

Understanding Medicaid's New Community Engagement Requirements and What This Means for Family Caregivers

Background

Beginning January 1, 2027, certain Medicaid beneficiaries ages 19–64 will be required to demonstrate at least 80 hours per month of qualifying community engagement activities, including employment, volunteer service, participation in a work program, or educational enrollment. These requirements – commonly referred to as work requirements – were established through H.R. 1, the One Big Beautiful Bill Act (OBBBA), and are being implemented through a CMS Interim Final Rule. Individuals who do not meet the requirements or qualify for an exemption may lose Medicaid coverage. Additional verification and documentation requirements take effect January 1, 2028.

This resource explains what the new requirement does, how the family caregiver exemption works and who qualifies, where the verification rules create risk, and what advocates, state officials, and caregivers themselves can do – including through the CMS public comment opportunity open until July 31, 2026 – to ensure eligible caregivers keep their coverage.

Key Caregiver Exemption

Eligible family caregivers are exempt from the community engagement requirement. The rule defines a caregiver broadly as an adult family member or other individual with a significant relationship to a dependent child or disabled individual who provides assistance or support. Caregivers do not need to be legally related, live in the same household, or provide multiple forms of care to qualify.

Caregiver Definition

Per § 435.554(a), a family caregiver is an adult family member or other individual who has a significant relationship with and provides care within a broad range of assistance to, a dependent child or a disabled individual. The definition is intentionally broad: a family caregiver **need not** be a legally recognized relative or a member of the same household, and “a broad range of assistance” can consist of a single form of help. The exclusion applies to both paid and unpaid caregivers.

Care Recipient & Caregiver Eligibility

Caregivers may qualify for the exemption if they provide care to: (1) a dependent child age 13 or younger, or (2) a disabled individual as defined under the Americans with Disabilities Act. The care recipient does not need to qualify for Medicaid on the basis of disability, and there is no age limit for disabled individuals. This means caregivers supporting aging parents and other adults with disabilities may qualify.

A person meeting the family caregiver definition is a specified excluded individual if they meet any one of the following:

1. **Co-residence:** They primarily reside with a dependent child or disabled individual for whom they provide assistance on a regular basis that is not solely incidental in nature.
2. **Relative, non-resident:** They are a relative (per the caretaker relative definition, without the live-with or primary-responsibility requirements) of such a person, provide regular, non-incidental assistance, but do not reside together.
3. **Neither resident nor relative:** They neither live with nor are related to the person but provide not less than 80 hours of non-incidental assistance per month.

Caregivers in categories 1 and 2 are **not** required to document a minimum number of hours; the 80-hour floor applies only to category 3. The rule treats co-residence and family relationship as strong evidence of the “significant relationship” element

Self-Attestation is not Afforded to Caregivers, Implementation Authority Relegated to States

While self-attestation (self-declaration) is cited as permissible verification for other populations within the IFR, no such process is detailed for family caregivers. Instead, there is a reliance upon the states’ determination of “what information is considered sufficient to verify... exception or exclusion.” In effect, when eligibility cannot be determined based on existing data or available documentation, states have the authority and discretion to determine what verification is ultimately sufficient. This ambiguity could lead to significant variability in interpretation across states and make it more difficult for caregivers to verify their status as a specified excluded individual.

Recommendations for CMS Public Comments and State-Level Implementation

A. Lead Ask – Establish a Self-Attestation Pathway for Family Caregivers

Urge CMS to create a self-attestation pathway for the family caregiver exclusion, similar to those available for pregnancy and medical frailty. CMS itself acknowledges that “informal” caregiving often occurs without formal documentation; requiring proof while recognizing family caregivers are unlikely to have it creates a significant risk of inappropriate coverage loss. CMS should further direct states to expressly recognize a signed self-attestation or completed caregiver screening tool as sufficient evidence of eligibility and encourage states to maximize ex parte verification using household composition and relationship information already available in eligibility systems.

B. Identify Information Collection Burden

Stakeholders should submit data-driven comments demonstrating that documentation requirements disproportionately burden family caregivers. Where possible, comments should quantify the prevalence of informal caregiving arrangements and the time and effort required to produce documentation for unpaid care. CMS should also encourage states to minimize administrative burden by relying on existing eligibility data whenever possible and requiring a single, consolidated request for any additional information that may be needed.

C. Clarify Key Terms

Advocacy should encourage CMS to provide guidance or model definitions for terms such as

“significant relationship,” “regular basis,” and “not solely incidental.” States should be encouraged to adopt broad, plain-language definitions that clearly encompass routine family caregiving activities rather than narrow interpretations that could exclude otherwise eligible caregivers.

Advocacy should encourage CMS to establish clear, nationally applicable guidance or model definitions for key terms such as “significant relationship,” “regular basis,” and “not solely incidental.” Absent a consistent federal framework, states may adopt varying interpretations and verification approaches, creating unnecessary administrative complexity, uneven access to exclusions, and confusion for both beneficiaries and eligibility workers. Given that states already rely on a range of established eligibility systems, caregiving definitions, and verification processes, introducing additional variability could further complicate implementation. CMS guidance should therefore promote broad, plain-language definitions that reflect the realities of routine family caregiving and support greater consistency across states while preserving flexibility for state administration.

D. Reconsider the 80-Hour Threshold

Advocates should suggest that CMS reconsider the 80-hour monthly requirement for non-resident, non-relative caregivers reflects the realities of caregiving. CMS should clarify how hours are calculated and confirm that activities such as travel and care coordination count toward the requirement. States should be directed to implement these standards in a manner that recognizes intensive but intermittent caregiving arrangements, including crisis-response and long-distance caregiving.

E. Simplify Caregiver Identification and Screening

Drawing on existing caregiver research and tools, advocates should recommend that CMS develop or require standardized, plain-language screening questions during eligibility and renewal processes. Consistent screening would help ensure caregivers are identified and can access available exclusions. NAC has previously provided Administrator Oz and CMS with a myriad of sustainable data sources to support accurate eligibility determination processes. States should also be encouraged to incorporate caregiver screening questions directly into applications and renewals using established resources such as NAC and AARP’s [Caregiving in the U.S. caregiver survey tool](#), NASHP’s Caregiver Communications and Marketing Toolkit, and the CDC BRFSS Caregiver Module.

F. Protect the Broad Definition of “Disabled Individual”

Emphasize strong support CMS’s use of the ADA disability standard, which appropriately imposes no age limit and does not require a formal Medicaid disability determination. CMS should also make clear that family caregivers supporting older adults with functional limitations, including those who require assistance with activities of daily living such as bathing, dressing, eating, mobility, or medication management, may qualify for the caregiving exclusion when those limitations meet the ADA standard. Clear guidance and caregiver education will be critical to ensuring that older adults with significant care needs are not overlooked due to an overly narrow interpretation of the term “disabled individual.”

G. Restore the Statutory Definition of “Medically Frail”

Contrary to the expectation of many states, CMS narrowed its classification of “medically frail” beyond the statutory precedent outlined in H.R.1. Under the interim final rule (IFR), a qualifying diagnosis is no longer sufficient in verifying exemption as a specified excluded individual. Instead, CMS has imposed an additional restriction, requiring that an individual’s “condition significantly impairs the individual’s ability to comply” with the work requirement in order to qualify for

exemption. This more stringent requirement will likely lead to greater coverage loss for people with serious health conditions like cancer and rare diseases, while forcing states to rebuild systems already underway. Furthermore, this elevated threshold places disabled people at serious risk for involuntary disenrollment. Under this standard, disabled enrollees may be required to attest that they are unable to work in order to maintain access to the very coverage that supports their independence and community participation. The inconsistent definition of disability across the IFR may create a situation in which a caregiver may meet the exemption for supporting a disabled person, but the disabled person themselves doesn't meet the exemption and loses coverage. We strongly oppose the narrowed definition of "medically frail" and urge CMS to restore qualifying diagnoses as the basis for exemption eligibility.

About the National Alliance for Caregiving

The National Alliance for Caregiving (NAC) is a catalyst for change, transforming how the United States recognizes, supports, and values the 63+ million family caregivers providing complex care. Through our nationally recognized caregiving research and advocacy, we drive policy, system, and culture change to elevate family caregivers as a national priority. To learn more visit www.caregiving.org