Department of Human Services
222 South Warren Street
P.O. Box 700
Trenton, NJ 08608

Date: October 14th, 2025, *Sent via email*

**Re: Advocate Recommendations for H.R. 1 Implementation**

Dear Commissioner Sarah Adelman, Assistant Commissioner Greg Woods, Deputy Commissioner Valerie Mielke, and Acting Commissioner Jeff Brown,

The **Garden State Coalition for Care** comprises advocates on behalf of aging, disability, and low-income communities, including children, who are committed to advancing policies that ensure all New Jersey residents can live with dignity and independence in the community of their choice. Our members bring deep expertise in Medicaid, Medicare, and long-term services and supports, as well as direct connections to the older adults, people with disabilities, and caregivers most affected by H.R. 1. Together, our work aims to promote equity, protect access to care, and strengthen the programs that support New Jerseyans throughout the lifespan as they age.

Although many older adults and people with disabilities are formally "carved out" of work requirements and additional eligibility verifications, our coalition remains deeply concerned about their impact. Many older adults ages 50 to 64 and individuals with disabilities are enrolled in the Medicaid expansion population, and now will be subject to these new requirements.[1] Likewise, many caregivers who support older adults and people with disabilities are also in this group. We are further concerned that, given system strain and confusion, populations that should be exempt could still lose coverage inadvertently.

[1] Notably, 2/3 of people with disabilities enrolled in Medicaid do not receive SSI. See KFF, *5 Key Facts About Medicaid Coverage for People with Disabilities.* February 2025.

Given the labor-intensive nature of work requirements and eligibility verifications, and the potential harm these provisions could cause for older adults, people with disabilities, and other Medicaid recipients, this letter focuses primarily on those two provisions of H.R. 1. We prioritize these provisions of the law, in part, because implementation will require both legislative and non-legislative actions on behalf of the state, and therefore, we would like our recommendations to be considered as part of state agency submissions in response to Governor Murphy's Executive Order #393.[2] We also include recommendations related to the state's engagement with the Rural Health Transformation Program, as the application is currently open and the deadline is imminent.

Our coalition greatly appreciates the care and attention you are giving to these complex issues, as well as the thoughtful stakeholder engagement reflected in the quarterly MAAC meetings. **To complement those important discussions, we request the following: 1) To meet with DOH before the state's submission of its Rural Health Transformation Program application and DMAHS before its submission of non-legislative recommendations pursuant to EO #393; and 2) Ongoing bimonthly meetings with DMAHS to discuss the state's implementation of H.R. 1.**

**Background and Rationale**

Georgetown University's McCourt School of Public Policy recently analyzed CMS data to assess state preparedness to implement H.R. 1, with a focus on Medicaid work requirements. Their analysis shows, based on January–March 2025 data, that New Jersey ranks poorly on key readiness metrics, raising serious concerns about the state's capacity to implement labor-intensive requirements, such as work requirements and additional eligibility verifications, without harming enrollees. On a scale of one to seven "red flags," where more flags indicate lower readiness, New Jersey received five flags.[3]

The data highlight several troubling weaknesses: more than one in four applications (26.3%) take longer than 30 days to process; the state's overall renewal rate is only 49.7% compared to the national median of 75.9%, indicating that less than half of those who had a renewal due retained coverage; ex parte renewals, where eligibility is verified using available data without burdening enrollees, occurred in less than one-third of cases;[4] and over 30% of renewals were still pending at the end of the month, reflecting system backlogs.[5] As a result of these system shortcomings, one in five New Jersey Medicaid members loses coverage during renewal processes, with more than 70% of those losses due to procedural reasons rather than ineligibility.[6]

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[2] Governor Phil Murphy, Governor Murphy Signs Executive Order Directing New Jersey State Agencies to Review Impacts of the One Big Beautiful Bill Act, July 2025.

[3] Georgetown University McCourt School of Public Policy, *Are States Ready to Implement HR 1 and Medicaid Work Reporting Requirements?*, September 2025.

[4] We acknowledge that in the last year, progress has been made regarding ex parte renewals, for example, regarding CSSAs and Conduit. We look forward to learning more about the state's efforts in this area.

[5] Ibid.

[6] Ibid.

These findings underscore the urgent need for the state to adopt policies that strengthen administrative capacity, reduce churn, and protect coverage continuity. We also acknowledge that the current system strain stems, in part, from staffing shortages and funding constraints; our coalition aims to holistically partner with DMAHS to reduce barriers to care through a combination of administrative and legislative advocacy, as well as public education.

## Rural Health Transformation Program Application Recommendations

**Include HCBS Providers in the State's Application and Spending Plans**

As you are aware, the application for the Rural Health Transformation Program opened on September 15 and will close on November 5. Given the short timeline and the state's ongoing discussions about how to apply and allocate this funding, our coalition urges New Jersey to include investments in home and community-based services (HCBS) providers within its application and spending plans. We suggest the state engage in specific, targeted outreach to determine how these providers can meet the requirements of this provision of the law. HCBS providers were already operating on very tight margins before H.R. 1; an investment in these providers, via the Rural Health Transformation Program, would enable better access to home and community-based care for older adults and people with disabilities, while strengthening the overall provider network that New Jersey residents depend on.

**Expand Rural Investments to Include Supportive Services Bridge Funding**

In addition to supporting HCBS providers, we urge DMAHS to include supportive services bridge funding in its Rural Health Transformation Program application. This funding would help cover gaps in service delivery caused by Medicaid disenrollment or delays in eligibility processing, particularly for rural residents with behavioral health needs, substance use disorders, or housing instability. States like Minnesota and Nevada have successfully implemented such funding to maintain continuity of care during coverage lapses. Given New Jersey's high rate of procedural disenrollments, this investment would advance continuity of care and reduce reliance on crisis services.

**Invest in Technology Solutions for Rural Supportive Housing**

We also recommend that DMAHS allocate Rural Health Transformation Program funds toward technology infrastructure in supportive housing settings. Telehealth, remote health monitoring, and digital health interventions have proven effective in expanding access to care for individuals with substance use disorders and co-occurring conditions. These tools are especially critical in rural areas where provider shortages and broadband limitations persist. Providing equipment such as tablets, mobile hotspots, and medication dispensers can significantly improve engagement with treatment and support services.

## Proactively Engage with CMS to Inform Operationalization of Work Requirements

While awaiting federal guidance, we strongly encourage DMAHS to proactively engage with CMS to help shape the implementation of work requirements. New Jersey should have the authority to implement the law in ways that minimize harm, both to apply exemptions broadly and design processes that reduce barriers to coverage. To achieve this, it is critical that DMAHS engage CMS now, before guidance is finalized. CMS staff have indicated that interim guidance may be released before the end of the year and that they are seeking state input on implementation. Acting quickly will put New Jersey in the best position to influence CMS's decisions and safeguard as many individuals as possible.

### Take a Broad View of Disability-Based Exemptions

- Use language that resonates with applicants to describe and screen for these exemptions. Many people who meet the exemption criteria may not view themselves as a "caregiver" or a "person with a disability." Testing descriptive language with enrollees, before release, is critical to ensure clarity and resonance.
    - By way of example, Section 1 of the NJ FamilyCare ABD application includes the question: "Does the applicant need 'nursing home-like' services...?" Although intended as a screening question for MLTSS, applicants often interpret this question to mean, "Do you want to live in a nursing home?" As a result, individuals who need LTSS but do not wish to live in a nursing facility may incorrectly answer "no," and unintentionally opt out of MLTSS screening. Testing application language with enrollees and allowing stakeholders to review the language before broad release would help ensure clearer screening questions.
- Incorporate standards like the RAISE Family Caregiver disability definition for the "medically frail" exemption.
- Consider IADLs (instrumental activities of daily living) as well as ADLs in terms of functional limitations that qualify.
- Incorporate the ADA definition of disability (significant limitation of a major life activity).

### Apply "Special Medical Needs" and "Serious or Complex Health Condition" Exemptions Broadly

- Lists of conditions should be illustrative and not definitive and should be clearly communicated to applicants, including, at a minimum:[7]
    - HIV or antiretroviral therapy;
    - Diabetes requiring insulin, GLP-1, or other similar medication; and
    - Cancer diagnoses receiving treatment of any kind.

### Make Exemptions as Automatic as Possible

[7] These suggestions expand beyond those specified in the law.

- Automatically exempt Medicaid expansion participants receiving state plan personal care services, self-directed services, DD Supports Program services, and DD Community Care Program services (qualifying as disabled/medically frail).
- Automatically exempt anyone who reports a disability as defined broadly, as noted in the discussion above.
- Automatically exempt HCBS caregivers using existing data on caregiving hours.
- Automatically exempt any individual with IDD who has been found eligible for services through DDD, including youth between the ages of 18 and 21.
- Automatically exempt any individual on the Medicaid Workability program, as they have already demonstrated disability to qualify and are working.
- Allow the longest reasonable period before requiring renewal of exemptions and make those renewals automatic, with the understanding that some conditions are permanent, such as developmental disabilities, and should not require subsequent reverification.

**Enable Use of Self-Attestation**

- When manual reporting is unavoidable, allow use of self-attestation, with reporting required only at application and renewal.

## Maximize Ex Parte Verification to Reduce Burden and Coverage Loss

New Jersey's current use of ex parte renewals is among the lowest in the nation, averaging less than one-third of the time (32.7%).[8] Expanding ex parte verification is critical: leveraging data to automatically verify both work requirement exemptions and community engagement compliance would significantly reduce staff burden and minimize enrollee coverage loss for procedural reasons. To the greatest extent possible, New Jersey should adopt processes to auto-verify all work requirement exemptions and compliance, as well as eligibility verifications.

To achieve this, DMAHS should consider the following actions:

**Strengthen Systems and Data Infrastructure**

- Conduct a high-level review of operational and IT systems, specifically Medicaid Eligibility Systems, NJMMIS, Integrated Eligibility System, and Benepath, to identify current program capacity.
    - Assess existing data availability, identify gaps, and fix gaps preventing ex parte verification.
- Explore ways to improve integration between data systems, eligibility determination entities (e.g. CSSAs), third-party vendors (e.g., Conduit), divisions, and state departments.[9] New Jersey can receive the enhanced 90% federal match for these efforts.
- Refine and streamline current data sources and add new data sources as needed.

[8] Ibid.
[9] CHCS, *Strengthening Cross-Agency Collaboration Across Medicaid and Other State Partners to Support Work Requirements Implementation,* September 2025.

**Improve Coordination to Reduce Enrollee Reporting Burden**

- Define information-sharing protocols across state and county agencies and programs to reduce enrollee reporting burdens.[10]
- Collaborate with managed care organizations (MCOs), providers, and third-party sources to identify innovative ways to ease administrative requirements for older adults, individuals with disabilities, mental health or substance use disorders, and those who are medically frail.
    - For example, use MCO, provider, and Support Coordination data to reduce the need for participants to submit verification.
- Leverage commercial and third-party databases to automatically determine community engagement compliance or exemptions and verify employment, volunteer hours, community college, and other qualifying activities.
- Engage community-based organizations (CBOs), such as statewide advocacy organizations, university programs, and other system partners in education, outreach, and verification assistance.

**Expand Support for Medicaid Eligibility Navigation in Rural Communities**

To reduce administrative burden and prevent coverage loss, we recommend that DMAHS expand the use of Application Assisters (navigators trained and certified by GetCoveredNJ) in rural communities. These trained professionals can help residents navigate complex eligibility and reporting requirements, particularly in areas with limited access to transportation, technology, or consistent communication channels. Application Assisters are especially critical for reaching older adults, individuals with disabilities, caregivers, and those experiencing homelessness, all of whom face heightened barriers to maintaining coverage under H.R. 1.

Additionally, we urge DMAHS to provide capacity-building grants to community-based organizations, including those that provide legal assistance and homeless service providers. These entities are often the first point of contact for individuals at risk of losing coverage and are well-positioned to offer hands-on assistance with Medicaid enrollment and renewal. Supporting their infrastructure and staffing will help ensure that New Jerseyans receive the support they need to maintain access to care.

## Leverage Existing Federal Authorities to Reduce Burden

DMAHS should maximize use of federal flexibilities to minimize reporting burdens:

- Apply public health unwinding strategies, such as the zero-net income and 100% FPL ex parte strategies, for both MAGI and non-MAGI populations.
- Use §1902(e)(14)(A) authority to eliminate annual eligibility verifications for non-MAGI populations; given this population's limited fluctuations in income and assets, this

[10] From conversations with DMAHS, we have learned that when an ex parte renewal cannot be completed, three application types are sent to members (MAGI, ABD, and a special application for people on MAGI turning 65 and/or becoming eligible for Medicare). We are interested in learning more about the state's process to enable online renewals, including any identified access disparities.

flexibility will reduce coverage loss and free up state resources to implement other administratively intense components of H.R. 1.

- Many people with disabilities are enrolled in Medicaid expansion. With the Medicaid expansion population now subject to work requirements as well as increased cost sharing, screening for eligibility under other categories, such as ABD, may be better suited to help them maintain their coverage. For example, approximately 1,000 individuals with IDD in New Jersey are on MAGI, of which 600 receive services through a DDD waiver program. DMAHS should therefore proactively identify Medicaid expansion enrollees who may qualify under other categories by using claims and diagnosis data.
- H.R. 1 postponed mandatory implementation of certain HHS "eligibility and enrollment" rules, while leaving others in place.[11] With regard to the mandatory provisions of those regulations still in effect, New Jersey (a group payer state) must auto-enroll individuals who are both (1) enrolled in SSI-based Medicaid (e.g., Medicaid Only) and (2) enrolled in premium-free Medicare Part A into QMB.
- Additionally, New Jersey can, and should, pursue non-mandatory eligibility and enrollment streamlining and coordination strategies for all participants, including but not limited to:
    - Allowing individuals a minimum of 15 calendar days to respond to requests for additional information (and 30 calendar days for MSP recipients);
    - Providing enrollees with a minimum of 30 calendar days to respond to requests for information or return a renewal form, with the 30 days beginning from the date the state sends the form (either when it is postmarked or sent electronically); and
    - Providing that if an enrollee's eligibility cannot be renewed based on information already available to the state, then DMAHS will provide a pre-populated renewal form containing information already available to the state.

## Ensure Accessible and Timely Manual Reporting

When ex parte verification is not possible, manual reporting must be simple, accessible, and timely to help eligible individuals retain benefits and reduce churn.

### Simplify and Modernize Reporting Methods

DMAHS should apply lessons learned from the public health unwinding process to both community engagement requirements and additional eligibility verifications by:

- Developing simplified reporting forms.
- Offering multiple submission methods, including:
    - Text message replies;
    - One-click buttons in texts or emails;
    - QR codes; and
    - Other secure electronic methods.

[11] KFF, *The Impact of H.R. 1 on Two Medicaid Eligibility Rules.* September 2025.

- Testing all reporting options with a subset of members and disability and aging advocates before launch to ensure accessibility and intended impact.

**Strengthen Timely Processing of Information**

System strain is already evident, with over one-quarter of applications taking longer than 30 days to process and nearly one-third pending at month's end.[12] Slow application processing times are particularly concerning, given the law's restrictions on retroactive coverage periods and, consequently, reduced consumer protection from medical debt and reduced provider coverage due to reimbursement concerns, necessitating the need to process applications timely.

To prevent coverage disruptions:

- Ensure that submitted information is processed promptly.
- Ensure accountability in the enrollee verification process by accurately tracking enrollee-submitted paperwork.
- Prioritize timely determinations to avoid delays in access to services.

**Prevent Erroneous Verification Requests for Exempt Populations**

- Safeguards must be in place to ensure that populations not subject to work requirements or additional eligibility verifications, such as the ABD population, do not incorrectly receive requests for verification.

## Build Transparent and Accountable Data Systems

Robust data collection and public reporting are essential to track the impact of H.R. 1 implementation, resolve problems quickly, and minimize harm to participants.

**Track Denials and Disenrollments in Real Time**

- Document all denials and disenrollments, including procedural terminations, in real time.
- Ensure data can be sorted by age, race/ethnicity, primary language, and geographic region to identify disparities.
- Record the specific reason for denial or termination to distinguish between failures to meet new Medicaid reporting requirements and other procedural causes.
- Consider system changes needed to process applications transferred from the federal Marketplace, which currently does not collect comprehensive exemption information.

**Develop a Public-Facing Dashboard**

- Post data on a timely, publicly accessible dashboard to increase transparency and accountability.

[12] Georgetown University McCourt School of Public Policy, *Are States Ready to Implement HR 1 and Medicaid Work Reporting Requirements?*, September 2025.

- Mirror Missouri's public dashboard, which includes the following H.R. 1-related content:[13]
    - Participant resources;
    - Stakeholder and partner resources;
    - Data and reports; and
    - News and updates.

## Ensure Clear and Accessible Communication

Successful implementation of H.R. 1 will depend on clear, timely, and accessible communication with a broad array of stakeholders in New Jersey, including enrollees, advocates, providers, direct care workers, and the community organizations that support these communities.

### Develop a Comprehensive Communication Strategy

- Partner with trusted community-based organizations to deliver culturally and linguistically appropriate outreach.
- Provide robust provider education to ensure these entities provide accurate information about the law's content.
- Provide information well in advance of any H.R. 1-related terminations or reductions so participants have time to understand and respond.
- Establish and maintain a well-staffed hotline dedicated to answering questions and concerns related to H.R. 1 implementation.

### Revise and Strengthen Participant Notices

- Update notices to clearly outline:
    - New obligations under H.R. 1 specific to MAGI and non-MAGI groups.
- Clarify that due to New Jersey's minimum wage, community engagement requirements based on the 80-hour federal minimum wage ($7.25/hour) translate to fewer than half as many hours in New Jersey.
    - 80 hours x ($7.25/hour for federal minimum wage) = 39 hours x ($15/hour minimum wage in New Jersey)
- Reaffirm that all individuals retain due process protections, including written notice before termination and the right to appeal adverse actions.
    - New Jersey should voluntarily adopt §435.907 and §435.916, which provide a 90-day reconsideration period if coverage was terminated or denied for failure to provide information.
    - Maintain the PHE unwinding practice of allowing individuals who were terminated within 60 days to request a fair hearing and continuation of benefits.

### Engage Stakeholders in Notice Development

[13] Missouri Department of Social Services, "H.R. 1 Implementation Hub."

- Conduct targeted outreach to older adults, people with disabilities, people with limited English proficiency, and disability and aging advocacy groups, to ensure accessibility and intended resonance of all consumer outreach materials related to H.R. 1.

## Pursue Federal Extensions to Protect Beneficiaries

The law authorizes HHS to grant extensions to states that demonstrate good-faith efforts to comply with community engagement requirements. Given New Jersey's existing system limitations, DMAHS should proactively pursue such an extension. Doing so would allow the state additional time to refine systems, strengthen data infrastructure, and reduce the likelihood of coverage disruptions.

## Conclusion

We look forward to the opportunity to discuss these recommendations with you in the near future. We greatly appreciate your thoughtful consideration of our suggestions and the care you are giving to these critical issues. Moving forward, the Garden State Coalition for Care hopes to support DMAHS throughout its efforts to implement H.R. 1, working together to minimize harm, protect coverage, and strengthen New Jersey's Medicaid program.

Thank you for your time and consideration. For more details on the contents of this letter, please contact Gwen Orlowski, Executive Director of Disability Rights New Jersey, gorlowski@disabilityrightsnj.org, and Hannah Diamond, Senior Policy Advocate at Justice in Aging, hdiamond@justiceinaging.org.

Sincerely,

**AARP NJ**

**Advocates for Children New Jersey**

**Alliance for the Betterment of Citizens with Disabilities**

**Community Health Law Project**

**Collaborative Support Programs of New Jersey**

**CSH**

**Disability Rights New Jersey**

**Fair Share Support Services, Inc.**

**Grotta Fund for Older Adults**

**Housing and Community Development Network of New Jersey**

**Justice In Aging**

**Mental Health Association in New Jersey**

**New Jersey National Academy of Elder Law Attorneys (NJ NAELA)**

**NJACP**

**NJ Long Term Care Ombudsman's Office**

**Partners for Health Foundation**

**PennReach**

**Planned Lifetime Assistance Network of New Jersey**

**SPAN Parent Advocacy Network**

**SOMA Two Towns For All Ages**

**Supportive Housing Association of New Jersey**

**The Arc of NJ**

**The Boggs Center on Disability and Human Development**

**The Waterfront Project**