National Rural Health Association

July 31, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-2454-IFC; Medicaid Program; Community Engagement Requirement for Certain Individuals

Submitted electronically via regulations.gov.

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) interim final rule (IFR) for the Medicaid Program; Community Engagement Requirement for Certain Individuals. NRHA appreciates CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America. However, NRHA is concerned that key elements of the IRF rule could unintentionally undermine access to care in rural communities by creating new administrative barriers for beneficiaries and operational challenges for rural providers.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

II. Provisions of the Interim Rule with Comment Period

B. Applicable Individuals

NRHA supports CMS's goal of allowing Section 1115 waivers for individuals whose circumstances make it difficult to meet Medicaid community engagement requirements. However, NRHA is concerned about the requirement for states to grant these exemptions on an individual basis. An individual-level exemption process would create significant administrative burdens for states and beneficiaries, potentially limiting access to coverage for populations already facing substantial barriers.

The IFR defines "applicable individuals" to include adults covered under certain Section 1115 demonstrations that provide minimum essential coverage. As drafted, CMS's approach sweeps entire waiver populations into the community engagement requirement, even when those demonstrations are designed for groups who are overwhelmingly exempt. These waiver populations are, by design, composed largely of individuals who meet statutory exemptions (e.g., medical frailty, disability, pregnancy, and intensive treatment needs). Including them as "applicable individuals" and relying solely on individual-level exemptions are overbroad and inconsistent with the purpose of both the statute and the waivers themselves.

In rural communities, the IFR's reliance on individual-level exemptions are particularly problematic. Rural populations experience higher rates of chronic disease, disability, and behavioral health conditions, increasing the share of individuals who should be exempt but may be missed in practice. Further, rural beneficiaries face transportation challenges, limited internet access, and fewer local offices, making it harder to submit documentation or respond to notices. By categorically excluding waiver populations that are predominantly exempt, CMS can substantially reduce these risks and better protect rural beneficiaries.

To preserve the flexibility that Section 1115 waivers provide in addressing population-level health and social needs, NRHA recommends that CMS adopt population-level exclusions, rather than requiring individual-level exemptions, for specified groups subject to community engagement requirements. A population-level approach would reduce administrative complexity, lessen the risk of eligible individuals being improperly subjected to community engagement requirements, and better enable states to use Section 1115 demonstrations to improve health outcomes for vulnerable populations.

C. <u>Demonstrating Community Engagement</u>

NRHA appreciates CMS's inclusion of broad definitions of work, a work program, education, and community service under § 435.552, which provide meaningful flexibility for rural beneficiaries navigating a more limited range of local qualifying activities. However, several aspects of the IFR's implementation of community engagement raise significant concerns for rural communities and warrant further refinement.

3. Work Program

NRHA is concerned that the rule's discussion of supported employment furnished through section 1915(c) and 1915(i) waivers does not accurately reflect how these programs operate in practice. NRHA urges CMS to revisit this discussion in consultation with State intellectual and developmental disability agencies and to align the final policy with how supported employment is actually structured, funded, and delivered under these waivers, particularly in rural areas where supported employment providers are scarce and often overlapping caseloads across multiple waiver authorities.[1]

NRHA opposes CMS's policy to limit job search activities to no more than half of the required hours within a work program. This restriction is inconsistent with how job search counts toward work requirements in other federal programs and is especially burdensome in rural labor markets, where job openings are less frequent and a qualifying job search can require significantly more time and travel.

4. Education Program

NRHA supports CMS's provision allowing individuals to remain compliant with the community engagement requirement during scheduled school breaks, which is particularly important for rural students who may also work seasonally or in agriculture.

5. Enrollment in an Educational Program Less Than Half-Time

[1] Centers for Medicare & Medicaid Services. Strengthening the Direct Service Workforce in Rural Areas. https://www.medicaid.gov/sites/default/files/2023-01/hcbs-strengthening-dsw-rural-areas.pdf

When an individual combines less than half time educational enrollment with another qualifying activity to meet the 80-hour requirement, NRHA encourages CMS to round up the calculation of educational hours. Rural students often have fewer course offerings and must travel greater distances to access in-person instruction, and rounding down could penalize otherwise-compliant students.

8. Monthly Income for Seasonal Workers

NRHA is concerned that applying community engagement requirements to seasonal workers may disproportionately affect rural communities, where seasonal employment is common, particularly in agriculture, tourism, resource extraction, and other industries that experience predictable fluctuations in work availability. Farmworkers across the United States are significantly more likely to experience cost-related barriers to accessing health care.[2] Community Health Centers (CHCs), which serve more than one million agricultural workers and residents, are often the primary source of care for these populations.[3] Maintaining continuous Medicaid coverage is therefore essential to ensure access to preventive and support rural primary care providers.

Under the IFR, an individual qualifies as a "seasonal worker" only if they meet the narrow definition at 26 U.S.C. § 45R(d)(5)(B), which is generally limited to workers employed on a seasonal basis as defined by the Department of Labor, including certain agricultural workers under 29 CFR 500.20(s)(1) and retail workers employed exclusively during holiday seasons. Such workers may demonstrate compliance based on average monthly income over the preceding six months rather than a single month's earnings. NRHA is concerned that this definition is too narrow to capture the full range of seasonal and agricultural work common in rural communities, where irregular schedules and fluctuating monthly income are common even for workers who do not fit neatly within the IFR's seasonal-worker categories. Monthly income and work-hour reporting requirements may not accurately reflect the realities of seasonal employment and could result in unnecessary administrative burden or inappropriate coverage losses for individuals who remain engaged in seasonal work over the course of the year.

To fulfill the rule's protective intent, NRHA urges CMS to establish clear safeguards for seasonal and agricultural workers whose employment patterns do not align with traditional monthly work requirements. These flexibilities would reduce unnecessary administrative burden, prevent inappropriate coverage losses resulting from predictable seasonal fluctuations in employment, and help ensure continued access to care for agricultural workers and other seasonal populations who rely on Medicaid. Specifically, CMS should:

- Extend the six-month income average currently available only to seasonal workers to the broader range of seasonal and agricultural workers common in rural communities.
- Provide automatic good-cause exemptions during documented off-seasons or periods of seasonal unemployment.
- Allow streamlined verification through employer attestations, unemployment insurance records, or other existing documentation already available to states.

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[2] Soto S, Yoder AM, Aceves B, Nuño T, Sepulveda R, Rosales CB. Determining Regional Differences in Barriers to Accessing Health Care Among Farmworkers Using the National Agricultural Workers Survey. *J Immigr Minor Health*. 2023;25(2):324-330. doi:10.1007/s10903-022-01406-9

[3] Hughes LS, Beck AF, Simpson L, et al. Advancing and Promoting Community Health: The Role of Accountable Health Structures. George Washington University, Milken Institute School of Public Health; 2023. Accessed July 15, 2026. https://accountablehealth.gwu.edu/sites/g/files/zaxdzs6441/files/2023-11/advancingandpromotingcommunityhealth.pdf

NRHA supports CMS's requirement that the monthly income calculation for demonstrating compliance through earnings be based on the federal minimum wage, applied uniformly even in states and localities that have adopted a higher minimum wage. This approach avoids penalizing rural beneficiaries in states with higher local minimum wage floors and provides a consistent administrable standard for verification.

D. Mandatory Exceptions for Certain Populations

NRHA urges CMS to ensure that individuals who are categorically excluded from the community engagement requirements under the work and training flexibility category are automatically and permanently exempted. Consistent with § 435.551 and 435.553. States already have the data necessary to identify these individuals and should not impose additional paperwork or screening on current enrollees who fall into these categories, nor create confusion for new applicants navigating paper or in-person applications. This is particularly important in rural communities, where 19% of the population is age 65 or older, compared with 15% in urban areas, and where limited local eligibility assistance resources make administrative errors more likely to result in coverage gaps.[4]

E. Specified Excluded Individuals

3. Parent, Guardian, Caretaker Relative, or Family Caregiver of a Dependent Child 13 Years of Age and Under or a Disabled Individual

NRHA supports CMS's broad exclusion for parents, guardians, caretaker relatives, and family caregivers under § 435.554, which recognizes the essential and often uncompensated work these individuals perform. NRHA encourages CMS to further adopt the full definition of "family caregiver" set out in the RAISE Family Caregivers Act, specifying any adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.

NRHA is concerned that the IFR narrows the family caregiver exclusion in ways that go beyond the definition used in RAISE Act. Under § 435.554(c)(3)(i), a family caregiver qualifies for the full exclusion only if the caregiver resides with, or is related to, the individual receiving care. Caregivers who do not meet this residency or relationship requirement do not qualify for the exclusion and must instead independently demonstrate 80 hours of caregiving, or a combination of caregiving and other qualifying activities, to meet the community engagement requirement. This distinction disregards the reality of caregiving in rural communities, where extended family, neighbors, and other non-relative caregivers often provide essential support to older adults and individuals with disabilities, particularly where family members have moved away for work or where formal home care is unavailable. NRHA urges CMS to extend the full family caregiver exclusion to caregivers who do not reside with or are not related to the individual receiving care, consistent with the RAISE Act's broader definition.

NRHA further notes that the IFC limits the family caregiver exclusion to caregivers of a dependent child 13 years of age and under or a disabled individual, which is narrower than the RAISE Act's inclusion of individuals with a chronic or other health condition or functional limitation. NRHA urges CMS to ensure that caregivers of older adults with chronic health conditions are not excluded from

[4] Hill, I., Burroughs, E., & Adams, G. (2020). *New Hampshire's experience with Medicaid work requirements: New strategies, similar results.* Urban Institute. https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf

this exemption because the person they care for has not been formally determined to be disabled. As previously cited, rural areas have disproportionate rates of older adults and a more limited health care infrastructure to care for them. Family caregivers play an essential role in ensuring these individuals can reside in their rural community's long term.[5]

5. An Individual Who is Medically Frail or Otherwise has Special Medical Needs

NRHA appreciates CMS's efforts to establish protections for individuals who qualify for the medical frailty exclusion and supports several of the provisions that reduce unnecessary administrative burden. Specifically, NRHA supports the policy to require states to use ex parte verification whenever possible by relying on reliable information already available through state agencies and existing data sources, including payroll data, TANF and SNAP eligibility information, and Medicaid claims and encounter data.

CMS should not permit states to require repeated documentation for medical conditions or disabilities that are permanent, terminal, or otherwise unlikely to improve. Similarly, CMS should not limit acceptable medical documentation to records from the previous 12 months when an individual's condition is permanent and clinically unchanged.

NRHA strongly opposes CMS's proposal to require that a qualifying condition or diagnosis "significantly impair" an individual's ability to comply with the community engagement requirement, for several reasons. This standard lacks a workable definition and cannot reasonably be implemented using claims and encounter data alone, since a beneficiary's functional capacity to work or engage in community service cannot be determined from billing records. NRHA believes the lack of definition risks discouraging the very volunteerism, work, and community engagement the rule is intended to encourage. Further, NRHA is concerned that CMS has significantly underestimated, in its regulatory impact analysis, the burden this standard would place on individuals seeking exclusion.

The IRF also allows states to rely on provider documentation and requires states to identify their allowable practitioner types. However, CMS's regulatory impact analysis includes no meaningful estimate of the burden this standard would place on rural providers, who are already leaving clinical practice due to administrative burden. Since 2018, administrative burden, particularly clerical and documentation demands, has been the top contributor to physician burnout.[6] While provider documentation may be appropriate in some circumstances, requiring confirmation from a limited set of practitioners could substantially increase administrative burden for rural providers, who already care for disproportionately large Medicaid populations.[7]

Furthermore, the more specific an allowed practitioner type is, the more difficult it may be for rural residents to access, as studies find that transportation barriers are exuberated when rural residents try to seek specialty care.[8] CMS should provide clear guidance establishing broad allowable practitioner categories for purposes of medical frailty documentation. At a minimum, CMS should

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[5] National Rural Health Association. *Caregiving Policy Paper.* July 2026. Accessed July 15, 2026. https://www.ruralhealth.us/NationalRuralHealth/media/Documents/Advocacy/2026/NRHA-Policy-Paper-Caregiving-Policy-Paper-Final-July-2026-(1).pdf

[6] Rios Partners. Administrative Burden in U.S. Healthcare: A Focus on Rural Systems and Workforce Sustainability - Health of Health Index. Health of Health Index -. Published May 13, 2025. https://www.healthofhealth.org/health-of-health-2024-administrative-burden-in-u-s-healthcare-a-focus-on-rural-systems-and-workforce-sustainability

[7] Medicaid Coverage Supports Rural Patients, Hospitals, and Communities | AHA. American Hospital Association. Published March 2, 2026. https://www.aha.org/fact-sheets/2026-03-02-medicaid-coverage-supports-rural-patients-hospitals-and-communities

[8] Allen H, Wright B, Broffman L. The Impacts of Medicaid Expansion on Rural Low-Income Adults: Lessons From the Oregon Health Insurance Experiment. *Med Care Res Rev*. 2018;75(3):354-383.

permit documentation from physicians, nurse practitioners, physician assistants, certified nurse midwives, licensed clinical social workers, psychologists, licensed professional counselors, and other licensed health care professionals acting within their scope of practice. Expanding the range of allowable practitioner types would improve access for individuals living in rural and underserved communities, where appointments with specific provider types may be difficult to obtain. It would also reduce administrative burden on rural clinicians already experiencing workforce shortages while promoting greater consistency across states in implementing the medical frailty exclusion.

Finally, this standard would establish a higher bar than the Social Security Administration's own disability determination process. NRHA requests that CMS clarify how states are expected to consistently determine whether an individual meets the medical frailty standard and what evidence will be considered sufficient. At a minimum, NRHA urges CMS to require states to adopt the Social Security Administration's Compassionate Allowances List of conditions that automatically satisfy the medical frailty standard. Individuals with conditions on this list should also be permitted a longer documentation look-back period and should not need to be re-verified.

Beginning January 1, 2028, states are permitted to accept at least one self-attestation of medical frailty during an individual's enrollment period. The interim final rule also allows states to accept self-attestation throughout 2027 when no reliable information is otherwise available. NRHA strongly opposes limiting self-attestation of medical frailty to a single occurrence. The statute permits states to accept self-attestation as an option without imposing a time limit, and the proposed restriction could unnecessarily delay or prevent eligible individuals from receiving the exclusion when their circumstances change or documentation is temporarily unavailable. NRHA encourages CMS to preserve and expand these flexibilities rather than narrowing their availability by permitting self-attestation whenever reliable state data are unavailable and allow self-attestation more than once during an enrollment period when circumstances warrant.

9. Pregnant or Entitled to Postpartum Coverage

NRHA urges CMS to apply the postpartum exclusion under § 435.554 for a full 12 months in all states, rather than tying the exclusion duration to the length of a state's postpartum Medicaid coverage period. Rural maternal health outcomes already lag urban outcomes,[9,10] and linking the community engagement exclusion to variable state postpartum coverage periods could create gaps in protection for new mothers in rural communities with limited access to obstetric and postpartum care.

G. Short-Term Hardship Exceptions

NRHA appreciates CMS's inclusion of an optional short-term hardship exception under § 435.555 for individuals experiencing inpatient hospitalization, receipt of non-institutional services of similar acuity to institutional care, or the need to travel outside their community for medically necessary treatment unavailable locally. These circumstances disproportionately affect rural beneficiaries, who must often travel long distances for specialized or inpatient care.

However, NRHA is concerned that the timing of the hospitalization-related hardship exception, which does not take effect until the month following the qualifying event, undermines the protection Congress intended for beneficiaries experiencing an acute hospitalization or comparable event.

[9] Kozhimannil KB, Interrante JD, Henning-Smith C, Admon LK. Rural–urban differences in maternal mortality trends in the United States, 1999–2017. *Am J Public Health.* 2023;113(1):90-98.
[10] Trost SL, Beauregard JL, Cox S, et al. Pregnancy-related mortality in the United States, 2015–2019: county-level variation by urban–rural classification. *Am J Obstet Gynecol.* 2023;228(2):201.e1-201.e12.

NRHA urges CMS to revise this timing so that the exception applies beginning in the month the qualifying event occurs.

NRHA also urges CMS to require states to use reliable information already available to them, such as claims and encounter data, to proactively identify individuals who may qualify for a short-term hardship exception based on inpatient care or travel outside their community for medical treatment, rather than placing the burden of identification solely on the beneficiary.

Finally, NRHA supports CMS's inclusion of non-institutional services of similar acuity to institutional care within the scope of the hardship exception, recognizing that rural beneficiaries are increasingly served through home- and community-based alternatives to inpatient care and have less access to skilled nursing facilities within their local community.[11]

I. Verification of Compliance with and Exceptions and Exclusions from the Community Engagement Requirement

NRHA supports CMS's requirement, discussed under § 435.557, that states rely on ex parte verification and other reliable information already available to the state, including information from other state agencies, payroll data, TANF, and SNAP records, and Medicaid claims and encounter data before requiring beneficiaries to submit additional documentation.

NRHA supports CMS's decision to disallow re-verification of statuses that do not change, such as veteran status for an individual with a permanent disability. NRHA also urges CMS to clarify that states are prohibited from re-verifying American Indian and Alaska Native status, as the preamble language on this point is currently contradictory and should be resolved in favor of the stronger protection against unnecessary re-verification.

4. Good Faith Effort Exemption

With respect to the good faith effort exemption for states under § 435.560, NRHA urges CMS to extend the duration of initial exemptions beyond the six months CMS anticipates approving, to a full year. Rural states and localities often face longer lead times for systems development, procurement, and workforce hiring, and a six-month exemption window may be insufficient to allow good faith implementation efforts to succeed before an exemption lapses.

L. Outreach

NRHA supports CMS's requirement that states notify Medicaid beneficiaries of the community engagement requirements at least three months before the January 1, 2027, implementation date. NRHA also supports CMS's requirement that states provide notices through both electronic and mailed communications to maximize beneficiary awareness.

However, evidence from Arkansas's implementation of Medicaid work requirements demonstrates that mailed and electronic notices alone are insufficient to ensure beneficiaries understand new eligibility requirements. Evaluations of Arkansas's program found that the state relied too heavily on mail- and telephone-based communication, which often failed to reach individuals facing literacy, transportation, technology, and other social barriers. In one focus group, a beneficiary explained, *"I*

[11] Sharma H. *Rural Nursing Home Closures – Trends, Characteristics, and Impact on Access.* RUPRI Center for Rural Health Policy Analysis; February 2021. Accessed July 15, 2026.

got 10 letters right in a row... I didn't know how to read them." [12] This testimony highlights that simply sending notices does not guarantee that beneficiaries receive, understand, or are able to act on the information.

These concerns are particularly relevant for rural communities. Research has consistently shown that rural residents experience lower levels of health literacy and face greater barriers to obtaining reliable health information. One study found that nearly one-third of rural residents with limited health literacy relied on companies or corporations for health information.[13] This study illustrates the importance of proactive, community-based outreach that goes beyond written notice.

Given these challenges, NRHA urges CMS to strengthen the outreach requirements by defining "on a periodic basis thereafter" to require states to conduct outreach at least every three months, or at a minimum halfway between a state's scheduled compliance or renewal reviews. More frequent outreach would serve as an important reminder for beneficiaries who may otherwise lose coverage because they were unaware of reporting requirements or changes in their obligations.

NRHA also recommends that CMS strengthen its expectations for community outreach. Rather than merely encouraging states to partner with trusted community organizations, CMS should require states to conduct ongoing outreach through established local networks. These should continue to include rural hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), provider networks, managed care organizations, schools, churches and other faith-based organizations, aging and disability networks, community-based organizations, and other trusted local partners.

Requiring states to engage these organizations would improve the likelihood that beneficiaries receive information through trusted sources, help address the health literacy and access barriers that disproportionately affect rural populations, and reduce preventable coverage losses resulting from lack of awareness rather than ineligibility.

Thank you for the chance to offer comments on this interim final rule. We look forward to our continued work together to ensure our mutual goal of improving quality and access to care for rural residents. If you would like additional information, please contact Marguerite Peterseim at mpeterseim@ruralhealth.us.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

[12] Hahn H, Shoup D, Giannarelli L. *New Hampshire's Experience With Medicaid Work Requirements.* Urban Institute; 2020. Accessed July 15, 2026. https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf

[13] Chen X, Orom H, Hay JL, et al. Differences in Rural and Urban Health Information Access and Use. *J Rural Health*. 2019;35(3):405-417. doi:10.1111/jrh.12335