March 30, 2026

Jessica Bax
Director, Missouri Department of Social Services

Dear Director Bax,

We recognize that the Missouri Department of Social Services faces a substantial undertaking in implementing the requirements of the federal Budget Reconciliation Act (H.R.1.). Our organizations care deeply about the impact of the federal bill and recognize that the decisions Missouri makes on implementing H.R.1 will have significant consequences for Missourians' access to health care coverage, the ability of providers to serve communities across the state, the solvency of the state budget and the economy overall.

We encourage you to adopt the following strategies, which are designed to minimize coverage losses, reduce administrative burdens and errors and protect the state from federal fiscal sanctions.

Minimizing Coverage Losses and Payment Errors

- One month "look back" period: At both application and renewal, require only one month of compliance with or exemption from the community engagement requirement.

- Compliance checks at renewal: Conduct compliance checks only at renewal to reduce staff workload and minimize the risk of errors.

- Ex Parte Processing: Utilize as many data sources for ex parte processing as possible to determine enrollees' compliance or exemption status automatically without contacting the enrollees. Specifically, DSS should use all available data sources, including managed care organization (MCO) claims data, Supplemental Nutrition Assistance (SNAP) data, higher education enrollment, and other sources. These sources should include both data sources DSS can automate as well as those that may require more manual work as the requirement is for the Medicaid agency to use reliable information available to it.

- Short-Term Hardship Exemptions: Adopt all available short-term hardship exemptions (e.g., for individuals who must travel for their medical treatment, who live in counties with unemployment rates over 8%, or who live in disaster areas) and should seek exemptions for those in counties with unemployment rates 1.5 times the national rate.

- Self-Attestation: To the maximum extent possible, accept applicant and enrollee statements about compliance with community engagement requirements and exemption status.

- Automatic Income Proxy: Ensure that the income proxy—HR 1's provision that individuals whose monthly income is equal to or greater than federal minimum wage multiplied by 80 hours complies with the community engagement requirement—is automatically applied to determine compliance.

- Medically Frail Exemptions: Develop a process to identify medically frail enrollees that includes self-identification, claims data analysis, and where available to the applicant or beneficiary, a health care provider referral (allowing sufficient time for responses to such a referral). The process should use all available data sources, including, for example, data from other state departments such as DHSS and DMH, and from MCOs. DSS should work with stakeholders to develop a definition of medical frailty that is consistent with HR 1 and not overly restrictive in its application. Such a process should also account for applicants who do not yet have health coverage to pay for treatment that would prove their "medical frailty."

- Family Caregivers: Ensure that caregivers of seniors and people with disabilities are properly excluded from participation using the RAISE Caregiver Act definition.

Communication and Transparency

We further recommend the following outreach strategies to help Missouri's Medicaid participants prepare for the changes.

Public education and outreach:

- Undertake an extensive communication campaign to ensure Missourians are aware of all changes to their Medicaid coverage. DSS should inform Medicaid participants of program changes well in advance of implementation.
- Ensure outreach and other publicly available information regarding community engagement requirements is thorough, understandable, and accessible. DSS should create FAQs and tutorials for completing verification processes that are readily accessible in multiple formats and languages, and widely available prior to the effective date.
- To the maximum extent allowed, DSS should enlist assistance from community partners, managed care organizations, Medicaid providers, and other groups to ensure its outreach is effective and far-reaching.
- Prioritize ensuring awareness campaigns are promoted in multiple languages and through multiple mediums. The communication strategy should include culturally and linguistically appropriate outreach, by trusted community partners, before any H.R.1-related terminations or reductions occur.
- Conduct outreach to persons with disabilities and disability groups to ensure accessibility of materials generated by DSS.

- Clearly communicate with enrollees, providers, and other stakeholders well in advance about its plan for implementation and progress once implementation is underway.
- Create a specific page on the DSS website at which the State can notify the public about "known" barriers or problems, what they look like, and how to notify the state if you've been affected by those issues.

Transparency: DSS should publicly post data, including a frequently updated dashboard tracking the requirements, processes, and coverage losses for Medicaid members, policymakers, and Missourians at large. New data systems should also allow for reporting of the *specific reason* for denial/termination, in order to identify individuals who are denied or terminated based on new Medicaid reporting requirements, apart from *other* procedural denials and disenrollments. Such public transparency will enable DSS to assess the impact of these changes and address any unnecessary coverage losses or other unforeseen implementation challenges and is essential to ensuring the integrity of Missouri's new system of work requirements.

Technology workgroup: DSS should form a workgroup of community-based stakeholders to test technology changes, including updates to applications or verification requests, as well as any new processes to verify community engagement reporting requirements. Allowing experts and community support organizations to identify potential glitches and provide feedback will ensure a smoother and more successful implementation.

Notices: Notices will need to be revised to apprise people of their rights and obligations under the new law, including how to comply with work requirements and avoid sanctions. To ensure the notices are clear and understandable, DSS should work with stakeholder groups to draft notice language, and conduct user testing to further refine notices before they are implemented.

Applications will need to be revised to screen for work requirements and stakeholders should be consulted for those revisions as well.

Staffing and Capacity

DSS should ensure its staff is fully equipped to carry out these changes and any increase in appeals. Specifically, DSS should ensure vacancies are filled and staff receive comprehensive training. DSS should consider having a specialized unit of staff that are highly trained to handle work requirements cases to reduce the risk of errors and coverage denials.

Timing

DSS should pursue an extension to delay implementation until DSS is fully ready to undertake these substantial new obligations. The law allows HHS to grant extensions to states that are making good faith efforts to comply with work reporting requirements. Missouri faces significant challenges in creating the necessary systems for implementing work requirements (on top of Missouri's existing eligibility and computer systems) and risks significant harm if it implements these changes too quickly. DSS must ensure that there are adequate systems in

place to reduce error and that Missourians are aware of how to comply with the changes prior to implementation.

We welcome any questions and discussion of these strategies. Thank you for all you do for Missouri.

Sincerely,

Sent on behalf of the following organizations

Michelle Trupiano, Executive Director
Beacon Reproductive Health Network

Dave Almeida, Director, State Government Affairs
Blood Cancer United

Maureen Cunningham, Executive Director
Brain Injury Association of Missouri

Denis Rigdon CEO
Caruthers Street Charities, Inc dba Project HOPE

Dr. Jared Bryson, Preside5& CEO
Catholic Charities of the Archdiocese of St. Louis

Darin Preis, Executive Director
Central Missouri Community Action

Puneet Leekha, CEO
Chestnut Health Systems, Inc.

Mallory Rusch, Executive Director
Empower Missouri

Jeanette Mott Oxford, Church Council President
Epiphany United Church of Christ

Jeremy Cagle, Vice President of Growth & Strategy
FosterAdopt Connect

McClain Bryant Macklin - Chief Policy and Impact Officer
Health Forward Foundation

Areeb Hasan

Healthcare Policy Pod

Diana Hayes, CEO
Jefferson Franklin Community Action Corp

Christian Kiefer, Pod Leader
Mental Health Policy Pod, Saint Louis University

Mary Quandt, Executive Director
Missouri Appleseed

Greg Weaver -Board President
Missouri Assocaition of Rural Health clinics

Nancy Pennington, Executive Director/CEO
Missouri Association of County Developmental Disabilities Services

Amy Blouin, President & CEO
Missouri Budget Project

Patrick Lee, President
Missouri Centers for Independent Living (MOCIL)

Jessica Emmerich, Executive Director
Missouri Coalition for Oral Health

Scott Miniea, Executive Director
Missouri Connections for Health

Sheldon Weisgrau, Vice President of Health Policy & Advocacy
Missouri Foundation for Health

Jack Seigel, Outreach Manager
Missouri Nurses Association

Amy R. Beck, PhD; Legislative Chair
Missouri Psychological Association

Dina van der Zalm, Community Engagement Director
Missouri Rural Crisis Center

Karen Gridley Executive Director
Missouri Statewide Independent Living Council

Amy Kuo Hammerman, State Policy Advocate
National Council of Jewish Women St. Louis

Anna Meyer, Director of Advocacy and Activist Engagement
National Multiple Sclerosis Society

Brooke Kendrick, Executive Director
NorthEast Independent Living Services

Cecile Courtney, CAC
Northwest Health Services, Inc.

Dale Wrigley, CEO
Novus Health

Latosha Fowlkes, CEO
Paraquad

Cassie Dawalt, President
Positively Cass, LLC

Brenda R Sharpe, President & CEO
REACH Healthcare Foundation

Bob Theis, CEO
Samuel U. Rodgers Health Center

Dede Coughlin
St. Cronan Church

Muriel Smith, Executive Director
St. Louis Area Diaper Bank

Ruth Ehresman, President
St. Pius V St. Vincent de Paul Conference

Legal Services of Eastern Missouri
Action.Justice.Hope.

Daniel K. Glazier
Executive Director and
General Counsel

Sent via email only: Jessica.Bax @dss.mo.gov

May 18, 2026

Jessica Bax, Director
Missouri Department of Social Services
221 W High Street
Jefferson City, MO 65101

Re: ABAWD Time Limits

Dear Director Bax:

We are writing to discuss Missouri's application of the expanded HR 1 work requirement/time limit rules for SNAP recipients referred to as Able-Bodied Adults Without Dependents (ABAWDs). As you know, HR 1 expanded the work/time limit policy to additional groups, including certain older adults, veterans, and individuals with dependents aged 14 and over.

DSS's application of these policies significantly affects clients that both Legal Services and DSS serve and may already be contributing to the steep decline in SNAP participation. March 2026 was the first month when SNAP participants subject to the expanded work requirements could lose benefits by exhausting their 3 countable non-work months. In March 2026, there were over 4400 fewer SNAP participants compared to February 2026.[1] While that decrease may be related to other changes to the SNAP program, at least some of this decline is likely attributable to expanded SNAP work requirements, and that impact is going to increase as more households come up for mid-certification and full recertification. Indeed, an early estimate from DSS indicated that 16,000 households could potentially be affected by the changes to SNAP work rules. Because of this significant adverse impact, these rules must be implemented as carefully and thoughtfully as possible.

As discussed below, we have suggestions for modifying FSD's policy and training. We are, however, also especially concerned with how this information is being integrated into the SNAP application and screening process. The SNAP application, interview, and notices do not properly inform SNAP recipients of the new rules and exemptions as detailed below. FNS guidance requires state agencies to screen for exemptions from both the general work requirements and the ABAWD work requirements at initial certification and recertification before determining countable months.[2] And state agencies are required to

[1] Center on Budget and Policy Priorities, *SNAP Tracker: People Are Losing Food Assistance as the Republican Megabill Is Implemented*, Updated May 6, 2026, at: https://www.cbpp.org/research/food-assistance/snap-tracker-people-are-losing-food-assistance-as-the-republican-megabill.
[2] 7 C.F.R. 273.24(k). See also FNS Memo to All SNAP State Agencies, September 5, 2025, at: https://www.fns.usda.gov/snap/obbb-implementation. FNS Memo to All State Agencies, October 3, 2025, at:

determine "good cause" for noncompliance in determining whether months count toward the time limit.[3] We have already had multiple clients attempt to navigate the new work requirements since Missouri's implementation of HR 1, and we are concerned that that FSD is not properly screening for exemptions and good cause before determining that months are countable. We therefore recommend revisions to the Income Maintenance Manual, training materials, applications, and notices to ensure staff are adequately screening these cases in accordance with the law and FNS guidance. These recommendations are described below.

1. The SNAP application should be revised to properly screen for ABAWD exemptions.

The application is the first and one of the most important places to explore exemptions, *even if* workers are screening for exemptions at other points in the process. While the current Missouri SNAP application includes a paragraph explaining the ABAWD rules (page 8), it *does not screen for exemptions*. There is a general question asking if any household members are disabled, but the ABAWD work requirement exemptions are *much broader* than just the Social Security definition of disability, and there likely are individuals who are physically or mentally unable to work who do not indicate as such because of this restrictive test. Additionally, other ABAWD exemptions are simply not addressed at all on the application (e.g., as caring for an incapacitated household member or attending a substance abuse program). Therefore, we strongly recommend adding simple screening questions with a "yes or no" checkbox asking if the applicant meets any of the exemptions.[4] We have previously shared a screener from Code for America that provides a good template for exploring these exemptions.[5] Civilla has also developed a similar "screener" for Medicaid work requirements.[6] We would be happy to work with you on screening questions for the SNAP application.

2. FSD's interview questions do not adequately screen for ABAWD exemptions.

In our experience, SNAP interviews also do not adequately screen for ABAWD exemptions or good cause. One of our clients' recent interview summaries shows that they were asked if they met a disability definition. There were then two additional questions about whether anyone in the household had quit or reduced their hours. There was no documentation that the client had been asked about *other* exemptions such as caring for an incapacitated household member or attending a substance abuse program. **We strongly recommend including questions that explore these exemptions.** The above-referenced

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https://www.fns.usda.gov/snap/obbb-abawd-exemptions-implementation; Supplemental Nutrition Assistance Program (SNAP) Abled bodied Adults Without Dependents (ABAWD) Policy Guide, Updated, September 2023 ("FNS ABAWD Policy Guide"), p. 4, at: https://www.fns.usda.gov/snap/guide-serving-abawds-time-limit-participation.

[3] 7 C.F.R. 273.24(b)(2).

[4] Massachusetts has a declaration form that could be used as a template: https://www.mass.gov/doc/snap-work-rules-exemption-self-declaration-form/download.

[5] Code for America, SNAP Work Requirements Screener, February 4, 2026, at: https://docs.google.com/document/d/1WjyyrIWM5JPZcIqPTx_B4fHpfiBpaRJ5045hTx_vGCQ/edit?tab=t.kd7xhrmc23lc#heading=h.fwjzaudmypmj.

[6] See Civilla, *Human-Center Application Templates for Medicaid Work Requirements*: A Practical ToolKit for States Implementing H.R. 1." Updated March 16, 2026, at: https://civilla.org/assets/files/Civilla-Report-Application-Templates-for-Medicaid-Work-Requirements.pdf, at p. 6 (Step 5).

information from Code for America and Civilla would also be helpful for adding appropriate screening questions to the interview process.

If you are already making any changes or have a draft list of ABAWD-related questions for SNAP interviews, we would appreciate a chance to review that information to provide feedback. But either way, the inclusion of such screening questions in the interview process is essential to a fair and well-functioning ABAWD policy.

3. DSS can improve its guidance to workers by updating and modifying its written policy manual and training.

DSS has provided workers with a good general overview of the ABAWD requirement in its training and the Income Maintenance Manual. However, the policy manual and training can be improved in several respects both to comply with federal law and to ensure that eligible individuals and families do not fall through the cracks.

Screening for exemptions: First, **the Manual needs to be revised to explicitly state the obligation to screen for exemptions** consistent with FNS regulations and guidance.[7] This includes the need **to first screen for general work requirements exemptions (other than aged 60-64) and then if those are not met, screen for ABAWD-specific exemptions**. The North Carolina policy, which we have shared previously, provides a good example of how to screen for exemptions: it provides detailed descriptions of the various exemptions with examples, questions for workers to ask participants (including open-ended questions and active listening), acceptable sources of verification, and a work rules screening checklist to comply with federal regulations. It also reiterates the FNS requirement that **countable months may not be assigned unless the individual has been screened and it is determined that no exemption applies**, which should be explicitly stated in the Missouri IM Manual.

Specific exemptions: We appreciate the inclusion of "obvious unfitness for work" as an exemption, but the policy could be elaborated on in several important ways. For example, while there is no longer an explicit exemption for homelessness, *chronic homelessness* can in fact establish that someone is "unfit for work" and the Manual should be modified accordingly.[8] As discussed below, Legal Services has clients adversely affected by the failure to explore homelessness in these circumstances. In addition, **the Manual should include other examples of obvious unfitness for work**, including but not limited to mobility limitation, chronic pain or fatigue, chronic medical conditions, cognitive or developmental disabilities, substance abuse disorders, or experiencing domestic violence.[9]

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[7] Note 2 supra.
[8] See FNS guidance, November 19, 2015 at: https://www.fns.usda.gov/snap/abawd/time-limit-policy-program-access-memo, https://www.dhs.state.il.us/page.aspx?item=174187 and FNS 260 ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWDS) 1 Section 260 Change #02-2025, December 1, 2025 ("North Carolina Policy Manual") at: https://policies.ncdhhs.gov/wp-content/uploads/FNS-260-Able-Bodied-Adults-without-Dependents-ABAWD-11.26.2025.pdf, at pp. 3, 13, 20.
[9] North Carolina Policy Manual at pp: 11-13.

Verification of exemptions: We also suggest emphasizing that **verification** is not needed for SNAP exemptions *unless the information is questionable*. Not only is this easier for the SNAP participant, but reducing unneeded verification minimizes the possibility of potential errors that could affect Missouri's error rate.[10] The IM Manual in section 5.6 makes no reference that verification is not needed for SNAP exemptions, other than a brief note about when verification is needed for disability. We recommend including a note in IM Manual 5.6.2 after the bullet point list of exemptions stating that verification is not needed unless the information is questionable.[11]

Good cause: The Manual should emphasize that FSD *must* determine if a SNAP participant has good cause for non-compliance with work requirements before imposing a disqualification period.[12] Good cause for not complying with work requirements is separate and distinct from the work exemptions. Individuals who do not meet an exemption and do not meet the work requirement must still be able to demonstrate good cause for not complying. DSS must screen for good cause before determining that months are countable toward the time limit.

FSD should flesh out the good cause provisions of the IM Manual. The Manual appropriately includes "circumstances beyond the participant's control" when determining good cause and gives a few helpful examples but unfortunately leaves out other critical examples such as court appearances or legal proceedings, household emergencies, including loss of housing, domestic violence situations, natural disasters, utility shutoffs, breakdown in child care arrangements, substance use disorder treatment, etc.[13] Worker are less likely to apply these legitimate good cause reasons if they are not spelled out in policy.

We also recommend adding "homelessness" to the good cause bullet points in section 5.6.3 of the IM manual and including questions about homelessness in any workflow for evaluating compliance good cause, as this situation comes up often. As noted above, although "homelessness" is no longer a stand-alone ABAWD exemption, chronic homelessness can still make someone exempt as "unfit for work."[14] It can also provide good cause for not meeting the work requirements where the individual was not initially determined to be exempt.

In our experience, DSS is not properly evaluating cases for good cause. For example, a recent client was chronically homeless without access to a shower or transportation. The comment section on his case even indicated that DSS knew he was homeless. When asked about evaluation under the ABAWD rules, the

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[10] See for example, the Illinois policy on verification of SNAP work rules: Illinois Department of Human Services, MR# 26.03, Updates to SNAP Rules Policy and Implementation of Time limited Benefits for ABAWDs. https://www.dhs.state.il.us/page.aspx?item=174187. FNS guidance also says that the State agency is not required to verify an exemption unless the information is question or requires verification under different program rules such as determining disability status: https://www.fns.usda.gov/snap/guide-serving-abawds-time-limit-participation

[11] For example, the manual could state, "Self-attestation from the client is sufficient to meet an exemption. Verification is only needed when the information is questionable or when verification is needed for other program purposes such as documenting disability."

[12] FNS ABAWD Policy Guide at: https://www.fns.usda.gov/snap/guide-serving-abawds-time-limit-participation, at 25.

[13] Id. at 25-26.

[14] See note 10 supra.

worker responded that homelessness was no longer an exemption but did not evaluate for good cause. This client should have been found exempt as unfit for work, but when noncompliance occurred, FSD should have found good cause. Clearer guidance is needed to ensure that individuals with these barriers do not fall through the cracks.

SNAP ABAWD Workflow: We further recommend including a "workflow chart" in the Manual and training materials to help guide workers in the screening and exemption process. While the ABAWD training guidance shared with Legal Services generally includes correct information about FSD's policy, the rules are complicated and the process can be difficult for a busy worker to navigate. North Carolina's policy includes a flow chart[15] taken from FNS guidance and adapted based on HR 1.[16] Missouri has used similar flow charts for its new SNAP immigration policy and something similar would be helpful here.[17] We would be happy to help you draft a flow chart for applying ABAWD policy.

We also suggest reorganizing the ABAWD section of the Manual to better guide workers in the decision-making process and to make it easier for individuals to navigate the ABAWD determination process. The current policy (in Section 5.6) does not clearly explain how exemptions and good cause factor in the decision-making process. The manual simply *lists the rules* without any guidance on *how to move through an evaluation of an ABAWD case*. There are no examples to show workers how the ABAWD rules are applied in a hypothetical case.[18] We recommend reorganizing this component of the IM manual to clearly order the process and explain what is needed at every stage. We are happy to propose a redraft of this section of the manual for your review.

Countable Activities: The Manual appropriately describes activities that meet the "work requirement." However, the Manual should expand on the definition of volunteer or unpaid work, as many people may already be volunteering through their church, which is sufficient to demonstrate compliance under the law but is not accurately reflected in the Manual or the paperwork for documenting volunteer work. Missouri does have a form to fill out for volunteer work, but it indicates an agreement to "volunteer in a program that promotes job readiness and builds work experience."[19] This definition is too restrictive, and the form

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[15] North Carolina Policy Manual at pp: 4-5. Missouri's IM manual includes a chart that lists work requirements but does not go through the workflow that a caseworker should follow in applying ABAD rules and exemptions. See: https://my.mo.gov/cms_fsd?id=fsd_policy_manual&sysparm_article=KB0010480 Guidance from North Carolina's guidance provide a tool that is easier to navigate.

[16] FNS ABAWD Policy Guide at: https://www.fns.usda.gov/snap/guide-serving-abawds-time-limit-participation, p. 12.

[17] Family Support Division Policy Manual, 18.6.2 (TA and SNAP Immigrant Eligibility Flow Chart) at: https://my.mo.gov/cms_fsd?id=fsd_policy_manual&sysparm_article=KB0010478&sys_kb_id=0f50d07e877f32147dd8113d3fbb355e

[18] For example, under good cause, you might include an example like this: "Mr. Smith is a 58-year-old SNAP recipient. The worker has evaluated him for exemptions to the work requirements, but he does not meet an exemption. However, in the FAMIS comments on the case, Mr. Smith indicated that his car had broken down, and he does not have the money to fix it. The worker can find good cause for Mr. Smith's non-compliance during months when he did not have transportation before determining countable months."

[19] DSS, How to meet 80 hours of Work/Training at: https://dss.mo.gov/employment-training-provider-portal/docs/abawd-volunteer-agreement.pdf

should be modified. Individuals can meet the work requirement through many kinds of volunteer work, not just job readiness or work experience programs.

Explanation of work requirement at application and recertification**.** If would be helpful for the Manual to include a requirement that workers explain both general work registration and ABAWD work requirements io the household, including such items as explaining each applicable work requirement, who is subject to the requirements, exemptions and good cause, how to request an exemption or claim good cause, consequences for failure to meet work requirements, general rights and responsibilities, including documentation in the case file that this information was explained to the participant.[20]

4. DSS does not provide legally sufficient notice to SNAP recipients subject to ABAWD requirement.

SNAP notices do not contain all the information necessary for SNAP participants to understand the ABAWD rules. A recent client received an adverse action notice stating that his application was denied because he had used his 3 non-work months. While the notice states that exemptions apply, it does not list all of these exemptions and uses unclear terminology. For example, the ABAWD "Action Notice" includes as an exemption "METP exempt" which no SNAP participant is going to understand. The notice needs to include a clear and understandable list of *all* of the exemptions that may apply to comport with due process. In addition, when the agency has determined that the client is not compliant with the work requirements and does not meet an exemption, the notices should explain "good cause" and give examples so participants can determine whether they may have good cause for their non-compliance. And all of this information needs to be communicated to the client *before* any action is taken.

Another recent client received a notice that his work registration status had changed. The notice correctly lists the exemptions for the *general* work requirement but *not* the ABAWD exemptions and fails to include "good cause" exceptions. It then informs the recipient that *no further action is needed*. On the same date, however, our client received an "action notice" denying his application for exhausting his *3 non-work months* and failing to meet the work requirements. The only other ABAWD related notice the client received was the general notice sent in September 2025 notifying *all* recipients of the upcoming SNAP changes. These *general* notices fail to notify clients about the program rules that actually apply to *them*. The notices provided to our client did not provide sufficient time for him to demonstrate compliance, participate in Skill-Up, claim an exemption, or establish good cause. These notices are inadequate to inform them of their responsibilities and possible exemptions and good cause exceptions from the ABAWD rules.

Furthermore, FNS regulations are clear that countable months must not be assigned until DSS has screened for exemptions, and we fear this is not happening. As noted above, a Legal Services client interview did not develop exemptions thoroughly, but when *the advocate* asked a simple question about medical conditions, the client gave information that arguably shows he is physically or mentally unfit for work.[21]

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[20] See North Carolina Policy Manual at pp: 28-30.
[21] 7 C.F.R.§ 273.24(k).

As discussed above, other states have explicitly stated in their policy manuals that countable months should not be counted until work exemptions are fully screened and so should Missouri.[22]

5. DSS should improve transparency by making data publicly available

In light of these monumental changes in HR 1, including the expansion of the ABAWD time limits to new populations and the potential for so many eligible individuals to lose vital nutrition assistance, it is important to produce publicly available data on a monthly basis regarding the numbers of individuals losing coverage due to the ABAWD requirement, the number determined to be exempt, the number with good cause, etc.

Conclusion

We know DSS is working hard to implement HR 1, including the recent changes to the SNAP program. However, given the noticeable drop in SNAP recipients since these changes were implemented and the lack of clear guidance, we are concerned that eligible Missourians are not being screened properly for exemptions and good cause, and that eligible individuals are falling through the cracks. These errors are also likely to adversely affect Missouri's error rate, as many ABAWDs are in now "mixed households" (i.e., households that also include individuals who are *not* subject to the SNAP time limit). Denying SNAP to *eligible* individuals (i.e., those who should have been determined to be exempt or have good cause) will result in SNAP underpayments and increase state error rates, thereby increasing the "state match" required to run Missouri's SNAP program.

We hope you consider these suggestions for helping the Agency and low-income Missourians navigate the ABAWD requirements. We welcome an opportunity to meet with you to discuss these ideas and proposed changes. Thank you for your consideration of these comments

Very truly yours

/s/ Patrick Sommer
Patrick Sommer
Attorney at Law

/s/ Joel Ferber
Joel Ferber
Director of Advocacy

[22] See Illinois Department of Human Services, PM 03-16-01, Screening for SNAP Work Requirement Exemptions, at: https://www.dhs.state.il.us/page.aspx?item=55119

Sent via email only: Jessica.Bax @dss.mo.gov

September 17, 2025

Jessica Bax, Director
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65102-1527

Re: H.R. 1: Implementation, Preliminary Observations

Dear Director Bax:

We enjoyed meeting with you and Heike to discuss the Department of Social Services (DSS)'s preliminary plans for implementation of H.R.1. We appreciate the care and attention you are giving to these complex issues that are so critical to our state and its residents. As you requested, we are sending our initial thoughts and recommendations to protect Missourians from unnecessary and harmful loss of Medicaid and SNAP benefits. We believe the strategies outlined below will also protect our state's budget, as well as state and local economies, to the greatest extent possible under the new law.

The new federal requirements will have a dramatic impact on our state and its residents, particularly the most vulnerable Missourians. They will upend existing state systems and processes, while placing great strain on DSS and its staff. Innovative and creative strategies can alleviate some of these challenges.

I. MEDICAID (MO HealthNet)

We discuss below issues that primarily affect Medicaid, but many will also affect SNAP given the interconnection between these DSS-administered programs.

A. <u>Transform Systems to Simplify Processes and Maximize Automation</u>

Missouri's IT systems require upgrades to comply with the new law. Since their inception, Missouri's computer systems (including FAMIS and MEDES) have come up short, with multiple barriers to application approvals, renewals and reporting; high rates of procedural terminations (well above the national average); excessive reliance on overburdened call centers; and confusing

and legally insufficient notices. Transforming these systems may be Missourians' best hope for keeping the health coverage and nutritional assistance to which they are entitled, and upon which they rely. We were pleased to learn you have dedicated a new staff person to this issue. We further suggest DSS should:

1. Automatically Verify Work Requirement Exemptions and Compliance

Utilizing data to automatically verify both work requirement *exemptions*, as well as work/service *compliance*, would eliminate burden on staff and improve delivery of benefits. This will require refining and streamlining current data sources, and adding new data sources to increase *ex parte* verification of these factors. DSS should further consider:

- Examining MCO and other third-party sources of data to reduce the need for participants to affirmatively report information and provide verification;
- Automatically verifying Home and Community Based Services (HCBS) caregivers as meeting work requirements based on existing and available data on caregivers' work hours;
- Expanding use of currently-available commercial and third-party databases and identifying new databases, such as The Work Number, which can determine compliance on an *ex parte* basis by verifying earnings, hours worked, volunteer work hours, community college attendance, etc.;[1]
- Identifying individuals who qualify for exemptions, including those currently receiving AEG coverage who *may* qualify based on eligibility for other Medicaid coverage categories. For example, Medicaid Expansion participants receiving long term services and supports, including home and community-based services provided through waivers or residing in skilled nursing facilities, should be automatically exempted because they meet the disability/medically frail exemption. Similarly, anyone who indicates a disability on their application should be exempted as medically frail while DSS explores eligibility for MHABD;
- Using existing state data—both within DSS's own systems (e.g., through MHD or MCOs) as well as within other departments—to establish *exemptions*. For example, anyone with an open DMH case can be determined to meet the medically frail or substance-use exemption without any contact with the individual. Since DMH already identifies AEG participants enrolled in these programs, DSS needs only to determine how to access this data in order to establish an exemption based on medical frailty;[2]
- Using MHD claims data to establish exemptions due to health status (e.g., persons with "special medical needs" and persons with a "serious or complex health condition"). This may include, for example, individuals prescribed anti-retroviral therapy used for HIV treatment, people with diabetes who use insulin, individuals with mental health conditions

[1] DSS should assess the most effective method for verifying earnings and hours. For example, in our experience, The Work Number is more effective than IMES in verifying earnings. IMES data is from the prior quarter, and it often leads to requests for verification for jobs the participant left months earlier. We saw many fewer requests for income verification when FSD used The Work Number.

[2] Collaborating with disability rights groups could help DSS to develop a functional and simplified way to ensure exemption of people with disabilities (including creation of a standardized "Medical Frailty" screening tool) and to test technology options with disability groups to ensure they are sufficiently accessible.

who use psychiatric medications, and folks with a cancer diagnosis getting chemotherapy; and;

- Ensuring people with disabilities are properly identified by taking a broad view of disability-based exemptions. This could include adopting the RAISE Family Caregiver disability standard referenced in H.R.1, considering IADLs (instrumental activities of daily living) as well as ADLs and/or incorporating the ADA definition of disability (significant impairment of a major life activity) when determining medical frailty. These safeguards are essential given the significant number of individuals with disabilities currently receiving AEG,[3] and the difficulty in identifying them.

2. Streamline and Ease the Burden of Manual Reporting

Participants who must report manually need simpler and more accessible options to comply with requests for information, which in turn will help eligible Missourians keep their benefits as well as reduce churn in the agency's caseload. DSS should develop a simplified reporting form and offer multiple methods for reporting; for example: brief text message replies, one-click buttons in text messages or emails, QR codes, and other simple and secure ways to electronically comply with manual reporting. It will be important to test technology options with disability rights groups to ensure they are accessible to all participants.

Under the current system, timely-submitted verifications often get lost in the determination process or are simply not acted on by FSD. DSS should expand and improve systems for flagging verifications when people submit them electronically, through the mail, or at county offices.

DSS should allow self-attestation of exemptions and compliance with work requirements as allowable, and should only require the reporting that the statute *actually requires*—at the time of application and renewal—rather than more frequently, which would be an administrative nightmare and an almost certain guarantee of improper terminations. Adopting the option to require one month of work prior to application, rather than looking back three months, would avoid needless denials of coverage and ease administrative burden. Similarly, DSS should allow the longest reasonable period before requiring renewal of exemptions. Indeed, some exemptions can be permanent, for example, for persons with significant and lifelong disabilities.

3. Adopt All Flexibilities to Maximize Automatic Renewals

To minimize the burden of new six-month reporting for AEG participants, DSS could automatically renew as many members as possible (*ex parte* renewals). This could include adopting and/or continuing all permissible unwinding flexibilities, like the zero net income and 100% FPL strategy, for both MAGI and non-MAGI populations. This approach will bolster Missouri's below-average *ex parte* rate and reduce procedural terminations; both these outcomes

[3] See David Machledt, National Health Law Program, *The Faces of Medicaid Expansion: Filling Gaps in Coverage Update* (Apr. 20, 2023)(examining the demographics of the Medicaid expansion population), https://healthlaw.org/resource/the-faces-of-medicaid-expansion-filling-gaps-in-coverage/.

will also reduce agency workload as staff will not need to process manual reports and verifications, or process new applications when a still-eligible participant is terminated improperly.

DSS must preserve annual renewals for all non-AEG eligibility groups and implement precise computer programming to prevent any 6-month reporting requests from being sent to people who should not receive them. Failing to do so would increase the burden on the most vulnerable Missourians—the elderly, blind and disabled—and also drain DSS capacity, tie up staff time, and increase errors.

4. Integrate and Invest in Data Systems

DSS should explore ways to improve integration or communication between systems, especially if it intends to continue using both FAMIS and MEDES. Further, DSS should ensure better integration of systems between its Divisions (e.g., systems employed by FSD and MHD) as well as integration between state departments (e.g., DSS, DMH and DHSS). DSS can receive the enhanced 90% federal match for these efforts.

New data systems should effectively document denials and disenrollments, including procedural denials and disenrollments. This documentation should occur in real time, and be sortable by race/ethnicity, language spoken, and geographic region. Such system changes would enable the agency to identify and resolve procedural issues quickly and minimize harm and disruption for participants. Data systems should also allow for reporting of the *specific reason* for denial/termination, in order to identify individuals who are denied or terminated based on new Medicaid reporting requirements, apart from *other* procedural denials and disenrollments. DSS will also need to consider how applications transferred from the Marketplace will be processed, since comprehensive exemption information is not currently collected through the federal Marketplace application.

It would also be advantageous for DSS to undertake consumer testing of new application and reporting systems, including work requirements compliance and documentation, before deployment.

5. Seek Extensions to Ensure Thoughtful Implementation

The law allows HHS to grant extensions to states that are making good faith efforts to comply with work reporting requirements. Given all of the systems challenges Missouri faces, and the risk of harm from implementing too quickly, it would be wise for DSS to pursue such an extension.

B. <u>Simplify Eligibility and Enrollment; Coordinate MAGI and Non-MAGI</u>

H.R.1 postponed mandatory implementation of certain HHS "eligibility and enrollment" rules, while leaving others in place. With regard to the mandatory provisions of those regulations still in effect, it is critical that Missouri deem eligibility for certain individuals who are eligible for Medicare Part A, and who are Supplemental Security Income beneficiaries eligible for Qualified Medicare Beneficiary (QMB) coverage, without requiring an application. 42 C.F.R § 435.909.

Pursuing the state option—left intact by H.R.1—to allow spenddown participants to deduct prospective medical expenses, 42 C.F.R. §§ 435.831 and 436.831, and/or establish an optional eligibility group for a reasonable classification of individuals under age 21, 42 C.F.R. § 435.223, creates an important opportunity to improve Missouri's Medicaid spenddown program. This would reduce burdens for individuals and families, health care providers, and the state agency while creating greater continuity of care.

Missouri can still pursue non-mandatory eligibility and enrollment streamlining and coordination strategies for all participants, including but not limited to: (1) allowing individuals a minimum of 15 calendar days to respond to requests for additional information (and 30 calendar days for MSP recipients); (2) providing enrollees with a minimum of 30 calendar days to respond to requests for information or return a renewal form, and the 30 days begins to run from the date the state sends the form (either when it is postmarked or sent electronically);[4] and (3) providing that if an enrollee's eligibility cannot be renewed based on information already available to the state, then DSS will provide a pre-populated renewal form containing information already available to the state.[5]

Because the response deadlines in the regulations are *minimum* time frames. DSS may want to consider longer time frames given significant mail delays and other difficulties with relying on mail delivery for compliance. It is also critical for DSS to accept applications and supplemental forms through any modality available, including phone, mail, in-person, and/or web-based modalities. While the new rule on this point is suspended by H.R.1, that provision merely clarified an existing regulation still in effect with which DSS must still comply. 42 C.F.R. § 435.907(a). It is also good practice to afford these different options to Medicaid beneficiaries.

Missouri should apply all beneficial MAGI enrollment and eligibility strategies to non-MAGI cases and continue prior plans to streamline MAGI and non-MAGI systems into a single MO HealthNet computer system[6]

C. Ensure Effective Communication

It will be essential to provide clear communication to medical and service providers as well as participants, applicants, and the community organizations that serve them. The communication strategy should include culturally and linguistically appropriate outreach, by trusted community partners, before any H.R.1-related terminations or reductions occur. That strategy should also

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[4] While no longer mandated, the vast majority of states were already providing 30 days for non-MAGI beneficiaries to return renewal information as of June 2024, per KFF, *see* https://www.kff.org/medicaid/issue-brief/medicaid-eligibility-and-enrollment-policies-for-seniors-and-people-with-disabilities-non-magi-during-the-unwinding/.

[5] The rule would have required pre-populated forms for non-MAGI beneficiaries, to align with MAGI requirements. While such alignment is no longer mandated, 38 states were already providing pre-populated renewal forms to non-MAGI beneficiaries as of June 2024 per the aforementioned KFF study. Missouri certainly could move in this direction, with or without the E&E rule.

[6] The E&E rule requires a 90-day reconsideration period for both MAGI and non-MAGI, in which the state must treat the receipt of the renewal form as a new application and reconsider the individual's eligibility. Even without the rule, the vast majority of states, including Missouri, provided a 90-day reconsideration period as of June 2024, per KFF, supra. The E&E rule provides that barring a change in circumstances, states must not renew eligibility more frequently than once every 12 months. While this rule is no longer in force, all states were doing annual renewals for non-MAGI participants as of June 2024. This option is not affected by the reconciliation bill, which only applies the 6-month renewal period to expansion enrollees. Thus, Missouri can continue to do annual renewals for non-MAGI populations.

include outreach to persons with disabilities and disability groups to ensure accessibility of materials generated by DSS. Furthermore, MHD should inform Medicaid participants of program changes well in advance of implementation.

Notices will need to be revised to apprise people of their rights and obligations under the new law, including how to comply with work requirements and avoid sanctions. To ensure the notices are clear and understandable, DSS should work with stakeholder groups to draft notice language, and conduct user testing to further refine notices before they are implemented.

D. Implement Nominal Cost-Sharing

New cost-sharing provisions will place a significant burden on Medicaid expansion participants. Research has consistently shown that cost-sharing in Medicaid makes it harder for participants to afford the medical care they need, and those with chronic conditions are the most vulnerable as they need the most medical care.[7] Cost-sharing may also have adverse consequences for health care providers, who may lose revenue due to reduced Medicaid participant utilization of care stemming from inability to afford co-payments. A nominal co-pay would help to minimize these concerns: H.R.1 allows a range of co-pay amounts, from $0.01 to $35. H.R.1 also gives the states flexibility to choose which services will be subject to cost-sharing. Missouri can greatly reduce harm by applying nominal cost-sharing to only a limited number of services. Further, Missouri should not allow providers to deny service for failure to make co-payments, as doing so would only undermine our healthcare system by incentivizing denials of care and leading to more expensive treatments later.

II. SNAP-SPECIFIC ISSUES

The cost shift of SNAP to state agencies will create significant budgetary challenges. Working to lower error rates, both overpayment and underpayment errors, will help decrease the cost of the match to the state. Missouri is in an especially good position to decrease the cost to the state by focusing on its error rate and getting it below 10%. Missouri's average error rate over the last three years was 10.54%. Getting below a 10% error will save Missouri about $75 million per year. To work to continue to decrease its error rates, DSS should be wary of "easy fixes" designed solely to reduce the state match. DSS should also avoid adding bureaucracy to an already complex system, as doing so is likely to increase error rates while burdening Missouri families who rely on SNAP. The state should instead focus on changes to processes and to policies that will both comply with the law and best preserve nutrition assistance for eligible participants.

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[7] Leighton Ku and Vicky Wachino, The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings, Center on Budget and Policy Priorities, Revised July 7, 2005 (available at: https://www.cbpp.org/sites/default/files/atoms/files/5-31-05health2.pdf). See also David Machledt & Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing* (Mar. 26, 2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/.

A. Simplify Applications and Reporting

Strategies that reduce unnecessary paperwork burdens and interactions between agency staff and participants could ease some of the strain of the cost-shift by reducing opportunities for errors, which in turn impacts the State's funding obligation.

1. **Eliminate the asset test for SNAP to the greatest extent possible:** In FY 2024, thirty-seven (37) states and the District of Columbia disregarded asset limits for most households applying for SNAP. They do this by adopting a policy called "broad-based categorical eligibility" (BBCE), which aligns the asset rules for SNAP with those of other assistance programs, such as Temporary Assistance for Needy Families (TANF). In addition to reducing the paperwork burden for applicants and saving on the staff time costs of verifying assets, this change would eliminate asset verification as a possible place for Missouri to be penalized for errors.

2. **Implement the Elderly Simplified Application Project (ESAP):** ESAP for individuals with no earned income who are over 64 or who are disabled will reduce paperwork, staff time, and minimize unnecessary recertifications and mid-certification reports. Relieving staff of paperwork and interview time for these very stable cases will allow them to focus on the more complicated cases that need oversight and are more likely to cause errors.

3. **Offer Transitional SNAP Benefits to as many people as possible:** Transitional benefits to families who are leaving the TANF Program offer a fixed benefit amount for 5 months. During this time period, there are no income or asset verification reporting requirements for the fixed benefit amount; thus, the state cannot be penalized for any under- or overpayment errors in those cases. Again, this change would decrease the opportunity for error and will reduce the state's overall error rate.

B. Implement Work Requirement Changes Carefully

Revisiting Missouri's implementation of SNAP work requirements is especially important both to preserve nutrition assistance for needy Missourians and to minimize errors. The law expands SNAP "work requirements" by extending time limits, which previously applied only to Able Bodied Adults Without Dependents or ABAWDs to older individuals and households with dependent children. Many households will now be "mixed status," including some members who are subject to the work requirement and others who are not (e.g., children). A failure to properly identify exemptions will cause errors in those cases and increase the state's error rates and will risk our fellow citizens losing benefits for which they remain eligible and which they need to survive.

New automated systems developed for Medicaid could also be leveraged to improve the implementation of SNAP work requirements and exemptions. The burden of establishing exemptions cannot be placed on households at the point of benefits termination. Instead, households should only be subject to SNAP "work requirements" after their next regularly scheduled recertification, when DSS can explain the change in the law, the new requirements, and how the household can comply. And DSS must screen for exemptions in accordance with federal regulations and recent FNS guidance.

III. IMMIGRANTS' ACCESS TO PUBLIC BENEFITS

H.R.1's restrictions on immigrant eligibility for Medicaid, SNAP and other benefits present tremendous challenges and will pose significant hardship for our immigrant communities. Nearly all these provisions affect immigrants who are lawfully present in the country. Missouri must ensure those who remain eligible for SNAP or Medicaid continue to receive benefits. Under H.R.1, lawful permanent residents (LPRs) remain eligible for these programs. Many individuals who are coded as refugees or asylees—groups that are no longer eligible under H.R. 1—have LPR status. In some cases, they have adjusted their status to LPR after their last interaction with DSS and had no reason to report their updated immigration status as it was not required. DSS must determine whether individuals no longer eligible under a prior category are still in fact eligible as LPRs or citizens. Terminating benefits without determining eligibility on another basis would be illegal. Further, many lawfully present immigrants are in "mixed households" and the failure to properly identify them as eligible will cause underpayments, which will increase the state's error rate while also denying benefits to eligible individuals and families.

CONCLUSION

Implementation of H.R.1 will require bold state leadership and engagement with participants, advocates, providers, foundations and other stakeholders. We look forward to discussing these and other details at our next meeting, and to partnering with you to protect access to medically necessary health coverage and SNAP benefits to the greatest extent possible under the law.

Very truly yours,

Amy Blouin, President and CEO
Brian Colby, Vice President of Public Policy
Missouri Budget Project

Joel Ferber, Director of Advocacy
Jamie Rodriguez, Managing Attorney
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Missouri Foundation for Health

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HB 2481 and SB 1616

Proposed New Documentation Requirements for Medicaid and SNAP

Joel Ferber and Geoff Oliver, Legal Services of Eastern Missouri

Updated, April 22, 2026

The Missouri General Assembly is considering legislation that would create unnecessary complications in Medicaid and SNAP. The House of Representatives passed HB 2481, while SB 1616 passed out of the Senate General Laws Committee. These proposals would create costly administrative burdens for the State and cause citizens and eligible lawfully present immigrants to lose access to health care and nutrition assistance. The proposed changes also increase the likelihood of agency errors, fiscal sanctions, and additional state costs. This paper focuses on key Medicaid and SNAP provisions of HB 2481,[1] but SB 1616 includes nearly identical requirements.[2]

Background

Under current law and policies, Medicaid applicants must attest under penalty of perjury that they meet the citizenship or immigration status requirements when completing their application for benefits. If they are found to meet all other Medicaid requirements but there is a delay in documenting the citizenship and or immigration status documentation/verification requirements, applicants are allowed a "reasonable opportunity period" to meet them. Medicaid law and regulations require states to use data matching directly with the Social Security Administration and provide explicit instructions for an alternative mechanism that may be used.[3] Medicaid uses SAVE (the Systematic Alien Verification for Entitlements Program operated by the United States Department of Homeland Security) to verify eligibility for immigrant applicants (e.g., to verify the immigration status of non-citizens based on information they provide to the State agency).[4]

SNAP currently allows individuals to attest to their citizenship and similarly relies on SAVE to verify eligibility for immigrant applicants. In practice, both SNAP and Medicaid already verify Social Security numbers through data matches with SSA.[5] Using Social Security numbers for

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[1] The consequences of many provisions extend beyond Medicaid and SNAP, as they would apply to any state or local agency who provides public benefits. "Public benefits" is defined broadly in the statute as "any grant, contract, or loan provided by an agency of state or local government; or any retirement, welfare, health, disability, housing, or food assistance benefit under which payments, assistance, credits, or reduced rates or fees are provided."

[2] This paper does not discuss the "Healthy SNAP" provisions in HB 2481 but focuses only on the new documentation provisions of that legislation.

[3] 42 C.F.R. § 435.956(a)(1)(i).

[4] Immigrants provide documentation numbers and that information is used for data checks with SAVE. Naturalized and derived citizens can have their status verified by SAVE, but that would require them to provide an "A" number, which is not often readily available to long-time citizens.

[5] While SAVE is being modified to include Social Security numbers of U.S. citizens, reports from other efforts to verify citizenship via the new SAVE data suggest that it is prone to errors, whereas the SSA match has proved effective. *See e.g.*, Jennifer Fifield and Zach Despart, *Not Ready for Prime Time: A Federal Tool to Check Voter Citizenship Keeps Making Mistakes*, Pro Publica and the Texas Tribune, Feb 13, 2026, at:

people who attest to being citizens, Medicaid matches with the Social Security Administration (SSA) first, and SSA can substantiate citizenship for the vast majority of people. Recent CMS guidance focuses on how states can use SAVE to verify the immigration status of qualified *non-citizens* and citizens *with naturalized or derived citizenship* (not for all citizens or citizens in general).[6]

Changes to Citizenship Documentation (Verification): HB 2481 requires any agency that administers public benefits to verify that the applicant or enrollee of that public benefit is a United States citizen, United States national, or an eligible alien for such public benefit through SAVE "and any other verification system"[7] at the time of application, at each eligibility redetermination, and whenever information is received indicating a change in circumstances affecting eligibility related to citizenship or immigration status. (§208.009.12).

- **Impact:** This provision would create unnecessary work for the State and cause eligible individuals to lose Medicaid and SNAP benefits.
- States already successfully use data matching with the Social Security Administration to verify citizenship. Running *citizens* through SAVE substitutes an unproven technology for one that is already working.
- DSS does not have capacity to verify citizenship or immigration status of every applicant or recipient through SAVE. It has requested funding of $15,349,288 for eligibility verification services related to H.R. 1 implementation, which includes system changes to automate the verification process with SAVE.[8] Without funding to implement these necessary system changes, a manual process will be required resulting in a need for additional staff, which also requires additional funding.[9]
- This provision would violate federal law, which prohibits states from subjecting certain populations to a citizenship documentation requirement:
    - Most individuals receiving Medicare, disability insurance benefits, or supplemental security income benefits, children in foster care, and children receiving foster care or adoption assistance groups are exempt from the requirement to document citizenship for Medicaid eligibility.[10]
    - Infants born to a mother who is receiving Medicaid or CHIP at the time of birth are not required to provide documentation of citizenship status. Rather, they are

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https://www.propublica.org/article/save-voter-citizenship-tool-mistakes-confusion; Phil Galewitz, *Trump's Hunt for Undocumented Medicaid Enrollees Yields Few Violators*, KFF Health News, March 31, 2026, at: https://kffhealthnews.org/news/article/medicaid-undocumented-enrollees-review-few-violators/.

[6] State Health Official Letter #26-001, April 8, 2026.

[7] It is not clear what is intended by the phrase "and any other verification system." It would appear that running individuals through though SAVE is the minimum requirement but that if the Agency chooses also to use some other verification system, it must verify citizenship and immigration status through that system as well.

[8] Because the costs in that budget request include all necessary eligibility verification service changes to implement H.R. 1, the amount directly related to automation of the verification process with SAVE is unknown.

[9] Committee on Legislative Research, Oversight Division, Fiscal Note, April 8, 2026 at: https://documents.house.mo.gov/billtracking/bills261/fiscal/fispdf/6262H.02P.ORG.pdf p. 5.

[10] 42 U.S.C. 1320b-7(x)(2); 42 C.F.R. § 435.406(a)(iii).

> "deemed to have provided satisfactory documentary evidence of citizenship and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance."[11]

- The legislation would require individuals to *re-prove their citizenship* at each eligibility reverification. This unnecessary hurdle increases the burden on both caseworkers and recipients. Citizens rarely stop being citizens and those that do, opt for this when they are leaving the U.S.; thus, citizenship verification in Medicaid is currently a "one and done" situation. For eligible non-citizens, LPR status need not be reverified unless there is some reason to think that such status has changed. This provision also violates federal requirements that prohibit states from reverifying immigration statuses, like LPR, that are unlikely to change.[12]
- The current practice of verifying citizenship for Medicaid through the SSA match and using SAVE to verify eligibility of non-citizens is sufficient for proper eligibility determinations.

Documentary Proof of Citizenship and Identity: The bill would make matches through any electronic or data verification system insufficient to prove identity. Instead, every applicant for public benefits would be required to provide *documentary* proof of United States citizenship, United States national status, or alien status to be eligible for public benefits. (§208.009.9).[13]

- **Impact:** This provision would require paper documentation of citizenship and identity, in addition to data verification. This proposal violates Medicaid law by conditioning eligibility on a factor outside program requirements. 42 C.F.R. §435.952(c) (an individual can only be required to provide additional information or documentation if the information cannot be obtained electronically). Additionally, it creates excessive requirements that burden people with low incomes who lack access to driver's licenses and other forms of documentation. Both programs already require personally

[11] 42 U.S.C. 1320b-7(x)(2)(D); see also 42 C.F.R. § 435.406(a)(iii)(E)(1); CMS, Dear State Health Official Letter, SHO No. 09-009 (Aug. 31, 2009), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf ("individuals who are initially eligible for Medicaid or CHIP as deemed newborns . . . will not be required to further document citizenship or identity at any subsequent Medicaid or CHIP eligibility redetermination").

[12] Generally, once citizenship has been verified, states are prohibited from reverifying it. 42 C.F.R. § 435.956(a)(4)(ii). According to CMS, states may not reverify U.S. Citizenship unless the individual reports a change in citizenship or the state has received information indicating a potential change in the individual's U.S. citizenship. CMS Instructions for States, August 20, 2025, n. 1, citing 42.C.F.R. §§ 435.956(a)(4)(ii) and 457.380(b)(1)(i). States may only reverify immigration status at renewal for those statuses that are subject to change, such as noncitizens with Temporary Protected Status (TPS), or if a change is reported. See CMS Final Rule, "Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP" (81 FR 86428) November 30, 2016, available at: https://www.federalregister.gov/documents/2016/11/30/2016-27844/medicaid-and-childrens-health-insuranceprogramseligibility-notices-fair-hearing-and-appeal

[13] This section appears to conflate citizenship and identity.

identifiable information and require all eligible immigrants to have their status verified through the SAVE system. There is no evidence that the current processes do not ensure that only eligible people are approved.

- Requiring *every* Missourian applying for SNAP or Medicaid benefits to provide documentation *even if* electronic sources can verify eligibility creates a tremendous but needless burden on the Family Support Division and would cause eligible Missourians to lose access to medical care and nutrition assistance.
- This revision increases opportunities for improper underpayments. Currently, Family Support Division does not consistently process applicants' submitted documentation due to poor functioning of the Agency's computer system.[14] The bill's "duplicate verification" requirement creates additional opportunities for eligible individuals to be denied benefits. As discussed below, these individuals would only be able to get one "reasonable opportunity period" *regardless* of whether the failure to process documents was their fault or the fault of the State agency.
- One source of identity verification that can be shared across all benefit programs is sufficient. For example, if someone matches successfully through the Social Security Administration for Medicaid, that match should be sufficient for all programs, including SNAP.

Limiting "reasonable opportunity" periods: The legislation would preclude any additional period of eligibility for "temporary benefit" for any applicant who was previously denied public benefits at any time due to failure to verify United States citizenship, United States national status or alien status eligible for such public benefits. (§208.009.7(3)).

- **Impact:** As noted earlier, Medicaid applicants are allowed a "reasonable opportunity period" to meet the citizenship and or immigration status documentation/verification requirements. Federal law places *no limit* on the number of reasonable opportunity periods an individual can have. This often applies when families need to acquire an out-of-state birth certificate. If someone fails to verify that the applicant is a citizen or has an eligible immigration status in one application, that does not preclude them from properly documenting their citizenship or status later. This provision would run afoul of federal requirements and penalize applicants and participants in perpetuity for failing to meet a procedural requirement at a single point in time.[15]

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[14] The failure to process submitted documentation is but one reason for Missouri's high rate of "procedural terminations" in the State's Medicaid program (terminations not based on paperwork/administrative problems, rather than *ineligibility* for Medicaid). See e.g., Timothy McBride, Missouri Medicaid update, 2025: Procedural concerns remaining for Medicaid recipients, April 1, 2026 (analyzing CMS data), available at: https://timothymcbride.substack.com/p/missouri-medicaid-update-2025-on. More documentation requirements are sure to increase such procedural terminations.

[15] This change will be even more harmful when incorporating §208.009.9, which requires every applicant to provide documentation of citizenship even if their citizenship has already been verified via SAVE or SSA, which will ensure that many more applicants will fail to verify their citizenship.

- The current policy on reasonable opportunity periods meets program goals and complies with federal requirements.

Legal Status of Non-Applicants: Missouri currently prohibits DSS from inquiring about the legal status of custodial parents or guardians applying for public benefits for their dependent child who is a citizen or lawful permanent resident. The legislation eliminates this prohibition (§208.009.5).

- **Impact**: The legal status of custodial parents who are *not* applying to get benefits for themselves is not relevant to the determination of their children's eligibility for benefits. Asking for the disclosure of this information is against federal policy. Missouri's existing law complies with this federal policy. If passed, this bill would deter ineligible parents from applying for Medicaid and SNAP for their eligible children, including but not limited to "unborn" children under the Show Me Healthy Babies program.
- Continuing current policy on non-applicants meets federal requirements and ensures that only citizens or legally eligible immigrants receive benefits.

Documentary Proof of Relationship: The bill requires individuals applying for benefits with minor children to provide documentary proof of their relationship to the children or proof of financial responsibility for the children. (§208.009.12(1)).

- **Impact:** This violates federal regulations that preclude the State from requiring all parents to provide "documentary proof" of their relationship to their children rather than rely on "ex parte" data sources available to the State agency.[16] All Missouri parents applying for benefits for their children would have to prove that they are their children's parents even though for most the State already has access to the children's birth records.
- This provision would create an unnecessary administrative burden for Family Support Division as well as the families. DSS estimates that it would require an additional 42 FTE staff to process the additional paperwork from this provision.[17]
- Accepting self-attestation of family relationships is appropriate unless there is reason to believe otherwise in a particular case. It is also more appropriate (and lawful) to verify relationships with vital records and other data before requiring documentary evidence.

Reporting to DHS: The bill provides that if any agency that administers public benefits is unable to determine an applicant's or enrollee's lawful presence after a SAVE query or other authorized verification, the agency must immediately suspend approval or continuation of benefits and refer

[16] Under 42 CFR § 435.945(a), the State agency may accept self-attestation for proof of family relationship but doing so is not required. However, if the State chooses not to accept self-attestation for household construction they cannot immediately jump to requiring documentation. Rather, they could only require documentation if the information could not be electronically verified. 42 CFR § 435.952.

[17]Committee on Legislative Research, Oversight Division, Fiscal Note, April 8, 2026 at: https://documents.house.mo.gov/billtracking/bills261/fiscal/fispdf/6262H.02P.ORG.pdf pp. 7-8.

the case to the United States Department of Homeland Security or other appropriate federal agency for investigation and enforcement action. (§208.009.12(3)).

- **Impact:** Lack of a match on SAVE or any other verification system only signals that more research is needed. It does *not* prove ineligibility or lack of acceptable immigration status and is therefore not a reason to report to DHS.[18] It is also not an acceptable reason to terminate benefits, as federal law requires a reasonable opportunity period to provide information.[19]
- This provision would have a chilling effect on participation by individuals who are eligible for Medicaid and/or SNAP and could well violate laws that restrict programs from such reporting.[20] The sharing of health coverage and SNAP data with DHS would likely make immigrant families more reluctant to access health coverage and care as well as SNAP benefits for eligible family members, including citizen children.
- It makes sense for DSS to continue complying with federal requirements regarding "reasonable opportunity periods" and it is inappropriate to report people based on failure to match on SAVE.

New Presumptive Eligibility Policies: The legislation would require the MO HealthNet Division to include a field for citizenship or immigration status on all presumptive eligibility applications. The Division would have to require hospitals, clinics, and other qualified entities authorized to conduct presumptive eligibility determinations to collect and transmit attestations of citizenship or eligible immigration status to the division. No presumptive eligibility application could be approved unless the applicant certifies that the applicant is a United States citizen, United States national, or alien with eligible immigration status for MO HealthNet. (§208.009.13).

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[18] Federal Register: Responsibility of Certain Entities To Notify the Immigration and Naturalization Service of Any Alien Who the Entity "Knows" Is Not Lawfully Present in the United States, at: https://www.federalregister.gov/documents/2000/09/28/00-24894/responsibility-of-certain-entities-to-notify-the-immigration-and-naturalization-service-of-any-alien.

[19] Federal regulations require states to provide a reasonable opportunity period for individuals to prove their citizenship or other immigration status and that states "may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during the reasonable opportunity period." 42 C.F.R. § 435.956.

[20] See e.g., 42 U.S.C. § 1396a(a)(7)(A)(i) requiring state Medicaid plans to provide "safeguards which restrict the use or disclosure of information concerning applications and recipients to purposes directly connected with […] the administration of the plan [.]; 42 C.F.R. Chapter IV, Subchapter C, Part 431, Subpart F ("Safeguarding Information on Applicants and Beneficiaries"), including §§ 435.907(e)(1) (limiting state agency collection of information to only what is necessary to make eligibility determinations or administer the state Medicaid plan), (e)(3) (limits on state collection of SSNs, including the at non-applicants' SSNs be voluntary and "used only to determine an applicant's or beneficiaries' eligibility for Medicaid or other insurance affordability program for a purpose directly connected to the administration of a State Plan"). Similarly, 42 U.S.C. § 1320b-7, which governs the system used by each state to verify income and eligibility for a number of public programs (Medicaid, SNAP, SSI, and more), mandates that states have adequate safeguards in effect "so as to assure that the information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving such information" and "is adequately protected against unauthorized disclosure for other purposes, as provided in regulations" established by HHS. That system covers protections for SSNs.

- **Impact:** Health centers and hospitals would have to alter their presumptive eligibility determinations to meet the new citizenship/immigration status requirement. The legislation places providers in a difficult position, forcing staff to ask about unrelated and private issues that could harm provider-patient relationships. It would almost certainly deter eligible individuals from pursuing presumptive eligibility and health care itself for fear of adverse consequences related to immigration and deter providers by creating additional red tape.
- The requirement may also negatively affect the Show Me Healthy Babies (SMHB) program. For example, will presumptive eligibility still be granted if a pregnant woman does not certify that they have an eligible immigration status but still meets all eligibility requirements for SMHB?

Changing the Eligibility Determination for "Mixed Households" in SNAP: When determining the eligibility and allotment of households in which some members are not eligible based on immigration status, current Missouri policy counts all of the ineligible household member's income minus a pro rata share of the ineligible member's income (as allowed by federal regulations). The bill requires the DSS to consider the entire income of the ineligible immigrant in determining the eligibility and allotment levels of the remaining members.[21] For example, currently in a 3-member household in which 2 members are eligible for benefits, Missouri would divide the ineligible immigrant's income by 3 and subtract a third of that income when determining eligibility and allocating benefits for the two remaining household members. The pending legislation would require the state to count the entire income of the ineligible immigrant against the remaining household members, thereby adversely affecting their eligibility or reducing their allotment of SNAP benefits. (§208.009.14(1)(2)).

- **Impact:** This revision would cause children and other remaining household members in "mixed" households (those with eligible and ineligible members) to receive fewer benefits than they now receive by counting the entire income of the ineligible individual in determining the rest of the household's income. This would further harm refugees, asylees and others who have just been denied SNAP benefits due to the HR1 changes and would disincentivize work.

Conclusion

This pending legislation would create a host of new bureaucratic requirements in Missouri's SNAP and Medicaid programs and exceed existing federal requirements. The legislation would cause hardship for citizens and other legal residents as well as the Department of Social Services. Missouri is already struggling to keep up with eligibility and renewal processing demands and has experienced application processing delays and long wait times at call centers. Administering these new documentation requirements — along with Medicaid work requirements and conducting

[21] Federal regulations and Missouri policy already require inclusion of the ineligible immigrant's resources.

Medicaid renewals twice as often for some enrollees, as HR 1 requires — will add substantial administrative burden to an already strained state workforce.

Because the legislation would impose new verification requirements on DSS, it also increases the opportunity for errors, the consequences of which are far more severe under HR 1. If eligible individuals in "mixed households" are improperly denied SNAP benefits, these "underpayments" will count against the SNAP payment error rate, with serious fiscal consequences (including increasing the amount of state match Missouri will have to spend in its SNAP program).[22] Medicaid payment errors are determined differently but additional bureaucracy increases the likelihood of errors, which can no longer be waived by the federal government.[23] Most importantly, many eligible individuals, most of whom are *citizens*, will fall through the cracks and be needlessly denied or chilled from receiving SNAP and Medicaid.

[22] HR1 included new "state financial participation" requirements, meaning that states will have to fund a greater share of administrative costs and for the first time, a share of the SNAP benefits themselves. The amount of state match is tied to the State's SNAP error rate, which would surely increase under this legislation. The impact of these changes would extend far beyond SNAP as the entire Missouri budget would be compromised by the unnecessary loss of federal funds and increased need for general revenue.

[23] HR 1 made significant changes to Medicaid's Payment Error Rate Measurement Program (PERM), limiting federal authority to waive financial penalties for Medicaid errors greater than 3 percent and expanding the universe of audits that can be used in this calculation. Missouri has noted a risk of over $1 billion in PERM sanctions even without the new requirements this legislation would impose. See Steph Quinn, *Missouri social services director requests investment to avoid 'bankruptcy territory,"* Missouri Independent, January 28, 2026; Missouri Department of Social Services, Information on Payment Error rate Measurement (PERM) (undated).

HOUSE JOINT RESOLUTION (HJR) NO. 154: PRELIMINARY OBSERVATIONS ON THE HOUSE COMMITTEE SUBSTITUTE*

Joel Ferber, Legal Services of Eastern Missouri, February 10, 2026

In July 2025, Congress passed and the President signed the budget reconciliation law, HR 1, also known as the "One Big Beautiful Bill Act."[1] This legislation made sweeping changes to Medicaid, including the imposition of new "community engagement" or work requirements on states and individuals. While the bill places many new demands on states, it provides flexibility in certain areas that could ease the burden of implementation for states and mitigate the harm to individuals.

House Joint Resolution 154 (HJR 154), recently passed out of committee, would amend the Missouri Constitution to impose several new requirements on the Medicaid expansion population and the Missouri Department of Social Services (DSS). Most significantly, the legislation limits the flexibility that HR 1 provides and would prevent DSS from making several advantageous policy choices.[2] HJR 154 would limit Missouri to the most restrictive options in several key areas. These constraints will likely increase coverage losses significantly while also imposing substantial administrative burdens on DSS. New burdens would in turn increase opportunities for errors and consequent fiscal sanctions against the state. HJR 154 would impose these limits on Missouri at the same time DSS must implement an array of new mandates under HR 1, including but not limited to standing up the computer systems necessary to implement work requirements, more frequent eligibility renewals, and an array of changes to the SNAP program including new "state financial participation" requirements (meaning states will have to fund a greater share of administrative costs and for the first time, a share of the SNAP benefits themselves).

The Landscape Under HR 1

Payment Errors: HR 1 made important changes to Medicaid's Payment Error Rate Measurement Program (PERM), limiting federal authority to waive financial penalties for Medicaid errors greater than 3 percent and expanding the universe of audits that can be used in this calculation.

To give some perspective, DSS indicates that:

- For the FY 2019 review, the Medicaid error rate was 35.32% overall and the CHIP error rate was 90.75% overall. **DSS was required to make a good faith effort to address these error rates or face a disallowance of $1,000,918,287 for Medicaid and $215,469,593 for CHIP.** These error rates were primarily due to the fact that DSS was significantly behind on annual redeterminations.

- For the FY 2022 review, the Medicaid overall error rate was 5.95% and the CHIP overall error rate was 11.32%. However, this was during COVID Public Health Emergency (PHE). The flexibilities then in place and the suspension of the requirement for annual redeterminations greatly reduced the possibility of errors.[3]

Wherever Missouri ultimately lands, the potential risk of lost funding is staggering, especially with limited opportunities for waiver from CMS. As discussed below, the policy choices forced upon DSS by HJR 154 would dramatically increase the risk of such errors.

*This paper relies on analysis by the Center on Budget and Policy Priorities as published in *A Guide to Reducing Coverage Loses Through Effective Implementation of Medicaid's New Work Requirement* by Wagner, Singleton & Stewart (Nov. 3, 2025), used here with permission.

State obligation to determine compliance and exemptions: HR 1 explicitly places the burden of determining compliance or exemptions on the state, mandating *ex parte* verification *without requiring the individual to submit additional information* when possible.[4] It requires states to use reliable information, including payroll and claims data, to make a determination that an individual is in compliance or exempt without requiring them to submit additional information.

To implement this provision, states must use data sources to determine if someone has sufficient income to be compliant, is medically frail, is a veteran with a 100 percent disability rating from the Department of Veterans Affairs, or is otherwise compliant or exempt.

Implementation Concerns: Missouri is already struggling to keep up with eligibility and renewal processing demands and has experienced application processing delays and long wait times at call centers. Administering the work requirement — and conducting Medicaid renewals twice as often for some enrollees, as HR 1 requires — will add substantial administrative burden to an already strained state workforce.

If DSS is forced into more burdensome implementation policies or has ineffective systems that push work to applicants, enrollees, and eligibility workers, it will incur additional staff expenses, costly churn (which happens when eligible individuals lose coverage and must reapply), and increased errors. Service to the entire Medicaid population would likely suffer as well, resulting in processing delays and long wait times for children, seniors, and people with disabilities. And errors will undoubtedly increase, potentially subjecting the state to significant financial sanctions.

Specific Policy Choices in HJR 154

(1) **Lookback at application**: The Committee Substitute now before the House of Representatives modified this provision. The original bill provided that no "applicable individual"[5] may be enrolled in MO HealthNet unless, at the time of application, the individual demonstrates compliance with the work requirements for the **three consecutive months** immediately preceding the month during which the individual applies. It also required the Department of Social Services and the MO HealthNet Division to require documentary evidence and prevents them from accepting self-attestation at the time of application (discussed in more detail below).[6]

HR1 allows states to require that an applicant is compliant with or exempt from the work requirement for the month prior to the month of application or for each of the prior two or three consecutive months prior to application. A shorter lookback period would enable more people to enroll, including those who are unable to meet the requirement (or to demonstrate that they meet it or are exempt) for a longer period. Adopting the option to require one month of work prior to application, rather than looking back three months, would avoid needless denials of coverage and ease administrative burden.

The House Committee Substitute includes a one-month look back period but retains the provision mandating the Department of Social Services require documentary evidence and precluding self-attestation at the time of application. This revised look back period is the only significant revision from the original bill.

(2) **Monthly Compliance:** HJR 154 provides that no applicable individual shall remain enrolled in MO HealthNet in any month unless the individual has demonstrated compliance with the work requirements.

This provision thus requires the individual to meet the work requirement in every single month of coverage, which could mean monthly reporting for individuals or at the at the very least requires documentation of compliance in every single month of an eligibility period, which imposes significant obligations on both the State and the individual well beyond what federal law requires.

While HR1 requires enrollees to periodically re-verify their compliance or exemption status, it gives states the option to verify compliance at renewal or more frequently, such as monthly. When verifying compliance at renewal, states may require enrollees to have been compliant for one or more months since the last renewal. For example, a state could require that enrollees report at renewal their activities for every month since the last renewal, for any one month since the last renewal, or somewhere in between.

Verifying only at renewal and requiring only one month of compliance since the last renewal would reduce the burden for enrollees and caseworkers and minimize coverage loss. In contrast, requiring re-verification more frequently than at renewal would place significant burden on enrollees to report their activities, on DSS to design an eligibility system capable of capturing such frequent information reports, and on caseworkers to process and verify reporting.

Imposing these additional requirements also creates greater opportunity for PERM errors and significant financial sanctions against the state because there are more opportunities for such errors to occur with the additional paperwork burdens both for individuals and administrative burden for DSS.

(3) **Documentation:** HJR 154 requires an individual seeking an exemption from work requirements to provide documentation for the exemption sought. DSS would be required to verify all exemptions,[7] but could not accept self-attestation from individuals seeking exemptions.

Under HR1 a state may elect *not* to require an individual to verify information regarding qualifying for any mandatory exemption from the work requirement. Thus, subject to final guidance from CMS, states can choose to accept an individual's statement (made on an application, renewal, or other form) about exemptions. Requiring documentation of all exemptions would delay processing, burden individuals who may have to acquire medical documentation, create more work for caseworkers, and increase churn. It would also significantly increase the opportunity for PERM errors.

As noted above, HJR 154 also requires documentation of *compliance* with work requirements at the point of application. HR1 explicitly allows for self-attestation of *exemptions* at the point of application and at renewal.[8] CMS has yet to weigh in on whether self-attestation will be allowed to determine compliance (as opposed to exemptions). Imposing these additional requirements creates greater opportunity for PERM errors and significant financial sanctions against the state.

PERM measures whether a state followed its own policy in making eligibility determinations. If a state chooses to verify compliance with the work requirement more frequently or to require additional documentation, PERM errors are likely to increase. Among other things, more administrative burden on eligibility workers increases the likelihood that paperwork will be overlooked or information mis-entered, and overworked staff are more likely to make mistakes.

As noted earlier, HR1 also requires states to use *ex parte* data sources *without* requiring additional information from the individual whenever possible to determine compliance and exemptions. States often have access to the data that will enable them to determine whether an individual meets

an exemption, including, for example, records from the Department of Mental Health, Department of Health and Senior Services, the MO HealthNet Division or managed care organizations.

This component of HJR 154 could be read to place the *entire* documentation burden on the individual in direct contradiction to HR1.

(4) **Optional Exemptions:** HJR 154 precludes the DSS and the MO HealthNet Division from seeking or implementing any additional optional exemptions unless a general statute law expressly authorizes the implementation of the exemption.

HR1 provides optional short-term hardship exemptions; states can choose whether or not to incorporate them into their programs. These include individual exemptions for people experiencing an acute medical event or having to travel to receive medical treatment, as well as exemptions for counties with an emergency or disaster declaration or high unemployment rate.

Implementation of these exemptions would enable people with qualifying medical needs to request a short-term exemption when eligible. States could also apply for county- or state-wide exemptions whenever eligible and automatically exempt everyone in the affected area to minimize coverage loss among people who have difficulty meeting the work requirement due to high unemployment, an emergency, or a disaster.

HJR 154 removes state flexibility to maintain coverage for individuals facing these difficult circumstances as allowed by HR 1.

(5) **Role of Managed Care Organizations:** HJR 154 prevents DSS and the MO HealthNet Division from accepting exemption designations, approvals, or determinations by a managed care organization.

HR1 already prohibits managed care organizations (MCOs) from making approvals and exemption determinations but does not preclude them from providing information to assist in determining exemptions. CMS' recent guidance acknowledges that states can delegate certain support activities to MCOs and indicates that further guidance on the role of MCOs is forthcoming.[9] Depending on how this provision is applied, it may go beyond the scope of HR1's prohibition and conflict with CMS' interpretation on this issue.

Conclusion

Missouri's policy choices will directly affect who qualifies for Medicaid (e.g., adopting a longer lookback period would disqualify some applicants who would have qualified under a shorter period). However, the primary impact of the policies required by HJR 154 would be to increase the administrative burden on applicants, enrollees, and eligibility workers. Implementing the work requirement will inevitably introduce new barriers for individuals and increase the DSS workload. Despite one significant change in the House Committee Substitute, HJR 154's policy choices would drastically increase the intensity of that burden. More people would lose coverage, despite remaining eligible because they are unable to navigate the maze of work requirements. At the same time, state agency staff will take on significantly more administrative work which will increase the likelihood of payment errors and fiscal sanctions. HJR 154's constraint on Missouri's ability to make policy choices allowable under HR 1 will detrimentally affect both Medicaid participants and our state Medicaid agency.

Endnotes

[1] An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14, Pub. L. No. 119-21, § 71112 (2025) ["HR1"].
[2] House Committee Substitute for House Joint Resolution 154, 103rd General Assembly, Second Regular Session, 2006, at: https://documents.house.mo.gov/billtracking/bills261/hlrbillspdf/6310H.02C.pdf.
[3] Missouri Department of Social Services, Information on Payment Error Rate Measurement (PERM) undated.
[4] HR 1, § 7119 (a), 42 U.S.C. §1396a(xx)(5).
[5] In Missouri, an applicable individual is someone enrolled in the State's Adult Medicaid expansion group.
[6] The bill mentions the MO HealthNet Division here and elsewhere, however that agency does not determine exemptions or compliance which are the responsibility of the Family Support Division within the Department of Social Services, the "single state Medicaid agency," for the purposes of federal law.
[7] The bill mentions also includes the MO HealthNet Division here, however these activities are the responsibility of the Family Support Division.
[8] HR 1, § 7119 (a), 42 U.S.C. §1396a(xx)(3).
[9] CMS recently issued guidance on work requirements. CMCS Informational Bulletin, December 8, 2025 https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf. While noting that MCOs and other health plans are prohibited from determining compliance with community engagement requirements, there is no other prohibition in the statute on states choosing to delegate some support activities to managed care plans to support states' successful implementation of community engagement requirements. CMS expects to issue further guidance on the potential role that managed care plans can appropriately play in activities that are not related to determining beneficiary compliance.

IMPLEMENTATION QUESTIONS

SNAP Update

1. Do you have any data on the implementation of expanded work requirements/time limits under HR 1? Has there been a decrease in SNAP participation attributable to the time limits? How many more people are incurring countable months?
2. Do you have any more information in response to our requests for more detailed policies, training materials, and screening tools?
3. Do you have any other information to share on how you are effectively screening for the SNAP work requirements consistent with FNS guidance?
4. How will you screen those who do not normally have interviews at recertification?
5. Are there any updates on Error Rate strategy? Are you making any changes in policies and practices? Are there any changes to certification policy? Any specific instructions to change certification policy?
6. Please describe plans for work and volunteer hours tracking. Specifically, how are you tracking volunteer hours?
7. What (if anything) are you doing to publicize the changes to immigrant eligibility? Any public-facing materials explaining the change? We saw at last week's Cover MO meeting that one of the refugee groups had no idea that this had changed and did not understand why their clients had lost eligibility.

Medicaid Work Requirements Update

<u>COMPLIANCE AND EXEMPTIONS</u>:

1. What will constitute compliance (how many months)?
2. How often will you review for compliance (only at renewal or more frequently)?
3. What is your current thinking about the length of the lookback period at application?
4. Do you have any updates on your plans for exemptions?
    a. To what extent will you employ self-attestation as allowable?
    b. Medical frailty
        i. Do you have any updates on a definition of medical frailty?
        ii. Any information on how you will screen for medical frailty and/or connect with data sources to verify medical frailty (i.e., MHD claims or other state department sources like DMH, DHSS, etc.)?
    c. Family caregivers: Do you have a working definition?
        i. Will you exempt individuals who care for older adults?
    d. Will you pursue short-term hardship exemptions (e.g., for acute medical events, travel for medical treatment, high unemployment areas)?

e. In what efforts are you engaged to coordinate Medicaid exemption with SNAP (e.g., SNAP definition of unfit for work)?
f. How often will you re-evaluate exemptions?
g. Will you run the draft exemption policy by stakeholders, including this group?
h. How will DSS ensure that HR 1's automatic income proxy (whereby individuals whose monthly income is equal to or greater than the federal minimum wage multiplied by 80 hours complies with the "community engagement" requirement) is automatically applied to determine compliance?

5. Any updates on ex parte strategies, data sources, "waterfall" approach to verification, systems changes?
    a. Which data sources will you be using for exemptions? State data, SNAP data, health information exchange, higher education enrollment data, vocational rehabilitation and unemployment data, Veteran's administration, other sources?
    b. Which data sources will you use to determine compliance?
    c. Where will consent-based verification fit within the workflow – e.g., is it embedded in the application flow or part of a separate process?
        i. Is SteadyIQ's consent-based verification tool the one you have chosen?
        ii. To what extent will you also use any traditional income/employment verification vendors (like Experian, The Work Number, etc.)?
        iii. What third party verification vendors are being used currently?
    d. Can you describe how your "waterfall" approach to verification will work?
6. Are you revising the application to screen for work requirements issues/exemptions (as opposed to requiring a separate process/form)?
    a. Are you aware of Civilla's work on this? If so, are you planning to take advantage of it?
7. Which vendors are you working with?
    a. What aspects of the system will they cover?
    b. Will one vendor be responsible for all requirements policy implementation or are you pursuing different vendors for different aspects of the system?
    c. What are the specific tasks that each vendor will perform?
8. What are your plans for handling transfers from the FFM and evaluating those cases for exemptions and compliance with work requirements (as the FFM will not have evaluated for this issue)?

INTERACTION WITH MCOs

9. How do you envision working with MCOs during this transition?
10. Will MCOs support data sharing for medical exemptions?
11. Will MCOs play a role in assisting enrollees in maintaining compliance with the work requirement?

DATA SOURCES AND TRANSPARENCY

12. Are you planning to report data publicly on application and renewal outcomes?
13. Will your existing data sources be capable of identifying compliance and/or exemptions? Where might there be gaps?
14. What new data sources are you considering using (e.g., to verify activities like work program or school enrollment to help reduce paperwork burdens)?

AGENCY PROCESS AND CAPACITY

15. What changes will you be making to the application and renewal forms? What questions might you add?
16. Will you be seeking stakeholder input on the revisions to these forms?
17. What are your plans to train caseworkers to ensure readiness for implementing and following new rules?
18. What is your latest thinking about increasing your current workforce capacity given the increased workload ahead?
    a. Are there any updates to your plans for boosting staff or hiring contract assistance? (covered in the DSS budget request)
19. How will the state train call centers and caseworkers?
20. Will there be a group of specialized workers trained specifically to handle work reporting requirements (or will requirements just be a component of everyone's job)?
21. Will there be a separate option on the IVR tree to get to a "work requirements reporting" specialist?

USER TESTING

22. Will you conduct user testing on the system once it is updated prior to launch?
23. How do you plan to incorporate user feedback into your system?
24. Are you working with external partners (like Civilla) on human-centered design?

COMMUNICATIONS

25. Do you have any updates to your outreach and communications plans and/or strategies?

26. How do you plan to communicate with enrollees to update them about these upcoming changes? Which communication modes will you use?
27. What plans do you have for translations?
28. Will there be focused outreach and assistance for those that do not use online services or those with difficulty proving exemptions or exclusions?
29. What training, support, and resources will you provide to community partners?
30. Is there a written communications plan?
31. Will DSS consider including on its website a page whereby the state notifies the public about known issues, what they look like and how to notify DSS if someone has been affected by these issues?

NOTICES

32. How do you plan to update your notices? Will stakeholders have an opportunity to review and contribute? Are you doing user testing on notices and education materials?

Communications with CMS

33. Has DSS prepared a response to CMS's state community engagement (CE) minimum viable product (MVP) monitoring and compliance checklist? Can you share a copy with us?
34. Has CMS provided any specific guidance to Missouri about implementation of work requirements? Can you share such guidance?

2025-26 Budget Reconciliation (HR 1)

Changes to Medicaid, Implementation Challenges, and Implications for Missouri

Joel Ferber, Director of Advocacy
Legal Services of Eastern Missouri

March 6, 2026
St. Louis Health Lawyers Association

HR 1 = One Big Beautiful Bill Act (OBBBA)

- OBBBA Overview
  - Budget and tax reform package enacted through Budget Reconciliation
  - Major cuts to programs for low-income people
    - $1 trillion from Medicaid
    - $1.1 billion from Marketplace
    - $187 billion from SNAP
  - Extends Trump tax cuts and allows new spending on immigration enforcement
- Today's Discussion Will Cover:
  - HR 1
    - Medicaid Cuts + Impact
    - Medicaid Work Requirements
    - Effects on Medicaid Expansion Population & States Like Missouri
    - Other Medicaid Changes in HR 1
    - What Medicaid Changes are *NOT* in HR 1
    - SNAP Changes
  - CMS Guidance & Non-Public Policy
  - Missouri Legislation + DSS Budget information
  - Unanswered Implementation Questions
  - General DSS information
  - Going Forward

HR 1: Cuts to Medicaid Eligibility and Services

- *New work requirements* (Effective 1/1/27)
  - $325.6 billion federal funding cut over 10 years
  - Can be implemented earlier at state's discretion, HHS can grant a one-time extension by 1/1/29
- *More frequent eligibility determinations for expansion adults* (Effective 1/1/27)
  - $62.5 billion federal funding cut over 10 years
  - CMS guidance expected
- *Eliminating health coverage for most legal immigrants* (Effective 10/1/26)
  - $6.2 billion federal funding cut over 10 years
- *Cuts to Emergency Medicaid funding for expansion states* (Effective 10/1/26)
  - $28.2 billion over 10 years
- *Increased cost-sharing for Medicaid expansion adults* (Effective 10/1/28)
  - $7.4 billion federal funding cut over 10 years

HR 1: Other Medicaid Cuts

- *Cuts to provider taxes* (Varying effective dates discussed below. Provider tax reductions are phased in starting FY 2028)
  - $191.1 billion over 10 years and state-directed payments ($149 billion over 10 years)
- *Effectively repeals eligibility and enrollment simplification requirements* (Effective on date of enactment through 9/30/34)
  - $56 billion federal funding cut over 10 years
- *Prohibition of funding for Planned Parenthood for one year*
  - *Increases* federal spending by $53 million
- *Cuts Retroactive Eligibility from 3 months to 1 month (for expansion enrollees) and 2 months (for non-expansion enrollees)* (Effective 1/1/27)
- Reduces Home Equity Limits (*Effective* 1/1/28)
  - Federal funding cut of $195 million over 10 years
- Changes to Payment Error Rates (PERM) rules (Effective October 1, 2029)
  - Federal funding cut of $8 billion over 10 years

HR 1: Impact of Medicaid Cuts

- More people uninsured
  - Medicaid and Marketplace cuts - 10 million more Americans become uninsured
  - Over 14 million if Enhanced Premium Tax credits not renewed
  - An estimated 216,000 Missourians will lose health coverage due to Medicaid and Marketplace changes*
- Increase in uncompensated care, cost-shifting, increase in premiums
- Significant state budgetary impact from loss of federal money
- Possibility of additional state Medicaid cuts – beyond the eligibility cuts required by this legislation? (see Missouri 2005)
  - Cutting eligibility?
  - Cutting optional benefits (e.g., dental, hearing aids, prescription drugs, home and community -based services)?
  - Not increasing or reducing reimbursement – deepening workforce shortages?
- Cuts to education and other parts of the state budget almost certain
- Tax increases unlikely

*Center on Budget and Policy Priorities (CBPP)

HR 1: Work Requirement Overview

- Mandatory work requirement for Medicaid expansion enrollees (called "community engagement")
- States must implement by 1/1/27 (or earlier at state's discretion), up to 1/1/29 if HHS grants a one-time extension
- Work requirement must be satisfied for at least one month **before** application and once between every 6-month redetermination
- Individuals who do not meet the requirement will be denied or lose coverage (subject to notice and hearing requirements)
    - Individuals who lose or are denied Medicaid due to work requirements are also locked out of Marketplace subsidies
- HHS must issue an interim final rule no later than 6/1/26, but guidance already being issued and more expected

HR 1: Consequences of Work Requirements

- **Federal spending cut of $325.6 billion over 10 years**
- **An estimated 5.3 million Americans will lose coverage** (according to CBO) (134,000 at risk of coverage loss in MO according to CBPP)
    - Arkansas: 18,164 individuals lost Medicaid coverage from Sept. – Dec. 2018 for failing to meet the new work requirement (before a court intervened)
    - Georgia: after 20 months, up-front work requirement led only 7,000 individuals out of an original projected pool of 345,000 people to enroll
- These penalties will not improve employment
    - Most working age Medicaid enrollees who can work already do, and millions of low-wage worker will lose coverage
    - The legislation does not create any new work programs or training opportunities

- Major administrative burden for states: GA spent twice as much on administrative costs than it spent on providing health care under its work requirements waiver

HR 1: Complying with Work Requirements

- Individuals can demonstrate compliance if they
    - Complete 80 hours of work, community service, or a work program
    - Enroll in an educational program at least half-time
    - Engage in a combination of such activities for not less than 80 hours
    - Have monthly income not less than minimum wage multiplied by 80 hours
        - Not limited to earnings according to statute so could be SSI, UI, child support but keep an eye on CMS guidance
    - If seasonal work, have average monthly income over 6 months of not less than the minimum wage multiplied by 80 hours
- States
    - must rely on *ex parte* processes such as wage databases
    - cannot waive or modify requirements of this provision

HR 1: Work Requirements: Mandatory Exemptions

- Parents, guardians, and caretakers of children ages 13 and younger or of individuals with disabilities
- Pregnant people and those receiving postpartum coverage
- Individuals who are "medically frail," including individuals who:
    - Are blind or disabled;
    - Have a substance use disorder;
    - Have a disabling mental disorder;
    - Have a significant physical, intellectual, or developmental disability, or have serious complex medical condition
- Veterans with disabilities
- Individuals who are:
    - Incarcerated or recently released from incarceration within the past 90 days
    - Entitled to Medicare Part A or enrolled in Medicare Part B
    - Meeting TANF work requirements
    - Receiving SNAP and not exempt from SNAP work requirements (confusing language)
    - Participating in a drug addiction or alcohol treatment program
    - Former foster care youth

HR 1: Work Requirements Verification & Non-Mandatory Exemptions

Verification

- States do not have to require verification of eligibility of exemptions (the statute allows self-attestation), but keep an eye on CMS guidance
- States must use *ex parte* process for exemptions (i.e., without requesting information from the individual) – must check available reliable data sources

Non-Mandatory Exemptions

- States can also provide certain limited short-term hardship exemptions:
  - Upon request from the individual: receives in-patient hospital services, nursing facility services, has to travel out of the community for extended period of time to receive medical services OR
  - Upon state request to HHS: individual lives in an area where the President has declared an emergency or disaster, resides in an area of extremely high unemployment
- States cannot provide additional exemptions but also cannot be more restrictive with exemptions
- Secretary of HHS cannot allow *more* exemptions
- Things missing from this list (e.g., domestic violence, receiving U/I benefits)

HR 1: Funding for Implementing Work Requirements

- HR 1 provides $200 million in implementation funding to all states and D.C. for implementation (but expected costs far exceed the limited amount of funding)
- $100 million for all states (including state that do not have a population subject to work requirements) and an additional $100 million based on the state's population subject to the work requirement
- Consistent with longstanding Medicaid law, there are also enhanced matching funds for additional costs
  - 90/10 (design, development, and implementation of IT systems)
  - 75/25 (maintenance and operations of these systems)

HR 1: Medicaid Expansion & the New Work Requirements

- Not all Medicaid Enrollees are subject to work requirements, only “applicable individuals” as defined in the statute
  - Medicaid expansion populations (41 states including Missouri
  - Individuals in expansion-like programs (e.g., Georgia, Wisconsin)

Medicaid Expansion: Who Is Covered?

- Adults, aged 19-64, with incomes under 138% FPL (about $22,000/yr. for one person, or $45,000 for a family of four)

- This category includes
  - **Parents and caregivers**
    - Family members caring for disabled youth or aging parents
    - Parents whose income exceeds the often extremely low threshold for Medicaid Parent and Caretakers category
    - A third of paid home care workers for people with disabilities

  - **People with disabilities** – 1 in 4 Medicaid expansion adults have disabilities
    - 1 in 5 enrollees under 65 who use institutional long-term care are covered through Medicaid expansion
    - 1 in 10 under 65 who use HCBS covered through expansion
    - In 1 state survey, 70% of expansion adults reported a chronic condition
  - **Low-wage workers**, including many caregivers

HR 1: Six-Month Renewals for Medicaid Expansion

- Most Medicaid recipients will be reviewed once a year (although the state can choose more frequent eligibility reviews)
- Medicaid expansion individuals must have their eligibility reviewed every six months
- Effective 1/1/27 (CMS guidance expected)
- Same concern as with work requirements. Missouri's capacity is limited now, struggling with 12-month eligibility renewals. How will it do six-month reviews?
- More frequent redeterminations increase risk of procedural disenrollments
- Spending cut of $62.5 billion over 10 years
- CBO estimates 700,000 will lose coverage due to this change
- Similar concerns to implementation of work requirements re: system capacity to handle this, risk of procedural terminations

HR 1: Cost Sharing for Medicaid Expansion

Effective October 1, 2028, all expansion states must require cost-sharing (co-pays) for services provided to expansion adults above 100% FPL

Exemptions:

- Previously exempt groups and services continue to be exempt (e.g., prenatal, family planning, and certain emergency services)
- New exemptions: Primary care, mental health, substance use disorder and services furnished by FQHCs, certified community behavioral health clinics and rural health clinics

Parameters:

- Up to $35 per service (except for prescription drugs which cannot exceed prior limits – must be “nominal”)
- States permitted to allow providers to deny services for failure to pay cost-sharing
- Aggregate Limit on of 5% household income continues to apply

Impact:

- Research shows that cost-sharing increases reduce utilization of needed services among low-income people
- Spending cut of $7.4 billion/10 years

HR 1: Retroactive Coverage

• Retroactive Coverage cut from 3 months to 1 month for expansion enrollees and 2 months for non-expansion enrollees (Effective 1/1/27)

• Given complexity of Medicaid eligibility rules,
  - many people do not realize they qualify
  - others become eligible because they have an unexpected medical emergency that prevents them for promptly filing an application

- This change will create significant hardship (delays and denials of care) and increase medical debt
- State option to implement retro coverage in CHIP (2 months)

Implementation Issue: Importance of requesting fair hearings to preserve eligibility

HR 1: Non-Citizen Coverage Changes to Medicaid Eligibility (Effective 10/1/26)

1. Restricts definition of qualified immigrants for Medicaid/CHIP coverage to:
- Lawful permanent residents,
- Cuban and Haitian Entrants,
- Individuals from COFA nations (the Federated States of Micronesia, the Republic of the Marshall Islands and Republic of Palau) residing in the U.S.

2. Rescinds Eligibility for Medicaid from all other qualified non-citizens, including asylees, refugees, people granted withhold of removal, trafficking survivors, survivors of domestic violence, and persons granted humanitarian parole for at least 1 year
    - Individuals with statuses that are not subject to the 5-year bar *should* be eligible once they transition to lawful permanent residents
    - Other lawful permanent residents are still subject to 5-year bar

Implementation Questions:
- How can we minimize the coverage loss, minimize confusion?
- How will Missouri ensure that the 5-year bar is not misapplied?

Changes to Payment Error Rate Measurement (PERM)

- Federal law directs CMS to recoup federal funds for erroneous payments made for ineligible individuals and overpayments for eligible individuals if the state's Medicaid error rate exceeds 3 percent. Prior to HR1, CMS could waive the recoupment if the Medicaid agency had taken steps to demonstrate a good faith effort to get below the 3 percent allowable threshold.
- HR 1 requires HHS to reduce federal financial participation to states for identified improper payment errors related to payments made for ineligible individuals and overpayments made for eligible individuals. Significantly restricts CMS's ability to waive recoupment for such payment errors.

Effective October 1, 2029

CBO estimates this provision will reduce federal Medicaid spending by nearly $8 billion over 10 years and will increase the number of people who are uninsured by 100,000 in 2034

Changes to PERM* (continued)

- Prior to HR 1, any disallowances due to high error rates could be waived by CMS if the State developed a corrective action plan and showed good faith in addressing the error rate.
- HR 1 removed the ability of CMS to waive the disallowances due to good faith efforts if the *error rate attributed to ineligible individuals erroneously found eligible* exceeds 3% effective October 1, 2029 (with extremely limited exceptions).
- Missouri's latest PERM reviews were in FY 2019, FY 2022 and FY 2025
  - For the FY 2019 review the Medicaid error rate was 35.32% overall and the CHIP error rate was 90.75% overall. DSS was required to make a good faith effort to address these error rates or face a disallowance of $1,000,918,287 for Medicaid and $215,469,593 for CHIP. These error rates were primarily due to the fact that DSS was significantly behind on annual redeterminations.
  - For the FY 2022 review, the Medicaid overall error rate was 5.95% and the CHIP overall error rate was 11.32%. However, this was during COVID Public Health Emergency (PHE). The flexibilities put into place and the suspension of the requirement for annual redeterminations greatly reduced the possibility of errors. FYI 2025 error rates under the 3% threshold.

- DSS states that "without investment and effort to keep current on annual redeterminations, DSS could face significant disallowances in the future."

HR 1: Medicaid Financing

- Limits use of provider taxes – which most states including Missouri heavily rely on to help finance their Medicaid program
- No new provider taxes and no increases in provider taxes in any state (effective *on enactment*) – so states cannot use new or increased taxes to fill budget shortfalls
- Provider tax limits gradually reduced annually from 6% to 3.5% (of revenue) in **Medicaid expansion states** (includes MO) from FY 2028 to FY 2032 and thereafter - .5% per year. MO relies heavily on provider taxes!
- Combined effect of prohibition on new/increased provider taxes and reduction for expansion states is a $191.1 billion federal funding cut over 10 years
- CBO estimates a $1.2 billion coverage loss from Provider tax changes
- Directs HHS to cap state directed payments (lower limit for new SDPs effective on enactment, reduction in existing SDPs effective 1/1/28)
  - 100% of Medicare rate in expansion states
  - 110% of Medicare rate in non-expansion states
- Temporary "Rural Hospital Transformation Fund" (FY 2026-2030)
  - Equivalent to roughly 5% of $1 trillion in cuts
  - Subject to significant HHS discretion
- **Key Question**: What will be the fiscal fallout: How will Missouri make up for a major hole in its budget? (further Medicaid cuts, cuts to other programs and services outside of DSS?)

HR 1: Eligibility and Enrollment

- Delays (for 10 years) Biden Administration's rules to simplify eligibility and enrollment
- But certain provisions already in effect survived due to the "Byrd rule" and must still be implemented:
  - CHIP protections (no more lockouts, no waiting periods, no annual/lifetime limits on services);
  - Simplifications that make it easier for people with spenddowns (by projecting medical expenses) (at state option);
  - Deeming certain individuals who are eligible for Medicare Part A and who are SSI beneficiaries eligible for QMB coverage without requiring an application;
  - Removed the requirement to apply for other benefits (in order to get Medicaid)
- Other provisions while no longer mandated are still optional – e.g., to coordinate MAGI and non-MAGI Medicaid
- But nursing home staffing rule repealed as are provisions that would streamline eligibility and enrollment in Medicare savings programs for seniors and people with disabilities
- And separate proof of ID and citizenship required for approval – rule would have allowed Successful data match with state vital records or DHS SAVE program to verify *both*

HR 1 and Medicaid: What's Not Included?

- No per capita caps or block grants – Medicaid is still an entitlement -- many legal protections still intact
- No reduction in FMAP for expansion states that cover individuals without regard to citizenship status with state-only funds*
- No prohibition on states claiming federal matching funds during a reasonable opportunity period
- No ban on gender affirming care coverage*
- CHIP protections in the Biden Administration's eligibility and enrollment rule (no more lockouts, no waiting periods, no annual/lifetime limits on services)*
- E and E rule protections that help spenddown participants and individuals seeking eligibility for Medicare savings programs*

* Struck due to "Byrd rule"

HR 1: A Few Words on SNAP

- Implements stricter work requirements for ongoing participation (extended to older adults, certain exemptions eliminated) – DSS will need to coordinate Medicaid and SNAP work requirements
- Major Changes to SNAP funding with increased states responsibility
- Restricts immigrant eligibility (like the Medicaid revisions)

SNAP Funding Changes

Currently, the federal government pays 50% of administrative costs.

- Beginning **October 2026**, the federal government will pay only 25%. Missouri will be responsible for the remaining 75%.

Currently, the federal government pays 100% of SNAP benefits.

- Beginning **October 2027**, a state agency's error rate will determine the portion of benefits the federal government pays.
- The higher the error rate, larger the portion the state must pay.
    - MO's 2024 error rate is 9.4%. If the error rate remains the same, the federal government will only cover 90% of the cost of benefits.
    - Missouri will be responsible for the remaining 10%, or over $150 million per year.

Sources: DSS data and https://www.cbpp.org/research/food-assistance/imposing-snap-food-benefit-costs-on-states-would-worsen-hunger-hurt-states

Immigrant Eligibility for SNAP

- Limits SNAP eligibility to US citizens, LPRs, Cuban and Haitian entrants, and individuals from COFA nations residing in US.
- Ends SNAP eligibility for refugees, asylees, Afghan evacuees (non LPR), people granted humanitarian parole for at least one year, survivors or human trafficking, and survivors of domestic violence
- DSS is implementing in March 2026
- Will have implications for Medicaid (Effective 10/26)

CMS Guidance – Work Requirements

- On November 18, 2025, CMCS issued an Informational Bulletin, but it does nothing more than summarize the provisions in HR 1, including work requirements

- On December 8, 2025, CMCS issued an Informational Bulletin that provides minimal new information, leaving many questions unanswered

- But: Earlier CMS provided information to Medicaid Directors at the annual NAMD Conference (November 19-21), including information that has not yet been released in any public setting(!!)

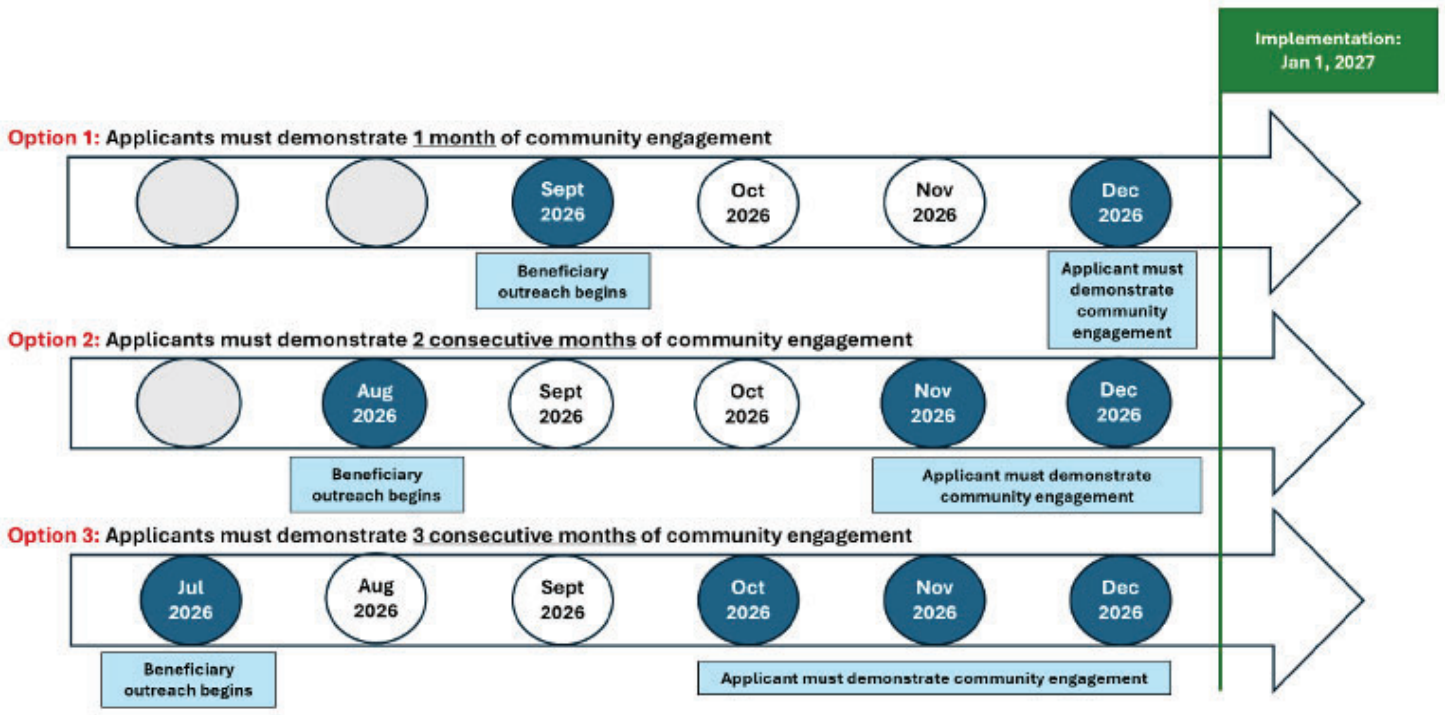
Note: CMS guidance on provider taxes and SDPs (11/14/25 and 2/2/26)

December 8 Guidance from CMS

- On December 8, 2025, CMCS issued an Informational Bulletin
- Confirms several policies as expected, such as outreach timelines, allowing MCOs to help enrollees comply (but not make determinations), and availability of administrative matching funds
- "Good Faith Effort" exceptions – approvals will be limited to states making “meaningful efforts toward implementation and experience severe or unexpected issues that hinder their progress
- Work requirements will apply to renewals when they are due, starting on or after January 1, 2027
- Other guidance coming: Ex parte verifications; Roles MCOs can play; 6-month redeterminations; SNAP/TANF exemptions; Required IFR by June 2026

*

December 8 Guidance – Outreach Timeline



December 8 Guidance – Key Details

- For renewals of coverage, states can select how many prior months of compliance are required for approval (default is one month)
- Under the guidance, the state cannot mandate which specific month(s) since the prior renewal will be considered nor require they be consecutive months
  - This policy applies to renewals only (not applications)
- For example, if a state has a two-month requirement, and an enrollee worked the required 80 hours in both February and April, the individual would be found compliant at a June renewal
- This applies to *compliance*; waiting to hear how/if it applies to *exemptions*

Non-Public “CMS Policy”

- At the November 19-21, 2025, NAMD Conference, CMS shared implementation information with Medicaid Directors, including important additional policies (status of policies is unclear and subject to change):
  1. States are permitted to use a screener to have individuals self-declare that they are medically frail and enroll such people without further proof, but the state would need to have some verification of medical frailty by the 6-month renewal
  2. For an individual who has a long-term exempt condition (ex. permanent disability), states may be able to provide exemptions lasting as long as 12 months

*Source, CMS, “Implementing Section 7119 of the Working Families Tax Cut Legislation: Key Requirements and Preliminary Policy Direction from CMS,” November 19, 2025.

HJR 154 – Missouri Legislation

- Amends the Medicaid Expansion provision of the State Constitution – if passed would have to go to a vote of the people
- Would enshrine work requirements in the Constitution
- Adopts the most restrictive approach to work requirements on most of the key policy issues:
  - Lookback period
  - Requires Monthly compliance
  - No self-attestation
  - No temporary hardship exemptions
  - Limits the role of managed care organizations
- Likely impact of these choices on beneficiaries and the State:
  - Increased errors, financial sanctions (against DSS)
  - Greater coverage losses

DSS Budget Legislation

- Department asked for significant funds for implementation of HR 1 (Technology, Staffing, etc.)
- FY 26 Technology *Supplemental* Budget Request includes*
  - $16.2 million for Community engagement/work requirements
  - $5.8 million for Eligibility verification
  - $8.3 million for automated interactive Voice Response (IVR)
  - $1.6 million for upgrades to the MEDES computer system (for MAGI-based programs)

*These include total dollars (state and federal)

DSS Budget Legislation (FY 2027)

H.R.1 Implementation

FY27 H.R. 1 New Decision Items	GR	Federal	Other	Grand Total
H.R. 1 Implementation (within HB11)	$ 34,982,737	$ 254,123,581	$ 5,500,000	$ 294,606,318
ITSD - GR Pickup for SNAP Admin	$ 2,571,064			$ 2,571,064
FMDC - GR Pickup for SNAP Admin	$ 879,592			$ 879,592
Fringe (estimated) - GR Pickup for SNAP Admin	$ 8,100,000			$ 8,100,000
	$ 46,533,393	$ 254,123,581	$ 5,500,000	$ 306,156,974

FY27 H.R. 1 Reductions	GR	Federal	Other	Grand Total
CRD.GV.305: Residency Requirements Savings	$ (3,250,000)	$ (19,500,000)		$ (22,750,000)
CRD.GV.306: Work Requirements Savings*	$ (30,200,000)	$ (272,208,838)		$ (302,408,838)
CRD.GV.308: Non-Citizen Requirements Savings	$ (13,170,285)	$ (23,866,512)		$ (37,036,797)
CRD.GV.309: Prior Period Coverage Savings	$ (21,826,930)	$ (118,230,099)		$ (140,057,029)
	$ (68,447,215)	$ (433,805,449)	$ 5,500,000	$ (502,252,664)
FY27 H.R.1 Net Impact	$ (21,913,822)	$ (179,681,868)	$ 5,500,000	$ (196,095,690)

	GR	Federal	Other	Grand Total
FY26 Supplemental - H.R. 1 Implementation	$9,044,653	$122,971,458		$132,016,111

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*GR savings from Work Requirements is recognized in the AEG GR Pickup NDI

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Work Requirements and Six-Month Renewals – Implementation Questions

- Will Missouri implement seek to delay implementation as the law allows (good faith waiver)?
- Will Missouri check (and require reporting) of compliance *more* frequently than once every six months?
- How many months of compliance will be required (can be 1 or more months)?
- What lookback period will Missouri choose (1-3 months)?
- Will Missouri allow self-attestation of compliance/exemptions (subject to CMS guidance)?
- How will Missouri define and determine "medical frailty"?
- How will Missouri define family caregivers? Will it include caregivers of older adults, adults with chronic conditions, functional limitations, etc.?
- Will Missouri seek short-term hardship exemptions?
- How will Missouri coordinate Medicaid with SNAP and TANF (for both compliance and exemptions) given complicated rules and system limitations?
- To what extent will Missouri be able to use *ex parte* processes to determine exemptions and compliance? What data sources will be used?
- Will Missouri have the capacity to do this without unfairly penalizing eligible individuals?
    - Dysfunctional computer systems, call centers, insufficient staffing
    - High rate of procedural terminations in Medicaid already – new requirements layered on top of that system

Work Requirements and Six-Month Renewals – More Implementation Questions

- How will Missouri involve stakeholder groups in implementation (e.g., revision of notices, application, etc.)? Any role for the BAC/MAC?
- Will Missouri publicly report data on application and renewal outcomes/impact of work requirements, procedural terminations?
- What change will be made to application and renewal forms?
- How will Missouri communicate with enrollees and the public about expected changes?
- What technological changes will be made to make the new system work smoothly and minimize harm?
- Which vendors will Missouri contract with and for which functions?
- Will the State conduct user testing of these new systems?
- Will Missouri increase its workforce capacity to meet the increased need?
- What role will managed care organizations play during this transition – e.g., data sharing for determining exemptions?
- Will forms and notices be accessible to persons with disabilities and individuals with limited English proficiency?
- How will the State accommodate the needs of individuals with disabilities?

HR 1: Cost Sharing Questions

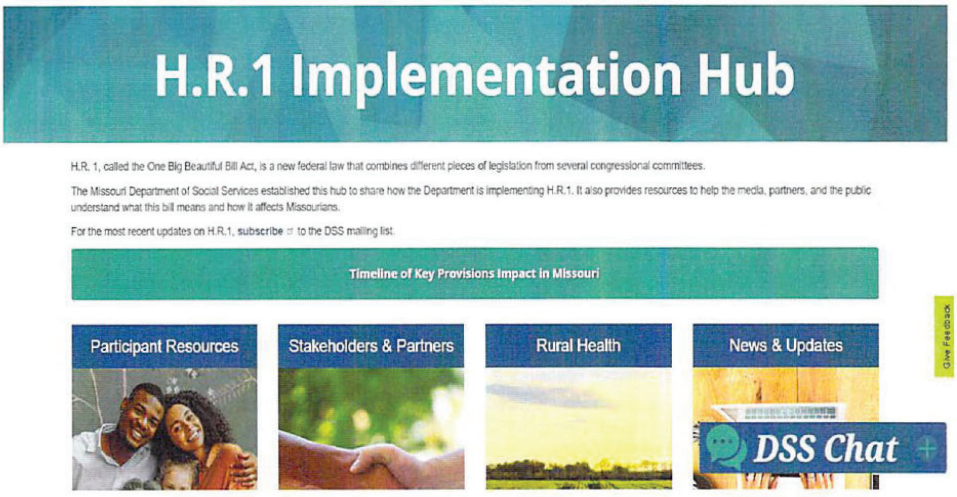
- What will be the size of the co-pays on services?
- Which services will be exempt from cost sharing (i.e., will there be opportunities to exempt additional services)?
- Will providers be permitted to deny services for failure to pay?

DSS Information on H.R.1

https://mydss.mo.gov/hr1

How to Stay Informed

H.R.1 Implementation Hub: **mydss.mo.gov/hr1**



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DSS Information – Rural Health Transformation – Missouri Secured a $216 Million Grant

https://mydss.mo.gov/mhd/rural-health
https://www.cms.gov/files/document/rural-health-transformation-50-state-spotlights.pdf

Rural Health Transformation Program (RHTP)

The legislation includes specific statutory mandates and deadlines that guide implementation planning.

1. **Regional Coordinating Networks and Hub Activation**
Building the foundation of Regional Coordinating Networks and Local Community Hubs to coordinate local care and delivery and expand entry points for physical, behavioral, and social services

2. **Alternative Payment Models**
Designing and launching alternative payment models to sustain ToRCH Care through rewarding collaboration and high quality and high value outcomes

3. **Digital Backbone**
Establishing the foundational layers of technology that enable ToRCH Care to function, including platform interoperability and data modernization

4. **Rural Health Workforce Programs**
Creating a talent pipeline that encompasses the cultivation, recruitment, training, and retention of rural clinicians and a broad array of healthcare professionals

5. **Provider Transformation**
Investing in operational innovations that modernize and increase the sustainability of rural providers while preserving access with strategic renovations

- 5 Year Grant
- $216 Million Awarded for Year 1 to State of Missouri on 12/29/25
  - Revised Budget due by 1/30
  - CMS has 30 days to approve
- Vision: Every rural Missourian has access to the high-quality care the need through a delivery system that is well aligned, community anchored, and built to last.
- Objectives: Expanding access to care, Improving health outcomes and Strengthening provider sustainability
- Rural Health Transformation Office will be established and housed in MHD.
- A state-regional-community Framework will be implemented to ensure consistent standards and shared infrastructure while empowering communities to design solutions tailored to their needs.

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Going forward

- **Mitigating harm:**
  - Meetings with the State agency
  - Written comments to State Agency about implementation
  - Individual representation
  - Litigation?
- **Documentation:**
  - Public Education
  - Stakeholder meetings
  - Engaging with community partners, national organizations
  - Client stories

Q&A