July 31, 2026

Submitted electronically

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2454-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Interim Final Rule titled, "Medicaid Program; Community Engagement Requirement for Certain Individuals," RIN number 0938-AV98, file code CMS-2454-IFC, 42 CFR Parts 431, 435, 438, 457, and 600 (June 3, 2026)

I. INTRODUCTION

ZERO TO THREE appreciates the opportunity to comment on the U.S Department of Health and Human Services (HHS or Department) Centers for Medicare & Medicaid Services (CMS) Interim Final Rule (IFR) entitled, *Medicaid Program; Community Engagement Requirement for Certain Individuals*. In implementing the new Medicaid community engagement requirement, the IFR incorporates a critical exclusion for providers of care for children under the age of 13. However, without further guidance on providers of child care and explicit flexibility on how such caregivers may demonstrate their eligibility, these essential caregivers are likely to erroneously lose health coverage—undermining the intent of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21) and jeopardizing access to child care for families across the country.

Since 1977, ZERO TO THREE has focused on ensuring that infants and toddlers have a strong start in life. The first five years of a child's life are pivotal for brain development, laying the foundation for all future learning, behavior, and health. By ensuring a strong, stable start, we can set children on a path to success, while preventing more significant, costlier challenges down the line.

In our July 14, 2025, comment on the Department's *Request for Information (RFI): Ensuring Lawful Regulation and Unleashing Innovation to Make America Healthy Again*, we laid out a "Framework for Babies," describing six principles ZERO TO THREE urges the Department and its divisions to consider in any proposed policy changes in order to ensure policies address the needs of infants and toddlers.[1] These include: 1) transparency and engagement; 2) using the science of child development to guide policy; 3) prioritizing the well-being of young children; 4) strengthening the family to support the child; 5) the need for knowledge, skills, and training to work with children; 6) and the need to ease the burden of policies on individuals and families, not just systems.

In line with principles two, three, four, and six, we appreciate the IFR's acknowledgement of a basic reality – no baby exists alone. Young children rely on the adults in their lives not only to meet basic

[1] ZERO TO THREE. (2025). *Public comment RE: HHS notice titled "Request for Information (RFI): Ensuring Lawful Regulation and Unleashing Innovation to Make America Healthy Again" (Docket AHRQ-2025-0001, 90 Fed. Reg. 20478).* https://www.regulations.gov/comment/AHRQ-2025-0001-0788

needs but for overall development. In fact, research consistently demonstrates that children's development and early learning are best supported by nurturing, responsive adults equipped to support their development.[2] The quality of caregiving and stability of the adults in children's lives are among the strongest predictors of positive early childhood outcomes.[3]

In other words, the best way to ensure young children receive the strongest start and to avoid the development of chronic conditions is by supporting caregivers – and that means ensuring that caregivers themselves are healthy enough to provide appropriate care. The caregiver exclusion to the Medicaid community engagement requirement is critical for ensuring young children receive the care they need, that parents and other primary caregivers can raise children, and that parents receive the child care they themselves need to remain in the workforce or fulfill other community responsibilities.

Effective implementation of this exclusion is not only vital for the well-being of young children—it is foundational to the community engagement requirement's stated goal of "empower[ing] Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation and dependency, build confidence, and achieve self-sufficiency and independence." Without this exclusion, many child care providers would be left with an impossible choice: continue to provide child care but lose health coverage, or retain health coverage but stop providing care, potentially forcing parents and other primary caregivers to themselves drop out of the workforce.

ZERO TO THREE appreciates the IFR's explicit inclusion of a wide range of caregivers that young children rely on for a healthy start, including parents and other primary caregivers, non-custodial parents, and "family caregivers" who provide frequently unpaid, informal child care. The IFR recognizes that multiple adults are needed to care for an individual child, and that each of these adults requires the flexibility and availability provided by the exclusion, consistent with congressional intent. ZERO TO THREE also appreciates the IFR's clarification that, during any month that an individual qualifies as an excluded individual, that individual does not need to demonstrate community engagement hours.

However, due to limitations in the caregiver exclusion and related exemptions, as well as burdensome and ambiguous evidentiary requirements, the IFR risks undermining Medicaid's program integrity by erroneously denying Medicaid coverage to potentially millions of eligible caregivers across the country. To ensure continuity of care by healthy, nurturing caregivers for young children, **ZERO TO THREE urges CMS to take the following steps:**

- Since many caregivers will not have documentation even after 2028, to prevent erroneous coverage denials, reaffirm the ongoing importance of self-attestation in the absence of "reasonably available" documentation. Further, provide guidance to states on the "reasonably available" standard for documentation and the sufficiency standard for alternative information,

[2] Schoch, A. D., Gerson, C. S., Halle, T., & Bredeson, M. (2023). *Children's learning and development benefits from high-quality early care and education: A summary of the evidence* (OPRE Report #2023-226). Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://acf.gov/sites/default/files/documents/opre/%232023-226%20Benefits%20from%20ECE%20Highlight%20508.pdf

[3] Center on the Developing Child. (2026). *From resources to routines: The importance of stability in the developmental environment* (Working Paper No. 4). Harvard University. https://developingchild.harvard.edu/wp-content/uploads/2026/03/HCDC-ECSCEE-Stability.pdf

including ensuring that caregivers are not required to generate or obtain documentation solely for purposes of the Medicaid community engagement requirement or its exemptions.

- Publicly release each state's policies regarding documentation and information sufficiency requirements, as well as annual (or more frequent) data on state-by-state Medicaid enrollment under the community engagement requirement, including a breakdown by exclusion or exception.
- Delay implementation of the community engagement requirement so that states are able to effectively and consistently implement the program.
- Issue guidance on and examples of "family caregivers" who are caring for children under age 13, regardless of disability status, including through sample screening questions and educational materials.
- For family caregivers, expand the "relative" definition to acknowledge a broader range of extended family and other caregivers and/or at minimum allow states to designate additional relatives beyond those selected by the state pursuant to the "caretaker relative" designation.
- Remove the 80 hours monthly minimum requirement for family caregivers who do not live with or are not related to the care recipient.
- For caretaker relatives, ensure primary caregivers currently available only under state option (such as extended family, domestic partners, and informal foster care arrangements) are included under the definition for all states. If this change is not made, at minimum, issue guidance on family caregivers explicitly noting that primary caregivers that states have not included under the "caretaker relative" designation would be considered family caregivers.
- Apply the hardship exception for individuals whose dependent must travel outside of their community for medical services or for a serious or complex medical condition to parents, guardians, and caretaker relatives of the dependent, as those terms are defined for purposes of the caregiver exclusion.
- Issue guidance to states to ensure continuity of coverage for pregnant and postpartum women, including through automatic transition across enrollment pathways and the minimization of administrative barriers.

II. CHILD CARE IS AN ESSENTIAL FORM OF CAREGIVING

The care that infants and toddlers receive from consistent, attentive caregivers lays the foundation for lifelong well-being. Whether from primary caregivers or the child care providers who nurture a young child's learning and development, caregivers are essential to young children's healthy growth. Child care providers are similarly crucial to the economic well-being of families and communities, as parents and other primary caregivers often rely on unpaid, informal caregivers to themselves work, pursue education, or otherwise engage in their communities.

Many caregivers are only able to provide child care thanks to programs like Medicaid, which allow caregivers to remain healthy enough to provide high-quality care. Nearly half (42%) of informal, unpaid

child care providers rely on public health coverage,[4] including Medicaid. In recognition of the importance of Medicaid coverage to the ability of parents and other caregivers (primary and otherwise) to raise children, the WFTC legislation includes an exclusion for caregivers of children under age 13, as well as people with disabilities.[5]

While ZERO TO THREE appreciates the inclusion of many caregivers under the IFR's implementation of the caregiver exclusion, narrow definitions and potentially unachievable administrative requirements risk leaving out or erroneously denying coverage to eligible, essential caregivers, undermining the care young children receive and parents' own ability to work.

III. BURDENSOME DOCUMENTATION REQUIREMENTS RISK ERRONEOUS COVERAGE LOSSES AND DENIALS

Effective implementation of the Medicaid community engagement requirement will necessitate efficient and low-burden administration for both states and individual applicants and enrollees. To that end, ZERO TO THREE appreciates the IFR's emphasis on data systems that automate evidentiary collection where possible, the emphasis on minimizing the burden on individuals, and the encouragement that states carry out extensive public education on the new requirement and its exceptions. However, despite some flexibility in the IFR, the burdensome evidentiary requirements in the IFR are likely to lead to erroneous coverage losses for caregivers across the country, undermining program integrity.

As acknowledged in the IFR, program integrity is compromised when eligible individuals are denied coverage.[6] This may occur, for example, when the evidentiary burden for the community engagement requirement's exclusions and exemptions proves unachievable for an enrollee or applicant—a situation that is particularly likely among caregivers, such as family caregivers offering informal and/or unpaid child care or caretaker relatives in informal foster care or kinship care arrangements. In fact, the IFR specifically notes that evidence of caregiving is particularly unlikely to exist in "reliable information available to the state" and that caregivers are unlikely to have relevant documentation, noting:

> "However, there will be circumstances in which no documentation exists, or documentation is not reasonably available. For example, an individual who lives with and provides regular assistance to their disabled parents may qualify for an exclusion on the basis of being a family caregiver. Because of the personal nature of this type of assistance, it often occurs outside of an employer/employee or other contractual relationship. As such, an individual is unlikely to have documentation to provide that demonstrates qualification for the exclusion."

Similarly, even primary caregivers may not have easy access to documentation. For example, there is frequently a significant wait for families to apply for either kinship care or foster care and be approved,

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[4] U.S. Department of Health and Human Services, Administration for Children and Families. (2023). *National survey of early care and education*. https://www.icpsr.umich.edu/web/ICPSR/series/2060

[5] Working Families Tax Cut Legislation, Pub. L. No. 119-21, § 71119, 139 Stat. 11 (2025). Section 71119 includes the following exemption to the Medicaid community engagement requirement: "(III) who is the parent, guardian, caretaker relative, or family caregiver (as defined in section 2 of the RAISE Family Caregivers Act) of a dependent child 13 years of age and under or a disabled individual".

[6] See, e.g., § 435.557(b): "…the impact on program integrity in terms of the potential for ineligible individuals to be enrolled and for eligible individuals to be denied coverage."

during which time official documentation of these arrangements may be unavailable. Further, while many children in foster care are cared for by relatives, 44% of children in foster care residing with relatives or kin live in an unlicensed home, making documentation similarly challenging to provide.[7] However, these caregivers must still be able to provide a healthy, stable home for a child, which necessitates caregivers maintaining their own health.

ZERO TO THREE appreciates the IFR's acknowledgement that many caregivers are unlikely to show up in evidentiary systems or to have relevant documentation, the requirement that state agencies "[a]ccept information other than documentation to verify an individual's eligibility when there is no reasonably available documentation," and the prohibition on state agencies "deny[ing] or terminat[ing] eligibility solely because the individual is unable to produce documentation where none exists or is reasonably available."[8] The explicit allowance of self-attestation until December 31, 2027 will similarly be helpful in preventing caregivers from being erroneously denied Medicaid coverage in the coming year. However, the lack of documentation or other evidentiary information for family caregivers will not end on that date.

Notably, when documentation is not reasonably available, the IFR allows states to "require[] the individual to provide specific information considered sufficient to verify the individual's eligibility." However, the IFR does not provide guidance on the "reasonably available" standard or what information might be considered "sufficient" in its absence, potentially creating substantial confusion and variation across states. The IFR is similarly ambiguous regarding how an individual could demonstrate the "regular basis" of caregiving, the number of hours (where applicable), if a child under 13 is a "dependent" beyond the child's age,[9] and what information states could consider as "sufficient" in the absence of reasonably available documentation.

Self-attestation, which occurs under penalty of perjury, remains the best way to verify eligibility for the caregiver exclusion in 2028 and beyond. **We urge CMS to reaffirm the ongoing importance of self-attestation to improve program integrity by preventing erroneous coverage denials. We further urge CMS to provide additional guidance to states on how to interpret the above terms, particularly the "reasonably available" and information sufficiency standards, to ensure that caregivers are not required to generate or obtain documentation solely for purposes of the Medicaid community engagement requirement or its exclusions.** This guidance should include the option for individuals to certify to the state that such documentation is not available, as well as non-exhaustive examples of the types of information states might consider to be sufficient to demonstrate applicability of the exclusion.

To improve program integrity and transparency, **we further urge CMS to publicly release each state's policies regarding what documentation is required and what information is sufficient in the absence of**

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[7] Adams, A., Inman, C., Allen, K., & Schreier, A. (2026, March). *States increasingly promote kinship care, though significant opportunity remains for improving licensing, definitions, and reach: Nearly two-thirds of jurisdictions have not yet amended Title IV-E plans to adopt separate licensing standards.* Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/9d9d8dc846e4e26acbab86c8d7e80ac8/Kinship%20Care%20Brief.pdf

[8] Interim Final Rule, 42 C.F.R. § 435.557(b)(2)(iii)

[9] The IFR is similarly unclear regarding how a caregiver could demonstrate that a care recipient has a disability without compromising the recipient's medical privacy, which may also impact caregivers of children with disabilities.

reasonably available documentation, as well as annual (or more frequent) data on state-by-state Medicaid enrollment under the community engagement requirement, including a breakdown by exclusion or exception, including the caregiver exclusion.

Finally, the short implementation timeline is likely to prove difficult, if not impossible, for many states as they struggle to build new data systems, adapt application materials, develop and implement new policies and procedures, and educate current and potential enrollees regarding the new community engagement requirement, its exemptions, and its requirements. Without an appropriate timeline to create such systems and then robustly educate the public, program integrity will be significantly undermined, and states will be unable to effectively fulfill the intent of the statute or the IFR. **ZERO TO THREE strongly urges CMS to further delay implementation of the community engagement requirement** so that states are able to effectively and consistently implement this new requirement.

IV. WHILE INCLUSIVE OF MANY CHILD CARE PROVIDERS, THE "FAMILY CAREGIVER" DEFINITION IS OVERLY NARROW AND NEEDS FURTHER GUIDANCE

ZERO TO THREE appreciates the IFR's inclusion of caregivers of young children under the "family caregiver" definition, including providers of part-time, informal, and unpaid child care. However, to ensure that caregivers understand their eligibility and do not erroneously lose coverage, further guidance on child care providers is needed, as are expansions to the scope of the "family caregiver" definition under the IFR.

Informal caregiving is a common, and essential, form of child care across the United States. Nearly half of children under age three (48.5%) are regularly cared for by someone other than a parent, mostly by individual unpaid caregivers,[10] and about one in five parents rely on a relative for child care for children under age five.[11] According to the latest data available, there are an estimated 4,030,000 unlisted, unpaid home-based child care providers in the United States, who each care for an average of 1.8 children; nearly a quarter of these providers (24.1%) care for a child under age three.[12] This caregiving is essential to families' economic well-being, as parents and primary caregivers often rely on unpaid, informal caregivers to themselves work, pursue education, or otherwise engage in their communities. As noted above, many of these caregivers rely on Medicaid for their own health coverage.

In recognition of the importance of family caregivers to the economic and overall well-being of both families and communities, the WFTC legislation includes "family caregivers" of young children under the

[10] U.S. Department of Health and Human Services, Administration for Children and Families. (2023). *National survey of early care and education*. https://www.icpsr.umich.edu/web/ICPSR/series/2060
[11] Eggleston, C., Meyers, M., & Garcia Trejo, Y. (2023, November 29). *Most parents don't have any formal child care arrangements*. U.S. Census Bureau. https://www.census.gov/library/stories/2023/11/child-care.html
[12] Schochet, O., Li, A., Del Grosso, P., Aikens, N., Atkins-Burnett, S., Porter, T., & Bromer, J. (2022). *A national portrait of unlisted home-based child care providers*. Erikson Institute. https://www.erikson.edu/wp-content/uploads/2025/02/2022-A-National-Portrait-Learning.pdf

caregiver exclusion. ZERO TO THREE supports the following elements of the IFR's implementation of this definition, which are consistent with the legislative text:[13]

- the inclusion of those who care for children under the age of 13 (regardless of the child's disability status),
- the inclusion of both paid and unpaid caregivers,
- clarification that the child does not need to be a dependent of the family caregiver,[14]
- the inclusion of relatives, those who live with the care recipient, and others who provide regular care.

However, the IFR's discussion of the "family caregiver" definition focuses almost exclusively on caregivers of people with disabilities, which is likely to cause confusion among both state agencies and potential Medicaid enrollees. For example, while ZERO TO THREE supports the use of screening questions for family caregiver status within Medicaid applications, we note that the sample screening questions provided in the IFR generally relate to caregivers of people with disabilities or older adults, not caregivers of children. Particularly given that the RAISE Family Caregivers Act definition of "family caregiver," from which the IFR's definition was adapted, focuses on the care of people with disabilities and older adults, **additional guidance from CMS is needed on examples of family caregiving involving young children**.

In such guidance, ZERO TO THREE urges CMS to include family, friend, and neighbor care for children, a common form of unlicensed child care that happens at home or in the community. For example, this may include a grandparent who resides in a separate household but provides child care so that the parent can work, or a neighbor who cares for their friend's child alongside their own. This guidance will be equally important both for states and caregivers themselves, given that CMS's own research has found that caregivers are particularly uncertain whether they qualify for an exemption from the community engagement requirement.[15] As such, **sample public education materials for states to adapt will be crucial** to ensure family caregivers of dependent children appropriately understand their eligibility for, and are appropriately approved for Medicaid coverage pursuant to, the caregiver exclusion.

ZERO TO THREE is further concerned that the IFR's definition of "relative" under the family caregiver provision, in addition to the addition of an 80-hour minimum requirement for certain family caregivers, are inconsistent with both the WFTC legislation and the RAISE Family Caregivers Act and will inappropriately exclude many child care providers from the caregiver exclusion.

We appreciate that the "family caregiver" definition explicitly includes both relatives and co-residents of the care recipient without a minimum hours requirement, as their inclusion reflects the day-to-day caregiving realities of these individuals and the fact that these caregivers in particular are unlikely and

[13] RAISE Family Caregivers Act, Pub. L. No. 115-119, 132 Stat. 23 (2018). In particular, the caregiver exclusion includes family caregivers of both "a dependent child 13 years of age and under" and of "a disabled individual," in addition to "an individual with a chronic or other health condition, disability, or functional limitation."
[14] Interim Final Rule, 42 C.F.R. § 435 (2020). As noted in the IFR: "[W]e are not requiring that a family caregiver reside with or assume primary responsibility for the care of the dependent child or disabled individual."
[15] Centers for Medicare & Medicaid Services. (2026). *Medicaid community engagement requirements: Qualitative research communication summary*. U.S. Department of Health and Human Services. https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement/resources/Community-Engagement-messaging.pdf

unable to track their caregiving hours. However, we caution that cross-referencing "relative" under "family caregiver" to the list of relatives under "caretaker relative" is likely to leave out essential members of the extended family and other near-family caregivers who are frequently called upon to provide child care.[16] Particularly for supportive, rather than primary, caregivers, a wider range of relatives is likely to provide care, including more distant blood relations such as cousins, family members of a parent's former spouse or domestic partner, or even family friends or godparents. Accordingly, **CMS should expand the definition of "relative" for family caregivers and/or at minimum allow states to designate additional** individuals**, in addition to those designated as caretaker relatives, for the purposes of interpreting "relative" under the "family caregiver" definition**.

We are further concerned that the family caregiver definition is significantly narrower than the RAISE Family Caregivers Act definition through the addition of the minimum hours requirement for those who do not live with or are not relatives of the care recipient. In the WFTC legislation, Congress chose to include a minimum hours requirement for the community engagement requirement; in contrast, for the caregiver exclusion, Congress intentionally chose not to include any such minimum. As such, the addition of an 80-hour monthly requirement effectively removes the distinction between the requirement and the exclusion under the statute. It is also inconsistent with the frequently unpredictable nature of the time commitment required for child care, which "meaningfully limit[s family caregivers'] ability to participate in work or other community engagement activities."

To ensure consistent implementation across states and understanding among caregivers about the scope of the family caregiver provision, **ZERO TO THREE urges CMS to issue further guidance focused specifically on family caregivers of children under the age of 13**, regardless of disability status, including through sample screening questions and educational materials. **ZERO TO THREE further urges CMS to expand the definition of "relatives" for family caregivers, and strongly urges that CMS remove the 80 hour minimum requirement for family caregivers who do not live with or are not related to the care recipient**, so that essential child care providers are not forced to choose between Medicaid coverage or discontinuing their child care obligations.

V. THE "CARETAKER RELATIVE" DEFINITION LEAVES OUT CERTAIN PRIMARY CAREGIVERS

Parents and other primary caregivers are responsible for the day-to-day upbringing of a young child, from meeting basic needs to supporting positive learning, growth, emotional regulation, relationships, and overall development. As Medicaid has long recognized, while parents are often a child's primary caregiver, many children are raised by other adults to support their health or safety, either on a permanent or temporary basis. This may involve shared custody, adoption, additional adults living in the household, both formal and informal foster care, kinship care, court-appointed guardianship, and more.

[16] While many of these caregivers could be included at state option from the following list, this approach is likely to lead to significant variability across states: "(iv) At State option, another relative of the dependent child or disabled individual based on blood (including those of half-blood), adoption, or marriage; the domestic partner of the parent or other caretaker relative; or an adult with whom the dependent child or disabled individual is living and who assumes the primary responsibility for the dependent child or disabled individual's care. To the extent a State has elected to include any of these relationships for the purpose of eligibility for the group at § 435.110, the same elections shall apply for this definition for such State."

In 2023, about 2.4 million children in the United States were raised by grandparents, other relatives, or close family friends because their parents were unable to care for them.[17]

ZERO TO THREE appreciates that the IFR's definition of "parent" includes non-custodial parents, whose availability to care for their children, pick them up in the event of an emergency, or otherwise provide appropriate, nurturing, and timely care are likely to substantially interfere with the ability to fulfill the community engagement requirement. However, the "caretaker relative" definition nevertheless risks excluding many other vital primary caregivers of young children, leading to inconsistency across states.

The WFTC legislation does not include a statutory definition for "caretaker relative," an essential category included within the caregiver exclusion. Pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), the Code of Federal Regulations includes a pre-existing definition established solely to implement Medicaid categorical eligibility for low-income families. Similar to the IFR's analysis of why a new definition was required for the term "dependent child," this different historical context and statutory purpose requires a different definition to fulfill the WFTC legislation's intent of an exclusion from the community engagement requirement.

In addition to a list of relatives considered to be caretaker relatives in all states, the proposed definition of "caretaker relative" includes optional categories that states may choose to select.[18] These optional groups include essential caregivers such as domestic partners of a parent, as well as extended family and other adults who take in a child, who often act as primary caregivers, particularly in informal foster care scenarios. By not requiring that these individuals be considered caretaker relatives in every state when acting as the primary caregiver to a child, this definition risks leaving out those who are raising children day to day in multiple states.

ZERO TO THREE is particularly concerned about the potential exclusion of "fictive kin" that care for young children involved in the child welfare system. Many state child welfare systems allow non-blood related adults who have a significant relationship with the child, such as godparents or close family friends, to take over primary care for the child, either through foster care placement or informal kinship care. These children are often in need of the most time-intensive, flexible support, making it that much harder—if not impossible—for these caregivers to meet the community engagement requirement. Further, as primary caregivers, fictive kin are unlikely to consider themselves "family caregivers."

ZERO TO THREE encourages CMS to require that all caregivers currently only included under the "caretaker relative" definition at state election, such as fictive kin and domestic partners, be included under the "caretaker relative" category in every state pursuant to the community engagement requirement. At minimum, **if this change is not made, we urge that any further guidance on family**

[17] U.S. Government Accountability Office. (2025). *Relatives raising children: Federal support helps, but challenges persist* (GAO Publication No. 26-107658). https://www.gao.gov/assets/890/883363.pdf

[18] See § 435.554(a): "(iv) At State option, another relative of the dependent child or disabled individual based on blood (including those of half-blood), adoption, or marriage; the domestic partner of the parent or other caretaker relative; or an adult with whom the dependent child or disabled individual is living and who assumes the primary responsibility for the dependent child or disabled individual's care. To the extent a State has elected to include any of these relationships for the purpose of eligibility for the group at § 435.110, the same elections shall apply for this definition for such State."

caregivers explicitly note that primary caregivers that states have not included under the "caretaker relative" definition would be considered family caregivers, and that this information be included in public educational materials.

VI. ALL PRIMARY CAREGIVERS SHOULD BE REFLECTED IN THE TRAVEL HARDSHIP EXCEPTION

The short-term hardship exception for individuals who themselves, or whose dependent, must travel outside of their community for medical services or for a serious or complex medical condition should similarly be expanded to reflect the full range of primary caregivers. As acknowledged elsewhere in the IFR, both custodial and non-custodial parents are essential to the regular, day-to-day care of a young child. Further, while parents and court-appointed guardians are frequently a child's primary caregiver, they are by no means the only such caregiver. As mentioned above, in 2023, about 2.4 million children in the United States were raised by grandparents, other relatives, or close family friends because their parents were unable to care for them.[19] The process of applying to become a foster parent (including kinship care) or guardian can take time, raising potential delays between when a relative or close family friend begin to care for a child and when they can be approved.

Accordingly, the exception's limitation of dependents to a minor child of the applicable individual who resides with the individual, a tax dependent of the individual, or an individual for whom the individual is a court-appointed guardian is overly restrictive. It will also require states to perform different analyses of primary caregiving for purposes of the caregiver exclusion and the travel hardship exception, complicating program administration. To simplify administration and ensure primary caregivers maintain Medicaid coverage while ensuring dependents receive needed care, **we urge CMS to apply the travel hardship exception to parents, guardians, and caretaker relatives of the dependent**, as those terms are defined for purposes of the caregiver exclusion.

VII. PREGNANT AND POSTPARTUM WOMEN MUST RECEIVE UNINTERRUPTED COVERAGE

A healthy baby relies on a healthy caregiver, including a healthy mother prior to and following birth. Medicaid, which covers over 4 in 10 births in the United States,[20] is a foundational program for maternal health. As stated in the IFR, adults enrolled may become pregnant, give birth, and experience the postpartum period while enrolled in the adult group. We appreciate CMS clarifying that a pregnant woman, as well as women receiving Medicaid under the mandatory postpartum period or 12-month extension, are excluded individuals. However, ensuring that pregnant and postpartum women do not experience a disruption in coverage will be challenging for states to implement.

Pregnant and postpartum women are likely to have particular challenges with evidentiary or administrative requirements, as they may be dealing with the demands of pregnancy or caring for a newborn, pregnancy or birth-related health challenges, or complications with the baby's health, such as premature birth or NICU stays. Accordingly, **ZERO TO THREE recommends that CMS reiterate to states that they must accept self-attestation of pregnancy and postpartum status beyond 2027, minimize**

[19] U.S. Government Accountability Office. (2025). *Relatives raising children: Federal support helps, but challenges persist* (GAO Publication No. 26-107658). https://www.gao.gov/assets/890/883363.pdf
[20] National Center for Health Statistics. (n.d.). *National vital statistics system: Birth data*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/nvss/births.htm

eligibility checks during the pregnancy and postpartum periods, and use administrative data to automatically transition enrollees who become pregnant into pregnancy-related enrollment pathways, consistent with recommendations issued by the Urban Institute.[21]

VIII. CONCLUSION

Caregivers of young children form the backbone of America's families and communities—ensuring that parents can work or attend to other community responsibilities, employers have a reliable workforce, and young children receive the stable, nurturing care they need for the strongest start in life. For many of these caregivers, Medicaid is a lifeline, without which they will be unable to continue providing the best possible care.

In recognition of the vital role of caregivers, the WFTC legislation established an exemption from the new community engagement requirement for both primary and supportive caregivers of children under the age of 13. ZERO TO THREE appreciates much of the IFR's implementation of that exclusion and related provisions, including the inclusion of parents who do not live with the child, multiple caregivers per child, a range of non-parental primary caregivers, and informal, unpaid child care providers. However, to fulfill the goals of the community engagement requirement and the intent of the exclusion, additional guidance, clarity, and changes to the IFR are urgently needed to ensure that states are able to effectively implement the exclusion and related exemptions and that eligible caregivers are not erroneously denied coverage.

ZERO TO THREE appreciates CMS's consideration of these recommendations.

[21] Haley, J. M. (2026, March). *Ensuring continuous coverage for pregnant and postpartum Medicaid enrollees under OBBBA*. Urban Institute. https://www.urban.org/sites/default/files/2026-03/Ensuring%20Continuous%20Coverage%20for%20Pregnant%20and%20Postpartum%20Medicaid%20Enrollees%20Under%20OBBBA_330.pdf