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H.R.1 Medicaid Eligibility Redeterminations: *New Requirements, Timeline and Recommendations*

May 2026

Road Map

- **H.R.1 Overview**
- **Eligibility Redetermination Deep Dive**
 - **H.R.1 Requirements**
 - **Implementation Guidance**
 - **Recommendations**
- **Resources**

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H.R.1 Overview

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- H.R.1 contains the bulk of the domestic policy agenda for the current Congress.
 - H.R.1 partially offsets the cost of tax cuts and other spending items in the bill through new restrictions on Medicaid.
- Overall, the new law will result in significant funding reductions to Medicaid, in many cases phased in over the next decade.
 - The Congressional Budget Office estimates that Medicaid provisions could lead to 10 million people losing coverage by 2034.



Medicaid's Role in Mental Health and Substance Use Care



- Medicaid is the **largest U.S. payer for mental health and substance use care.**
- Medicaid pays for approximately **25% of mental health services** and **40% of all substance use care.**
- The program covers nearly **1/3** of adults experiencing **mental health challenges** and **1/5** of adults experiencing **substance use challenges.**



Medicaid and National Council Members

National Council member organizations serve patients, the majority of whom in many cases are Medicaid enrollees.

- Our members employ hundreds of people per clinic, on average.
- Members are efficient and run on extremely thin margins, **typically 1.8%-2.8%**.

Changes to Medicaid have service and workforce implications for our members.

- With a reduction in revenue from Medicaid, we will likely see reductions in service offerings and workforce, as well as financial impacts for clinics.



Member Impacts

- National Council members may experience the following impacts (among others):
 - Increased uncompensated care provided
 - Increased workforce strain
 - Technology challenges
 - Greater administrative burden



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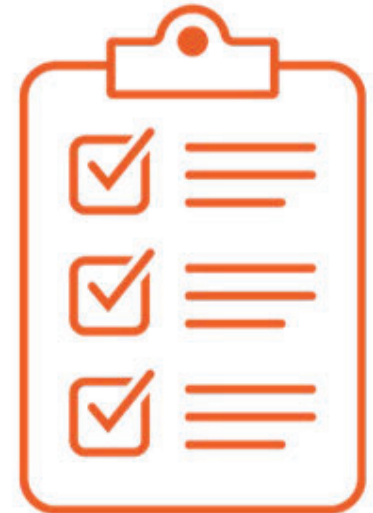
Eligibility Redetermination Requirements

Requirements Provided in H.R.1

Effective Jan. 1, 2027, states must conduct eligibility redeterminations for the expansion population **every six months**, down from the current 12-month requirement.

Updates:

- CMS released [guidance](#) in March that provides states with two options for implementation. The National Council issued a [memo](#) outlining this guidance.
- The bill appropriates \$76 million to CMS for FY26 to carry out this provision.



CMS Guidance for Implementation

- On March 6, CMS issued a [State Medicaid Director Letter](#) providing clarifying guidance. In the letter, CMS described two implementation options for states:

Option 1: Reschedule renewals to move people onto a six-month cycle sooner.

- *CMS acknowledges this is administratively burdensome.*

Option 2: Keep already-scheduled 2027 renewals and apply six-month eligibility at the next renewal.

- *CMS signals this is permissible and operationally less disruptive.*

- The six-month renewal requirement applies only in states that cover the full Medicaid expansion adult group under the state plan or an MEC-equivalent 1115; states operating partial expansion demonstrations are excluded.



CMS Example for Option 1

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 this group on Jan. 1, 2027, to a six-month renewal cycle. Because Jill’s eligibility period began more than six months before Jan. 1, 2027, the state would initiate her renewal on Jan. 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 her a six-month eligibility period based on the date on which her eligibility is renewed.



CMS Example for Option 2

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.

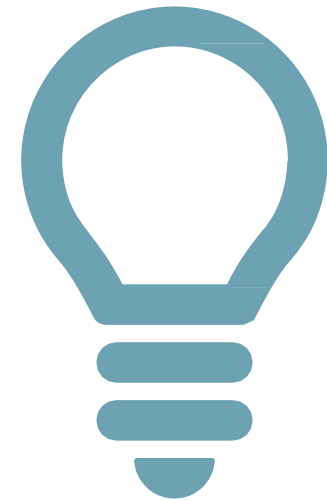
The state takes approximately 90 days to complete all steps in the renewal process before the end of an eligibility period and initiates Jane's renewal on May 3, 2027, as was already planned. The state determines that she remains eligible for the adult expansion group, and that she meets the community 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).



CMS Guidance: Additional Considerations

- **Due process:** Shortening an existing 12-month eligibility period to transition an individual to a six-month cycle constitutes an appealable action, requiring advance notice (at least 10 days) and fair hearing rights.
- **Work requirement linkage:** Compliance with community engagement (i.e., work) requirements must be assessed at each six-month renewal, effectively making renewals the primary enforcement point.
- **Household misalignment:** States may not shorten or extend eligibility periods solely to align renewal dates across household members, even where this results in mixed renewal cycles within the same household.



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Eligibility Redetermination Recommendations

Recommendations for Clinics

- Maintain updated patient contact information.
- Proactively monitor eligibility by incorporating related questions into existing office and/or clinical practices.
- Develop policies and practices for periods between clients' Medicaid termination and reinstatement.
- Stay in regular contact with CMS, your state Medicaid agency and your state association.
- Consider training and processes that enable peer support specialists and community health workers to assist clients in navigating renewal processes.



Key Points When Talking With Clients

- The law requires Medicaid eligibility to be evaluated at least every six months. This used to occur once a year.
- Starting next year, you may get letters or calls from the state more frequently, and you will need to complete related paperwork to certify your eligibility.
- Be on the lookout for notifications at least twice as often. Also, it's now possible that renewals may be on different schedules for different family members in the same household.
- If you lose coverage, don't wait until your next scheduled appointment to contact us. Reach out to your provider immediately for clarification or support in getting reenrolled.



Additional Practice Considerations

- Start planning education, outreach and enrollee evaluation for eligibility pathways, coverage and benefits.
- Are systems or technology needed to track renewal determination processes?
- Do staff need resources, education or training to help them understand the new requirements?
- Are there partners you can work with to increase universal screenings?
- Are there systems needed for proactive disability determination?
- Are there costs you can control now? Consider a review of IT infrastructure or contracts for efficiency.
- Collect data now to establish a baseline and collect it continuously in the future, so you can measure the impact of policy changes on clients, programs and workforce.



Data Collection and Story Banking

- **Data collection could include:**

- Uncompensated care furnished
- Waitlists due to capacity
- Amount of people turned away/not able to be seen due to capacity
- Amount of staff reductions to remain operating
- Amount of emergency care (or higher level of care) needed to identify trends
- Trends in increased patient acuity
- State reimbursement rates

- **Story Banking:**

- Consider building a repository of patient, provider and community stories illustrating the impact of Medicaid coverage losses on behavioral health service access or clinic operations.



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National Council Resources

Resources

Resources published:

- [H.R.1 Journey Map](#)
- [Work Requirements White Paper](#)
- [Baseline Survey and Results](#)
- [RHTP Webinar](#)
- [Eligibility Redeterminations Memo](#)

What's coming:

- Ongoing **webinar series and white papers** highlighting implementation strategies and considerations for the Medicaid provisions of H.R.1
- Resources to support discussing H.R.1 requirements with clients
- Updated information as new guidance and rules are issued



Explore the National Council's new
H.R.1 Hub for tools, resources and
guidance.



H.R.1 help starts here.

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 - Policy@TheNationalCouncil.org



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Thank you!