THE PARTNERSHIP FOR MEDICAID

November 25, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Washington, DC 20201

RE: **Implementation Considerations of H.R.1's Medicaid Provisions from the Partnership for Medicaid and Meeting Request**

Administrator Oz:

On behalf of the Partnership for Medicaid, we write to share our requests and recommendations regarding the implementation of the One Big Beautiful Bill Act (OBBBA). In existence for twenty years, the Partnership for Medicaid is a nonpartisan, nationwide coalition of twenty-five organizations representing clinicians, health care providers, safety-net health plans, and counties. Our goal is to preserve and improve Medicaid.

Eligibility Determinations
Beginning in 2027, states will be required to redetermine the eligibility of Expansion enrollees every six months. As the Centers for Medicare and Medicaid Services (CMS) develops guidance to implement this section, we urge you to encourage states to use data matching as much as possible. By using trusted data sources, states and CMS can ensure that eligible enrollees whom Congress intended to remain covered are not inadvertently caught in paperwork errors. Data matching reduces burden on states and avoids costly disruptions in coverage for eligible enrollees.

Further, the statute specifically exempts individuals who are Indian and Urban Indian as defined in the Indian Health Care Improvement Act (IHCIA), California Indian as defined in Section 809(a) of the IHCIA, or who have otherwise been determined eligible as an Indian for the Indian Health Service as determined by the Secretary. Under this exemption, these individuals' eligibility redeterminations occur annually and not the 6-month cadence as required in the OBBBA. We urge CMS to reiterate this exclusion in its guidance to states. CMS should also consider using its discretion to except the other categories of individuals who are exempted from the community engagement requirement from the biyearly eligibility determinations.

Cost Sharing
Beginning in 2028, states will be required to collect cost sharing for health care services from Expansion enrollees with incomes over 100% of the Federal Poverty Level. The statute excludes certain services and locations, including primary care, mental health care, substance use disorder services, and services provided in a federally qualified health

center (FQHC), certified behavioral health clinic, or rural health clinic (RHC). We urge CMS to use its discretion to define primary care broadly to include non-pregnancy primary care services provided by an OB/GYN, preventive and diagnostic dental services, and other preventive and primary care services.

States should be provided maximum flexibility to comply with the letter of the law in a way that does not burden Medicaid participating providers. As the law allows states to implement cost shares as low as a penny for services, states should be allowed to assess provider compliance without undue burden on either the state or the provider through provider self-attestation of collection upon any necessary remittance or accounting of collected fees to the state.

Additionally, American Indian and Alaska Native people who receive care from Indian health programs continue to be exempt from the cost sharing requirements in the OBBBA. Under 42 U.S.C. § 1396o(j) "no cost sharing for items or services furnished to Indians through Indian health programs." Any guidance CMS releases on the OBBBA's cost sharing provision should include this information to ensure compliance with the law.

State Directed Payments

OBBBA placed limits on the total payment rate for state directed payments. CMS recently issued guidance[1] to assist states with implementation while it works on regulatory changes to comply with the law. In that guidance, CMS indicates that it plans to include facilities beyond the four services listed in the statute. We urge CMS to proceed with caution. State directed payments allow states to tailor payments to providers to mitigate low Medicaid base rates and supporting the health care system and maintaining access to care for millions of Medicaid enrollees. State directed payments help keep essential providers afloat, including rural hospitals, mental health care providers, hospital-based dental services, and other essential services.

We urge CMS to only place the limitations described in the statue. CMS should also collaborate with stakeholders to ensure that the new Medicare-level limits on state-directed payments are implemented in a manner that supports all services currently reimbursed under the Medicaid program. It is essential that implementation of this new policy recognizes that certain Medicaid-covered services lack a direct Medicare counterpart. This consideration is critical to preserving access to care for millions of Medicaid beneficiaries and ensuring the continued viability of Medicaid providers.

Provider Taxes

There are new provider tax requirements included in OBBBA, freezing existing provider taxes, placing restrictions on new provider taxes, and imposing new parameters under

[1] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf

which waivers of uniformity can be granted for provider tax structures. The new restrictions on provider taxes will require states to reconfigure how they finance their Medicaid programs. To prevent harmful impact to providers and the Medicaid enrollees they care for, it is important that the new provider tax requirements are implemented clearly and in a manner that is consistent with the statute. Regarding the new requirements for states to receive waivers of uniformity for certain provider taxes, these taxes may be deemed out of compliance upon enactment of the legislation. The law provides secretarial discretion in the timeframe states are permitted to bring non-compliant taxes into workable compliance. In doing so, states should be afforded not less than three years and timely technical assistance from CMS to align their taxes with statutory and regulatory intent.

We urge CMS to engage with stakeholders to inform guidance to states to ensure that implementation of the new requirements is clear and straightforward, to allow states to continue leveraging this financing mechanism while maintaining compliance with changing requirements.

Community Engagement Requirements

OBBBA requires states to implement community engagement requirements for Expansion enrollees to maintain their Medicaid coverage. It also includes several exemptions that received significant attention during committee hearings. Members of Congress frequently emphasized the exemptions throughout the debate of OBBBA. They described a vision for this legislation where the only enrollees who would lose coverage are those who are able to work but choose not to.[2]

To meet this vision, we urge CMS to require states to use data matching to the maximum extent possible to reduce burden on states and individuals and ensure that eligible enrollees remain covered. The statue specifically describes the use of ex parte verifications. To promote use of ex parte verifications, states should use data on earnings or enrollment in educational institutions from state databases. States should also use data matching to determine exemptions, including for disabled veterans, SNAP recipients, for families with dependent children under age 14, and American Indian and Alaska Native people. Also, states should be able to use their own claims data – and should be encouraged to accept Medicaid MCO's data – to collect information on medical conditions, disabilities, homelessness, pregnancy, participation in drug and alcohol programs (including outpatient programs), and any other conditions or attributes that provide an exemption from the community engagement requirement. Finally, stakeholders have indicated that data sharing between the Social Security Administration (SSA) and states can often entail a significant lag time, raising concerns that delays may pose a barrier to securing needed exemptions from community engagement requirements and negatively

[2] https://energycommerce.house.gov/posts/chairman-guthrie-op-ed-a-common-sense-budget-reconciliation-bill

impact enrollment. We ask that CMS work with the SSA to support timely data sharing with states, so they have the best information available to ensure that community engagement requirements function effectively.

While the statue allows states to conduct more frequent compliance verifications than enrollee's regularly scheduled redetermination, we strongly urge CMS to only approve states for more frequent verifications if they have a strong ex parte renewal system and are conducting the kind of data matching that we described above. More frequent verifications without such systems increases the chances that eligible enrollees, those described by Congress as not at risk of losing coverage, will fall through the cracks.

OBBBA allows states to be granted an extension on implementing community engagement requirements in the event that they need more time but make a good faith effort towards compliance. We ask that CMS grant these extensions for states as appropriate. Additional time will allow states to leverage workforce programs to support employment, reduce administrative burden, and ensure that eligible individuals can retain coverage.

Finally, CMS should encourage states to take the election allowed in OBBBA to not require an individual to verify information, meaning that states should allow enrollees to self-attest to their information, such as employment status, enrollment in school, role as a caregiver, or enrollment in a drug or alcohol program.

Eligibility and Enrollment Rule

OBBBA placed a moratorium on implementation of rulemaking completed by the previous Administration regarding eligibility and enrollment in Medicaid and Children's Health Insurance Program (CHIP). The impacted sections are detailed in the statute.[3] Several provisions had already taken effect and are not halted by the moratorium. These especially include the end of lifetime and annual limits, waiting periods for enrollment, the deduction of medical expenses to support continuous eligibility, and lockout periods in the CHIP. We urge you to maintain these and all provisions not halted by the statute. Additionally, we urge that states be provided latitude to continue with implementation of policies that would comply with other provisions of these rules where they are not in direct conflict with the newly enacted statute.

Thank you for your attention to these issues. For more information and to schedule a meeting with our coalition, please contact Paulo Pontemayor, Chair of the Partnership for Medicaid, at ppontemayor@chausa.org or 202-721-6339.

Sincerely,

[3] 42 CFR Sections 431.213(d), 435.222, 435.407, 435.907, 435.911(c), 435.912, 435.916, 435.919, 435.1200(b)(3)(i)-(v), 435.1200(e)(1)(ii), and 435.1200(h)(1).

American Academy of Pediatrics
America's Essential Hospitals
American College of Obstetricians & Gynecologists
American Dental Association
American Dental Education Association
American Network of Community Options and Resources (ANCOR)
Association for Community Affiliated Plans
Catholic Health Association of the United States
Easterseals, Inc.
The Jewish Federations of North American
LeadingAge
Medicaid Health Plans of America
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Council of Urban Indian Health
National Health Care for the Homeless Council