for SSDI, and their spouse makes just over the threshold to keep them from getting SSI, and they are clearly physically disabled, do you know if they will have to provide current diagnosis and medical records to prove they are exempt every six months?

Response: This response is like the response to question 43. If the person is part of the expansion population in their state, and does not qualify for SSI, they *may* have to provide updated medical documentation every six months, depending on the state's process and if they are not exempt through the definition of medically frail – "*physical, intellectual, or developmental disabilities that significantly impair activities of daily living.*" Federal rules do not mandate a fixed six-month- redocumentation cycle for medically frail/exempt individuals, but they require states to verify eligibility at least every six months, and states must establish- documentation standards.

This means that in practice many states will require periodic proof of exemption.

48. If folks don't succeed in working, they lose their benefits and reduced SSI.

Response: If an individual is on SSI, the individual may already be on Medicaid through the traditional pathway which is not subject to the community engagement/work

requirements. The community engagement/work requirements are only for those individuals who qualify for Medicaid through the Affordable Care Act (ACA) expansion population. Not every state expanded their Medicaid population when the ACA passed. First, check to see if your state is one of the expansion states or states that expanded their Medicaid population, and if yes, confirm that the individual is part of the Medicaid expansion population. If they are not part of the expansion population, then they are exempt from the Medicaid community engagement/work requirements.

49. Is there a list of qualifying mental health diagnoses that would make a tenant exempt from these work requirements?

Response: There is no list of federally published qualifying mental health diagnoses that automatically exempt someone from the Medicaid community engagement or work requirements. It is good to check with your state to see if they have a list or will have a list.

50. I work with Medicaid Members. Many express concern if they work, they will earn too much and lose their Medicaid.

Response: Since the passage of H.R.1. in July 2025, it is now law that Medicaid members who live in a state that has expanded their eligible population through the Affordable Care Act and are a part of that expansion group, will need to meet the community engagement/work requirements. This is a significant change that many Medicaid members may not realize or know about. Your work with Medicaid members is important in helping them understand how the new community engagement/work requirements may affect their Medicaid coverage. Please use these resources and others available in your state to help prepare Medicaid members.

Please also advocate with your state for simple pathways from Medicaid Coverage to Health Insurance Marketplace coverage. Many states immediately transfer someone from Medicaid to Marketplace coverage when their income rises, and they are no longer eligible for Medicaid but are now eligible for Marketplace coverage.

51. At times if we increase tenants' income, they can lose benefits or reduce benefits that are still needed like SNAP. I had a tenant get 1.00 in SNAP and still struggled to feed her family and pay bills. How is that navigated?

Response: SNAP now also has work requirements. Please see response to question 19 for additional information on how SNAP work requirements compare to Medicaid's work requirements. The other point you are making is regarding the cost of food and having the SNAP benefit amount to keep pace with the costs. This is a really important point that is navigated through your state's SNAP agency.

52. ***Any specific suggestions for folks in states that have historically lacked interest in preserving Medicaid coverage for individuals? Any models of coalition work in situations like this that have been particularly successful at either advocating for state action or working around state gov to preserve coverage?***

Response: Most states have coalitions around universal health insurance coverage, and CSH recommends that you join your state specific coalition around this issue. A listing of state health care coverage advocacy coalitions is here.

53. ***If someone is utilizing or has been issued a S+C subsidy, which requires a qualifying disability, will that suffice as an exemption?***

Response: Please see the responses to questions 14 and 18.

54. ***What is the best way to locate local Individual Placement and Support (IPS) employment specialists (specifically in a rural area)?***

Response: Most states have IPS programs listed under their **behavioral health** or **state vocational rehabilitation** services websites. You can also call your local county social services or mental/behavioral health office to inquire if they have Individual Placement and Support (IPS) programs. Sometimes it can be referred to as Supported Employment (SE) or Competitive Integrated Employment (CIE).

While not IPS-specific, many IPS programs are contracted as Employer Network (EN) providers. For those receiving disability benefits, check out the **Social Security "Ticket to Work"** find help tool that lets you search for providers by zip code. This is particularly useful in rural regions where IPS agencies overlap with broader disability employment networks.

55. ***Can you launch IPS Programs in tandem with case management already in place and how does that work with federal agencies such as the county housing authority - how/where would we ask for this? How would we get it? Do you need to be a non-profit?***

Response: Yes. IPS is explicitly designed to integrate with existing services, including case management. IPS programs use a multidisciplinary team approach that combines employment specialists with mental health providers and housing case managers. IPS programs also function successfully within county-based systems, meaning your existing case management structure can align with IPS if you follow fidelity principles (e.g., coordinated team communication, shared treatment planning, etc.).

When thinking about launching an IPS program, use this Agency Readiness Checklist to inventory your organization's values alignment and opportunities to bring employment supports into your services portfolio. State-level behavioral health and vocational

rehabilitation agencies often fund or authorize IPS. Housing agencies are not required to run IPS – but can partner with IPS. Substance Abuse and Mental Health Services Authority (SAMHSA) is a federal agency that has many IPS resources and holds many grants and contracts for IPS services, and you can reference those here.

56. If my state is not highlighted, can I still connect residents to an IPS community? Our program is in Mesa, Arizona.

Response: Yes. Many states, even the ones who are not (yet) members of the IPS International Learning Community, have IPS programs listed under their **behavioral health** or **state vocational rehabilitation** services websites. You can also call your local county social services or mental/behavioral health office to inquire if they have Individual Placement and Support (IPS) programs. Sometimes it can be referred to as Supported Employment (SE) or Competitive Integrated Employment (CIE).

57. When are these regulations going into effect in 2027?

Response: States must implement these requirements by January 1, 2027, or sooner. CMS is required to promulgate an interim final rule no later than June 1, 2026. Please see response to question 1 for conditions when a state could delay implementation.

58. Is there a directory of compliant IPS programs in the US?

Response: No. There is no single national public directory of all compliant IPS programs in the US. Some states individually maintain IPS provider directories, but only for their own state. Rosters for IPS programs are only available for International Learning Community members. However, you can contact the IPS Employment Center directly if you have specific questions.