Supplemental Technical Guidance for States to Reduce Harms from Medicaid Work Reporting Requirements

BENEFITS TECH ADVOCACY HUB

An update in response to CMS's Interim Final Rule

September 2026

NATIONAL HEALTH LAW PROGRAM

TECHTONIC JUSTICE

Upturn
Toward Justice in Technology

Introduction

The Centers for Medicare and Medicaid Services' Interim Final Rule (IFR), published June 2026, further complicates the implementation of H.R. 1's punitive work reporting requirements for the Medicaid expansion population. As the window to implement the rule narrows, states must seriously consider the immediate and long-term consequences of both implementation failures and successes.

While parts of the IFR do add clarity, others create confusion or fail to address questions from states. In terms of changes that affect technical design and implementation, the IFR contains additional details on how to calculate hours toward compliance using income and clarifies that total household income counts toward compliance for all individuals in that household. However, it also adds significant verification requirements for the medical frailty exclusion, and the data reporting and monitoring requirements it specifies may not be sufficient to meaningfully reveal issues.

This document supplements our January 2026 guide, adding technical guidance responsive to the IFR and to implementation developments from states. As in that guide, we emphasize here that technology will not be a panacea for the impending procedural disenrollments and administrative burden of work reporting requirements. We underscore that coverage for applicants and enrollees must be the highest priority when implementing work requirements. Specifically, states should minimize reverification frequency and prioritize permanent or long-term exclusions to reduce the risk of applicants and enrollees losing coverage during the transition.

This supplement contains considerations for and discusses limitations of the use of automation to implement work requirements—including specific details for most of the nine categories of Specified Excluded Individuals (SEIs)—plus testing, monitoring, and vendor accountability recommendations.

A note on terminology: To align with the specific language in the IFR, this supplement uses the terms "exclusion" and "exception" to refer to people who should not be required to comply with the new work requirements. Excluded people (i.e., SEIs) are not "applicable individuals," meaning work requirements are not a component of Medicaid eligibility for them and states are not permitted to assess whether they

are compliant with work requirements. People falling into a "mandatory exception" category are considered "applicable individuals," so work requirements are an eligibility component for them. However, if they fulfill a mandatory exception for all or part of a given month, they must be deemed compliant with work requirements. These terms are not interchangeable.

Carefully consider implementation details to protect eligibility

Medicaid program integrity depends partly on states correctly translating rules into implementation details and processes. Seemingly trivial choices can have major impacts on whether people and households are determined to be eligible. For example, a checklist that only allows one selection instead of multiple selections (e.g., a screener tool that lists potentially overlapping circumstances) may result in people not being considered for the appropriate exclusions/exceptions.

This section describes general implementation considerations, as well as specific considerations for most of the nine categories of SEIs. However, this information does not replace direct feedback from applicants and recipients, which states should solicit to confirm that all implementation and design choices align with community needs and expectations.

Reduce administrative burden when automation is not simple

States and caseworkers must exhaust *ex parte* data sources prior to moving the burden of documentation onto applicants. There are many data sources available to states, and we map some of them to the relevant categories of compliance and exclusions/exceptions in **Appendix A** of this document. However, states should also contemplate how to reduce administrative burden given the inevitable gaps in the available data.

States should build tools that caseworkers can use to easily document their work manually confirming exclusions/exceptions. This documentation is necessary to minimize the payment error rate and to facilitate audits. It is also critical for proper supervision and quality monitoring, as well as the provision of a complete case file, which should be available to any applicant or beneficiary if they appeal a determination. These tools should be able to quickly look up and provide a record of the data a caseworker searched for and relied on when making their final decision.

States should avoid passing the administrative burden onto applicants simply because manually accessing necessary data could be costly or difficult. The IFR explains that states should enhance their eligibility systems "to incorporate connections to additional electronic data sources into the existing system." However, states should consider the costs of worker time, enrollee churn, appeals, etc., when determining the feasibility of incorporating data sources. Although a state's system may not have an application program interface (API) or other technology designed for incorporating data in a more automated way, states can replicate existing processes that direct workers to check databases for certain information.

States can create desk-level procedures to help caseworkers identify and document exclusions/exceptions using a mix of automation and manual processes. These desk-level procedures could help caseworkers navigate the process of gathering documentation from different organizations and explain how proof of exclusions/exceptions should be documented in the case file. These procedures could also be updated over time with lessons learned on gathering proof from a variety of sources and in different formats. The systems could include flags and other reminders directing workers to the relevant manual processes to improve consistency where manual intervention is necessary. Individuals should not have to navigate these complexities on their own when states could enable caseworkers to navigate them more effectively at scale, with far less administrative burden placed on all parties.

Implementation considerations for Specified Excluded Individuals

There are two primary considerations for minimizing the burden on SEIs and the associated risk of coverage loss:

- **States should limit the need for reverification of exclusions by prioritizing longest term length, starting with permanent exclusions.** For example, if an individual is an American Indian who is also a parent to a dependent child under the age of 14, the state should exclude them from work requirements based on their status as an American Indian, because the American Indian status is permanent and will never need to be reverified. If the state were to exclude this person under the parent/caretaker exclusion category instead of the American Indian exclusion category, the basis of their SEI status would change when their child turned 14, triggering a change in circumstances and a new verification process that would put the person at risk of losing coverage.
- **States should not reverify exclusion status more often than the minimum frequency required.** Some exclusions specify a minimum reverification frequency (e.g., medical frailty must be reverified at least once every 12 months), but the IFR also permits states to reverify those exclusions more frequently at their discretion (e.g., states can choose to reverify medical frailty at every six-month renewal). To minimize the burden on both applicants/enrollees and the states, and to limit the risk of coverage loss, states should opt for the longest possible period between reverifications. Unlike verifying compliance, states do not have the option to reverify SEI status more frequently than at every six-month renewal **unless** there is information suggesting that the individual is no longer an SEI or may be losing their SEI status due to an anticipated change in circumstances, such as a dependent child turning 14.

States should also remember that they must proactively attempt to identify SEIs **before** verifying compliance with work requirements, meaning the threshold question for the state is whether an individual belongs to any of the nine exclusion categories. Only if an individual does not belong to any of the exclusion categories can the state then assess whether they are either

mandatorily excepted from or compliant with work requirements. (Note that people who are "excepted" from work requirements are deemed compliant for their review period.) Further, the state **must always** determine an individual to be an SEI when there is sufficient information to support that determination.

The following subsections are specific considerations for individual categories.

Former Foster Care Children (FFCC)

The FFCC eligibility category is typically near the bottom of the eligibility cascade, meaning it is one of the last categories that states check when processing Medicaid eligibility determinations. Therefore, individuals who could be eligible under this category may instead be in the Medicaid expansion category. States may not have readily available data on young adults who were involved with the foster care system in a state other than the one in which they currently reside, but they should be accessing the data they do have. In order to fully capture the FFCC SEI category, states should consider implementing additional screening questions intended to identify FFCC as SEIs and/or move them into the FFCC eligibility category as appropriate.

States must also meet their obligation to check for eligibility on all bases before terminating Medicaid coverage. Before terminating an expansion enrollee who is potentially an FFCC for noncompliance with work requirements, states must run the entire eligibility cascade to determine whether the enrollee is eligible as part of another category (e.g., as an FFCC) and move them into that category if appropriate. It is important to note that not all people meeting the FFCC exclusion criteria will be eligible for the FFCC eligibility category; eligibility hinges on several factors, including the state where they live, the state where they were in foster care, and when they turned 18. Further, the FFCC exclusion only applies to foster youth who aged out of care, **not** to those who left foster care through adoption or other permanent placement.

Importantly, this exclusion does not need to be reverified until the enrollee turns 26, which is an anticipated change in circumstances known to the state. Since the FFCC exclusion has the potential to exclude individuals from work requirements on a long-term basis, states should prioritize this exclusion (when applicable) over others in the exclusion hierarchy that may not last as long or will need to be reverified more frequently.

American Indians

This exclusion encompasses Indigenous people who are "Indians," (including Alaska Natives, per the regulatory definition), "Urban Indians," or "California Indians" under the Indian Health Care Improvement Act (IHCIA) or who have otherwise been determined eligible for Indian Health Service (IHS) services. This information may already be collected at the point of Medicaid application via the optional question concerning race, but it is also collected to identify Indigenous people in these groups, as they are eligible for certain benefits such as cost-sharing exemptions and income deductions for Medicaid and the Children's Health Insurance Program (CHIP). Relevant information may also be available through the Federal Data Services Hub (FDSH). States **do not ever need to reverify this exclusion**, consistent with existing verification policy related to information that is not subject to change. States should therefore prioritize this category (when applicable) over other, non-permanent categories in the exclusion hierarchy.

Parent/Guardian/Caretaker Relative/Family Caregiver

Because each subcategory for this exclusion has different definitions and requirements, the information needed to verify SEI status is different for each subcategory, and states' access to reliable information varies. Household composition data will be vital for verifying the caregiver and care recipient's familial relationship or co-residence, as well as whether the care recipient is a dependent child age 13 or under.

However, data for other components of this exclusion may be less prevalent in data sources currently connected to the eligibility system. These components include whether the caregiver is a legal guardian, whether the care recipient meets the regulatory definition of a "disabled individual," and the hours of care provided by a family caregiver who is not related to and does not reside with the care recipient. States should consider implementing additional screening questions on applications and renewal forms to identify individuals who could be eligible for this exclusion but have a care arrangement that existing data may not capture. States that choose to implement additional screening questions to this end should streamline their application and renewal forms as much as possible to minimize the burden applicants and enrollees experience as a result of "raising their hand" to identify themselves as possible SEIs.

States may require a "minimum amount of information necessary" to determine that the person receiving care meets the definition of a "disabled individual." The definition of "disabled" aligns with that of the Americans with Disabilities Act (ADA) and thus focuses on whether the person's condition(s) impair major life activities. The care recipient does not need a formal disability determination to be considered disabled for purposes of this exclusion. There is also no requirement that the care recipient pay the caregiver. The state cannot require that the caregiver identify the care recipient, nor may they condition SEI status on the caregiver's willingness to identify the care recipient. If additional information is needed (including documentation, if applicable), states should attempt to obtain all needed information through a single request (e.g., hours of care provided and proof of disability should be requested all at once).

Per the IFR, states can use a "statement or screening tool" to verify an individual's status as a caregiver to an adult with a disability in cases where the disabled adult does not consent to the caregiver releasing their identifying information to the state. States should prioritize a statement over any kind of screening tool, and should make the parameters for such a statement as simple as possible, to reduce friction in the verification process for both caregivers and eligibility workers. States must also be careful of coercion when requesting the consent of the care recipient to use their information or to provide it. While it may be easier to verify eligibility using data gathered with the consent of the disabled individual, it should always be clear to caregivers in this situation that there are other ways to qualify for this exclusion if they are unable to obtain consent to share the relevant data.

Veterans with a Total Disability Rating

Veterans who have permanent or temporary total disability ratings should qualify for this exclusion as long as the disability is rated at 100 percent. This includes multiple disability ratings that add up to 100 percent. This exclusion also encompasses veterans with "total disability based on individual unemployability" (TDIU) designations, even if their combined disability rating is below 100 percent.

States should establish data connections with VA as quickly as possible in order to maximize *ex parte* verification of this exclusion category; they should not wait for CMS to potentially make VA data available through the FDSH. The Public Assistance Reporting Information System (PARIS) also contains data that could be useful in identifying veterans who qualify for this

exclusion, such as eligibility for certain categories of disability-related benefits and payments made to the veteran and/or their dependents under these disability-related categories. For example, the PARIS output records instances where an eligible spouse or dependent elects to receive Chapter 35 survivors' benefits, which are limited to certain categories of spouses and dependents, including spouses and dependents of veterans with a permanent and total disability.

Permanent total disability status may not be reverified. States should therefore prioritize this category (when applicable) over other, non-permanent categories in the exclusion hierarchy. However, states must reverify *temporary* total disability status at least every 12 months (but cannot reverify more frequently than at every six-month renewal). States should limit reverification to the minimum required by law to reduce burden and limit the risk of coverage loss.

Medically Frail/Special Medical Needs

The medical frailty exclusion is crucial to maintaining continuity of health coverage for people who face a high risk of harm from gaps in access to care. The IFR defines the exclusion as applying to people whose health condition "significantly impairs" their ability to comply with work reporting requirements. This choice of language adds significant technical and procedural complexity, requiring more layers of verification as well as additional training for clinicians, increasing the risk of coverage gaps.

These details of the medical frailty exclusion as further defined by the IFR are at the center of litigation challenging the IFR, one from 26 states and another from plaintiffs including individuals and providers. The cases' claims include that, contrary to regular communications and preliminary guidance that they relied upon, the IFR improperly narrowed congressionally established exclusions, including for medical frailty. Currently, under the IFR, individuals with significant health conditions (as defined by the statute) **also** have to be found to be significantly impaired in their ability to work.

This section provides some discussion of limitations created by the IFR as well as general principles for design choices and technical infrastructure that states may use to implement the medical frailty exclusion. However, because the policy is currently under dispute, this discussion is for general purposes only and not specific to what policy is ultimately implemented.

The IFR does require that states use encounter and claims data available to them as verification sources to establish qualification for the medical frailty exclusion. While it is important that states use this data to minimize administrative burden, it has significant limitations. For example, the IFR limits the window of acceptable claims data to a 12-month period, despite the fact that this data can be subject to processing delays as long as six months.

Further, the IFR specifies that states are required to use encounter and claims data because it is determined "available to the state" as the records are contained in Medicaid agency systems, but otherwise gives states discretion to determine whether building connections to other data sources would be "effective." Combined with the 12-month claims data window, this increases the potential that some individuals with health conditions will have few, if any, usable claims or encounter records to verify exclusions—either because they did not obtain healthcare in this period (potentially due to obstacles such as lack of insurance or clinician availability) or because their healthcare did not result in a claim available to the Medicaid agency.

It is also important to note that claims processing systems such as Medicaid Management Information Systems (MMIS) present their own sources of complexity and can add to the challenge of investigating technical issues or process mismanagement related to medical frailty. Because claims data does not exist in eligibility and enrollment systems, it must be transferred or made available from the MMIS back to the eligibility and enrollment system. This means that in addition to each individual system, the communication between systems can be a source of technical or procedural errors. **Appendix B** goes into further detail about the technical issues that must be considered when implementing a claims-based search for medical frailty exclusion.

Although the details of medical frailty exclusions under the IFR remain contested, states can and should make design choices to reduce administrative burden that are agnostic to these details. For example, states should make sure that any condition or diagnosis lists used for *ex parte* determinations of medical frailty are flexible and easily updated instead of "hard coded" into the system or only modifiable by a vendor. Creating this infrastructure now will help reduce negative impacts of the policy on a population at great risk of harm from coverage gaps and will be useful if the state adds new healthcare services or if the policy is changed in the future. It is also considered best practice in software programming to create infrastructure this way.

Individuals Compliant with TANF Work Requirements or Subject to SNAP Work Requirements

Most states have integrated their Medicaid systems with their SNAP/TANF systems, so this information should generally be readily available, although the level of integration and sharing of information varies by state. If that connection does not yet exist, states **must** establish a process for their Medicaid agencies to obtain both SNAP and TANF information.

Participants in Drug Addiction or Alcoholic Treatment and Rehabilitation Programs

States should be able to use claims and encounter data for this exclusion but should remain cognizant of the considerations and potential pitfalls of such data described in the section of this guide discussing the medical frailty exclusion. States must also ensure that all data sharing conducted to implement this exclusion aligns with the privacy protections in 42 C.F.R. Part 2.

Inmate of a Public Institution

The Consolidated Appropriations Act (CAA) of 2024 requires states to suspend, rather than terminate, Medicaid coverage for individuals who are incarcerated in public institutions such as prisons and jails. This means states should have much more information available than they would have previously about Medicaid enrollees who are currently and/or were recently incarcerated in public institutions. For example, states should already be in the process of establishing data connections with state correctional departments and facilities to suspend coverage upon incarceration and resume coverage upon release (or if an individual needs inpatient care). States should leverage this data, in addition to the sources we discuss in the appendix, to maximize *ex parte* verification.

Enable transparency and monitoring

Transparency and monitoring enable a state to gain valuable feedback on whether its system meets its goals in terms of functionality and accessibility and, if not, help pinpoint the sources of issues. Conversely, a lack of transparency around how the system makes decisions, particularly in notices, can interfere with individuals' rights to due process.

The IFR has a very short list (at § 435.562) of required data elements that states must submit to CMS, which was expanded on days later via an update to the Eligibility Processing Data Report and Renewal Compliance Template. The Georgetown University Center for Children and Families highlights issues with these expanded figures and how they could be made more useful. Beyond this data, there are many other ways states can provide transparency into their system and collect useful data on its functioning.

Transparency of design choices

States are required to document and submit to CMS their plans for determining and verifying compliance, exceptions, exclusions, use of *ex parte* data, and determination controls. States should also make these high-level design documents available to the public when possible, as it could help reveal potential issues before they are baked into the system—or at least provide context to help the public navigate any issues that happen after implementation. For example, plans may be missing certain data sources that the public would expect states to use for *ex parte* determinations, or they might be missing important details on how the state will provide accommodations to individuals with disabilities. Sharing these plans, especially within the sort of robust feedback channels that we recommended in our initial guidance, can enable affected populations to both prepare for the coming changes and flag issues after implementation.

Monitoring and testing systems

States should monitor additional aspects of their Medicaid administration system in a way that goes beyond what the IFR recommends. This additional monitoring should capture errors applicants or caseworkers experience while navigating applications or renewals in an eligibility and enrollment system, including the quantity of those errors, descriptions of the errors, how the errors were handled, and any costs the state incurred in resolving the errors. States could do this by publishing reports about these errors and the change requests (a formal document that manages a specific change to a system) created to fix them. Each state should maintain a public list of current known issues and workarounds alongside information on how to get help if a known issue is impeding access to the application or renewal process.

States should also monitor their application and renewal abandonment rates to show how many applications or renewals are not completed, which could indicate deeper issues such as over-burdening applicants by requiring them to provide too much documentation. Preferably, this data would be broken down such that it tracks when the abandonment occurs (e.g., at application/renewal form, in response to a request for additional information, etc.).

In order to monitor Medicaid program administration and evaluate eligibility process changes, states are required to track call center volume, average wait times, and call abandonment rates as part of receiving enhanced federal match for IT systems. To be more useful, this data should also break down abandonment rates by timing (e.g., hanging up early while trying to navigate a phone tree versus hanging up after waiting on hold). The data should also capture how long a person had to wait to speak to a representative, whether they reached a resolution, and whether they had to call multiple times to reach that resolution. Further, the data should track these outcomes for people who request interpreter services and any disability accommodations provided by the call center. Call center monitoring should also include user experience testing to test for quality of information provided and to ensure issues are surfaced that may not appear in the data.

States should also collect qualitative feedback directly from recipients to gauge their perceptions of navigating the eligibility and enrollment system. Simple quantitative analysis could be done on this data to flag any trends in sentiment over time. This could be one indicator of whether an eligibility and enrollment system is having issues, prompting further investigation into whether the system is serving all needs of applicants and enrollees.

States should publish reports containing the data mentioned above so that the community of recipients and advocates can understand if there are widespread issues with the enrollment process. States should also be transparent about whether caseworkers report experiencing increased manual work or larger backlogs associated with processing compliance or exclusions to the work reporting requirements.

Decrease reliance on private vendors

Vendor dynamics play a large role in whether states can properly administer their public programs. Vendors can introduce glitches or errors into the system, make discretionary implementation choices that are misaligned with users' needs, or push states to adopt unnecessarily risky or expensive tools. Contract requirements often do not cover system outcomes, such as whether eligibility is correctly determined for all individuals, which can make vendor accountability challenging. For these reasons, states should take caution when working with vendors and consider options for in-house development or publicly built tools.

Our initial guide for states has more details on specific accountability mechanisms for working with vendors, and this Medicaid eligibility system vendor map has more details on states' involvement with the largest private vendors of Medicaid systems, including some of their contracts. Here, we highlight some additional strategies for avoiding vendor-based issues.

Prioritize internal technical capacity and public data sources and tools

One way for states to have better control over the implementation of their systems is to decrease reliance on private vendors, using their internal technical expertise to build system parts when possible and to integrate publicly built/managed tools and data sources. Private data sources and vendors are often opaque in their operations and may be harder for states to hold accountable. Further, some of the nation's biggest private vendors of government technology and data are under scrutiny for unfair business practices, cost inflation, and poorly built systems that have led to harm. Even if states do choose to use private vendors, having internal technical capacity will facilitate better management of those systems and help mitigate the asymmetry of technical expertise between states and vendors.

States should remain skeptical of not just large, entrenched vendors, but also newer and/or smaller private companies that have sprung up to fill technological niches in the eligibility process. These companies may provide tools for consent-based verification or other intermediary functions, but each additional vendor creates a silo wherein issues are more difficult for states to proactively address and resolve. Applicants and enrollees may also be confused or deterred by the addition of these tools, even when they could potentially reduce administrative burden, because it adds to the ecosystem of entities with access to their personal information.

Talk to other states using the same vendors

Another aspect of the problematic dynamic between states and vendors is that many states all separately contract with a handful of vendors to implement similar policies. This allows vendors to see system details across many states, while each state can only see its own system and is charged independently. Further, not all states have the same contract provisions (e.g., what kind of system testing is required) with a given vendor. States should collaborate with each other to negotiate better contract terms with vendors and identify similar issues across systems. States can employ these tactics regardless of internal technical expertise by paying attention to where problems show up (e.g., within a particular category of eligibility).

Conclusion

States and the private vendors they work with now have even less time to deliver a well-planned and thoroughly tested implementation, because the IFR includes numerous details for states to consider. States should apply for good faith waivers in order to ensure they have the time to implement all the data infrastructure necessary to evaluate eligibility, including exclusions/exceptions, as accurately and effectively as possible and without burdening applicants to provide that data themselves.

Appendix A

Data Source to Compliance and Exclusion Crosswalks

Below, we provide a crosswalk between compliance or exclusion/exception factors and the common data sources containing information that can be used to verify whether a person meets one of those factors. There are a significant number of data sources that states can use to verify these factors on an *ex parte* basis (as the law requires). This list was created before states began adding sources for IFR implementation and **is not exhaustive**. (A more comprehensive list of state data sources, current as of May 2025, is on file with the authors, and we invite readers to reach out if interested.) Please note that data sources are listed in alphabetical order, and this list is not intended to suggest any hierarchy or priority among those sources.

There are several important threshold considerations for using these data sources in the new context of Medicaid work reporting requirements:

- Not all data relevant to verifying compliance with or exclusion/exception from work requirements will be available through electronic data sources. Some information, such as gig work, caregiving hours, or community service, may remain difficult to verify on an *ex parte* basis. As we noted in the January 2026 release of this technical guide, this is a limitation to automating work verification. Reporting apps and consent-based verification (CBV) options are gaining traction as alternatives to traditional database-type sources, but the extent to which states and enrollees will take up these options and how well they will work remains to be seen.
- For exclusions/exceptions, the data source landscape is widely varied. Most relevant information can be gleaned from sources that states already use for Medicaid and SNAP eligibility; however, states will have to integrate at least some new data sources to facilitate *ex parte* verification of Medicaid eligibility factors unique to work requirements (e.g., educational

status). To that end, CMS has released a work requirements-related supplement to the verification plan preprints that states must use to document the data sources they will use to verify information relevant to compliance and exclusions/exceptions from work requirements.

- Even where certain information is available through an electronic data source, the common data sources that states already use often cannot provide real-time information or updates to that information. It is critical that states have a strong awareness of the limitations of each data source and implement proactive solutions to mitigate coverage loss.

Note: The crosswalk below includes the Federal Data Services Hub (FDSH) as a data source and also lists sources encompassed by the FDSH as separate data sources, as the IFR permits states to establish direct connections to data sources instead of using the FDSH.

Compliance	
Factor to Verify	**Common Data Sources Containing Relevant Information**
Work (80 hours per month)	• CBV sources, such as CMS's Emmy software • State labor data (although this data typically does not include hours worked) • The Work Number (sometimes also known as TALX)
Community service/ volunteering	• SNAP data
Participation in a work program	• SNAP Employment and Training (E&T) data • State unemployment compensation agencies • Vocational rehabilitation agency data • Workforce Innovation and Opportunity Act (WIOA) reporting
Education (at least half-time enrollment)	• National Student Clearinghouse and similar state-level education databases (note that not all states have these) • State departments of education

Compliance	
Factor to Verify	**Common Data Sources Containing Relevant Information**
Monthly MAGI-countable income of at least $580 (or an average of $580 per month over the previous six months for seasonal workers)	• Beneficiary Earnings Exchange Record (BEER) • Beneficiary and Earnings Data Exchange (BENDEX) • CBV sources (e.g., Emmy) • IRS • National Directory of New Hires (NDNH) • Public Assistance Reporting Information System (PARIS) • SNAP/TANF data • State Data Exchange (SDX) • State On-line Query (SOLQ)/State On-line Query-Internet (SOLQ-I) • State unemployment compensation agencies • State Verification and Exchange System (SVES) • State Wage Information Collection Agency (SWICA) • The Work Number

Exceptions	
Factor to Verify	**Common Data Sources Containing Relevant Information**
Under age 19	• BENDEX • Existing Medicaid eligibility data • FDSH (in states that use it) • SNAP/TANF data • SSA Composite • State vital statistics data
Entitled to/enrolled in Medicare Part A or enrolled in Medicare Part B	• BENDEX • Existing Medicaid eligibility data • SDX

Exceptions	
Factor to Verify	**Common Data Sources Containing Relevant Information**
In mandatory eligibility groups (I)-(VII)	• Existing Medicaid eligibility data
Specified Excluded Individual (SEI)	See below.

Exclusions	
Factor to Verify	**Common Data Sources Containing Relevant Information**
Former Foster Care Children	• Adoption and Foster Care Analysis and Reporting System (AFCARS) • Existing information collected as part of the Medicaid application (in some cases) • National Youth in Transition Database • State-level foster care databases
American Indians	• Existing information collected as part of the Medicaid application • FDSH
Parent, Guardian, Caretaker Relative, or Family Caregiver of Dependent Child Age 13 or Under or Disabled Individual	• Household composition data (for family relationship and co-residence) • Payments to caregivers of Home and Community Based Services (HCBS) enrollees who self-direct their services • State probate court records for guardianships (availability depends on state and sometimes county) • State vital statistics data
Veteran with a Total Rated Disability or TDIU	• Veteran Service History and Eligibility API

Exclusions	
Factor to Verify	**Common Data Sources Containing Relevant Information**
Medically Frail/ Special Medical Needs	• BENDEX • Claims and encounter data (including through MMIS or state All-Payer Claims Database (APCD)) • HCBS enrollment or utilization data • SDX • State unemployment insurance data
Compliant with TANF Work Requirements **or** Not Exempt from SNAP Work Requirements	• SNAP/TANF data
Participating in a Drug or Alcohol Rehabilitation or Treatment Program	• Claims and encounter data (including through MMIS or state APCD)
Inmate of a Public Institution	• Prisoner Update Processing System (PUPS) • State and federal correctional databases (for incarcerated individuals) • State and federal court databases • SOLQ/SOLQ-I • SVES
Pregnant or Entitled to Post-Pregnancy Coverage	States must accept self-reported information about pregnancy status as a matter of law. H.R. 1 and the work requirements IFR do not change that.

Appendix B

Medical Frailty Technical Implementation Considerations

Implementing a claims-based search for the medical frailty exclusion is complicated by the fact that claims are not static and can be adjusted or even voided. States should account for this volatility by ensuring their technical infrastructure creates a persistent record of claims data at the point in time it is used in decision making. States should also create a persistent and time-stamped record of all decisions made for a recipient, such as determining they meet the medically frail criteria and on what basis/records. Further, states must ensure their systems properly handle adjusted or voided claims and trigger the appropriate action when this data changes. These considerations matter for core system functionality and also for states' ability to conduct robust system audits, investigate technical issues around claims data, and facilitate appeals for applicants/enrollees.

If a state's eligibility system is designed to only store a subset of an individual's usable claims as documentation for the medical frailty exclusion, future modification of the claims in that subset may cause issues for that individual, especially if there is no documentation of all their other claims at that point in time. For example, a claim may be voided months later, which may trigger the state to review the individual's exclusion status and consider whether it has changed. If states have access to the other claims that existed at the time of application/renewal and/or access to the decisions made prior, they could simply select a different claim or decision that provides equivalent information in order to maintain that individual's eligibility. Otherwise, states may have to request information from individuals, who may not have access to acceptable documentation months later (e.g., claims that would have been usable at the original time of application may now be more than 12 months old).