How Montana Can Ensure Eligible Montanans Stay Covered When Implementing Medicaid Work Requirements

March 2026

Executive Summary

Montana Medicaid provides health care coverage to more than 200,000 Montanans with low income, including children, pregnant women, people with disabilities, and adults. In 2016, Montana expanded Medicaid to cover adults with incomes up to 133% of the Federal Poverty Level, or $20,814 for an individual in 2025.[1]

Under new federal policy, Montana must check whether adults with low income enrolled through Medicaid expansion have completed 80 hours of work or other qualifying community engagement activities a month at enrollment and renewal.[2,3,4] While these work requirements are mandatory, states retain significant discretion in how they are implemented. The strategies Montana chooses for implementing work requirements will have a significant impact on the number of Montanans with low income who lose Medicaid coverage due to administrative factors, even if they are working or exempt from work requirements.

Informed by emerging lessons from other states, this report identifies six strategies that Montana can consider to promote program integrity while protecting health care coverage for eligible Montanans:

1. **Assess medical frailty carefully** by developing a rigorous definition and leveraging claims and health information exchange data at renewal and a user-friendly screening tool at application.
2. **Maximize the use of available databases and automated systems** to support federal compliance and identify enrollees who are exempt from the new requirements.
3. **Enhance state capacity for assisting applicants and determining eligibility** by training existing staff on new systems and hiring additional staff to support implementation.
4. **Use clear, consumer-friendly applications, renewal forms, and notices** to reduce Medicaid members' confusion.
5. **Support outreach and engagement with trusted community partners,** including providers, community-based organizations, and Tribal entities to ensure members understand new requirements and how to meet them.
6. **Monitor outcomes, ensure transparency, and course correct early,** using timely data to identify unexpected disenrollments and adjust processes to mitigate further impact.

---

[1] In 2025, Governor Gianforte signed House Bill 245, "Revise the Montana HELP Act," which made Medicaid expansion permanent in Montana.
[2] Additional information about provisions in the new federal policy and projected impacts on Montana Medicaid are available here.
[3] Pub. L. No. 119-21 (2025). Available here.
[4] Some populations, such as parents of children 13 years of age and younger, individuals who are American Indian/Alaska Native, and those who are medically frail, are exempt from work requirements.

New Work and Community Engagement Requirements

On July 4, 2025, the President signed legislation which includes significant federal Medicaid policy changes that establish new restrictions on Medicaid eligibility, enrollment, and financing. One of the key provisions states are required to implement is work and community engagement requirements. Effective January 1, 2027, states must condition Medicaid eligibility for adults enrolled through Medicaid expansion on participating in 80 hours per month of qualifying activities—such as employment, education, or community service—or demonstrating an income of at least $580 per month. Some populations are exempt from work requirements, including, but not limited to, individuals who are parents of children under the age of 13; American Indian/Alaska Native (AI/AN); or medically frail.[5]

How Montana defines qualifying activities, identifies exemptions, and operationalizes work requirements will have a direct impact on whether eligible Montanans lose health care coverage.

Work requirements will create new administrative hurdles for Medicaid members to maintain coverage, even if they are working, participating in qualifying activities, or if they qualify for an exemption.

Experience from states that have previously implemented work requirements show unnecessary coverage losses for otherwise eligible Medicaid members.[6]

---

[5] Pub. L. No. 119-21 (2025). Available here.

[6] In 2019, Montana also established Medicaid work requirements. Montana undertook significant planning at that time, even though the requirements were ultimately not implemented. The new federal requirements also prompted Montana to revisit this issue and submit a new Section 1115 waiver in September 2025 to implement work requirements prior to January 2027. As of March 2026, the application has not been approved by CMS.

State Experiences Implementing Medicaid Work Requirements

Arkansas and Georgia previously implemented Medicaid work requirements. Both states experienced significant coverage losses among Medicaid members and faced technical system barriers and considerable administrative costs:[7]

- Arkansas implemented work requirements in 2018, which resulted in more than 18,000 individuals losing health care coverage in a five-month period. Almost half of total case closures were due to administrative and technical barriers, including an inability to locate members and the failure of members to return requested information—not lack of compliance with work requirements.[8]
- In 2023, Georgia expanded Medicaid eligibility to cover adults with low income who met work requirements. The state estimated 100,000 individuals would enroll in the program in the first year; however, in practice, only approximately 8,000 individuals have ever enrolled, largely due to burdensome administrative reporting requirements and technical implementation challenges.[9] Furthermore, implementing work requirements carried significant administrative costs—in the first two years of the program, the state spent $52 million on eligibility and enrollment technology.[10]

As of October 2025, nearly 75,000 Montana adults with low income were covered through Medicaid expansion.[11] An estimated 29,000 of these individuals—over a third (35%) of the Medicaid expansion population—could lose health care coverage as a result of new requirements.[12,13] This estimate includes many enrollees who are either working or legally exempt from work requirements, but who nonetheless may lose coverage due to administrative barriers. The number of Montanans who actually lose coverage, however, will depend on how the state enhances its eligibility and enrollment processes and uses available data to support eligibility determinations. This report provides six strategies Montana can implement to minimize coverage losses among people who remain eligible for Medicaid.

---

[7] Center for Health Care Strategies, "Engaging Medicaid Members and Community-Based Organizations in Medicaid Work Requirements Implementation" (December 2025). Available here.; E. Hinton and R. Rudowtiz, "Implementing Work Requirements on a National Scale: What We Know from State Waiver Experience", Kaiser Family Foundation. Available here.

[8] R. Rudowitz, M. Musumeci, and C. Hall, "February State Data for Medicaid Work Requirements in Arkansas", Kaiser Family Foundation. Available here.

[9] M. Coker, "Georgia Touts Its Medicaid Experiment as a Success. The Numbers Tell a Different Story.", ProPublica (February 19, 2025). Available here; M. Musumeci et. al, "Few Georgians Are Enrolled in the State's Medicaid Work Requirements Program," The Commonwealth Fund," September 11, 2024. Available here.

[10] Ibid.; L. Chan, "Pathways to Coverage: Looking Back Two Years and Into the Future", Georgia Budget and Policy Institute. Available here.

[11] Montana Department of Public Health and Human Services, "Montana Medicaid Enrollment" (October 2025). Available here.

[12] This estimate is inclusive of other Medicaid provisions in H.R. 1, including six-month eligibility redeterminations.

[13] Manatt Health, "Senate-Passed H.R. 1: Updated Estimates on Impact to State Medicaid Coverage and Expenditures, Hospital Expenditures, Including Impacts by Congressional District", State Health and Value Strategies (July 1, 2025). Available here; A. Burns et al., "How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?", Kaiser Family Foundation (August 20, 2025). Available here.

Emerging Best Practices for States Implementing Work Requirements

Montana has discretion in how it implements many aspects of work requirements. State implementation decisions will directly impact how effectively Montana is able to use its data systems to make *ex parte* eligibility determinations, and how easily Montana Medicaid members can demonstrate compliance with or exemption from the new requirements. Montana can employ the following strategies to **protect health care coverage for eligible individuals while maintaining program integrity and complying with federal requirements.**[14]

1. Assess medical frailty carefully by developing a rigorous definition and leveraging claims and health information exchange data at renewal and a user-friendly screening tool at application.

Federal law requires states to exempt individuals who are considered "medically frail" from work requirements, including those with substance use disorders (SUDs), disabling mental disorders, serious or complex medical conditions, physical, intellectual, or developmental disabilities, or who are blind or disabled. Implementing this exemption effectively will be crucial to helping eligible individuals maintain access to care. Montana can leverage a medical frailty screening tool when individuals apply for Medicaid coverage and use available data at renewal to ensure individuals who have serious physical and behavioral health conditions are not unintentionally disenrolled.

AT APPLICATION

For individuals who are not currently enrolled in Medicaid, Montana can develop a simple medical frailty screening tool and incorporate it into the application. A targeted, user-friendly screener would allow the state to flag individuals who may be medically frail based on self-reported health conditions or functional limitations, even before claims data are available.

[14] As of February 2026, Montana's Section 1115 waiver has not been approved by CMS. Montana's proposed waiver includes certain important steps that can help eligible people maintain coverage: offering all optional short-term hardship exemptions, providing a one-month-long lookback period at application, and evaluating compliance every six months at renewal (rather than more frequently). Other states looking to guard against coverage losses from administrative barriers should adopt similar approaches.

AT RENEWAL

Consistent with the federal statutory requirement to maximize *ex parte* verifications when identifying exemptions (see strategy 2 below), Montana can use available data to identify Medicaid enrollees who are medically frail and automatically exempt them from work requirements at renewal. To do this effectively, Montana needs to develop a detailed list of diagnosis and service codes to identify individuals who are medically frail using Medicaid claims data. However, because Medicaid claims are known to undercount the prevalence of chronic illnesses among enrollees, supplementing claims data with (often more timely and comprehensive) clinical data available through the state's Health Information Exchange, Big Sky Care Connect, could yield a more accurate and effective system for *ex parte* determinations.[15] Once medically frail individuals are identified in claims and/or clinical data, Montana can establish processes to share this information with Montana's Combined Healthcare Information and Montana Eligibility System (CHIMES), which processes renewals. This would allow the state to identify individuals who are medically frail without requiring additional documentation.

Conditions That Should Qualify as Medical Frailty

Diagnoses that Montana should include when identifying individuals who are medically frail include:[16]

1. **Substance Use Disorder.** An individual with SUD is someone who has a problematic pattern of substance use that leads to clinically significant impairment or distress.[17]

   This could include individuals with:

   - Opioid use disorder
   - Alcohol use disorder with medical or psychiatric complications
   - Stimulant use disorder
   - Sedative, hypnotic, or anxiolytic use disorder
   - Cannabis use disorder with functional impairment
   - Polysubstance use disorder
   - Substance-induced psychiatric or medical complications
   - Individuals requiring medication for addiction treatment (MAT), withdrawal management, intensive outpatient treatment, or residential SUD treatment

---

[15] K. Serafi et al., "How Health Information Exchanges Can Identify Medically Frail Work Requirement Exemptions", Manatt Health (February 18, 2026). Available here.

[16] The diagnoses listed are derived from a number of data sources including, but not limited to, a review of publicly available state code/condition lists from states that have previously defined medical frailty (Indiana, Iowa, Kentucky, Michigan, Nebraska, New Hampshire, New Jersey, New Mexico, and North Dakota) and the Center for Medicare and Medicaid Innovation Center's Innovation in Behavioral Health Model's ICD-10 code list.

[17] This definition is from the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders.

2. **Disabling Mental Disorder.** An individual with a disabling mental disorder is someone who has a significant mental illness, including both persistent and episodic, that impacts an individual's ability to function in daily life activities.[18]

   This could include individuals with:

   - Schizophrenia-spectrum and other psychotic disorders
   - Bipolar disorder
   - Major depressive disorder
   - Severe anxiety disorders, obsessive-compulsive disorder, and trauma-related disorders with marked impairment
   - Eating disorders with medical or psychiatric instability
   - Severe personality disorders with repeated decompensation
   - Chronic psychiatric conditions requiring intensive outpatient services, partial hospitalization, or recurrent inpatient care

3. **Serious or Complex Medical Condition.** An individual with a serious or complex medical condition is someone with an illness, impairment, injury, or physical or mental condition that significantly impairs health.[19]

   Montana can consult with providers to develop and finalize an approach to identifying people with serious or complex conditions that is relevant to the Montana Medicaid expansion population. This could include individuals with specific diagnoses, such as those listed here:

   - Aortic aneurysm and other major vascular disease
   - Moderate to severe hypertension with cardiac risk factors
   - Pulmonary hypertension
   - Chronic obstructive pulmonary disease (COPD)
   - Asthma requiring two or more ED visits or hospitalizations in the preceding 12 months
   - Interstitial lung disease
   - Serious thyroid or adrenal disorders with systemic effects
   - Systemic lupus erythematosus
   - Rheumatoid arthritis with organ involvement
   - Vasculitis and severe connective tissue disorders such as Sjogren's Syndrome and Scleroderma
   - Other autoimmune disorders such as Myasthenia Gravis
   - Multiple sclerosis

[18] This definition is consistent with the Americans with Disabilities Act definition of a disabling mental disorder that substantially limits one or more major life activities.

[19] This definition has been proposed by the State Health and Value Strategies. The 2020 No Surprises Act defines a serious and complex medical condition as, in the case of an acute illness, a condition that is sufficiently serious to require specialized medical treatment to avoid a reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, it is one that (i) is life-threatening, degenerative, potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period.

- Bronchiectasis
- Cystic fibrosis
- Chronic kidney disease, particularly advanced stages
- Kidney stones, recurrent or with complications
- End-stage renal disease or dialysis dependence
- Kidney transplant status
- Cirrhosis and complications of portal hypertension
- Advanced hepatitis and chronic viral hepatitis
- Inflammatory bowel disease with systemic impact
- Chronic and recurrent pancreatitis
- Cholelithiasis with complications
- Active or metastatic cancer
- Cancer requiring chemotherapy, radiation, or immunotherapy
- Leukemia, lymphoma, multiple myeloma
- Solid organ or bone marrow transplant recipients
- HIV infection, with or without AIDS
- Parkinson's disease
- Amyotrophic lateral sclerosis (ALS)
- Huntington's disease
- Epilepsy with ongoing seizures
- Stroke, recurrent or with residual deficits
- Traumatic brain injury with lasting impairment
- Major neurocognitive disorders
- Other comparable conditions resulting in substantial functional limitation or medical instability
- Pharmacy and durable medical equipment codes indicating medical frailty
- Combination of diagnosis codes and service utilization data (e.g., multiple hospitalizations within a defined period)
- Utilization data showing complex health care needs based on service utilization (and not diagnosis codes)

4. **Physical, Intellectual, or Developmental Disability.** An individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living.

   This could include individuals with:

   - Moderate or more severe intellectual disability
   - Autism spectrum disorder with significant functional impairment
   - Down syndrome and other chromosomal/genetic syndromes
   - Cerebral palsy
   - Spina bifida
   - Congenital neurologic or metabolic disorders resulting in lifelong impairment
   - Paraplegia or quadriplegia
   - Hemiplegia
   - Limb amputation
   - Severe mobility impairment
   - Significant musculoskeletal deformities
   - Reliance on durable medical equipment (e.g., oxygen therapy, ventilator support, feeding tube)
   - Chronic conditions requiring life-sustaining therapy

2. Maximize the use of available databases and automated systems

When implementing work requirements, the federal law requires states to conduct *ex parte* verifications—automated processes of checking available data sources to verify an individual's eligibility before requiring them to manually provide documentation—to the greatest extent possible.[20]

Using available data sources to verify compliance with or exemption from work requirements, rather than relying on paperwork submissions from individuals, improves accuracy, reduces administrative burden on the individual and the state, and minimizes the number of individuals at risk of losing coverage. When states require individuals to affirmatively report or document compliance with requirements, eligible individuals can lose coverage for procedural reasons, such as missed mail, limited internet access, confusion about requirements, or difficulty navigating requests for information.[21]

For example, as states redetermined Medicaid eligibility after the COVID-19 public health emergency ("unwinding"), states with higher rates of automated, data-driven *ex parte* renewals consistently retained more eligible individuals than states that relied more heavily on manual reporting processes. Montana was among the states with the lowest rate of *ex parte* renewals during unwinding and was also among the states with the highest share of individuals who were disenrolled from Medicaid.[22]

Of the approximately 90,000 Montanans who lost Medicaid coverage between April and September 2023, nearly two-thirds (64%) lost coverage because of procedural reasons (e.g., incomplete paperwork) according to the Department of Public Health & Human Services (DPHHS).[23]

When implementing new federal work requirements, Montana has an opportunity to enhance existing eligibility and enrollment processes by expanding its use of state and federal data sources to maximize *ex parte* verifications.[24,25] For example, Montana currently relies on quarterly wage data to verify whether individuals meet income or hours requirements. To more accurately identify individuals who are meeting work requirements, the state can incorporate additional data sources, such as The Work

---

[20] H.R. 1 requires that states "establish processes and use reliable information available to the State (such as payroll data or payments or encounter data) without requiring, where possible, the applicable individual to submit additional information."
U.S. Congress, "H.R. 1 — 119th Congress (2025–2026)" Congress.gov (2025). Available here.
[21] Herd et al., "Interventions to Automate Medicaid Renewals Reduce Procedural Denials And Increase Coverage", Health Affairs (November 2025). Available here.
[22] Ibid.; J. Tolbert and B. Corallo, "An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding", Kaiser Family Foundation (September 18, 2024). Available here.
[23] Montana Department of Public Health and Human Services, "Medicaid Redetermination Process Updates". Available here.; J. Semmens, "Lessons Learned from the Medicaid Unwinding", Montana Budget and Policy Center (February 15, 2024). Available here.
[24] K. Serafi, L. Sbrana, and L. Dervan, "Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions", State Health and Value Strategies (September 5, 2025). Available here.
[25] Manatt Health, "Strategic Verification Hierarchy for Medicaid Work Reporting Requirements", State Health and Value Strategies (October 6, 2025). Available here.

Number,[26] or leverage consent-based data sources that allow income verification for gig economy workers.[27] In addition, the state can explore using relevant federal databases that the Centers for Medicare & Medicaid Services (CMS) has indicated it is building—such as the National Student Clearinghouse—to confirm individuals enrolled in part-time education.

Montana can also establish automated processes to identify individuals who are exempt from work requirements, including, but not limited to:

- Individuals receiving adequate wages to show compliance with the requirement, via quarterly wage data or other income verification sources;
- Individuals who are participating in Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP), via matching with the SNAP/TANF data sources;
- Parents of children who are 13 years of age or younger, via information provided at application;
- Disabled veterans, via the Veterans Administration's application programming interface (API) platform;[28]
- Individuals who are American Indian/Alaska Native, via information provided at application; and
- Individuals who are considered medically frail (see strategy 1 above).

By taking a strategic, data-based approach to verifying compliance and exemptions from work requirements, Montana can lessen reliance on manual eligibility processes and ensure otherwise eligible Montanans maintain access to health care coverage.

3. Enhance state capacity for assisting applicants and determining eligibility

Even with automated data systems in place, administrative staff remain essential to conduct outreach, engage and educate members about new work reporting requirements, respond to member questions, support verifications, and handle appeals or grievances—functions that technology systems alone cannot effectively perform. Training staff on the new requirements and processes and having sufficient administrative capacity to handle these new Medicaid program functions can help states avoid lengthy processing times and better support members throughout the application and renewal processes.[29]

---

[26] Automated service by Equifax that provides real-time employment and income data directly from employers and payroll providers.
[27] K. Serafi, L. Sbrana, and L. Dervan, "Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions", State Health and Value Strategies (September 5, 2025). Available here.
[28] U.S. Department of Veterans Affairs, Veteran Service History and Eligibility API. Available here.
[29] Medicaid and CHIP Payment and Access Commission, "Building Capacity to Administer Medicaid and CHIP" (June 2014). Available here; A. Diana et al. "Challenges with Implementing Work Requirements: Findings from a Survey of

Montana can conduct trainings for existing staff—including staff from other DPHHS divisions that manage benefits like SNAP—on the new requirements and on the data systems and processes the state is putting in place to operationalize work requirements. Montana has also acknowledged a need for additional administrative staffing to implement the new requirements.[30] As part of this effort, Montana could consider expanding or re-opening Offices of Public Assistance (OPA) that support Montanans in applying for and maintaining Medicaid coverage and other benefits. In 2017, budget reductions caused Montana to close roughly half of the OPAs in the state.[31] Re-opening OPAs could support timely application processing and provide additional support to Montanans as they navigate the new requirements.

Montana can also enhance the number of callback slots in the Medicaid "Helpline". The state reports current capacity for 150 callback slots and estimated that 300 additional slots would need to be added to accomplish a callback option for each caller.[32]

4. Use clear, consumer-friendly applications, renewal forms, and notices

Where Medicaid processes require members to fill out forms, states can offer clear, simple, and consumer-friendly applications and notices to maximize accessibility. Research and practice show that complex forms and notices with legalistic language, poor sequencing, and unclear action steps contribute to procedural coverage losses, particularly for individuals with limited literacy, limited English proficiency, disabilities, or limited access to broadband and digital devices. Simplifying application and renewal language, reducing redundant questions, clearly signaling when no action is required, and designing forms for mobile use have improved rates of successful Medicaid application completion (and reduced churn) and reduced administrative burden.[33]

Montana could also consider conducting user testing with individuals who have lived experience navigating Medicaid. User testing can ensure communications are understandable, actionable, and aligned with how individuals experience eligibility systems—reducing confusion, errors, and avoidable coverage loss.[34]

State Medicaid Programs", Kaiser Family Foundation (October 31, 2025).Available here; M. Coker, "Georgia Touts Its Medicaid Experiment as a Success. The Numbers Tell a Different Story.", ProPublica (February 19, 2025). Available here.

[30] M. Silvers, "Montana will need dozens of new employees to roll out federal Medicaid work requirements", Montana Free Press (September 16, 2025). Available here.

[31] O. Pena, "State Budget Cuts will Cripple Rural Montana, Restrict Food Assistance", Flathead Beacon (October 15, 2017). Available here.

[32] Montana Governor's Office of Budget and Program Planning, Fiscal Note 2027 Biennium: HB0230: Generally revise Medicaid laws. Available here.

[33] Civilla, "Human-Centered Work Requirements for Medicaid" (Fall 2025). Available here; D. Mintz, M. Mazzocchi, and F. Mendez, "Blueprinting Medicaid Work Requirements", Code for America (September 11, 2025). Available here.

[34] Civilla, "Human-Centered Work Requirements for Medicaid" (Fall 2025). Available here; Health Equity Solutions, "Engaging Enrollees in Medicaid Work Reporting Requirements Implementation", State Health & Value Strategies (December 2025). Available here.

5. Support outreach and engagement with trusted community partners

Outreach and engagement are foundational to successfully introducing new eligibility requirements, including changes to reporting expectations, deadlines, and exemption and documentation requirements. Traditional state communication channels—such as mailed notices or call centers—can fail to reach or resonate with eligible individuals, particularly those who live in rural communities, are medically frail, have disabling conditions, are in residential treatment for substance use, have limited broadband access, or face language or literacy barriers. Federal guidance on work requirements emphasizes the importance of proactive outreach, requiring states to notify affected individuals through mail and at least one additional pathway, and for these notices to clearly explain compliance and exemption pathways.[35]

National implementation research further shows that states that use trusted community partners, such as community-based organizations, faith-based groups, local advocates, Tribal entities, and providers, are better positioned to reach individuals who may not respond to state communications alone.[36] Sustained partnerships with local organizations foster trust, surface unforeseen barriers, and improve program responsiveness.[37] Montana has extensive experience working with Tribal entities and other partners to communicate state program changes. Montana regularly hosts Tribal consultations, for example, and could use one of these forums to develop outreach solutions with Tribes. Similarly, Montana can engage hospitals and behavioral health providers to help reach people at risk of losing coverage.

6. Monitor outcomes, ensure transparency, and course correct early

Ongoing monitoring, transparency, and early course correction are essential to ensuring work requirements do not lead eligible Montanans to lose their health care coverage. Publicly tracking the number of individuals who are disenrolled and the reasons for their disenrollment—either because they were income ineligible or did not respond to requests for information—is essential for responding to unintended or concerning trends with program partners.[38]

Without the monitoring of timely data, procedural disenrollments or disparities across populations—especially in rural and tribal communities—may go undetected until disenrollments are widespread.

---

[35] Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin: December 8, 2025," U.S. Department of Health and Human Services (December 8, 2025). Available here.
[36] Center for Health Care Strategies, "Engaging Medicaid Members and Community-Based Organizations in Medicaid Work Requirements Implementation" (December 2025). Available here.
[37] Health Equity Solutions, "State Examples of Medicaid Community Engagement Strategies: Two Case Studies", State Health and Value Strategies (January 2023). Available here.
[38] Medicaid and CHIP Payment and Access Commission, "Increasing the Rate of Ex Parte Renewals" (September 2023). Available here.

Montana has the opportunity—and data analytic capabilities—to track outcomes and address systems or policy issues if procedural disenrollments are unexpectedly high.

Conclusion

How Montana implements work and community engagement requirements in Medicaid will have a significant impact on how many eligible Montanans lose Medicaid coverage. Montana has latitude to develop systems and processes that minimize administrative barriers for Montanans with low income who are working or exempt from work requirements.

The six strategies outlined in this report identify concrete actions Montana can take to meet federal requirements while protecting access to care for otherwise eligible individuals. By prioritizing data-driven strategies, accessible communications, trusted community partnerships, and transparent monitoring with a commitment to course correction, Montana can mitigate coverage losses among eligible Montanans.

Research support for this brief was provided by Manatt Health. The views expressed in this primer are solely those of the Montana Healthcare Foundation and do not reflect the view of Manatt Health.