



NORD Rare Action Network® Policy Explainer

Prepared: June 3, 2026

NORD RARE ACTION NETWORK

[CMS 2454-IFC; Medicaid Program; Community Engagement Requirements for Certain Individuals](#)
Interim Final Rule 42 CFR Parts 431, 435, 438, 457, and 600

SUMMARY

On June 1, 2026, the Centers for Medicare and Medicaid Services (CMS) released an interim final rule (IFR) that requires certain adults enrolled in Medicaid to prove they are working, in school, or doing community service for at least 80 hours a month to keep their coverage. This rule establishes binding requirements for state Medicaid programs and builds upon the framework for Medicaid community engagement (work) requirements set forth in the 2025 federal budget reconciliation law, referred to as the One Big Beautiful Bill Act (OBBBA), or H.R. 1.

The CMS IFR for Medicaid Community Engagement Requirements (CMS-2454-IFC), applies to all 50 states and Washington, D.C., but in practice impacts mainly the 40 states and D.C. that have expanded Medicaid under the Affordable Care Act, as well as Georgia and Wisconsin through separate federally approved programs. Some people can qualify for an exemption from the requirement including caregivers, people with serious medical conditions, former foster youth, pregnant people, Native Americans, and others listed in the rule, but in many cases they must demonstrate that they qualify, and the process for doing so is explained in detail in this document. States must have the requirement in place by January 1, 2027, and must set up systems to verify compliance, notify people of their rights, and follow a specific process before ending anyone's coverage.

This translation is designed to be read alongside the actual regulatory text and reflects NORD's careful review of the rule; it is intended to make the rule accessible and understandable, but it is not a substitute for the rule itself.

BASIS AND SCOPE (§435.550)

This rule, known as the CMS IFR for Medicaid Community Engagement Requirements (CMS-2454-IFC), establishes the framework states must use to implement the new **Medicaid community engagement (work) requirements**. While the rule applies nationwide, including Washington, D.C., it primarily affects states that expanded Medicaid under the Affordable Care Act, as well as a small number of non-expansion states that cover certain low-income adults through federally approved Medicaid waivers.

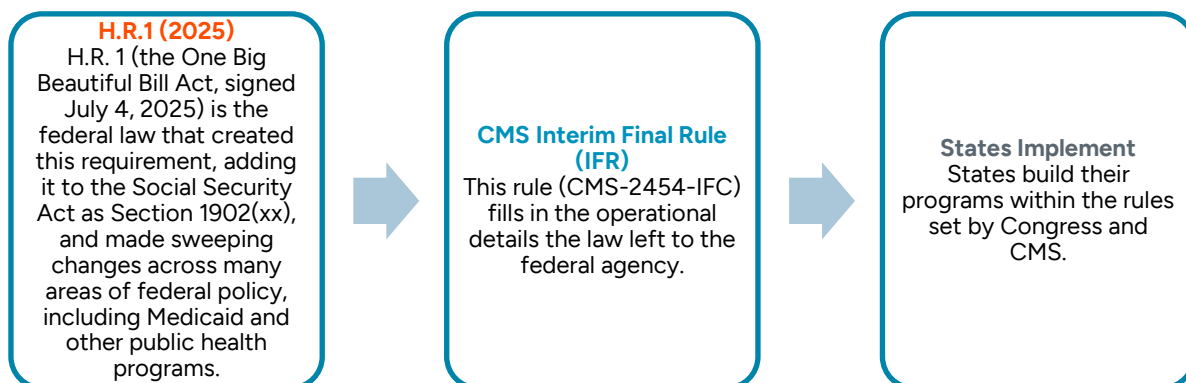
As of 2026, **40 states and the District of Columbia** have expanded Medicaid and will be required to build and administer these work requirement systems for their Medicaid expansion populations. Two non-expansion states, **Georgia and Wisconsin**, also have applicable populations through Section 1115 demonstration waivers and will be subject to the requirement **beginning January 1, 2027**. In the remaining eight non-expansion states, the impact is expected to be limited because there is little to no population for the requirements to apply to. Those states are: Alabama, Florida, Kansas, Mississippi, South Carolina, Tennessee, Texas, and Wyoming.

The rule does not apply to U.S. territories such as Puerto Rico or Guam.

Where This Rule Comes From

This rule was written by the **Centers for Medicare and Medicaid Services (CMS)**, the federal agency that runs the government's major public health insurance programs, including Medicare, which covers

older Americans and people with disabilities, and Medicaid, which covers people with low incomes. The CMS Community Engagement Requirements rule is a step in a chain that started with an act of Congress on July 4, 2025.



Understanding that chain helps explain both what the rule does and why it looks the way it does.

[H.R. 1](#) set the framework of who this applies to, the 80-hour activities, the exceptions and exclusions, the optional short-term hardships, the data-first (“*ex parte*”) verification approach, the 30-day noncompliance process, the outreach duty, the ban on waiving the requirement, and the temporary good-faith implementation delay. But Congress also left many specifics for the agency CMS to define, using phrases like “as determined by the Secretary” and “in accordance with standards specified by the Secretary.” This is common practice, and the CMS Community Engagement Requirements rule fills in those details. Each individual state will also have choices left to them by CMS in how they interpret and implement the rule in their given state. Therefore, the way this mandate is implemented will look very different state by state.

How the Rule Document Is Built (and How to Read It)

The rule was published in the [Federal Register](#), the federal government’s official daily record of new rules and notices. The full document runs to roughly 390 pages. Here is how the document is laid out, front to back:

Part of the Document	What It Contains / What It Is For
Front matter (p.1-4)	The cover section. Lists who wrote this (CMS), what it is called (CMS-2454-IFC), when it starts (effective July 31, 2026), and how to send the government your opinion about it (public comments due July 31, 2026).
I. Background (p.5-13)	Why this rule exists. Congress passed a law in 2025 requiring work requirements for certain Medicaid enrollees. This section explains that history and how this rule came to be.
II. Provisions of the Interim Final Rule (p.13-250)	CMS goes through each part of the rule one by one, explains what it means, and explains why they wrote it that way. This is the section that tells you how CMS will interpret the rules when states have questions.
III. Good Cause for an Interim Final Rule (p.250-251)	A short explanation of why this rule could take effect right away without asking the public for input first. Normally, the government must allow a public comment period before a new rule goes into effect. Congress waived that requirement for this rule.
IV. Collection of Information Requirements (p.252-296)	A required estimate of how much time and paperwork this rule creates — for states, for Medicaid agencies, and for people applying for or enrolled in Medicaid. Every new federal rule must include this calculation by law.

V. Regulatory Impact Analysis (p.296-338)	A required analysis of what this rule will cost and who will be affected. CMS also had to describe what other options it considered before choosing this approach.
The regulatory text — “the language” (p.338-387)	The rules, written into the Code of Federal Regulations (CFR), organized by Part (431, 435, 438, 457, 600) and then by section (§).The work requirement rules are in sections 435.550 through 435.563.

The narrative sections (I-V) are called the preamble and its important:

- Section II, in particular, lays out how CMS intends to interpret and apply the regulatory text.
- When states design their programs and bring requests to CMS, those requests will be evaluated through the lens of what CMS has articulated in Section II.
- In that sense, while the preamble cannot be enforceable in a regulatory sense, it defines the framework within which states will need to operate.

Asterisks (* * * * *) in the regulatory text mean that the existing language was left out to save space.

APPLICABLE INDIVIDUALS (§435.551)

Who This Rule Affects and Where They Live

The rule only applies to certain adults on Medicaid. It calls them “**applicable individuals.**” To be an applicable individual, a person must first be enrolled in or eligible for one of two types of Medicaid coverage:

- **Standard Medicaid Expansion (§435.119):** available in states that chose to expand Medicaid under the Affordable Care Act, covering single, childless adults earning up to 138% of the federal poverty level (about \$22,000 a year for a single person in 2026); or
- **A Federally Approved Special Medicaid Program (§1115 Demonstration):** available in states running CMS-approved Medicaid programs that provide “minimum essential coverage.” This is how states like Georgia and Wisconsin, which have not adopted full Medicaid expansion, still have populations the requirements reach.

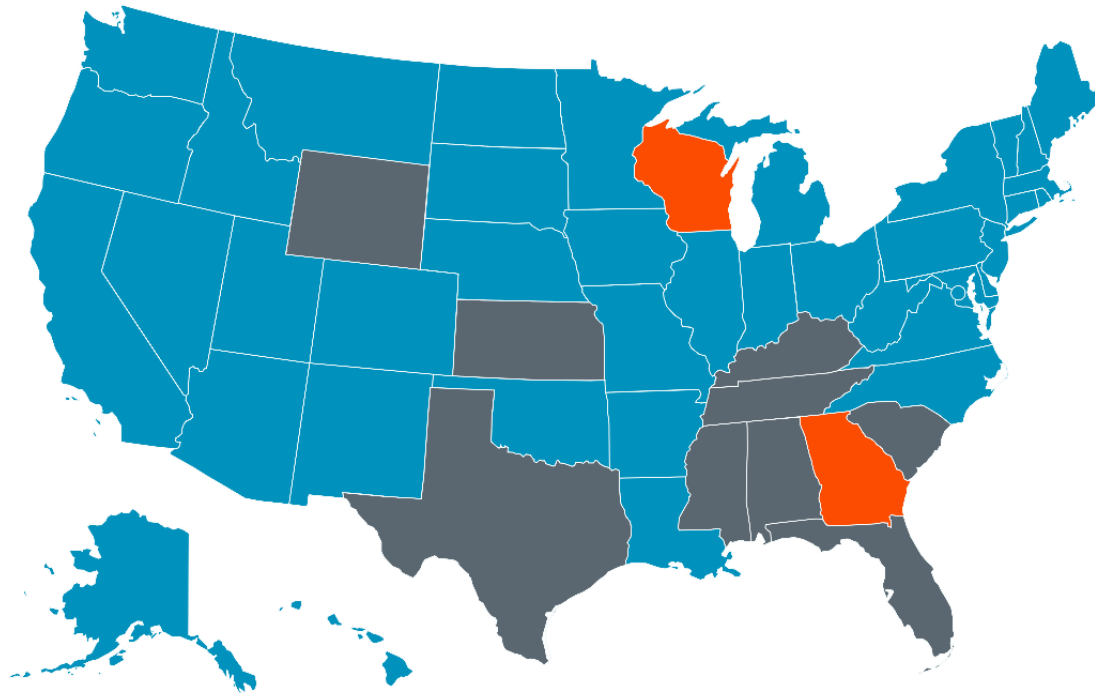
In addition, **the person must meet ALL FOUR of the following criteria:**

<input type="checkbox"/> Age	Between 19-64 years old.
<input type="checkbox"/> Pregnancy	NOT currently pregnant.
<input type="checkbox"/> Medicare	NOT enrolled in or eligible for Medicare Parts A or B (a separate federal health program for people age 65 and older and people with certain disabilities – not the same as Medicaid).
<input type="checkbox"/> Other Medicaid Eligibility	NOT already eligible for Medicaid through another pathway, and NOT someone who can be considered exempt. (more below).

The requirement attaches to specific Medicaid populations, not all Medicaid enrollees, so, its reach depends on how each state has structured its program. Every state must comply, but as of 2026, the requirement will mainly reach the 40 states and the District of Columbia that expanded Medicaid, plus Georgia and Wisconsin through their Section 1115 programs. In the remaining eight non-expansion states, there is no applicable population for the requirement to reach.

The map below shows where the requirement will apply:

Where the Requirement Mainly Applies: State Status, 2026



- Expanded Medicaid - requirement applies here (40 states + DC)
- Partial applicability - partial Medicaid population subject to the requirement (2 states)
- Has not expanded - little/no population for the requirement to reach (8 states)

DEMONSTRATING COMMUNITY ENGAGEMENT – What to Show (§435.552)

To obtain and keep their Medicaid coverage, applicable individuals must prove that they met the community engagement requirement for a set number of months. Each state will decide how many months they will count but, it must be at least one. There are seven ways a person can prove this for a month:

Qualifying Activity	How Much	What Each Term Means
1. Work	80+ Hours per month.	<ul style="list-style-type: none"> Being paid in money; Being paid in goods or services ("in-kind" work); or Doing unpaid work that is not community service. <p>Self-employment, gig work, and in-kind arrangements all count. Medicaid-covered employment services do not count.</p>
2. Community service	80+ Hours per month.	<p>Unpaid work done voluntarily — or because a court required it — for the direct benefit of the community through a public or nonprofit organization. To qualify, the host organization must:</p> <ul style="list-style-type: none"> Provide oversight of the activity; Ensure the activity does not serve a partisan purpose; and Have a system in place to track the type of activity, the dates and hours completed, and a point of contact who can confirm the hours. <p><i>On the community service partisan purpose rule: the rule does not define "partisan purpose" beyond that phrase.</i></p>

3. A work program	80+ Hours per month.	<p>One of the following federally recognized programs:</p> <ul style="list-style-type: none"> • A WIOA Title I workforce program; • A Trade Act Section 236 program; • A state or local government employment and training program approved by the Governor, including SNAP Employment and Training (E&T) programs — but supervised job search or job search training can only be included as a subsidiary activity, making up less than half the required hours; • A Department of Labor or Department of Veterans Affairs employment and training program for veterans; or • A SNAP workforce partnership.
4. Education	Enrolled at least half-time.	<ul style="list-style-type: none"> • A college or university (institution of higher education under the Higher Education Act); • A career and technical education program (Carl D. Perkins Act); • A high school; or • A state-approved program leading to a high school equivalency certificate, for someone who has not yet received a high school diploma.
5. A combination	Any mix of the above. <i>There are rules for how to add them up.</i>	
6. Monthly income	Earning monthly income at least equal to the federal minimum wage multiplied by 80 hours.	
7. Seasonal worker income	An average monthly income over the past six months at least equal to the federal minimum wage multiplied by 80 hours.	

School Enrollment Status Rules

The school or institution determines whether a person is enrolled full-time, half-time, or less than half-time.

- Enrollment status begins on the first day of the school term.
- It continues through normal periods of attendance, vacation, and recess. During breaks, enrollment status is based on the person's status just before the break began.
- Enrollment status ends at the end of the month in which the student is expelled, withdraws, finishes a term without registering for the next term (not counting optional sessions like winter or summer terms), or graduates — unless they immediately enroll in another qualifying program.

Less-Than Half-Time Enrollment: Converting Credit Hours to Monthly Hours

If a person is enrolled less than half-time, their credit hours must be converted to monthly hours as follows:

For programs that use credit hours do both steps in order:

- **Step 1:** Multiply each credit hour by 3. This gives you total weekly education hours. (Example: 2 credit hours x 3 = 6 weekly hours)
- **Step 2:** Multiply that weekly total by 4.33. This converts weekly hours to a monthly total. (Example: 6 weekly hours x 4.33 = 25.98 monthly hours)

For programs that do not use credit hours:

- Count the actual hours spent attending class and participating in educational activities.

Combination Rules

A person can combine qualifying activities to reach the 80-hour threshold, with two important rules:

1. **Education hours can only be combined with other activities if the person is enrolled less than half-time.** If a person is enrolled at least half-time, education alone satisfies the requirement — it cannot be mixed with other hours.
2. Hours for work, community service, and work programs must each be counted separately, based on the actual time spent on each activity in that month.

Income Pathways

For both the monthly income and seasonal worker pathways, income is measured using the person's MAGI-based income for their MAGI-based household.

If a person's monthly income is less than the federal minimum wage multiplied by 80 hours and the state does not have documentation of the exact hours worked, the state can estimate hours by dividing the person's MAGI-based monthly income by the federal minimum wage. The state must use a reasonable method to divide those hours among household members.

Educational Note: Modified Adjusted Gross Income (MAGI) is the income figure the government uses to determine Medicaid eligibility. It is based on a household's total income with certain adjustments applied. Medicaid already uses MAGI to determine who qualifies, so this is not a new calculation for states or enrollees.

MANDATORY EXCEPTIONS – Who Is Not Impacted (§435.553)

Sometimes a person does not need to complete any qualifying activities, and the state must automatically count them as having met the requirement for that month. These are called **mandatory exceptions**. The state has no choice but to apply them.

When the Mandatory Exception Applies

A state must count a person as having met the requirement for a month if **any** of the following applied:

During all or part of that month, the person was:

- Under 19 years old;
- Enrolled in or entitled to Medicare Part A, or enrolled in Medicare Part B (a separate federal health program).
- In one of the mandatory standard Medicaid coverage groups (these are the categories of people states are required by federal law to cover under their standard Medicaid program like people receiving Supplemental Security Income); or
- A specified excluded individual (explained in the next section).

At any point during the 3-month period ending on the first day of that month, the person was:

- An inmate of a public institution.

How CMS Reads "A Month"

The rule requires people to demonstrate compliance "for a month." CMS has clarified that this means any month within whatever review period the state has chosen, not just the current month.

Here is an example of what that means in practice: a state chooses to look back three months when someone applies. The applicant applies in October. The state checks July, August, and September. The applicant only needs to show they met the requirement in one of those three months, whichever month they choose to demonstrate. "A month" means one month within that window, not a specific month the state picks for them.

SPECIFIED EXCLUDED INDIVIDUALS – Who Is Exempt (§435.554)

A person can also be excused from having to prove they are working, in school, or volunteering. The requirement does not apply to them if they can show they are an **exempt "Specified Excluded Individual."** A person is a specified excluded individual and will not have to prove they are working, in

school, or volunteering to get or keep Medicaid coverage if they can show they fall into one of the following ten categories:

Category	Key Details
Former Foster Youth	Whether or not they turned 18 on or after January 1, 2023.
American Indians and Alaskan Natives	Member of a federally recognized tribe; Urban Indian; Alaska Native (Eskimo or Aleut); California Indian; eligible for IHS; or otherwise determined to be Indian by the Secretary of the Interior or Secretary of HHS.
Parents, Guardians, Caretaker Relatives and Family Caregivers	A family caregiver qualifies if they: <ul style="list-style-type: none"> (A) Live with the child/disabled person and provide regular, more-than-incidental help. (B) Are a relative who provides help but doesn't live with them (C) Are unrelated, don't live with them, and provide 80+ hours of assistance in a month that is not incidental. <p>More than one caregiver in a home can qualify.</p>
Disabled Veterans	A veteran with a temporary or permanent disability rated total by the VA.
Medically Frail or Otherwise Has Special Medical Needs	See full breakdown below.
Already meeting TANF Requirements	the Temporary Assistance for Needy Families (TANF) Program
SNAP household members non-exempt from SNAP Requirements	Supplemental Nutrition Assistance Program (SNAP)
Participating in a Drug Addiction or Alcoholic Treatment/Rehab Program	States can set a minimum time commitment that is consistent with clinical guidelines.
Incarcerated Individual at a Public Institution	A public institution is a government-run facility such as a jail or prison. A person is an inmate if they are living there, but not if they are there temporarily or for educational purposes.
Pregnant or Postpartum	Pregnant or entitled to postpartum Medicaid coverage.

The Medically Frail Exemption

Category 5 covers people who are medically frail or have special medical needs. To qualify, two conditions must be true at the same time:

Condition 1		Condition 2	
		At least one of...	Which Means
The physical, mental, or other behavioral health condition significantly impairs the person's ability to comply with the requirement that they prove to be working, volunteering, or in	+ AND	(A) Blind or Disabled	A person who meets the definition of blind or disabled under the Social Security Act.
		(B) Substance Use Disorder	Substance use disorder, excluding an individual in recovery of 5+ years.
		(C) Disabling Mental Disorder	A mental disorder that is disabling.
		(D) Physical, Intellectual or Developmental Disability (I/DD)	A physical or I/DD that significantly limits their ability to perform one or more activities of daily living (ADLs).

<p>school for 80+ hours each month.</p>		<p>(E) Serious or Complex Medical Condition</p>	<p>A condition that is:</p> <ol style="list-style-type: none"> 1. life threatening, 2. seriously disabling without necessarily being life threatening, 3. causing significant pain or discomfort that can cause serious interruptions to life activities, 4. requiring a major time or effort commitment from caregivers for a substantial period of time, 5. requiring frequent monitoring, 6. associated with severe consequences or negative consequences for someone else, 7. affecting multiple organ systems, 8. requiring management to tight physiological parameters, 9. requiring coordination of multiple specialties, 10. requiring treatment that carries a risk of serious complications, or 11. requiring adjustment in non-medical environments.
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The State List Requirement

Each state must create and maintain a written list of diseases, diagnoses, disorders, and health conditions that could qualify for a “medically frail” exemption.

This list must:

1. Be auditable, justifiable and in line with how medical frailty is defined above.
2. Be revised on a regular basis to add or remove diseases, diagnosis, disorders, or health conditions based on the State’s experience applying the medical frailty exemption.

If a person’s condition is NOT on that list, the state **must** have a reasonable process and set of criteria in place for the person to request consideration for the “medically frail” exclusion.

Verifying the “Medically Frail” Exemption (Portion of §435.557)

Verifying that someone qualifies as medically frail or has special medical needs follows different and stricter rules than general compliance verification.

Required data sources

The state must attempt to verify medical frailty using reliable information including:

- Claims related to the person from the past 12 months, including paid, pending, and denied claims; and
- Encounter data related to the person from the past 12 months.

When state data is not enough

When	What the State Can Accept If Their Own Data Is Not Enough
Before January 1, 2028	Can require documentation or accept a signed statement that carries legal consequences for lying aka "self-attestation". The state can do this every time it verifies medical frailty.
Starting January 1, 2028: first time claiming medical frailty status in an enrollment period	Can accept a signed statement that carries legal consequences for lying aka "self-attestation", but only once per period of enrollment.
Starting January 1, 2028: at the first regular renewal after status was set using a statement	Must verify using reliable data. If data is not enough, must use documentation submitted by or on behalf of the person. A signed statement alone "self-attestation", is no longer accepted.
Starting January 1, 2028: if the same person claims medical frailty again in the same enrollment period after already using a statement	Must verify using reliable data. If data is not enough, must use documentation submitted by or on behalf of the person. A signed statement alone "self-attestation", is not accepted.

Reverification

Once a person's medical frailty status has been confirmed using reliable data or documentation, the state must reverify that status at least every 12 months.

Privacy requirements

Whenever the state accesses, stores, or handles data to verify medical frailty or participation in a drug or alcohol treatment program, it must comply with all applicable federal privacy laws, including:

- Section 1902(a)(7) of the Social Security Act (Medicaid confidentiality requirements);
- Part 431, Subpart F of 42 CFR (Medicaid privacy rules);
- HIPAA (Health Insurance Portability and Accountability Act);
- 42 CFR Part 2 (substance use disorder confidentiality rules); and
- Any other applicable federal privacy law.

The Caregiver Exclusion

Category 3 provides an exemption from the requirements for parents, guardians, caretaker relatives, and family caregivers of a dependent child age 13 or younger or a disabled individual. The definitions and criteria differ depending on the role a person plays, their relation to the person they support, and where they live.

For example, the rule defines “caretaker relative” and “family caregiver” separately. A caretaker relative must live with the dependent child or disabled individual and assume primary responsibility for their care. A family caregiver does not have the same residency or primary responsibility requirement

The Three Family Caregiver Pathways

A “family caregiver” can qualify for the caregiver exemption by any one of the following three pathways:

Pathway	Who It Covers	What Is Required
Lives with	A family caregiver who lives primarily with the dependent child or disabled individual	Must provide assistance on a regular basis that is not solely incidental in nature
Relative who does not live with	A family caregiver who is a qualifying relative of the dependent child or disabled individual but does not live with them	Must provide assistance on a regular basis that is not solely incidental in nature
Non-relative who does not live with	A family caregiver who is not a relative of and does not live with the dependent child or disabled individual	Must provide at least 80 hours of assistance per month that is not solely incidental in nature

When There are Multiple Caregivers in the Same Home

In homes where more than one person is a parent, guardian, caretaker relative, or family caregiver, each person who meets the relevant definition can qualify for a caregiver exemption separately.

The rule states that being in the same household as another qualifying caregiver does not disqualify anyone.

Definitions

Dependent Child – A child age 13 or under who relies on another person for care.

Disabled Individual – A person who meets the Americans with Disabilities Act (ADA) definition of disability. The person does not need to be on Medicaid or any other federal program on the basis of disability to meet this definition.

Parent - A person with the legal status of mother or father, including by adoption under state law, who provides some level of care to a dependent child or disabled individual

Guardian - An adult appointed by a court to care for and make personal decisions for a dependent child or disabled individual who cannot care for themselves

Caretaker Relative - A relative of a dependent child or disabled individual by blood, adoption, or marriage, who lives with the child or individual and assumes primary responsibility for their care. Qualifying relationships include parents, grandparents, siblings, stepparents, aunts, uncles, first cousins, nephews, nieces, and the spouses of those relatives even after the marriage ends. States can expand this list to include domestic partners, other relatives, or other adults living with and primarily caring for the child or individual.

Family Caregiver - An adult family member or other individual who has a significant relationship with a dependent child or disabled individual and provides a broad range of assistance to that person.

OPTIONAL SHORT-TERM HARDSHIPS (§435.555)

States have the option to provide that certain people subject to the requirement are treated as having met it for any month in which they experience a qualifying short-term hardship event. This exception is **optional for states** — not every state will offer it. It does not apply to people who are already specified excluded individuals.

<p>Definitions</p> <p>Dependent - Any one of the following:</p> <ul style="list-style-type: none"> • A minor child (as defined by state law) who lives with the applicable individual; • A tax dependent of the applicable individual (does not need to live with the individual; could include a child for whom the person pays child support); or • A person for whom the applicable individual has been appointed guardian by a court. <p>Individual Acting on Behalf of an Applicable Individual - An adult from the person’s household or family, an authorized representative, or someone responsible for the person if they are a minor or are incapacitated.</p>
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The Four Short-Term Hardship Events

A short-term hardship event exists when any of the following four circumstances applies, for all or part of a month. Two hardships are applied automatically by the state; two require a request.

AUTOMATIC – The state applies these on its own. No request from the person is needed.

	What Triggers It	How it Works
Federally Declared Emergency or Disaster (d)(2)	The person lives in a county with a Presidentially declared emergency or disaster.	<p>National Emergencies Act: Applies only where the emergency actually affects people’s ability to meet the requirement. Can cover one county, multiple counties, or the whole state. The state must notify CMS of its plan to use it; CMS reviews implementation.</p> <p>Stafford Act (disaster declarations): Exception runs from the first month the incident period begins through at least the end of the month it ends. The state can request CMS approval to extend beyond that if barriers to meeting the requirement persist in the area.</p>
High Unemployment County (d)(3)	The person lives in a county where unemployment is at or above 8%, or 1.5 times the national unemployment rate — whichever is lower.	The state must submit a request to CMS backed by data from the Bureau of Labor Statistics or another reliable source. Once CMS approves, the exception applies automatically to all applicable individuals in that county.

REQUEST REQUIRED – The person, or someone acting on their behalf must submit a request.

	What Triggers It	How it Works
Receiving Inpatient or Institutional Care (d)(1)	The person is receiving qualifying inpatient or institutional care services.	<p>Qualifying services include:</p> <ul style="list-style-type: none"> • Inpatient hospital services • Nursing facility services • Services in an ICF/IID (intermediate care facility for individuals with intellectual disabilities)

		<ul style="list-style-type: none"> • Inpatient psychiatric hospital services (including for people under 21) • Critical access or emergency hospital inpatient services • Inpatient services in an institution for mental diseases • Inpatient services in other facilities the state recognizes <p>Also counts: Intensive non-institutional services (such as home-based care) that, if not received, would likely result in the person needing one of the inpatient services listed above.</p>
<p>Travel for Medical Care (d)(4)</p>	<p>The person, or their dependent, must travel outside their community of residence for an extended period to receive care for a serious or complex condition that is not available locally.</p> <p><i>Note: The rule does not define “extended period” or “community of residence.” Both are left to states to determine.</i></p>	<p>When the dependent travels without the person:</p> <p>The person must show that their ability to meet the requirement was affected by the dependent’s condition or travel. The rule gives these examples:</p> <ul style="list-style-type: none"> • Taking the dependent to local medical appointments related to or in preparation for the trip; • Conducting logistical activities related to the travel; or • Maintaining primary responsibility for communicating with the dependent’s medical providers. <p>The person does not need to travel with the dependent. They need to show their time and ability to complete work activities was affected.</p>

What States That Offer This Exception Must Do

Any state that elects to offer short-term hardship exceptions must set up a process. The requirements differ based on whether the hardship is automatic or request-based.

- **Emergency/disaster and high unemployment (automatic)** - Must notify applicable individuals that the state offers this exception, including the anticipated end date of the exception. No request from the person is required.
- **Inpatient care and medical travel (request-based): Must provide:**
 - Instructions on how to request the exception and the timeframe for doing so;
 - A timely process for reviewing and deciding on the request;
 - Written notice of the decision, including the anticipated end date if the exception is granted; and
 - An appeals process if the request is denied.

Notice about the availability of short-term hardship exceptions must also be included in the state’s noncompliance notices.

This section does not apply to specified excluded individuals. People who are already excluded from the requirement entirely do not need a hardship exception.

ASSESSING COMPLIANCE WITH COMMUNITY ENGAGEMENT REQUIREMENTS (§435.556)

This section sets the rules for how many months of compliance a state can require, and over what time period. It also sets out what the state must tell people about the result of their eligibility check.

- At Application**
 When a person applies for Medicaid, the state must require them to show compliance for at least 1 month, but no more than 3 consecutive months, immediately before the month they apply. Each state picks the number of months in its State Plan or waiver.
- For People Already Enrolled**
 For people already enrolled, the state must require at least 1 month of compliance during each eligibility period. The specific period during which that compliance must be demonstrated depends on the situation:

Situation	Period During Which Compliance Must Be Demonstrated
Standard case (state checks every 6 months)	The period from the person’s most recent eligibility determination or renewal to the due date of their next renewal (typically about 6 months).
State conducts more frequent checks	The period from the most recent demonstration of compliance to the due date of the next required demonstration.
Change in circumstances that makes the person newly subject to the requirement	The period from the person’s most recent eligibility determination or renewal to the end of the month before the month the new applicable individual status takes effect.

States can require more than 1 month of compliance per period and can check compliance more often than the standard 6-month renewal cycle. However, **states cannot require a person to show compliance for a time period longer than the applicable period described in the table above.**

This Requirement Does Not Apply to Specified Excluded Individuals

States cannot apply the compliance assessment rules in this section to a person who is a specified excluded individual. If a person qualifies as excluded, the state cannot require them to demonstrate community engagement for any period.

Required Notification of Results

After each eligibility check, the state must notify the person of the result. The notice must clearly state one of the following:

Outcome	What the Notice Must State
Person is a specified excluded individual	That the person meets the criteria for specified excluded individual status and is not subject to the community engagement requirement.
Person is an applicable individual who demonstrated compliance	That the person is an applicable individual and demonstrated (or is deemed to have demonstrated) community engagement for the required months.
Person is an applicable individual who did not demonstrate compliance	That the person is an applicable individual who did not demonstrate community engagement for the required months, and the specific months in question. This triggers the noncompliance procedures.

VERIFYING COMPLIANCE WITH, EXCEPTION, OR EXCLUSION FROM REQUIREMENTS (§435.557)

Before a state can ask a person to provide any proof, it must first use the information it already has access to. The rules in this section set out exactly what information states must use, in what order, how they must document their approach, and when they can ask the person for more.

These rules apply to all verification checks **except medical frailty**, which has its own separate rules previously described.

Sources of Reliable Information

The rule identifies eight specific types of information that count as reliable information available to the State. The state can identify more:

- Electronic data sources the state has identified as effective and documented in its verification plan.
- Information from other state or local agencies.
- Information from federal agencies through an electronic data service CMS establishes (includes data from Social Security Administration, the Department of the Treasury, and the Department of Homeland Security).
- Information in the state's own eligibility system.
- Information in the person's case record.
- Payroll data.
- Health insurance related to the person from the past 12 months, including claims paid, pending or denied.
- Encounter data related to the person from the past 12 months.

Definitions

Period of Enrollment – The continuous time a person has been enrolled in Medicaid without being disenrolled. This period continues through multiple renewals and eligibility redeterminations, and through transitions between different eligibility groups, as long as coverage never lapsed.

Reliable Information Available to the State - Information the state has access to, or should have access to, that is necessary for determining eligibility.

Educational Note: Encounter data is a record of medical services a person received through a Medicaid managed care plan. Unlike a paid claim, encounter data captures services delivered under arrangements where the plan pays the provider directly.

The State Verification Plan

Each state must create and document a verification plan that describes how it will check a person's compliance with the community engagement requirement. The plan must be kept up to date and must include:

- The data sources the state has identified as providing reliable information;
- The state's policies and procedures for verifying compliance, exemptions, and exclusions; and
- The state's decisions about which data connections it will establish.

States can decide that connecting to a particular data source is not worth the cost or effort. **If a state decides not to connect to a source, it must document that decision in its verification plan.** When deciding, the state must weigh the cost of building and maintaining the data connection against the cost of asking people for paperwork instead, and must consider the risk to program accuracy if the connection is not built.

The Data-First Rule

Before asking a person to provide paperwork or proof, the state must first check all available and reliable information sources it already has access to. States cannot limit their review to only certain records or types of exemptions, they must continue checking available data sources until they can confirm whether someone meets the requirement or qualifies for an exemption. In other words, states are supposed to use the information they already have before asking patients and families to provide additional paperwork or documentation themselves.

The state can only ask the person for additional information after:

- It has checked all available reliable information sources for all relevant months; and
- It was still unable to confirm that the person:
 - ✓ Met the requirement by completing qualifying activities;
 - ✓ Is treated as having met it through a mandatory exception (under 19, on Medicare, in a standard Medicaid coverage group, or incarcerated) or a qualifying short-term hardship exception; or
 - ✓ Is exempt from the requirement entirely as a specified excluded individual

The state cannot require a person to provide documentation or other information **unless the state's own data sources were not sufficient to verify eligibility.**

Educational Note: This approach is called “*ex parte*” verification — the state uses data it already has, without asking the person to do anything. The person only has to provide proof if the state's own data is not enough.

If State Data Is Not Enough: Documentation Rules

Remember, these rules apply to all verification checks except medical frailty, which has its own separate rules described on page 8 of this document.

When	What the State Can Require
Before January 1, 2028	The state can require documentation or accept other information, including a written statement from the person (“self-attestation”).
Starting January 1, 2028	The state must require documentation whenever documentation is reasonably available. If documentation does not exist or is not reasonably available, the state must accept other information the person can provide.

At all times, regardless of date: Even if someone cannot produce formal paperwork or documentation — because those records do not exist or simply cannot be obtained — the state cannot deny or end their Medicaid coverage on that basis alone. In that case, the state must allow other types of proof. States may set their own standards for what counts as acceptable proof when formal documentation is not available.

Note: People can still be denied through the noncompliance process if they provide no information at all and the state cannot verify eligibility through any means. This protection applies specifically to situations where documentation genuinely does not exist — it ensures people are not penalized just for lacking paperwork.

Who Can Submit Information and How

Any of the following people can submit information:

- The person themselves;
- An adult in the person's household or family;
- An authorized representative; or
- Someone responsible for the person, if the person is incapacitated.

Information can be submitted by:

- Internet;
- Telephone;
- Mail;
- In person; or

- Other commonly available electronic means.

Additional Verification Obligations

If someone qualifies as exempt, the state must recognize it — even if they are also meeting the requirement.

Even if a person is already meeting the 80-hour requirement on their own, the state must still formally recognize and apply their exempt status if they qualify for one. Being recognized as exempt is a stronger protection — it means the person does not have to prove compliance going forward. The state cannot skip this step just because the person happens to be meeting the requirement.

Enroll now, verify exclusion later.

If the state has confirmed a person meets the community engagement requirement but has information suggesting the person can also be a specified excluded individual thus exempt (but cannot yet confirm it), the state must enroll the person immediately. The state then verifies the possible exclusion status after enrollment. The same applies to existing enrollees at their next redetermination.

More Frequent Verification (State Option)

States can choose to verify compliance more often than the standard six-month renewal schedule. States that choose to do so must follow these rules at each additional check:

- Check exclusion status first — before checking whether the person met the 80-hour requirement, the state must check whether the person has become a specified excluded individual since the last determination;
- If the person is still subject to the requirement, check all available reliable information for all relevant months before asking the person for anything; and
- Do not re-verify confirmed exempt status — if the person was already confirmed as a specified excluded individual at their last determination or renewal, the state cannot re-verify that status at an in-between check unless the state has information suggesting the status has changed.

The Federal Electronic Data Service

CMS is required to establish a federal electronic data service that states must use to obtain verification information. States must connect to this service and use it to the extent information is available through it.

When a new data source becomes available through the CMS service:

- The state must establish a connection within 12 months of the source becoming available.
- States can request approval from CMS to use an alternative data source or direct connection outside the standard service if it will reduce administrative costs and delays and meet program requirements for accuracy and privacy.
- If CMS determines an alternative source meets program requirements, CMS can remove the need for formal approval. The 12-month deadline still applies.

Verifying Mandatory and Optional Exceptions

Mandatory exceptions

States must use reliable data first before asking the person for proof of a mandatory exception. However, if the person already indicated on an application, renewal form, or other state form that a mandatory exception applies, and the state has no reliable data on the matter, the state can choose not to seek any further information from the person. Coverage continues based on the person's statement.

Optional short-term hardship exceptions

States that offer optional short-term hardship exceptions must use all available reliable information before asking the person to prove a hardship applies. This rule applies specifically to two of the four hardship types:

- The person received **inpatient or institutional care** during the month; and
- The person or their dependent had to **travel outside their community** for an extended period to receive medical care not available locally.

Two short-term hardships must be applied automatically, with no information or request from the person required:

- Living in a county where a federally declared emergency or disaster occurred that affects the person's ability to meet the community engagement requirement; and
- Living in a county where CMS has approved a high-unemployment short-term hardship exception.

NONCOMPLIANCE PROCEDURES (§435.558)

When a state cannot confirm that a person met the community engagement requirement or qualifies for an exception or exclusion, it must follow a specific process before denying or ending coverage. The steps below **apply to both new applicants and people already enrolled in Medicaid**. For new applicants, the process moves from Step 1 directly to Step 3. For people already enrolled, the process can include Step 2 before reaching Step 3.

When This Process Is Triggered

The rule defines three specific situations in which a state is considered unable to verify compliance. The process described in this section begins in each of these situations:

Situation	What Unable to Verify Means
At application	After reviewing both the information the person submitted with their application and all reliable state data, the state still cannot confirm the person met the requirement for the required number of months
At renewal	At the regular Medicaid renewal, the state cannot confirm compliance after (1) pulling all reliable data automatically and it is not enough, and (2) sending a renewal form that is either not returned or does not provide sufficient information
At a more frequent check (if the state opted in)	If the state chose to check compliance more often than every renewal, the state cannot confirm compliance after its reliable data is not enough and after asking the person for more information that is either not returned or not sufficient

Step 1: Check all available data first

Before sending any notice, the state must review all reliable information it already has access to. This includes payroll records, Medicaid claims and encounter data, records from other state and federal agencies, and federal data systems. The state must complete this data check before asking the person to provide anything.

Step 2: For enrolled people at renewal: send a renewal form

At renewal, if the state cannot confirm compliance using its own data, it must send a pre-populated renewal form to the person. **If that form is not returned, or if the information provided does not confirm compliance or an exemption, the state must proceed with a formal notice of noncompliance.**

Step 3: Send a written notice of noncompliance

The state must send a notice of noncompliance that meets all of the requirements described below.

Notice Content Requirements

The notice must include clear statements of all of the following:

The Notice Must Include	What It Means
Which months are being reviewed	Which month or months the state is assessing, and how to show compliance for those months
How to show compliance	How to demonstrate qualifying activities under the 80 hour requirement, and how to show a mandatory exception or short-term hardship applies
How to claim an exemption or exclusion	How to show that a specified excluded individual status applies, or that the person is not an applicable individual
The response deadline and how to respond	The exact date the 30-day window closes and the ways the person can submit information to the state
Consequences of not responding	Loss of Medicaid coverage and loss of advance premium tax credits (APTC) or premium tax credits (PTC) used to pay for Marketplace coverage
How to reapply	Steps to reapply for Medicaid if coverage is denied or ends
Short-term hardship exceptions	If the state offers them, information about how to request one

The 5-day receipt rule

A notice is considered received by the person 5 days after the date printed on the notice, unless the person shows otherwise. The 30-day response window begins on the day the notice is considered received. **Example:** A notice dated June 1 is treated as received on June 6. The 30-day window closes on July 6.

Electronic notice requirements

If a state delivers the notice electronically, it must do all of the following:

- Confirm the person's choice to receive electronic notices by sending a confirmation by regular mail;
- Inform the person they can switch back to mail delivery at any time;
- Post the notice to the person's online account within 1 business day of the notice being created;
- Send an email or other electronic alert notifying the person that a notice has been posted to their account;
- If an electronic communication fails, send the notice by regular mail within 3 business days of the failure; and
- Provide any notice by regular mail upon the person's request.

Language and accessibility requirements

Notices must be accessible to all individuals. States must provide:

- Written translations and oral interpretation in a person's language at no cost (for people with limited English proficiency);
- Auxiliary aids and services at no cost in compliance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act (for people with disabilities); and
- Taglines in non-English languages on all notices indicating that language services are available and how to access them.

Step 4: Give the person 30 calendar days to respond

From the date the notice is considered received, the person has 30 calendar days to do either of the following:

- Show they met the community engagement requirement for the required months, including by showing a mandatory exception or short-term hardship applied; or
- Show that the requirement does not apply to them because they do not meet the definition of applicable individual or because they are a specified excluded individual.

For people already enrolled, coverage continues for the full 30 days.

Step 5: Check all other Medicaid eligibility pathways

If no satisfactory response is received within 30 days, the state must first check whether the person qualifies for Medicaid through any other pathway before moving to denial or disenrollment. No application can be denied and no person can be disenrolled before this check is completed.

Step 6: Deny or disenroll, with written notice and appeal rights

If the person does not qualify through any other Medicaid pathway, the state must deny the application or end coverage. This cannot happen before the end of the month following the close of the 30-day window.

Before denying or disenrolling, the state must provide:

- Written notice that includes a clear statement of the specific reasons for the action. The notice must state that the person failed to show compliance with the community engagement requirement for the specific months assessed, and failed to show that the requirement does not apply to them; and
- The right to a fair hearing (a formal appeal before an independent reviewer) before coverage ends.

The state must also determine whether the person can be eligible for other insurance affordability programs, including premium tax credits through the Marketplace. **Losing Medicaid coverage for noncompliance does not automatically make a person ineligible for other insurance options.**

The state cannot place any restrictions on the person’s ability to reapply for coverage at any time, or on their ability to receive coverage if they are found eligible upon reapplication.

Reconsideration Window

This protection applies specifically to people who were on MAGI-based Medicaid and were disenrolled because they did not return information the noncompliance notice asked for. **If that person submits the information during the reconsideration period, the state must review their eligibility rather than requiring them to file a brand-new application.**

The reconsideration period is 90 days after coverage ends, or longer if the state chooses to extend it.

IMPLEMENTATION TIMING FOR THE COMMUNITY ENGAGEMENT REQUIREMENT (§435.559)

July 31, 2026	The rule (regulations) takes effect.
Jan 1, 2027	States must condition Medicaid eligibility on the community engagement requirement, unless granted a good faith effort exemption. States can implement earlier through a State Plan Amendment or a Section 1115 demonstration.
Jan 1, 2028	Documentation requirements tighten. Self-attestation for medical frailty is limited to once per period of enrollment.

Dec 31, 2028	All good faith effort exemptions expire. No exemption can be renewed or extended past this date under any circumstances.
Oct 1, 2034	Several related procedural rules sunset (expire), including the restored ban on in-person interviews. CMS would issue new rules to replace them.

For people already enrolled: The state checks compliance for the first time at the person’s first regularly scheduled renewal on or after the implementation date. The state does not check compliance immediately when the requirement starts.

GOOD FAITH EFFORT EXEMPTIONS FOR STATES (§435.560)

CMS can grant a state a temporary delay from the January 1, 2027 start date if the state can show it is genuinely working toward full implementation. The state must submit a formal request to CMS covering all four of the following:

<p>1 Steps already taken Any actions the state has already taken toward implementing the community engagement requirement</p>	<p>2 Barriers encountered Significant challenges the state has faced, including those related to funding, system design, development, procurement, or building necessary technology</p>
<p>3 Plan and timeline A detailed plan with specific milestones and a timeline for reaching full implementation</p>	<p>4 Urgent circumstances Any emergency or circumstance beyond the state’s control that affected its ability to implement on time</p>

Duration and Limits

First exemption: no more than 6 months.
Extensions: CMS can grant additional extensions if the state keeps making progress. The length of each extension is determined by CMS based on its review of the state’s updated timeline and progress reports.
Hard deadline: All exemptions expire December 31, 2028. This cannot be extended.
Early termination: CMS can end an exemption early if the state fails to meet its reporting requirements or stops making a genuine effort toward implementation.

What States with an Exemption Must Report

- A quarterly progress report on the state’s implementation milestones; and
- Information on any new barriers and the state’s plan to address them, in the format and on the schedule CMS specifies.

STATE REQUIREMENTS FOR OUTREACH (§435.561)

States are required to proactively communicate with enrollees and potential applicants to inform them of the changes to Medicaid. Medicaid agencies must contact all individuals who are eligible or enrolled in Medicaid under Medicaid expansion, or under a 1115 demonstration that provides coverage equal to the “minimum essential” coverage of a health care plan under the Affordable Care Act. Like the Adult

Medicaid Expansion, this population includes adults who are ages 19-64, not pregnant, and not otherwise eligible for Medicare, but they are also not eligible for Medicaid under their state's plan.

Frequency of Outreach

States must adhere to the following schedule:

Initial notice timing formula:

Send the initial notice at least **3 months + the number of look-back months the state chose** before the requirement starts. For example, for a January 1, 2027 start date:

- 1 month look-back → notice goes out by September 1, 2026 (4 months ahead)
- 2 month look-back → notice goes out by August 1, 2026 (5 months ahead)
- 3 month look-back → notice goes out by July 1, 2026 (6 months ahead)

After the initial notice, states must send notices in these situations:

1. **Upon enrollment** — for anyone who enrolls during the gap between the initial notice and the start date of the requirement
2. **At each eligibility decision** — when a person is found eligible at application, at renewal, or after a change in circumstances
3. **When hardship exceptions change** — when the state adopts the short-term hardship exception, when a disaster or emergency hardship becomes available, or when the high-unemployment hardship takes effect
4. **When reducing eligibility** — when the state drops its short-term hardship exception, when a disaster or unemployment hardship is anticipated to end, or when a person is losing their specified excluded individual status
5. **On CMS request** — when the state's monitoring data indicates a compliance problem and CMS requires additional outreach

Content of Outreach

All outreach must include the following:

1. **How to comply with work requirements**, including:
 - a. An explanation of exceptions, including optional short-term hardship exceptions if the state provides them;
 - b. Who is considered an "applicable individual" (who is subject to work requirements) and an explanation of who is excluded from the definition;
 - c. How many months of community engagement an individual needs to demonstrate at renewal;
 - d. How often will the state verify compliance between renewals if the state has chosen to verify more frequently than every six months.
2. **Consequences of not meeting work requirements**, including the impact on both Medicaid eligibility and eligibility for Marketplace premium tax credits (APTC/PTC) used to pay for Exchange coverage.
3. **How to report a change** in situation that would affect their eligibility for an automatic exception, a short-term hardship exception (if available in the state), or status as an excluded individual.

How Notices Must Be Delivered

All outreach notices must be accessible and available in plain language. The state must provide free language services for people who have limited English proficiency and free auxiliary aids for people with disabilities. All outreach must be sent through regular mail and at least one of the following: the individual's electronic account, telephone, text message, or another commonly available electronic method.

Medicaid agencies have the option to send an eligibility determination notice bundled with any other communication it is already sending. Agencies also can use managed care organizations (MCOs),

prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care managers (PCCMs), and PCCM entities to notify their enrollees about the work requirements.

REQUIREMENTS FOR STATES TO SUBMIT DATA FOR MONITORING COMMUNITY ENGAGEMENT (§435.562)

CMS requires states to regularly report, on a schedule determined by CMS, data related to Medicaid community engagement and work requirements, beginning on the state's implementation date. States must submit to CMS the following data:

1. Total Medicaid enrollment;
2. Application and renewal processing timelines, including pending applications and renewals that exceeded timeline standards;
3. Outcomes of eligibility determinations and redeterminations;
4. Number of people subject to work requirements, whether they are complying and how they are complying;
5. Any other data specified by CMS.

In addition to the standard requirement for reporting, state agencies that are subject to corrective action are required to collect more data or send additional outreach notices in the following scenarios:

1. The agency's reported data isn't timely, complete, or of good quality, or;
2. The reported data indicates that the state is failing to comply with community engagement and work requirements, or the determination and/or redetermination outcomes indicate a need for more outreach.

PROHIBITION OF WAIVERS OF THE REQUIREMENT (§435.563)

CMS will not approve any Section 1115 demonstration project that waives the community engagement requirement, whether fully or in part. A partial waiver is treated the same as a full waiver and will not be approved. A state that is implementing the community engagement requirement through a Section 1115 demonstration must comply with every requirement of the rule. Using Section 1115 authority does not give a state the ability to reduce or eliminate any part of the requirement.

Educational Note: A **Section 1115 demonstration** is a federal approval that allows a state to test an approach to Medicaid that differs from the standard rules. This rule specifically prohibits CMS from approving any demonstration that would waive the community engagement requirement, even partially. This prohibition applies regardless of the form of waiver language a state submits.

EFFECTIVE DATE AND APPLICABILITY:

Effective: July 31, 2026

Applicability: All 50 States plus the District of Columbia; ACA Expansion Population and people eligible for, or enrolled in, certain § 1115 demonstration coverage whose benefits equal comprehensive ("minimum essential coverage") between 19 and 64 years old; not pregnant; not entitled to or enrolled in Medicare (Part A or Part B); and not otherwise eligible for Medicaid under the regular State plan.

Questions?

Contact policy@rarediseases.org

About the National Organization for Rare Disorders

Founded in 1983, the National Organization for Rare Disorders (NORD®) is a leading independent, nonpartisan, nonprofit and patient advocacy organization dedicated to improving the health and lives of

over 30 million Americans living with rare diseases. In partnership with more than 350 disease-specific member patient organizations, NORD drives progress in rare disease research, care, and policy.

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The Rare Action Network® is (RAN) the nation's leading advocacy network working to improve the health and well-being of the 30+ million Americans living with a rare disease. For over 10 years, NORD has educated and mobilized RAN members on key disease agnostic issues impacting our community.

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