

July 31, 2026

RE: Comments on Interim Final Rule, “Medicaid Program; Community Engagement Requirement for Certain Individuals” (CMS-2454-IFC, RIN 0838-AV98 91 Fed. Reg. 33348, June 3, 2026)

I. Statement of Interest

The Society for Adolescent Health and Medicine (SAHM) is a multidisciplinary organization of physicians, nurses, psychologists, social workers, nutritionists, and other health professionals dedicated to improving the physical and psychosocial health and well-being of all adolescents and young adults (AYA). Our members provide direct clinical care, conduct research, and shape policy on behalf of young people roughly ages 10 through 25, a population for whom Medicaid is a foundational source of coverage for primary care, reproductive and behavioral health services, chronic disease management, and the preventive care that supports a successful transition into adulthood.

In 2025, SAHM issued a position paper, “Protecting Financial Access to Health Care for Adolescents and Young Adults,” building on the position of the United Nations and World Health Organization that access to health care is a fundamental human right. SAHM asserts that all AYA possess this right regardless of background or circumstance and recognizes the essential role that publicly funded health insurance, health care, and social services play in AYA well-being. We submit these comments on the Interim Final Rule (IFR) implementing the Medicaid community engagement (“work”) reporting requirement promulgated pursuant to H.R. 1 (the “One Big Beautiful Bill Act,” or OBBBA) in direct fulfillment of SAHM’s position.

We also submit these comments recognizing the demonstrated value of the public comment process itself. When Kentucky and Arkansas implemented Medicaid work requirements under prior law, thousands of beneficiaries and organizations submitted public comments describing Medicaid as an opportunity ladder, a safety net, and a lifeline. Federal judges who struck down both states’ work requirements in 2019 cited these public comments directly in their rulings. The record built during this comment period may prove similarly consequential, and we draw on those comments as well to establish why fully financed healthcare for AYA is a societal essential.

II. Adolescence and Young Adulthood Is a Developmental Period That Warrants Deliberate Protection, Not an Afterthought

Adolescence and young adulthood is not a waiting room on the way to “real” adulthood — it is a distinct developmental period that shapes the trajectory of a person’s entire life. The health habits, chronic disease management, and provider relationships established between ages 10 and 25 predict outcomes across the lifespan and for future generations. Investment in AYA health yields dividends that compound over time: healthier young people become healthier adults who go on to raise, support, and provide for the next generation. Conversely, when this developmental window is destabilized by coverage loss, the consequences alter life trajectories.

Yet AYA are frequently under-prioritized in health policy, including in the rule now before the agency. This IFR appears to be written with a stable, full-time, continuously employed adult worker in mind and applied uniformly to a population whose lives rarely resemble that model, often due to circumstances far outside any individual's control. When policymakers fail to safeguard AYA health coverage, they are not making a narrow budgetary tradeoff. They are foreclosing safer, more stable life trajectories for millions of young people at precisely the moment those trajectories are being set. SAHM urges CMS to treat the developmental realities of this population as central to — not incidental to — its implementation of H.R. 1.

III. Background: OBBBA's Medicaid Cuts and the IFR's Departure from Statute

OBBBA, signed into law on July 4, 2025, cuts more than \$1 trillion from Medicaid — roughly 14% of the program's budget — over the coming decade, and is estimated to strip coverage from 10 million beneficiaries. Its most consequential provisions eliminate incentives for states to maintain Medicaid expansion, which had previously improved insurance rates by **8.9 percentage points** among 19- to 25-year-olds, and impose nationwide work reporting requirements. Beginning in January 2027, states may provide Medicaid only to adults who certify 80 hours of monthly employment, education, or volunteer activity, or who qualify for an exclusion, exemption, or good-cause reason; the statute requires recertification every six months.

The IFR published by CMS on June 3, 2026, with an effective date of July 31, 2026, goes further than this statutory text in two consequential ways. First, it narrows the medical frailty exemption Congress created for people with serious and complex health conditions, essentially permitting states to exempt only enrollees whose medical condition “significantly impairs the individual's ability to comply” — a materially stricter standard than what H.R. 1 requires. Second, beginning in 2028, it eliminates self-attestation as a means of establishing medical frailty and instead requires enrollees to obtain third-party documentation of their condition at least every 12 months, or as often as every six months at state option. Individuals who are subject to the rule and do not meet the medical frailty exemption or one of the other allowed exemptions must satisfy the 80-hour work, documentation, and reporting requirements, which will be difficult for many AYA to do.

Because this is an interim final rule rather than a proposed rule, CMS is not required to resolve public comments before the rule takes effect; nonetheless, submitting comments creates an essential public record of the rule's departure from statute and its likely harms, a record that can inform litigation, oversight, and future rulemaking.

OBBBA's other provisions compound these harms for AYA specifically. The law limits subsidized coverage available through the Affordable Care Act, which is projected to increase coverage gaps for young people who transition between Medicaid and marketplace coverage. It excludes refugees, asylees, and humanitarian parolees — many of whom are AYA — from Medicaid and ACA coverage. It targets Medicaid-funded family planning services on which many AYA rely, and it drastically cuts funding to rural hospitals and community health centers, both critical access points for young people. OBBBA also imposes new work requirements on the Supplemental Nutrition Assistance

Program (SNAP) and specifically terminates SNAP benefits for young people exiting foster care. This layers food insecurity on top of health coverage loss for an already-vulnerable group.

IV. Adolescents and Young Adults Are Uniquely Vulnerable to Work Reporting Requirements

Work reporting requirements assume a stable, documentable, full-time adult employment relationship – *this does not describe how most AYA actually work, learn, and live*. The following are known mechanisms by which this rule will disproportionately strip coverage from young people:

- Unstable, informal, or seasonal work: Since the COVID-19 pandemic, young people are more likely to hold seasonal, informal, or gig-style jobs rather than the steady, easily documented employment these rules assume, making monthly hour thresholds and reporting requirements structurally difficult to satisfy even for AYA who are actively working.
- Unstable student status: Many AYA rely on a student exemption, but rising financial pressure is driving more young people to drop below full-time enrollment or leave school altogether, silently disqualifying them from the very exemption meant to protect them.
- Stigmatized or poorly recognized disabilities: Conditions common in this age group — eating disorders, substance use disorders, mental health conditions, violence-related injury — often do not fit neatly within statutory definitions of disability, making it harder for AYA to qualify for a medical frailty exemption even when their condition is serious and complex.
- Developmental and care transitions: AYA lives are often in flux — aging out of foster care, transitioning from pediatric to adult health systems, moving for school or work — each of which raises the likelihood of documentation or reverification gaps that reflects administrative challenges, not improved health.
- Thin or discontinuous provider relationships: Compared with older adults who often have established relationships with primary care providers, AYA are more likely to rely on health care provided in school or college health centers, community health centers, or episodic urgent care, making it harder to obtain the repeat third-party documentation the IFR requires.
- First-time navigation of public systems: Many young people are completing benefits paperwork, exemption requests, or appeals on their own for the first time — often without a parent’s help — with the least administrative experience of any age group in the system.
- Caregiving responsibilities that do not register as “work.” Young parents balancing infant or child care with intermittent employment may struggle to document hours in a way the system recognizes, even while functioning at full capacity. Young adults assuming responsibilities for the care of a parent or older family member would face similar obstacles even if their “work” were recognized at all.

Each of these mechanisms produces the same outcome: an eligible young person loses coverage not because their circumstances changed, but because the system was not built to recognize the way AYA actually live.

V. The Evidence Is Clear: Medicaid Access Drives Measurable Gains in AYA Health

The harms SAHM anticipates from this rule are the mirror image of well-documented gains associated with expanded Medicaid access for this population following the ACA's 2010 Medicaid expansion. Published, peer-reviewed research demonstrates that when AYA gained Medicaid eligibility, well-visit rates and preventive service delivery increased substantially, with the largest gains among low-income and minoritized young people. HPV vaccination rates rose, particularly among adolescent boys. Young people hospitalized with asthma, chronic obstructive pulmonary disease, or heart failure required mechanical ventilation less often. Mortality rates fell among young adults hospitalized for traumatic injury, including firearm injury (which is a leading cause of mortality in this age group). And young adults with cancer benefited from earlier detection and improved survival, with the most pronounced gains among Black young adults and those living in rural areas.

This body of evidence establishes a clear, causal relationship between stable Medicaid access and measurable improvements in AYA health across primary prevention, chronic disease management, trauma, and cancer outcomes. *A rule that predictably strips coverage from millions of otherwise-eligible AYA should be expected to reverse these gains and cost lives.*

VI. History Warns Us: Prior State Work Requirement Experiments Failed on Their Own Terms

Kentucky, Arkansas, and Georgia each attempted Medicaid work requirements under prior law, and the results offer a preview of what this nationwide requirement will do. Research on Kentucky's program found that even beneficiaries who were employed, or who had a qualifying disability, lost or were expected to lose coverage due to reporting and verification failures rather than actual ineligibility. The legality of these programs was repeatedly challenged in court, and in 2019 federal judges vacated both Kentucky's and Arkansas's work requirements, citing the harms documented in the public comment record — including firsthand accounts from beneficiaries — as part of their reasoning.

This history offers two lessons directly relevant to this comment period. First, work reporting requirements have a demonstrated track record of removing eligible people from coverage through administrative obstacles and failures rather than genuine ineligibility, and there is no reason to expect this IFR's more restrictive terms to perform better. Second, the public comment process has previously formed part of the evidentiary basis for successful legal challenges to Medicaid work requirements.

VII. The Stakes: Multigenerational Harm if Millions of AYA Lose Coverage

The scale of harm at issue is national and multigenerational. Independent estimates project that OBBBA's Medicaid provisions could strip coverage from roughly 10 million beneficiaries, and the

Urban Institute has estimated that the work reporting requirement alone could cause between 3 and 7 million people to lose Medicaid coverage in 2028 — a range that depends heavily on how much flexibility states retain to maximize exemptions and ease compliance. Because this IFR restricts those flexibilities, and imposes an extraordinary array of complex requirements that states must satisfy in an unreasonably short period of time, the higher end of that range, or a figure beyond it, is now more likely. Health policy researchers have projected that the full scope of OBBBA's coverage losses could contribute to an estimated 51,000 additional deaths per year nationally, an analysis presented to the U.S. Senate during the bill's deliberation.

For AYA specifically, coverage loss at this scale does not resolve at the end of a benefit year — it compounds across a generation. A young person who loses coverage during a mental health crisis, a cancer diagnosis, or a postpartum period does not simply forgo a single year of care; they lose the preventive relationships, medication continuity, and early intervention that shape long-term health. A young parent who loses coverage risks that instability extending to their children. A young person aging out of foster care who loses both Medicaid and SNAP benefits in the same policy stroke faces compounding deprivation at the exact moment they are expected to become self-sufficient. Multiplied across millions of AYA, these individual harms become a demographic-scale erosion of the health of an entire generation of parents, workers, and caregivers — with consequences for the health system, the labor force, and public health that will be borne for decades, not years.

VIII. Recommendation

SAHM urges CMS to withdraw this Interim Final Rule and issue a different rule that: (1) restores a medical frailty exemption standard consistent with the statutory text of H.R. 1, covering enrollees with serious and complex health conditions rather than only those who cannot work at all; (2) preserves self-attestation as a valid means of establishing a medical frailty exemption; (3) eliminates the mandatory 12-month reverification requirement in favor of state and clinical discretion appropriate to the enrollee's condition; and (4) provides states a realistic implementation timeline that does not lead to last-minute eligibility denials based on regulatory changes being applied to work already completed in good faith. In the absence of a withdrawal and reissuance of the rule, at minimum, any future CMS guidance must account for the developmental, clinical, and administrative realities of AYA Medicaid enrollees, and should consult with pediatric and adolescent health care providers and experts in AYA health, including SAHM, in doing so.

Thank you for the opportunity to comment. SAHM and its members are available as a resource to CMS on the clinical and developmental needs of adolescents and young adults as the agency considers these issues further.

Sincerely,

Society for Adolescent Health and Medicine

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