

September 30, 2025

Administrator Mehmet Oz, M.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Implementation Considerations for the Working Families Tax Cuts Act (Public Law 119-21, also known as the One Big Beautiful Bill Act) – Follow-up to MHPA/CMCS Quarterly Call on August 21st

Dear Administrator Oz:

On behalf of the Medicaid Health Plans of America (MHPA), we appreciate your leadership and commitment to stakeholder engagement at the Centers for Medicare & Medicaid Services (CMS). On August 21st, MHPA convened with staff from the Center for Medicaid and CHIP Services (CMCS) to discuss Medicaid priorities under the Trump Administration and to convey our considerations as CMCS moves towards implementation of Medicaid-related provisions from the **Working Families Tax Cuts Act (Public Law 119-21, also known as the One Big Beautiful Bill Act)**, and referred to in this letter as **OBBBA**). In this letter we seek to memorialize those considerations to facilitate CMS' compilation of stakeholder feedback. MHPA and its member managed care organizations (MCOs) stand ready to partner with CMS, states, and providers during the implementation of OBBBA while continuing to deliver high-quality services to Medicaid enrollees.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 160 MCOs serving nearly 51 million Medicaid enrollees in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid enrollees receive health care through MCOs, and MHPA provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid enrollees.

Below are MHPA's considerations for the implementation of Medicaid-related provisions of OBBBA.

Community Engagement Requirements

MCOs are uniquely positioned to collaborate with states and CMS to support the implementation of community engagement requirements. As discussed in our recent

meeting with CMCS, MHPA has several considerations regarding operationalizing this provision of OBBBA.

We understand that OBBBA restricts MCOs from serving as the compliance entity for community engagement requirements. However, we believe MCOs can serve as an important resource for enrollees, including through outreach and education, to ensure that eligible individuals who are compliant with community engagement requirements continue receiving Medicaid benefits.

In support of maintaining eligible coverage, as states resumed Medicaid redeterminations during the unwinding of the COVID-19 Public Health Emergency (PHE), MCOs served as key state partners reaching and educating Medicaid enrollees through multiple modalities, enabled by temporary relief from Telephone Consumer Protection Act (TCPA) restrictions. Our member plans found that TCPA flexibilities led to higher call connection rates, email open rates, and text received rates than outreach prior to redeterminations. We believe MCOs continue to be well-positioned to leverage these best practices to support states in the implementation of community engagement requirements.

Therefore, we request clear guidance on the role that MCOs can play in this process, outlining permissible ways MCOs can support states and beneficiaries. We also request guidance that the TCPA flexibilities can be utilized, and that MCOs specifically are permitted to conduct text outreach to beneficiaries. This clarity would ensure that plans are not unnecessarily constrained in supporting states and enrollees through this transition.

OBBBA provides exceptions for individuals who are medically frail or otherwise have special medical needs (as defined by the Secretary), including an individual with substance use disorder (SUD) and individuals participating in a drug addiction or alcoholic treatment and rehabilitation program. We recommend that CMS work closely with states, plans, and other stakeholders to ensure clear and consistent definitions in this category to support implementation. Creating standardized definitions would create state alignment and drive efficiencies and would streamline processes for multi-state MCOs who operate in multiple markets. Additionally, we seek guidance from CMS on best practices for relevant stakeholders, including states, plans, and providers, to share SUD patient data while remaining compliant with patient privacy protections which are heightened for that condition. Standard practices and a toolkit would help stakeholders navigate this process while preserving the legal rights of enrollees.

Since self-attestations as a compliance mechanism for community engagement requirements are not prohibited by OBBBA, we also encourage CMS to explicitly include and permit self-attestations as a tool for states to leverage when determining compliance with community engagement requirements. Work requirements for the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) allow for self-attestation to be used in certain circumstances and can be similarly leveraged here

while allowing for subsequent third-party documentation and data matching to confirm compliance.

To streamline the compliance process for states and enrollees, we recommend CMS empower states to align reporting requirements with program eligibility determinations, using electronic data sources to validate when possible. We suggest that CMS explicitly allows a broad base of activities to count toward employment, education, or volunteering. To minimize administrative burden, CMS can require states to include which members will need to verify activities and when in 834 files shared with MCOs. Technical assistance to states in leveraging current data sources to verify eligibility, specifically for income verification, would be helpful as well.

Finally, as noted in our comment letter on the [Draft 2025-2026 Medicaid Managed Care Rate Development Guide](#), several factors are contributing to a unique environment creating significant rate pressures for states and health plans. Factors include unpredictable trends, program design changes, prescription drug policies, economic pressures relating to tariffs, and regulatory pressures. The applicability of enhanced eligibility requirements for the expansion population including the community engagement requirements will likely result in a decrease in enrolled beneficiaries and a significant shift in the acuity and complexity of remaining enrolled beneficiaries (traditional Medicaid and expansion beneficiaries meeting exemption requirements). Learning from the experience during the redeterminations unwinding, we anticipate that rate setting during this time will be difficult. It is imperative that we maintain prospective rate setting processes, but establish protocols and expectations to review rate assumptions, experience and risk adjustment at least quarterly to ensure stability in the program.

Eligibility Redeterminations

The provision of OBBBA requiring states to conduct eligibility determinations twice a year instead of annually for expansion enrollees will likely contribute to bandwidth constraints for states. We are concerned that counties in states with a strong county role in administering Medicaid will also face bandwidth constraints in processing eligibility determinations more frequently.

Technical assistance from CMS would be helpful to support states and counties in standing up these systems (including information technology systems), as well as how states can benefit from the existing administrative match available to help them develop and maintain infrastructure relating to eligibility.

Cost-sharing

We have several considerations relating to the cost-sharing provision of OBBBA. As CMS develops guidance on the implementation of this provision, we seek clarity on how the 5% income cap will be calculated and how MCOs will be made aware that an enrollee has

reached their 5% cap on cost-sharing. This is especially pertinent for states with bifurcated systems such as when pharmacy, behavioral health, or long-term services and supports (LTSS) are carved out and administered through a separate MCO or fee-for-service (FFS). Clear guidance is needed to help states, providers, and MCOs understand how the cap will be calculated and how MCOs and providers will be made aware of enrollee cap status.

In addition, we seek clarity on how the cost sharing and cap will work in conjunction with the provision to check eligibility every six months. Some enrollees will only be enrolled for a portion of the year due to the more frequent redeterminations. We ask CMS to provide guidance on the cost-sharing limits for individuals who are enrolled in Medicaid for less than a year or who leave the program and re-enroll. We recommend that CMS work with states that either currently or previously had cost-sharing requirements to obtain best practices for implementation.

We thank CMS for considering our feedback as we approach the effective dates for OBBBA's provisions. We look forward to continuing to collaborate with CMS, states, and providers to deliver on the vision for the Medicaid program while continuing to provide high-quality care for Medicaid enrollees.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Senior Vice President, Government Relations, Policy and Advocacy