NATIONAL HEALTH COUNCIL

December 5, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Upcoming Guidance under Subtitle B, Chapter 1 of the One Big Beautiful Bill Act [PL 119–21]

Dear Administrator Oz:

The National Health Council (NHC) is writing to provide perspective in advance of the release of expected Medicaid guidance required by the budget reconciliation act of 2025 (H.R. 1). The community of people with disabilities and chronic diseases frequently faces the most disruption when policy changes shift how Americans access health care coverage. With that in mind, we urge the agency to leverage its authority in developing guidance and rulemaking to ensure appropriate protections exist, particularly for those with disabilities and chronic diseases and their caregivers.

Created by and for patient organizations more than 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of more than 180 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

Most recently, state Medicaid programs faced post-covid unwinding after the end of continuous enrollment requirements. Now, these same Medicaid programs face a relatively short timeline to implement work requirements, and other policy changes enacted in H.R. 1. Changes to Medicaid eligibility and enrollment will increase the administrative work that state programs must tackle, and the bureaucracy that patients must navigate. While technology will undoubtedly play an important role in implementing these requirements, the timeframe for developing and testing these systems is limited. Short timelines, when viewed in conjunction with large shifts in policy, elevate the importance of establishing the clearest standards and guidance possible for state Medicaid programs.

The NHC is committed to working with the agency to achieve our shared goal of assuring that Medicaid changes are implemented in a way that supports eligible people with disabilities and chronic diseases retaining health care coverage. As such, the NHC offers the following statements of support to CMS as the agency develops guidance and rulemaking.

State systems must minimize the potential for errors in adjudicating Medicaid eligibility.

Past experiences with states that have implemented work requirements suggest that some portion of eligible individuals will be at risk of losing coverage. This outcome also occurred during the post-covid unwinding. KFF's tracker of the unwinding reported that of those disenrolled, "nearly seven in ten (69%) were disenrolled for paperwork or procedural reasons while three in ten (31%) were determined ineligible."[1] The NHC urges the agency to work closely with states to minimize the potential for this problematic consequence. Across any and all sources of data validation, states and CMS should prioritize the outcome that eligible individuals are enrolled and stay enrolled in Medicaid. This could include, for example, use of technology and data to increase rates of *ex parte* renewals as well as income proxy assessments.

Guidance and rulemaking should allow the full extent of state flexibilities included in H.R. 1.

The law allows for state flexibility across an array of policies (e.g., optional exemptions, adherence to requirements in month(s) prior to application, etc.). States must be permitted to elect options for these flexibilities that allow states to manage their administrative efforts and minimize the loss of enrollment for those eligible for Medicaid.

Where possible, the agency should encourage states to allow self-attestation in new applications and renewals.

In guidance and rulemaking, the agency should clarify the full extent of opportunities for states to permit those applying for and renewing Medicaid coverage to attest regarding their compliance or exemptions. Federal Medicaid regulations (42 C.F.R. § 435.945(a)) generally permit states to allow attestation as a means of determining many of the application requirements for Medicaid.

Guidance and rulemaking should clearly and fully define who is exempt from community engagement requirements, minimizing administrative burden on states and individuals.

The law clearly establishes that certain groups of beneficiaries are exempt from requirements related to community engagement. Within the language of the law, however, the full extent of those exemptions is not consistently defined. In other words, the exemption references some undefined categories of individuals. While the Medicaid program must allow for considerable discretion for states to tailor the program for their unique needs, clear definitions of exemption-eligible groups of beneficiaries must be promulgated federally.

[1] KFF. (2025, November 18). Medicaid Enrollment and Unwinding Tracker. https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#8815e057-6ee9-4945-8ca1-705913d143b8

Exemption processes must be manageable and reasonable.

Patients and caregivers must not have an unreasonable administrative burden placed on them to prove they are in a category exempted from community engagement requirements. States should be encouraged to create processes that minimize time and paperwork that someone must invest in verifying their exemption. Without that guidance, eligible individuals could lose coverage just as they might under overly burdensome community engagement requirements. Complex and/or unreasonable exemption processes would, in essence, nullify the intended purpose of the exemptions. Additionally, exemption processes should be manageable for people with long-term or permanent conditions and disabilities to ensure they are not asked to repeatedly demonstrate that they qualify for an exemption. States also should be encouraged to create processes that enable people with episodic health conditions to qualify for exemptions.

Technical guidance must specify how to work with employers, schools and training centers, treatment programs, and nonprofit volunteer sponsors to partner with states and Medicaid recipients to provide compliance with community engagement requirements.

Successfully implementing new community engagement requirements will require substantial changes within Medicaid departments and collaboration with organizations that are not considered typical partners of the Medicaid program. The federal government has a responsibility to share information broadly with the employment, education, and non-profit community about these new requirements. While state Medicaid departments have been planning this implementation since the passage of the law, these new partners are likely unaware of the important role they will play in the validation of people's Medicaid community engagement requirements.

Ensure states provide the assistance that Medicaid beneficiaries will need to meet program requirements.

Any significant shift in eligibility and enrollment policy for a health care program, particularly one as impactful as Medicaid, requires an uptick of administrative work for program employees. CMS should encourage states to adopt every possible tool to engage the public, leveraging the lessons learned from post-covid unwinding. In addition to increasing staff support and call center capacity, other efforts could include maximizing information sharing across a variety of methodologies (e.g., mail, email, print media, electronic media, social media, text, etc.) and channels (e.g., CHCs, doctors' offices, pharmacies, Medicaid plans, etc.). Simplifying language and improving the readability of communications to the public is also critical to ensuring the public understands the upcoming changes. Additionally, CMS and the states must ensure that these communications are accessible for people with disabilities.

Finally, the NHC recommends the agency closely monitor implementation of state applications and renewals and respond to states that show inappropriate coverage losses.

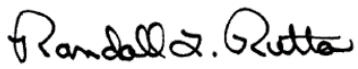
Specifically, the agency should continue to require states to submit data to its Medicaid and CHIP Eligibility and Enrollment Performance Indicators Data Dictionary and to

report those data results publicly in a timely manner. The agency should commit to working closely with and supporting states that experience higher than expected losses of coverage, particularly administrative issues rather than issues of non-compliance.

The NHC values the opportunity to engage with CMS on this important process and remains committed to working together to ensure that people with disabilities and chronic diseases have appropriate access to Medicaid coverage.

Thank you again for the opportunity to provide input to CMS in advance of this guidance. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs at kbeer@nhcouncil.org or Shion Chang, Senior Director, Policy & Regulatory Affairs at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
Chief Executive Officer

cc: Stephanie Carlton