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Illinois Department of Healthcare and Family Services

*Sent Via Electronic Mail Only*

**Re: H.R. 1 Implementation Timelines**

Dear Director Whitehorn,

Protect Our Care Illinois (POCIL) appreciates the ongoing efforts by the Illinois Department of Healthcare and Family Services (HFS), the Illinois Department of Human Services (IDHS), and the Governor's Office to implement the budget reconciliation act of 2025 (H.R. 1) in a manner that prioritizes the health and wellbeing of all Illinoisans. We appreciate the transparent, stakeholder-focused communications and the thoughtful implementation process that is well underway.

We are part of a national campaign to ensure that the federal Centers for Medicare and Medicaid Services (CMS) grapple with how difficult it is for states to meet the drastic timelines that H.R. 1 demands. We are urging CMS to commit to providing good faith extensions in compliance with H.R. 1's statutory language.

We are truly grateful for the Herculean efforts from states like Illinois, but worry that Sisyphus might be a more apt mythological analogy: we as advocates are concerned that CMS will force states to proceed with a buggy, barebones, mistake-prone 'minimum viable product,' which will have devastating consequences for the people impacted by these systems. People will attempt to refill prescriptions or attend a doctor's appointment and realize they've been wrongly terminated. We know that Illinois would prefer to launch work requirements as part of a timely, accurate, equitable, and optimized system, but H.R. 1 appears designed so states will not be able to achieve this, given the time it takes to produce work up to those standards.

We are also closely watching Nebraska, an early adopter, and are seeing the significant bumps that H.R. 1's expedited deadlines cause. We are concerned that CMS's public statements indicate that good faith waivers may be illusory, and that states will be dissuaded from seeking the good faith extensions that Congress contemplated. CMS has—without having reviewed a single application for such exemption and while simultaneously admitting that work requirement implementation “is a significant undertaking for states that will require policy, operational, and system changes”—determined that the criteria used to evaluate the compliance extension will be limited to those states that “experience severe and/or unexpected issues that hinder progress.”<sup>1</sup>

We are committed to supporting our state, where the Governor, HFS, and IDHS, have prioritized ensuring eligible people can maintain their benefits and that the process be as transparent and workable as is feasible. We understand the uncomfortable federal environment regarding the extension and we also appreciate that HFS is preparing to implement H.R. 1 in good faith. If the timeline proves too much to reasonably meet, we respectfully ask the state to request an extension. We will lend our voice on the national stage and in every audience we have available to ensure that Illinois and other states are not unfairly denied the extensions offered in H.R. 1.

We are grateful that HFS is looking at improvements in CY2027 as well, but we hope these improvements are not mutually exclusive with your decision to request an extension if system constraints make an accurate, equitable rollout unachievable. H.R. 1 demands that states substantially reconfigure their Medicaid programs to meet an exceptionally compressed federal timeline. POCIL advocates expect that we share HFS's concern that designing, coding, testing, and otherwise achieving operational readiness by January 1, 2027 includes substantial risk.

We enthusiastically support the planning and process HFS is engaging in to meet these difficult deadlines to fully implement H.R. 1, including but not limited to:

1. Pursuing ex parte confirmation of work-requirement compliance and coordinating with IDHS and advocates to apply lessons from the SNAP rollout.
2. Executing new data-sharing agreements between state agencies, Medicaid health plans, providers, human services organizations, and others, to use verifiable data to maximize ex parte approvals.

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<sup>1</sup> CMCS Informational Bulletin, Section 71119 of the ‘Working Families Tax Cut’ Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals” (Dec. 8, 2025), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf>.

3. Considering the use of screeners for 'medically frail' and other exemptions, and exploring use of diagnostic codes and self-attestation where appropriate to facilitate exemptions ex parte and limit coverage disruption.
4. Designing comprehensive training, including toolkits for partners, about the changes, modeled on the state's stellar PHE unwinding performance.
5. Planning broad outreach communications with language access at front of mind, coordinating with trusted partners and navigators prior to launch.
6. Evaluating the use of dedicated resolution channels for advocates to resolve administrative issues quickly.
7. Engaging in efforts to meaningfully reduce application and redetermination processing delays.

However, we are concerned that this work cannot be effectively completed in the amount of time states have been given under H.R. 1. We are concerned that the whole system is at risk, despite HFS, IDHS, DOIT, and other state agencies working as hard as they possibly can.

We are particularly concerned about the following:

1. **Compressed schedule:** The January 1, 2027 effective date is too tight and will make it difficult to design these systems, execute and user-test them, and prepare clear and accurate notices and screeners without errors that cause inappropriate coverage loss. This is on top of the October 1, 2026 immigrant eligibility deadline, which is also an incredible scope of work that CMS requires in an extremely tight timeframe. We can anticipate how difficult it will be for HFS to prepare the variety of written materials to support these changes on this timeline, including plain-language, accessible formats and translated materials. Additionally, trusted partners who will carry out outreach need to plan appropriately, and may need grant funding to be able to take on this additional work on this compressed schedule.
2. **Late federal guidance:** POCIL and advocates throughout the country understand the significance of CMS's key guidance arriving so late. We appreciate how much system work has to come out now, before the federal guidance, and we appreciate the pickle the state may be in if state decisions conflict with the final rule. HFS has been very transparent about the fact that system changes and updates require extended development time and extensive user testing before they should go live. CMS's late-coming federal guidance is exceptionally concerning, as it risks significant rework and disruption.
3. **Existing system limitations:** Many states, including Illinois, have experienced substantial challenges in the past with their eligibility and enrollment systems. We appreciate, and HFS has again been transparent about, the fact that large changes to these systems take

time, can cause unintended consequences, and must be continuously monitored and updated. The speed and scale forced by H.R. 1 will likely cause challenges despite HFS's significant efforts. We are also concerned about the vendor transition. While we are agnostic about that process, we appreciate the reality that transitioning vendors is another extraordinary circumstance that will make smooth implementation difficult despite all agencies' best efforts.

4. **Data-sharing build challenges:** HFS's conscientious effort to build out new data-sharing mechanisms is the right approach to enable ex parte reviews. Providers including managed care organizations, hospitals, and clinics, welcome collaboration to support patients through this process and to ensure no one inappropriately loses coverage. However, integrating these disparate systems, evaluating new systems, and ensuring reliable, secure data exchange historically takes significant time, effort, and oversight. Under current timelines, we are concerned that there is insufficient time to coordinate with providers, vet vendors, ensure privacy and security, and rigorously test these integrations to the standard they require.
5. **Risky new technologies:** H.R. 1's encouragement of the use of artificial intelligence for rural hospitals raises additional concerns. (See § 71401, H.R. 1, 119th Cong. (2025), amending 42 U.S.C. § 1397ee(h)(6)(D).) These technologies require, at a minimum, careful privacy safeguards, informed consent, and user and bias testing.<sup>2</sup> AI raises significant risks, and the current timeline does not allow adequate time for the testing and oversight required when using any AI system.

We are committed to working with the state to implement H.R. 1 while mitigating harms to Illinoisans. We have already seen that Illinois is making a good faith effort to comply with the work requirements. We feel strongly that Illinois has a strong basis to be granted an exemption from the requirements through December 31, 2028, should the state seek one.

CMS has previously granted states good faith effort exemptions where states were required to make similar (but significantly smaller scale) changes to their eligibility and enrollment systems. For example, under Title VII of the Supplemental Appropriations Act (P.L. 110-252) states were required to adopt specific mechanisms to electronically verify assets directly from financial

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<sup>2</sup> See, e.g., Norori, N., Hu, Q., et al, *Addressing bias in big data and AI for health care: A call for open science*, *Patterns*, 2(10), 100347 (2021) <https://doi.org/10.1016/j.patter.2021.100347> ("AI is prone to reinforcing bias, which can lead to fatal outcomes, misdiagnoses, and lack of generalization."); Schwartz R., Vassilev A., et al., *Towards a standard for identifying and managing bias in artificial intelligence*, NIST special publication 1270: National Institute of Standards and Technology, U.S. Department of Commerce (2022), <https://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.1270.pdf> (describes the challenge of addressing bias in artificial intelligence, the types of bias perpetuated, and provides examples of how and why it can chip away at public trust).

institutions, rather than continue to rely on applicant-reported information.<sup>3</sup> Congress imposed a 2013 implementation deadline. By February 2016, just four states had fully modified their eligibility and enrollment systems to capture the data electronically. By 2020, however, only nine states were out of compliance. To explain the delay, one state pointed to “major challenges related to procurement and contracting,” while “another experienced substantial functional issues with its eligibility system, and a third had difficulty securing funding from its legislature.”<sup>4</sup> States also cited lack of CMS guidance as contributing to their delay. While the law allowed CMS to withhold federal funds for non-compliant states, it also built in a good faith effort exception. Rather than immediately withhold funds once the 2013 deadline ran, CMS spent seven additional years working with states on compliance. This demonstrates strong historical support for CMS providing good faith effort exemptions for states reconfiguring their eligibility systems.

CMS has taken a facilitative rather than punitive approach toward implementation on larger projects as well. For example, under the Affordable Care Act enacted in 2010, CMS and states were given four years to implement new, streamlined income eligibility methodologies.<sup>5</sup> CMS engaged in extensive outreach and education to states to support successful implementation, but with only four years to implement, the “modernized, streamlined system” envisioned by the ACA would still “require time, persistence, and a commitment to continual program improvement.”<sup>6</sup> Although states made progress, “readiness varie[d] considerably as 2014 nears, and implementation work and ongoing process improvements will continue into the foreseeable future.”<sup>7</sup>

Here Congress’s implementation timeline is much shorter (18 months from enactment to implementation). Even the two-year extension offered under § 1396a(xx)(11) would not give states the same lead time they have previously had to redesign and operationalize new

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<sup>3</sup> MACPAC, *State Compliance with Electronic Asset Verification Requirements* (Oct. 2020), <https://www.macpac.gov/wp-content/uploads/2020/10/State-Compliance-with-Electronic-Asset-Verification-Requirements.pdf>.

<sup>4</sup> *Id.*

<sup>5</sup> MACPAC, *Eligibility, Enrollment, and Renewal: Case Study Findings* (Nov. 2018), <https://www.macpac.gov/wp-content/uploads/2018/11/Eligibility-Enrollment-and-Renewal-Case-Study-Findings.pdf> (“The federal government and states had less than four years to establish the rules and infrastructure needed to comply with the new requirements. The initial implementation period was challenging for states; they had to modernize legacy eligibility determination systems, transition to new rules for counting income and household size for some eligibility groups, and enroll the new adult group into Medicaid, while at the same time integrate Medicaid with the developing exchange systems.”).

<sup>6</sup> Martha Heberlein, Tricia Brooks, et al, *Getting into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies into Drive*, Kaiser Family Foundation (Nov. 21, 2013), <https://www.kff.org/medicaid/getting-into-gear-for-2014-shifting-new-medicaid-eligibility-and-enrollment-policies-into-drive/>.

<sup>7</sup> *Id.*

Medicaid eligibility criteria and processes. CMS must take these other projects and timelines into account when evaluating whether states are making good faith efforts toward work requirement implementation.

CMS must follow the Administrative Procedure Act, 5 U.S.C. §§ 701–706, when evaluating state requests for good faith effort exemptions under § 1396a(xx)(11). If CMS “relie[s] on factors which Congress has not intended it to consider, entirely fail[s] to consider an important aspect of the problem, offer[s] an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise,” then the agency’s action is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law under the APA, 5 U.S.C. § 706(2)(A). *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). CMS cannot disregard the H.R. 1 statutory language in evaluating the exemption request, and CMS cannot ignore evidence that Illinois puts forth to support its request.

We also appreciate that Illinois’s support for the well-being and health of its residents has unfortunately put a target on the state. We know that the federal climate is unwelcoming to Illinois. For CMS to unfairly deny Illinois an extension because of its politics would be arbitrary and capricious, and we are supporting national efforts to ensure CMS will evaluate requests for extensions fairly.

If extensions are not possible, we all anticipate that there will be many eligible people who need intervention to be able to keep their benefits. As outside partners, we are committed to supporting through education and other means, but solving those cases will require dedicated state channels and state resources. We strongly feel that time and effort spent on ensuring community partners have dedicated resolution channels through HFS and IDHS is time well spent.

We urge HFS to commit to contingency plans should the H.R. 1 rollout cause errors. We encourage HFS to think about, if you have not yet, contingencies and rollbacks while in the design phase, to ensure that things can be turned off or clawed back if CMS does permit grace periods. We support HFS in insisting on rigorous vendor vetting, security reviews, and quality assurance for its systems. We know we share the state’s commitment to safeguarding the health and safety of Illinoisans by ensuring appropriate time is allocated for integration, legal review, and testing even if that requires requesting a good faith extension to the H.R. 1 timelines. We know the state intends to do these changes well, and that takes incredible bandwidth. We are happy to support the state should it be in the position to request an extension.

We commend the Governor's Office, HFS, and IDHS for the strong, stakeholder-centered steps already underway. POCIL looks forward to continuing to work collaboratively to protect access to care for Illinoisans during this significant transition.

We would be remiss in closing this letter if we did not explicitly state: we are committed to Illinois's success and we are here to help. We are engaged in many different stakeholder venues with HFS and IDHS and we look forward to addressing our shared concerns in those venues, and partnering with you in member-facing engagement, and any other support we can provide.

Thank you for your incredible leadership under exceptionally difficult circumstances.

Sincerely,

Protect Our Care Illinois

CC: Secretary Quintero ([dulce.quintero-at-illinois.gov](mailto:dulce.quintero-at-illinois.gov)), IDHS; Priya Khatkhate ([priya.khatkhate-at-illinois.gov](mailto:priya.khatkhate-at-illinois.gov)), IDHS; and Brandon Ragle ([brandon.ragle-at-illinois.gov](mailto:brandon.ragle-at-illinois.gov)), DOIT

*Protect Our Care Illinois (POCIL) is a coalition of nearly 100 organizations across the state committed to defending Medicaid and the Affordable Care Act (ACA) against federal threats. Established in 2016, we successfully partnered with national groups to oppose efforts to repeal the ACA and cut Medicaid. Today, we work together to tackle the ongoing challenges presented by the current federal Administration and Congress. Our coalition encompasses a diverse array of partners, including provider and payer associations, advocates, community organizations, consumer groups, healthcare providers, and researchers. We use proven strategies like community engagement, policy analysis, lobbying, and storytelling to engage communities and inform the healthcare debate.*