

H.R.1 Eligibility Redeterminations: Fact Sheet and Recommendations

What's Changing?

Beginning Jan. 1, 2027, states will be required to conduct eligibility redeterminations for the Medicaid [expansion population](#) **every six months**, down from the current 12-month requirement.

What Do I Need to Know?

One of the key decisions states will need to decide when to begin transitioning enrollees to a six-month renewal cycle. In its [March 6 guidance](#) related to this provision, the Centers for Medicare and Medicaid Services (CMS) gives states two options for when to begin the renewal process for currently enrolled Medicaid expansion beneficiaries.

Option 1

States would shorten the eligibility period for beneficiaries whose renewal is set to be initiated on or after Jan. 1, 2027, giving beneficiaries as close as possible to a six-month eligibility period from the effective date of their last eligibility determination. **This likely would be a challenge for states, which will already face significant administrative strain from implementing community engagement requirements, also beginning Jan. 1, 2027.**

Option 1 example:

Jill is enrolled in the “adult expansion group” before Jan. 1, 2027, and her eligibility period is May 1, 2026, to April 30, 2027. The state elects to immediately transition beneficiaries already enrolled in the “adult expansion group” on January 1, 2027, to a 6-month renewal cycle. Because Jill’s eligibility period began more than 6 months before January 1, 2027, the state would initiate Jill’s renewal on January 4, 2027 (the first business day after the New Year’s Day holiday). If Jill continues to be eligible for the “adult expansion group” and meets all factors of eligibility, the state would grant Jill a 6-month eligibility period based on the date on which her eligibility is renewed.

Option 2

States would begin establishing six-month renewal dates starting with renewals initiated in January 2027. Since states typically begin the ex parte verification¹ process 60-90 days in advance, this means continuing their current process but simply setting the next eligibility period to end in six months rather than 12 months. **This option preserves existing coverage periods for enrollees, and its implementation would place significantly less administrative burden on states.**

Option 2 example:

Jane is enrolled in the adult expansion group before Jan. 1, 2027, and her Medicaid eligibility period is Aug. 1, 2026, to July 31, 2027. She is subject to the community engagement requirements that become applicable in January 2027, and her state elects to verify one month of community engagement at renewal. The state takes approximately 90 days to complete all steps in the renewal process before the end of an eligibility period and initiates Jane's renewal on May 3, 2027, as was already planned. The state determines that she remains eligible for the adult expansion group, and that she meets the community engagement requirements that became applicable on Jan. 1, 2027. Because Jane's previously scheduled renewal process was initiated in May 2027 based on the date her eligibility period ends (July 31, 2027), the state schedules her next renewal for Jan. 31, 2028, six months after the date on which her new eligibility period begins (Aug. 1, 2027).

What Can I Do Now to Prepare?

The following high-level recommendations are designed to help with implementation of these changes.

Maintain updated patient contact information

It will be critical for clinics and providers to maintain updated contact information, including phone, address and email. This should be done at intake and at every appointment, to ensure clients receive notification of an upcoming renewal, as they may be unaware of the increased frequency of redeterminations. Some clients may be experiencing housing instability, in which case providers should document alternative contacts who can relay renewal notices (e.g., a case

¹ **Ex parte verification** refers to an automated or administrative process in which an agency or institution verifies a person's eligibility for benefits using existing data sources, without requiring them to submit paperwork or contact the agency or institution directly

manager or family member). Patients should be encouraged to update their contact information with their state Medicaid agency whenever it changes, and you should be prepared to provide the agency's contact information to simplify that process.

Develop Policies and Practices for Periods Between Clients' Medicaid Termination and Reinstatement

Some patients will experience coverage lapses despite clinics' or states' proactive efforts to keep individuals enrolled in the program. Providers may benefit from having regular practices and policies to follow for the periods between Medicaid termination and reinstatement.

Clinically, you might consider identifying which services are most urgent to protect in terms of continuity. This may include things like psychiatric medication management and participation in medications for addiction treatment. Once you have identified these services, you might consider whether bridge doses or clinical samples of medication can cover gaps. It also may be helpful to obtain manufacturer rebates for prescription medications that you can share with clients, if possible.

Providers should be familiar with whether retroactive coverage reinstatement is available to a client (and you may wish to check with your state Medicaid agency to confirm relevant state laws here, but generally for Medicaid expansion clients retroactive coverage will be limited to one month prior to obtaining coverage). Once you understand the options, make sure you have trained billing staff on how to resubmit claims when coverage is restored after a lapse. In the March 6 guidance, CMS acknowledges a potential increase in difficult scenarios where households have members with different renewal schedules, and where someone shifts between eligibility groups and therefore moves from a twelve-month to a six-month redetermination window. Billing staff should be specifically trained to handle these types of mixed-household scenarios.

Stay in Regular Contact with CMS and Your State Medicaid Agency

It will be important for providers to regularly engage with their state Medicaid agency and with CMS during the implementation window. This can be done either individually or through your state association, or both if you'd prefer.

It will be important to know the following: What is the state's plan for transitioning current enrollees to a six-month renewal schedule? How will renewal notices be delivered? What languages will be used in forms sent to clients? How can renewals be completed, whether that will be via phone, online, in-person, or through any or all of these methods?

Proactively monitor eligibility by incorporating related questions into existing office and/or clinical practices, and use peer specialists and community health workers where possible

Providers can proactively monitor eligibility by incorporating related questions into existing office and/or clinical procedures, such as regular medication management appointments and care coordination check-ins. Peer support contacts present another opportunity to ask questions that can help determine basic information about eligibility. Peer support specialists and community health workers generally are well suited to assist with the basics of navigating renewals, given their experience in navigating similar health systems.

Next Steps

The National Council for Mental Wellbeing will continue to provide information and implementation recommendations related to this and other H.R.1 provisions as it becomes available.