CHILDREN'S HealthWatch

801 Albany Street
2nd Floor
Boston, MA 02119

Phone: 617.414.6366
Fax: 617.414.7915
www.childrenshealthwatch.org

July 30, 2026

Submitted electronically via www.regulations.gov

The Honorable Mehmet Oz, MD

Administrator, Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-2454-IFC

P.O. Box 8016, Baltimore, MD 21244-8016

RE: Comments of Children's HealthWatch on the Interim Final Rule with Comment Period, "Medicaid Program; Community Engagement Requirement for Certain Individuals," File Code CMS-2454-IFC, 91 Fed. Reg. 23,368 (June 3, 2026)

Dear Administrator Oz:

Thank you for the opportunity to submit comments on the interim final rule, "Medicaid Program; Community Engagement Requirement for Certain Individuals," published by the Centers for Medicare & Medicaid Services (CMS) in the *Federal Register* on June 3, 2026 (File Code CMS-2454-IFC). On behalf of Children's HealthWatch, we write in strong opposition to this rule. As pediatricians and public health researchers, we know that a parent's health coverage is one of the most powerful protections for their child's health, and that conditioning Medicaid on monthly work-reporting paperwork will take coverage from eligible adults, and, in turn, harm the children who depend on them. We urge CMS to rescind the IFC; at a minimum, we urge the agency to withdraw the provisions identified below and to delay the effective date so that coverage of eligible people is not lost to administrative error.

Children's HealthWatch is a nonpartisan network of pediatricians, public health researchers, and policy experts who examine how household hardships and policy decisions affect the health and well-being of young children and their families. We accomplish this by interviewing caregivers of children under age four in emergency departments and primary care clinics in four U.S. cities: Boston, MA; Minneapolis, MN; Little Rock, AR; and Philadelphia, PA. Since 1998, we have interviewed more than 80,000 caregivers and analyzed those data to determine how policy decisions affect the health and development of young children. Although this rule speaks in terms of "applicable

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individuals" who are adults, its consequences fall squarely on children, and it is from that vantage point - the health and development of young children - that we submit these comments.

We also note our serious concern that CMS has issued this sweeping eligibility change as an interim final rule that takes effect the very day the comment period closes, July 31, 2026. A policy projected to end Medicaid coverage for millions of people warrants the notice-and-comment process the Administrative Procedure Act (APA) ordinarily requires before a rule takes effect. Issuing the rule first and inviting comment afterward deprives the public of a meaningful opportunity to shape it and signals that comments may not genuinely inform the policy. We ask CMS to treat the comments it receives as the law requires, as a basis for revising the rule, and to respond to them in a manner consistent with the APA.

1. Parents' loss of Medicaid Harms Children, Even When the Children Keep Their Own Coverage

If the government is serious about children's health, then threatening their parents healthcare coverage is misguided. Children do not experience their parents' coverage as separate from their own, they simply experience the family's loss of stability, access to care, and economic security. The youngest children bear the consequences most acutely.[1]

DeVoe et al.'s (2015) "Oregon Experiment" study found that **children** whose parents were randomly selected to apply for Medicaid had **18% higher odds of coverage in the first 6 months**, and **children** whose parents actually obtained coverage had **more than double the odds (AOR 2.37) of coverage**.[2, 3] The AAP's 2026 Technical Report confirms this, noting that "parents who are enrolled in coverage are more likely to have children enrolled in coverage, and parents with coverage are also more likely to maintain their children's coverage over time".[4] This is one of the strongest claims in the letter. A rule that un-enrolls

[1] Ettinger de Cuba S, Sheward R, Poindexter D, Bovell-Ammon A, Ochoa E Jr. Affordable Health Care Keeps Children and Families Healthy. *Children's HealthWatch*. Published October 24, 2018. Accessed July 30, 2026. https://childrenshealthwatch.org/affordablehealthcare/
[2] DeVoe JE, Marino M, Angier H, et al. Effect of expanding Medicaid for parents on children's health insurance coverage: lessons from the Oregon Experiment. *JAMA Pediatr*. 2015;169(1):e143145.
[3] Hudson JL, Moriya AS. Medicaid expansion for adults had measurable "welcome mat" effects on their children. *Health Affairs*. 2017;36(9):1643-1651. doi:10.1377/hlthaff.2017.0347
[4] American Academy of Pediatrics. Medicaid and the Children's Health Insurance Program: Technical Report. *Pediatrics*. March 2026;157(3):e2025075749.

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parents will therefore un-enroll children, precisely the outcome CMS should work to prevent.[5]

Parental coverage also matters because parents' health is foundational to children's health. A parent whose chronic condition goes untreated, whose depression is unmanaged, or who faces a medical crisis without insurance is less able to provide the stable, responsive caregiving that fosters relational health, and which early childhood development requires.[6] Losing Medicaid does not make a parent more able to work or to care for a child; it makes both harder. A large meta-analysis by Rogers et al. (2020, JAMA Pediatrics) of 191 studies found consistent small-to-moderate associations between maternal perinatal depression/anxiety and adverse child social-emotional, cognitive, and language development from infancy through adolescence.[7] The Lancet's 2024 "Next 1000 Days" series confirmed that parental mental health problems (particularly untreated depression) are associated with adverse child social-emotional development through reduced responsive caregiving.[8]

2. The Rule Will Un-enroll Eligible Families Through Administrative Burden, Not Increase Work

The central lesson from prior community engagement experiments is that work reporting requirements do not meaningfully increase employment; they reduce coverage among eligible people. When Arkansas implemented a Medicaid work reporting requirement during 2018–2019, more than 18,000 adults lost coverage in a matter of months, with no measurable gain in employment, largely because eligible people could not navigate the reporting system, did not receive notices, or did not know the requirement applied to them.[2] These confirmed **18,000 adults lost coverage** and found no employment increase

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[5] Shen Y, Sommers BD, Hatfield LA, Hayes C, Pandya A, Menzies NA. Insurance Dynamics During Childhood in the Fragmented US Health System. *JAMA.* 2025;334(17):1533–1540. doi:10.1001/jama.2025.15488

[6] Stoeckel M, Weissbrod C. Growing up with an ill parent: an examination of family characteristics and parental illness features. *Families, Systems, & Health*. 2015;33(4):356-362. doi:10.1037/fsh0000140

[7] Rogers A, Obst S, Teague SJ, et al. Association Between Maternal Perinatal Depression and Anxiety and Child and Adolescent Development: A Meta-analysis. JAMA Pediatr. 2020;174(11):1082–1092. doi:10.1001/jamapediatrics.2020.2910

[8] Draper CE, Yousafzai AK, McCoy DC, Cuartas J, Obradović J, Bhopal S, Fisher J, Jeong J, Klingberg S, Milner K, Pisani L, Roy A, Seiden J, Sudfeld CR, Wrottesley SV, Fink G, Nores M, Tremblay MS, Okely AD. The next 1000 days: building on early investments for the health and development of young children. Lancet. 2024 Nov 23;404(10467):2094-2116. doi: 10.1016/S0140-6736(24)01389-8. Epub 2024 Nov 18. PMID: 39571589; PMCID: PMC7617681

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over 18 months, with those who lost coverage experiencing severe consequences: 50% reported serious medical debt, 56% delayed care, and 64% delayed medications.[9] A 2025 replication using national survey data by Gangopadhyaya and Karpman confirmed a 12% decline in coverage and 19% increase in uninsurance with **no employment effects**.[10]

This rule recreates that machinery nationwide and adds new reporting obligations at application, at renewal, and, at state option, at more frequent intervals.

As state eligibility systems and caseworkers strain to verify community engagement for millions of people, errors and delays will ripple across the entire Medicaid program, including for children, pregnant and postpartum people, seniors, and people with disabilities to whom the requirement does not apply. Our research demonstrates that in states with more bureaucratic barriers, fewer eligible families participate in the supports, including Medicaid, that they need.[11] Diverting eligibility infrastructure to police work hours will make it harder for every eligible person, including children, to enroll and stay enrolled.

3. The Narrowed Definition of "Medical Frailty" Exceeds the Statute and Endangers People With Serious Conditions

We are especially concerned by the IFC's treatment of the medical frailty exclusion. The statute lists categories of qualifying conditions, including blindness or disability, substance use disorder, a disabling mental disorder, a physical, intellectual, or developmental disability, and serious or complex medical conditions. The IFC adds a requirement found nowhere in the H.R.1 statutory text: that the individual must also demonstrate that the condition impairs their ability to comply with the work requirement, and it provides that a person who is in fact meeting the requirement cannot be considered medically frai[l.12]

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[9] Sommers BD, Chen L, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. Health Aff (Millwood). 2020 Sep;39(9):1522-1530. doi: 10.1377/hlthaff.2020.00538. PMID: 32897784; PMCID: PMC7497731.
[10] A. Gangopadhyaya and M. Karpman , " The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data," Health Services Research 60, no. 5 (2025): e14624, https://doi.org/10.1111/1475-6773.14624.
[11] Gago CM, Sheward R, Ettinger de Cuba S. Efficiency reimagined: designing public programs that work for families and government. *Am J Public Health*. 2026;0:e1-e3. doi:10.2105/AJPH.2026.308619
[12] Centers for Medicare and Medicaid Services. Medicaid Program; Community Engagement Requirement for Certain Individuals. 91 Fed. Reg. 23,368 (June 3, 2026) (interim final rule with comment period) (to be codified at 42 CFR pts. 431, 435, 457).

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This added test inverts the purpose of the exclusion: to protect people at the highest risk of harm from losing coverage. National data demonstrate that many income-eligible adults work and manage serious chronic conditions. The new restrictions would deny the medical frailty exclusion to people whose serious conditions are managed precisely because they have consistent access to care - a parent with cancer in active treatment, for example, who is able to work in some months but not others. Under the narrowed definition, such a parent may be found compliant when working and only "medically frail" once their health has deteriorated enough to stop working, after the very coverage interruption the exclusion was meant to prevent. For people with serious conditions, even a brief, paperwork-driven lapse in coverage can be dangerous or fatal, a tragic outcome not only for the parent but also for their children.

The change also imposes a substantial new administrative burden on states and healthcare providers. Because medical frailty can no longer be identified from diagnosis data alone, states must build and maintain auditable lists of conditions, severity indicators, and functional-impairment data, and far fewer people will be identified automatically through existing claims data. The street-level implementation burden will fall on the shoulders of the safety-net hospital healthcare workforce, thereby reducing the time available for actual clinical care. More families will be forced to navigate complex screening and documentation requirements to prove an exclusion they plainly qualify for, and many will lose coverage simply because they cannot meet them.

These losses have individual and societal costs – research demonstrates that lack of access to basic needs, including health care, result in enormous and avoidable health care costs for the nation.[13,14,15, 16]

We urge CMS to conform the medical frailty definition to the statute, to maximize automatic identification of excluded individuals, and to make permanent - not

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[13] Gaffney A, McCormick D, Dickman SL, et al. Risk of Burdensome Health Care Spending Over Time in the US. *JAMA Intern Med.* 2026;186(2):203–213. doi:10.1001/jamainternmed.2025.6948

[14] Cook JT, Poblacion AP. Estimating the health-related costs of food insecurity and hunger. In: Bread for the World Institute, ed. *2016 Hunger Report*. Bread for the World; 2016: 247-264.

[15] Thomas, A, Valero-Elizondo, J, Khera, R. et al. Forgone Medical Care Associated With Increased Health Care Costs Among the U.S. Heart Failure Population. *J Am Coll Cardiol HF.* 2021 Oct, 9 (10) 710–719.https://doi.org/10.1016/j.jchf.2021.05.010

[16] Melgoza E, Falk DS, Bustamante AV, Newberry JA. Cost-Related Delayed or Forgone Care and Emergency Department Visits Among Latino Adults. JAMA Netw Open. 2026;9(3):e260237. doi:10.1001/jamanetworkopen.2026.0237

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temporary - the ability to rely on self-attestation where confirming data are unavailable.

Conclusion.

By design and through substantially increasing administrative burden, this policy change will strip health coverage from eligible parents and, with them, their children; it will deny the medical frailty exclusion to people with serious conditions in violation of the statute; and it will overwhelm the eligibility systems that children, pregnant people, seniors, and people with disabilities also depend on. The harms - untreated illness, family financial instability, food insecurity, and avoidable long-term costs to children's health and to the public - are well documented and entirely foreseeable.

For the health and future of our nation's children, we urge CMS to rescind this interim final rule.

Sincerely,

Stephanie Ettinger de Cuba, PhD, MPH

Executive Director

Children's HealthWatch