NATIONAL HEALTH COUNCIL

February 23, 2026

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

Dear Administrator Oz:

The National Health Council (NHC) is writing to offer additional perspectives to inform final guidance for implementation of the Medicaid community engagement requirements included in (Public Law 119-21, hereafter H.R. 1). This letter responds to CMS' request for additional specificity following our January 13, 2026, discussion with agency staff. 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 nearly 200 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.

The NHC's December 5, 2025, letter to CMS described overarching themes of our advocacy for additional agency guidance and rulemaking. Following that correspondence, we met with agency officials on January 13, 2026, to discuss opportunities for CMS and the NHC to partner on implementation and to minimize undue burden on patients. The NHC has worked closely with its members over the past five months to organize efforts across the patient community to ensure a common understanding of the new law and its implementation timeline as well as to align on and implement a set of shared actions aimed at protecting Medicaid access for patients and caregivers who qualify. At CMS' request, this letter provides additional policy positions, specific recommendations, relevant data, and supporting sources.

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

According to CMS enrollment data from October 2025, 39.2 million adults are enrolled in Medicaid nationwide. Approximately half of whom (about 20 million) are eligible through the Medicaid expansion under the ACA. Public Law 119-21 establishes new community engagement requirements for adults eligible through the Medicaid expansion group, while also creating statutory exemptions intended to protect individuals who face barriers to employment.

The law also establishes exemption categories, though some will require further clarification from CMS to support consistent interpretation and implementation. As an organization focused on patients and family caregivers, the NHC is particularly attentive to clear definitions and minimized administrative burdens related to the following categories: parents, guardians, caretaker relatives, or family caregivers of a disabled individual or of a dependent child under 14, and medically frail individuals or persons with special medical needs (to be defined by the Secretary).

For medically frail individuals or persons with special medical needs, the law requires the Secretary's definition to include individuals who:

- Are blind or disabled according to the Social Security criteria;
- Have a substance use disorder;
- Have a disabling mental disorder;
- Have a serious or complex medical condition; or
- Have a physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living (ADLs).

These statutory exemptions for people who are "medically frail" and family caregivers are intended to allow these populations continued access to Medicaid. However, the NHC is concerned that, in practice, people who should continue to qualify for Medicaid will not be able to do so due to lack of clarity, variations of definitions between states, and undue administrative burden to prove the exemption. Data from prior implementations of Medicaid work and reporting requirements, as well as states' experience during the Medicaid unwinding following the COVID 19 continuous coverage period, show that eligible individuals can lose coverage for procedural and administrative reasons rather than changes in eligibility[1]. To prevent wrongful coverage loss and ensure continuity of care, the NHC emphasize that CMS regulations must recognize the full breadth and variability of medical frailty and caregiver responsibilities.

Specifically:

- Promulgated regulations that define these exempted categories must recognize the law's five categories for the medically frail as floor, not a ceiling. Congress

[1] https://www.nejm.org/doi/full/10.1056/NEJMsr1901772?utm_source=chatgpt.com

indicated that the "medically frail" exemption "includ[es]" these categories; Congress clearly did not limit the exemption to those five categories.

- States must use plain language to describe exemptions to applicants and enrollees. Eligible individuals must be able to understand when an exemption applies to them across medical literacy levels and regardless of whether they consider themselves "medically frail."
- The regulations must clarify the potential for overlap between the five enumerated categories of medical frailty, and the definition of medical frailty must encompass the array of people with health or functional limitations that reasonably would not be subject to work requirements.
- In defining exemption criteria, state policies should recognize that some conditions may be serious but well managed, while others may be serious or complex and episodic. Individuals in either circumstance should not be excluded from qualifying for an exemption.
- Implementation of the exemptions for those who are medically frail or have special medical needs and those who are caregivers must not be tied to an individual attesting or otherwise showing their inability to work.
- The NHC is aligned with proposals by National Alliance on Mental Illness (NAMI) as follows:
    - "Federal and state policymakers must ensure that any definition of 'disabling mental disorder' they adopt accounts for several key features, which are discussed in greater detail below:
        - It cannot be limited to people who are considered or determined to have a mental disability;
        - It should include people who have a diagnosis but not be limited to people who do; and
        - It should recognize that mental health conditions are chronic health conditions that fluctuate in terms of severity and functional limitations, and it should strive to ensure that people with these disorders have access to the health care services they need to prevent their conditions from becoming more acute or making them unable to work.
    - To understand what "disabling mental disorder" means, it must be compared to the other exemptions included in H.R. 1 because this term was intentionally listed separately and therefore cannot have the same meaning as any other exemption."[2]
- The NHC is also aligned with proposals by the National Alliance for Caregiving regarding the definition of family caregivers:
    - "The rule should not adopt a narrower interpretation of 'family caregiver' than what H.R.1 provides through its reference to the RAISE Family Caregivers Act. The statutory language intentionally encompasses caregivers of individuals with chronic conditions, disabilities, or functional limitations."[3]
- In clarifying impairment to one or more ADLs, the regulation should reflect that significant impairment includes those who need reminders, assistance,

[2] https://www.nami.org/wp-content/uploads/2025/11/2025-Work-Reporting-Requirements-and-Mental-Health.pdf

[3] Not yet published; forthcoming

supervision, and/or cueing in performing an ADL. Further, we encourage the agency to include instrumental ADLs (IADLs), which are more complex activities necessary for functioning in community settings, such as managing finances, shopping, cooking, and using transportation, among others.

Finally, CMS must actively engage with states to ensure that any definitions and process states established in response to federal requirements and regulations do, in fact, meet or exceed the minimum standards established by the federal government. CMS should not permit states that had prior medical frailty standards to proceed with those requirements unaltered to meet the new federal standards, for example.

Exemption processes must be manageable and reasonable.

Of the approximately 20 million Medicaid expansion beneficiaries, many are likely working already and/or eligible for an exemption. Various surveys of expansion enrollees indicate substantial rates of substance use disorders, mental health disabilities, use of long-term supports and services (LTSS) or home and community-based services (HCBS), and caregiver responsibilities. New processes must appropriately identify those who meet exemption criteria. People could lose coverage they are eligible to receive if they don't understand which circumstances qualify them for an exemption and how to apply for it. Without effective processes, the most vulnerable patients and caregivers risk the loss of health care access, which would substantially worsen the health status of these individuals.

The law enumerates several mandatory exemption categories whose underlying eligibility is unlikely to change, including veterans with a total disability rating and members of the American Indian/Alaska Native population. Similarly, many, if not all, of the five specified groups of medically frail individuals or persons with special medical needs should be treated as permanently exempt. Thus, screening must be able to identify individuals with chronic or intermittent conditions that qualify as special medical needs, even when symptoms are not currently present. Once eligibility is established, individuals should not be required to repeatedly verify their health status, as many special health care needs are lifelong. States should limit ongoing reporting and documentation requirements accordingly.

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

Public Law 119-21 explicitly requires states to use reliable information, including data sources and coordination with appropriate agencies, to validate that applicants and beneficiaries meet community engagement requirements or an exemption without asking individuals to submit additional information, where possible. States must first leverage data sources, understanding the possible limitations of those sources, to determine if an individual has the income to be compliant with community engagement requirements or qualifies for an exemption of any kind. Claims data should be included as an early screening source to determine exemption status, but the absence of relevant claims should not connote the absence of a condition. Further, all data sources leveraged by Medicaid agencies for these processes must be also protected by relevant law, HIPAA or otherwise.

CMS must develop reporting criteria for states to track the implementation of these new requirements and the impact of this shift in policy; all data collected must be posted publicly and in a timely manner. Public access will allow researchers, advocates, and others to examine outcomes and the distribution of approvals by various means (e.g., case information, state data matching, paperwork), denials due to ineligibility and due to procedural/administrative issues. These data elements will also help researchers examine how work requirements influence Medicaid enrollment, employment, and outcomes for those who lost Medicaid because of the work requirement.

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

Building adequate systems to process exemptions and to identify those who are meeting community engagement standards requires precise targeting, clear and coherent processes, and minimal administrative burden for enrollees and applicants. This approach will also be critical for those who are not working but meet community engagement requirements, which will be difficult to validate through any traditional source of data. With membership composed of many organizations that work with volunteers, we advise CMS to encourage states to include the following types of community engagements to count towards monthly hours:

- Mentoring and peer support
- Participation in support groups
- Content creation and review (e.g., patient organizations ask patients to develop videos, tell their stories at events, review materials for usability)
- Advocacy (e.g., participation in a Hill Day, testimony)
- Managing or founding a volunteer-led organization (no matter what size).

The statute allows states to accept information showing a person qualifies for an exemption without further verification, which is both efficient and straightforward, whether the information is self-provided or through the ex parte process. States have long relied on beneficiary-provided information in various elements of applications and renewals. One example of self-attestation is the HHS-recommended process for the "medically frail" exemption for automatic enrollment in benchmark and benchmark-equivalent plans. Following the first year of implementation, self-attestation should be adopted as one of multiple standard pathways for collecting information during applications and renewals to reduce administrative burden and support continuity of coverage.

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

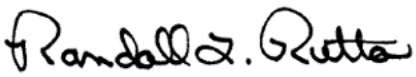
Successful implementation of these new requirements will stem from more than clear policies and new technology systems. States must leverage every possible communication channel with standard, easy-to-understand messages with calls to action that are relevant and memorable. Waiting until three months before implementation, as is required by law, will likely result in a population of Medicaid beneficiaries who are not informed about these large policy changes.

Further, any written notices and outreach materials that states send to beneficiaries and applicants must follow the principles of plain language and should also be subject to user testing to identify needed adjustments. Since many, if not most, Medicaid enrollees and new applicants engage with the internet through mobile phones, state websites, applications, and outreach tools that are online must be built with mobile capabilities. Finally, the federal government should ensure that all possible sources of one-on-one assistance—such as 1-800-Medicare, the Social Security Administration, Navigators, and SHIPs—must have accurate information and resources to be able to appropriately point individuals in need of assistance to the correct resources in their states.

The NHC values the opportunity to continue engaging with CMS and remains committed to partnering to ensure that community engagement requirements are implemented without wrongful coverage loss and with appropriate protections for people with disabilities, chronic diseases and their caregivers.

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, Deputy Administrator and Chief of Staff, Centers for Medicare and Medicaid Services
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