

# When December 2026 Won't Work: Extension Requests and Interim Status

## The Timeline That Doesn't Add Up

Dr. Sandra Chen stares at the Gantt chart on her office wall, running her finger along the colored bars that represent her state's work requirement implementation timeline. She's been the Medicaid Director for six years, long enough to know the difference between aggressive timelines and impossible ones. This one is impossible.

It's March 2026. December 31st is nine months away. The federal deadline for implementing work requirements isn't negotiable. But the reality on her wall tells a different story.

The technology vendor they selected last August is now projecting a go-live date of February 2027. Their original bid promised October 2026 delivery. Three months of scope clarification followed by two months of staffing delays pushed everything right. The vendor's project manager stopped promising specific dates two weeks ago.

The navigator workforce training program was supposed to launch in January. The curriculum is only now going through final review because CMS guidance didn't arrive until June, as the statute required, and her team needed clarity on exemption definitions before they could train anyone to explain them. Her training director estimates they'll have the first cohort certified by August. They need 400 trained navigators across the state. Current projection: 150 by December, maybe 200 if they run weekend sessions.

The exemption processing system doesn't exist yet. Her IT team built a requirements document based on the statute and early CMS signals. Then the interim final rule clarified exemption categories in ways that invalidated half their design assumptions. They're essentially starting over, and the development team that was supposed to build the exemption module is still working on the core verification system.

The community organization partnerships her outreach director championed are falling apart. Three of the five anchor organizations they'd identified as regional verification hubs pulled out after reviewing the compliance requirements. The liability language alone scared off most of the faith-based partners. The two organizations still committed are underfunded and understaffed.

Sandra pulls up the implementation funding allocations on her laptop. Her state received \$4.2 million from the federal distribution, split between the base allocation and the population-based share. Her preliminary budget estimated they'd need \$18 million for adequate implementation. The gap is \$13.8 million, and the legislature declined her supplemental appropriation request in the last session.

She has two options. She can launch whatever systems exist on December 31st, knowing they're inadequate, and watch the coverage losses accumulate as administrative failures compound. Or she can request an extension from CMS, acknowledging publicly that her state isn't ready and hoping the federal administration grants a good faith waiver.

Neither option is good. Both carry political risk. One carries certain harm to her Medicaid members. She reaches for the phone to call the Governor's health policy advisor, rehearsing the conversation she's been dreading for months.

## The Readiness Problem

The One Big Beautiful Bill Act established December 31, 2026, as the implementation deadline for Medicaid work requirements. States must have operational systems capable of verifying work activity, processing exemptions, conducting outreach, and managing compliance for approximately 18.5 million expansion adults. The timeline is aggressive by any measure.

To understand why December 2026 won't work for many states, consider what implementation actually requires. States need technology systems to accept and process verification data from multiple sources: employers, educational institutions, community organizations, and individual members. They need eligibility system modifications to incorporate work status into enrollment and renewal processes. They need data matching infrastructure connecting Medicaid systems to wage databases, educational enrollment records, and other verification sources. They need member portals, mobile applications, and phone systems for self-reporting. They need exemption processing workflows that can evaluate medical conditions, caregiving status, and other qualifying circumstances.

**Major Medicaid IT procurements typically require 18 to 24 months** from initial planning to operational deployment. This timeline includes needs assessment, requirements documentation, procurement planning, RFP development and release, vendor evaluation, contract negotiation, system development, testing, training, and staged deployment. States that began procurement in January 2026, immediately after the law's passage, would be on schedule for mid-2028 delivery under normal timelines. States that waited for CMS guidance before beginning procurement are looking at 2029 or later.

**The vendor capacity problem compounds the timeline challenge.** Every state with Medicaid expansion needs work requirement systems simultaneously. The major health IT vendors, including Deloitte, Accenture, Optum, Gainwell, and the SDOH platforms, face unprecedented demand. Implementation teams are finite. States competing for the same vendor resources find themselves in queue behind states that started earlier or offered better contract terms. A vendor promising October 2026 delivery to three different states may only be able to deliver to one.

Beyond technology, states need trained workforces. **Eligibility workers must understand new requirements, exemption categories, and verification procedures.** Call center staff need scripts and protocols for member inquiries. Care coordinators at managed care organizations need to integrate work requirement support into their workflows. **Community navigators need certification and ongoing supervision.** Training programs require curriculum development, instructor preparation, scheduling, delivery, and competency assessment. States cannot simply announce new requirements and expect existing staff to figure it out.

Community organization partnerships require cultivation. **Faith-based organizations, community health centers, workforce development boards, and social service agencies can serve as trusted intermediaries for verification and navigation support.** But these partnerships don't materialize instantly. Organizations need to understand their roles, assess their capacity, negotiate participation terms, train their staff, and integrate new workflows into existing operations. Organizations that have never worked with state Medicaid agencies may need months of relationship-building before they're ready to participate.

**The CMS guidance timeline creates a compressed decision window.** The statute required HHS to issue an interim final rule by June 1, 2026. States receive authoritative implementation guidance

seven months before the deadline. Decisions made before guidance arrives may prove inconsistent with federal requirements, requiring costly rework. Decisions deferred until after guidance may not leave enough time for implementation. States face a dilemma: move early and risk misalignment, or wait for clarity and risk missing the deadline.

A recent KFF survey of state Medicaid directors found widespread concern about the implementation timeline. Several states described the deadline as "unrealistic." Others noted the difficulty of making system design decisions before receiving federal guidance. States expressed concern that rushing implementation would increase errors and coverage losses. Some states questioned whether any implementation approach could achieve adequate coverage protection under the current timeline.

## The Extension Framework

The statute provides a pressure release valve. The Secretary of Health and Human Services may grant states temporary compliance exemptions extending the implementation deadline up to December 31, 2028. This two-year extension window acknowledges that not every state will achieve operational readiness by the statutory deadline.

The extension authority requires states to **demonstrate a "good faith effort" toward implementation**. States cannot simply decline to implement and expect automatic extensions. They must show that they attempted compliance but encountered obstacles beyond their reasonable control. The distinction between good faith delay and deliberate non-implementation will determine which states receive extensions and which face consequences for non-compliance. What constitutes good faith effort remains undefined as of this writing. CMS guidance on extension requests is expected to clarify the documentation requirements, evaluation criteria, and approval process. Reasonable interpretations might include evidence of procurement activity, vendor contracts, staffing plans, training programs, stakeholder engagement, budget allocations, and implementation milestones. States that can demonstrate active preparation but encounter legitimate obstacles are more likely to qualify than states that took minimal action and cited the same obstacles as justification.

The timing of extension requests matters strategically. **States that request extensions early signal proactive acknowledgment of implementation challenges**. States that request extensions late, after missing deadlines and causing member harm, appear reactive and unprepared. Early requests also give CMS time to evaluate applications, negotiate conditions, and approve extensions before deadlines arrive. A state requesting an extension on December 15, 2026, leaves little time for review regardless of the merits.

Extension duration likely depends on the nature of the obstacles and the credibility of the remediation plan. A state whose vendor delivered late might receive a six-month extension to complete testing and deployment. A state that never issued an RFP might receive a longer extension but face stricter conditions. A state requesting an extension due to principled opposition rather than implementation challenges likely receives neither extension nor sympathy.

Conditions attached to extensions will shape state behavior during the extended period. CMS might require interim progress reports, milestone commitments, member protection provisions, or specific system design choices. States receiving extensions may face enhanced federal oversight compared to states that met the deadline. **The terms of extensions become important negotiating points between states and CMS.**

The extension framework creates a federal-state dynamic with competing incentives. CMS wants states to implement on time and may resist normalizing extensions. States want flexibility and may see extensions as preferable to rushed, inadequate implementation. The early extension decisions will establish precedents that shape later requests. A federal administration that grants liberal extensions signals tolerance for delay. A federal administration that denies reasonable requests signals that the deadline is inflexible regardless of circumstances.

## The Political Dynamics of Delay

Requesting an extension is not merely an administrative decision. It carries political implications that state leaders must navigate carefully.

In states whose leadership supported work requirements, requesting an extension may appear as implementation failure. Governors who championed work requirements as welfare reform face awkward questions when their states can't implement on time. Legislative majorities that voted for federal work requirements may view extension requests as incompetence rather than prudence. The political narrative of "we wanted this but couldn't do it" is uncomfortable for officials who staked positions on the policy.

***In states whose leadership opposed work requirements, extension requests may signal deliberate delay masquerading as implementation challenges.*** Critics will question whether the state genuinely tried to implement or whether obstacles were manufactured to justify the delay advocates wanted all along. States in this position face credibility challenges even when their implementation obstacles are legitimate.

***Governor-legislature conflicts add complexity.*** A governor who opposes work requirements serving under a legislature that mandated them faces competing pressures. Aggressive implementation may violate the governor's principles. Delayed implementation may provoke legislative backlash. The extension request becomes a proxy battle in larger policy disputes. Kentucky illustrated this dynamic when Governor Beshear vetoed work requirement legislation that the legislature subsequently overrode.

***The federal administration's stance on extensions will influence state calculations.*** Under the current administration, which supported the work requirement legislation, extension requests may receive skeptical review. States may fear that requesting extensions will invite enhanced federal scrutiny, worse terms, or outright denial. Alternatively, the administration may recognize that inadequate implementation serves no one's interests and approve reasonable extensions to ensure better outcomes.

Advocacy communities will frame extension requests according to their policy preferences. Organizations that support work requirements may characterize extensions as obstruction. Organizations that oppose work requirements may characterize extensions as appropriate caution to prevent member harm. The same extension request will appear as good governance or bad faith depending on the evaluator's perspective on the underlying policy.

Media coverage of implementation delays tends toward simple narratives. ***"State fails to implement federal requirements" makes a cleaner headline than "State requests reasonable extension due to vendor delays while protecting member coverage."*** Political opponents will exploit delay narratives regardless of the underlying justifications. States requesting extensions should prepare communication strategies that explain the decision in accessible terms.

The political dynamics create asymmetric risk. States that implement inadequate systems on time may cause significant member harm but face less political criticism than states that acknowledge unreadiness and request extensions. ***The bias toward action over acknowledgment of limitation may push states toward harmful implementation when prudent delay would serve members better.***

## Member Status During Extensions

What happens to Medicaid members while their state operates under an extension? This question has significant practical implications for 18.5 million people.

***The most protective interpretation*** holds that work requirements don't apply during the extension period. Members remain enrolled under pre-requirement rules. Eligibility depends on income and other traditional factors, not work activity. This interpretation treats extensions as delaying the effective date of work requirements for the state's entire expansion population.

***A more restrictive interpretation*** holds that work requirements apply but verification is suspended. Members are technically subject to requirements but aren't terminated for non-verification while the state's systems aren't operational. This interpretation creates uncertainty: members don't know whether they're meeting requirements they can't yet document. It may also create retroactive compliance questions when systems eventually launch.

***The retroactive application problem deserves explicit attention.*** If a state receives a one-year extension and launches work requirements in January 2028, does it evaluate members' work activity for 2027? Must members prove they were working during a period when they had no mechanism to document work? Retroactive application would be administratively chaotic and arguably unfair. Extension terms should explicitly address whether compliance periods begin only when verification systems become operational.

Communication to members during extension periods requires careful messaging. Members need to understand that their coverage is not immediately at risk but that requirements are coming. They need to know what requirements will apply, what documentation they should begin gathering, and when the requirements will take effect. Confusion about member status during extensions could cause unnecessary anxiety or, conversely, inadequate preparation for eventual implementation.

Provider and MCO planning during extensions faces similar uncertainty. Healthcare providers serving Medicaid expansion patients need to know whether their patients will retain coverage. Managed care organizations need enrollment projections for rate-setting and care management planning. A state operating under extension cannot provide definitive answers about future enrollment, making planning difficult for the entire healthcare ecosystem.

The extension period may actually enable better implementation than rushed deadlines would allow. States with additional time can conduct more thorough testing, train larger navigator workforces, build stronger community partnerships, and refine exemption processes. ***Members in extension states may ultimately experience better implementation than members in states that launched inadequate systems on time. The short-term limbo could produce long-term benefit.***

## Which States Are At Risk

Certain state characteristics predict implementation challenges and extension likelihood. Understanding these risk factors helps stakeholders anticipate which states may struggle with the December 2026 deadline.

Late starters face the most obvious challenge. States that delayed procurement hoping the law would change, waiting for CMS guidance, or navigating internal political disputes have compressed timelines that may be unrecoverable. A state beginning serious procurement in mid-2026 cannot complete implementation by year-end under any realistic scenario.

**States with complex legacy eligibility systems face technical obstacles that simpler systems do not.** Aging mainframe infrastructure may not support the API integrations modern work verification requires. States that deferred eligibility system modernization now face simultaneous modernization and work requirement implementation. The technical complexity multiplies both cost and timeline.

Limited administrative capacity correlates with implementation difficulty. **Smaller state Medicaid agencies with fewer staff, less specialized expertise, and thinner budgets struggle to manage complex implementations.** They may lack the project management capability, the procurement sophistication, or the technical expertise that larger states take for granted. Administrative capacity is not evenly distributed across states.

**Political opposition creating implementation drag** slows progress in subtle ways. A governor who opposes work requirements may not actively obstruct implementation but may also not prioritize resources, expedite approvals, or resolve conflicts. Agency leaders may receive mixed signals about urgency. Contractors may perceive ambivalence and adjust their own priorities accordingly. Implementation moves fastest when political leadership genuinely wants it to succeed.

**Rural states with dispersed populations face infrastructure challenges that urban states do not.** Building navigator networks across vast geographic areas requires more resources than concentrating navigators in metropolitan centers. Community organization partnerships are harder to develop when potential partners are spread across hundreds of miles. Digital infrastructure gaps in rural areas complicate technology-dependent verification approaches.

States without prior work requirement experience start from zero. Georgia, despite its troubled implementation, has operational work requirement infrastructure that other states lack. States that pursued Section 1115 waivers under the first Trump administration but never implemented have partial preparation. States that never pursued work requirements have no existing systems, no institutional knowledge, and no lessons learned to build upon.

**Funding constraints predict implementation quality regardless of timeline.** The \$200 million federal implementation appropriation distributes to 41 expansion states, **averaging under \$5 million per state** before population adjustments. Prior state work requirement attempts cost \$6 million (New Hampshire) to \$86 million (Georgia). States without supplemental state funding may implement systems that technically satisfy requirements but practically fail members.

Multiple risk factors compound. **A rural state with limited administrative capacity, legacy technology systems, political ambivalence, no prior experience, and inadequate funding faces implementation challenges on every dimension.** Such states are candidates for extension requests whether or not their leaders acknowledge it.

## Planning for the Deadline That Won't Be Met

States recognizing that December 2026 is unlikely should begin contingency planning now rather than hoping problems resolve themselves.



Realistic timeline assessment comes first. States should conduct honest evaluation of where implementation actually stands versus where it needs to be. This assessment should identify specific gaps: systems not built, staff not trained, partners not engaged, processes not designed. Vague optimism that "things will work out" is not a plan. Concrete gap analysis enables concrete remediation.

***Extension request preparation should begin immediately for states with significant gaps.***

Documentation of good faith effort requires evidence: procurement records, vendor contracts, training materials, stakeholder meeting minutes, budget submissions, and implementation milestones achieved. States cannot produce this documentation retrospectively. Building the extension request file should become part of ongoing implementation management.

***Phased rollout offers an alternative to full extension for states with partial readiness.*** Rather than launching incomplete systems statewide, states might implement in regions where infrastructure is strongest, with populations where verification is simplest, or through voluntary participation before mandatory requirements. CMS may accept phased approaches as demonstrating progress even if universal implementation isn't achieved by deadline.

Pilot populations can test systems before broad deployment. States might implement work requirements first for new applicants rather than existing enrollees, for single populations rather than all expansion adults, or for geographic areas with concentrated infrastructure. Pilots reveal system weaknesses while limiting harm if systems fail. Pilot results strengthen extension requests by demonstrating that the state is actively testing and refining its approach.

***Geographic phasing recognizes that readiness varies within states.*** Urban areas with concentrated service providers, strong community organizations, and robust digital infrastructure may be ready before rural areas with none of these advantages. States might implement work requirements in ready regions while extending timelines for regions with infrastructure gaps. This approach protects populations in underserved areas from systems designed for different circumstances.

Communication strategies should address stakeholder uncertainty. Members need to understand what's happening and when. Providers need enrollment projections. MCOs need planning guidance. Community organizations need implementation timelines. A state that doesn't know whether it will meet the deadline should be honest about that uncertainty while providing the best available information about next steps and decision points.

***Minimum viable product thinking focuses on core functionality.*** States that cannot implement comprehensive systems might implement basic systems that satisfy statutory requirements while deferring enhancements. What is the minimum verification capability, the minimum exemption process, the minimum member portal that constitutes implementation? Building the minimum first creates the possibility of meeting deadlines that comprehensive systems would miss.

## The Calculation

Dr. Chen puts down her phone. The conversation with the Governor's office was shorter than expected. The political calculation, it turns out, was simpler than the implementation challenges that produced it.

The Governor's health policy advisor listened to her timeline analysis, asked a few clarifying questions, and delivered the verdict: request the extension. The administration would rather acknowledge implementation challenges and do this right than launch broken systems and

manage the fallout. The coverage losses that inadequate implementation would cause would become the political story. Better to be the state that asked for time than the state that caused a crisis.

Sandra begins drafting the extension request that afternoon. She documents the procurement timeline, the vendor delays, the training gaps, the community partnership challenges. She outlines the remediation plan: revised vendor milestones, accelerated training schedules, alternative partnership strategies. She identifies the specific date when her state can achieve operational readiness: August 2027, if everything goes well. She requests a nine-month extension, building in contingency for the problems that always emerge.

The request acknowledges what she's known for months: December 2026 was never realistic for her state. The timeline assumed procurement speeds that don't exist, vendor capacity that isn't available, training infrastructure that wasn't built, and community partnerships that take years to develop. The statute set a deadline without regard for what implementation actually requires.

She thinks about her counterparts in other states. Some have better starting positions: prior work requirement experience, modern eligibility systems, larger implementation budgets, more political will. They might make the deadline. Others are further behind than she is, with less awareness of how far behind they are. They'll discover in October what she's acknowledging in March.

*The extension request won't solve all her problems. CMS might deny it, impose conditions she can't meet, or approve a shorter extension than she needs. The political criticism will come regardless. But at least she's being honest about reality rather than pretending away problems that won't solve themselves.*

Her Medicaid members deserve systems that work, not systems that exist. If getting there requires acknowledging that December 2026 won't work, then that's the acknowledgment she'll make.

She hits send.

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