H.R.1

WHAT TO KNOW ABOUT ELIGIBILITY REDETERMINATIONS

July 2026

NATIONAL COUNCIL for Mental Wellbeing®

The National Council for Mental Wellbeing has developed the following white paper focused on the upcoming six-month eligibility redetermination requirement under the Medicaid program. It provides background on the passage of the 2025 landmark legislation, H.R.1, and the guidance issued since the bill's passage, and highlights lessons from states' recent experience with the unwinding of the Medicaid continuous enrollment provision, the largest nationwide eligibility redetermination effort in the program's history. It also offers recommendations from the National Council to clinics and provider organizations preparing to implement these requirements.

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Section I: Background on H.R.1 and Updated Guidance

Background

On July 4, 2025, President Trump signed H.R.1 into law. H.R.1 includes significant changes to Medicaid, [1] including a new requirement that states conduct eligibility redeterminations for members of the Medicaid expansion population every six months, down from the current 12-month requirement.[2] This provision applies to renewals scheduled on or after Dec. 31, 2026, which means that states will begin operating under the new schedule starting Jan. 1, 2027, the same day the law's community engagement ("work") requirements take effect. H.R.1 provides $75 million in federal implementation funding for fiscal year (FY) 2026 to support the change. [3]

The redetermination provision interacts closely with the community engagement requirements. H.R.1 requires states to verify that an enrollee has met community engagement requirements during regularly scheduled eligibility redeterminations, or more often at a state's choosing. As a result, for most expansion enrollees, compliance will be verified on the new semiannual cycle. States are also required to use existing state data sources to verify eligibility wherever possible (a process known as ex parte verification), rather than requesting new documentation from enrollees. [4]

March 2026 CMS Guidance

A critical implementation decision for states is when to begin transitioning currently enrolled expansion beneficiaries to a six-month renewal cycle. On March 6, 2026, the Centers for Medicare and Medicaid Services (CMS) released guidance to states on implementing the six-month redetermination requirement. [5] The guidance provides states with two options:

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. Under this option, a beneficiary whose current eligibility period began more than six months before Jan. 1, 2027, would have their renewal initiated almost immediately in the new year. This approach is likely to be a challenge for states, which will already face significant administrative strain from implementing community engagement requirements on the same date.

Option 2: States would begin establishing six-month renewal dates starting with renewals initiated in January 2027. Because states typically begin the ex parte verification process 60 to 90 days in advance of a renewal, this means continuing their current process but setting the next eligibility period to end in six months rather than 12. This option preserves existing coverage periods for enrollees, and its implementation would likely place significantly less administrative burden on states.

In the March 6, 2026 guidance, CMS also acknowledges a potential increase in difficult scenarios where households have members on different renewal schedules, and where an individual shifts between eligibility groups and therefore moves from a 12-month to a six-month redetermination window. [6] These mixed-household and group-transition scenarios will lead to operational implications for providers' front-office and billing staff, discussed in Section III.

Congressional Budget Office Analysis

The Congressional Budget Office (CBO) estimates that the six-month redetermination provision will reduce federal Medicaid spending by approximately $63 billion over 10 years and increase the number of people who are uninsured by roughly 700,000 in 2034. [7]

Notably, these coverage losses are attributable to the increased frequency of eligibility checks. This provision does not alter who qualifies for the expansion group. Doubling the number of renewal touchpoints creates more opportunities each year for an eligible person to miss a notice or be caught by a data-matching error.

In an October 2025 supplemental estimate, CBO projected that 10% of the Medicaid expansion group will no longer have coverage after the first six-month redetermination, based on disenrollment probabilities drawn from experience with 12-month redeterminations, adjusted for the effects of more frequent reviews. [8]

Section II: State Experience with the Medicaid Unwinding

While no state has previously operated a six-month renewal cycle for the expansion population at this scale, states have very recent experience conducting eligibility redeterminations under compressed timelines and high volumes through the unwinding of the Medicaid continuous enrollment provision. The unwinding offers the closest available evidence base for what happens when renewal activity increases quickly, and what practices can help individuals retain coverage and avoid becoming uninsured due to administrative issues.

Background: Continuous Enrollment and the Unwinding

In March 2020, in response to the COVID-19 pandemic, the Families First Coronavirus Response Act required state Medicaid programs to keep people continuously enrolled in exchange for enhanced federal funding. The continuous enrollment provision ended on March 31, 2023, and beginning April 1, 2023, states resumed disenrollments and were required to complete an eligibility renewal for all Medicaid and CHIP enrollees. This process is commonly referred to as the "unwinding." [9]

National Renewal Outcomes

By the end of the unwinding in most states, over 56 million people had their coverage renewed and over 25 million people had been disenrolled, leading to an overall disenrollment rate of 31% of completed renewals, somewhat higher than some projections developed at the outset of the process. 10 Despite these disenrollments, national Medicaid and CHIP enrollment remained roughly 10 million higher than pre-pandemic levels once the process concluded. 11

Procedural Disenrollments and State Variation

Across all states with available data, 69% of all people disenrolled during the unwinding had their coverage terminated for procedural reasons. These are primarily cases where people are disenrolled because they did not complete the renewal process, which can occur when the state has outdated contact information or the enrollee does not understand or complete renewal packets within a specific timeframe. [12] High procedural disenrollment rates are concerning because many people disenrolled for these paperwork reasons may still be eligible for Medicaid coverage. [13]

Outcomes varied widely across states. Five states had disenrollment rates of more than 50% (Montana, Utah, Idaho, Oklahoma and Texas), while five states had rates under 20% (North Carolina, Maine, Oregon, California and Connecticut). [14] Differences in renewal policies, ex parte capacity, eligibility system functionality and the order in which states targeted renewals explain much of this variation. [15]

Churn, Re-enrollment and Ex Parte Renewals

Although more than 25 million people were disenrolled during the unwinding, overall Medicaid enrollment declined by only about 13 million. It is likely that people who lost coverage were still eligible and re-enrolled soon after. State data regularly showed a large spike in application volumes following a month with a high number of procedural terminations. [16] This churn (the rate of individuals losing coverage) produced coverage gaps for enrollees, administrative burden for providers and additional workload for states processing the same individuals twice. [17]

The unwinding also demonstrated that ex parte renewal capacity can be improved quickly when it is sufficiently prioritized. National ex parte rates of renewal rose from roughly 30% when unwinding began to over 55% by its conclusion. [18] At the same time, the unwinding exposed the risks of flawed automation. In September 2023, CMS announced that 30 states would need to reinstate coverage for approximately 500,000 individuals, many of whom were children, who were erroneously disenrolled due to an issue in how states processed ex parte renewals at the household rather than individual level. [19]

Enrollee Experience and Behavioral Health Impacts

KFF's national survey of Medicaid enrollees conducted during the unwinding found that among those who were disenrolled, 47% eventually re-enrolled in Medicaid and 28% found other coverage, but about a quarter (23%) remained uninsured. A majority (56%) of those disenrolled reported skipping or delaying health care services or prescriptions while attempting to renew their coverage, and six in ten said they were worried about their mental health as a result of losing coverage. [20]

As of November 2023, more than six months into the unwinding, more than one-third (36%) of Medicaid enrollees reported having heard nothing at all about the return of renewals, despite extensive state and federal outreach. [21]

The evidence also indicates that people with behavioral health conditions were disproportionately affected. Peer-reviewed analyses of the unwinding found that Medicaid disenrollment was higher among people with mental health conditions, [22] and a four-state survey of low-income adults found that nearly half of those leaving Medicaid became uninsured, with fewer than one-third of those losing Medicaid transitioning to new coverage without a gap. [23] For people managing conditions that depend on treatment continuity, even short gaps can be destabilizing.

These findings suggest that when renewal frequency doubles for the expansion population, procedural coverage losses among still-eligible individuals are likely to be significant without proper safeguards in place, including accurate contact information and proactive enrollee outreach.

Section III: Eligibility Redetermination Implementation Recommendations

Implementation Recommendations for Clinics and Providers

Given the lessons of the unwinding and the challenges of implementing a semiannual renewal cycle, the National Council for Mental Wellbeing has developed the following recommendations, which may help ease the administrative burden faced by both providers and patients and help prevent avoidable coverage losses as the six-month redetermination requirement takes effect.

RECOMMENDATION 1:
Maintain updated patient contact information.

It will be critical for clinics and providers to maintain updated contact information for clients, including phone number, home address, and email address. This should be done at intake and at every appointment, to ensure clients receive notification of an upcoming renewal, particularly because many clients may be unaware of the increased frequency of redeterminations. During the unwinding, outdated contact information was a leading driver of procedural disenrollments among people who remained eligible. [24]

Some clients may be experiencing housing instability, in which case providers should document alternative contacts who can relay renewal notices, such as a case manager or family member. Patients should be encouraged to update their contact information with their state Medicaid agency whenever it changes, and staff should be prepared to provide the agency's contact information to simplify that process.

RECOMMENDATION 2:
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. Providers may benefit from establishing standard practices and policies to follow for the periods between Medicaid termination and reinstatement.

Clinically, organizations should consider identifying which services are most urgent to protect in terms of continuity. This may include psychiatric medication management and participation in medications for addiction treatment. Once these services are identified, clinics can consider whether bridge doses or clinical samples of medication can cover gaps, and whether things like manufacturer rebates for prescription medications can be obtained and shared with clients where possible.

Providers should also be familiar with whether retroactive coverage reinstatement is available to a client. Clinics may wish to check with their state Medicaid agency to confirm relevant state rules, but generally, for Medicaid expansion clients, retroactive coverage will be limited to one month prior to obtaining coverage. Billing staff should be trained on how to resubmit claims when coverage is restored after a lapse. Because CMS has acknowledged a potential increase in scenarios where households have members with different renewal schedules, and where someone shifts between eligibility groups and moves from a 12-month to a six-month redetermination window, billing staff should be specifically trained to handle these types of mixed-household scenarios.

RECOMMENDATION 3:

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, either individually, through their state association, or both. Key questions to track include:

- What is the state's plan for transitioning current enrollees to a six-month renewal schedule (i.e., which CMS transition option has the state elected)?
- How will renewal notices be delivered?
- What languages will be used in forms sent to clients?
- How can renewals be completed—by phone, online, in person, or through any or all of these methods?

RECOMMENDATION 4:

Proactively monitor eligibility through existing office and clinical practices and use peerspecialists and community health workers where possible.

Providers can proactively monitor eligibility by incorporating related questions into existing office and clinical procedures, such as regular medication management appointments and care coordination check-ins. Peer support interactions 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 navigating similar health systems.

Final Considerations

H.R.1's six-month eligibility redetermination requirement introduces complex operational challenges for states, coinciding with community engagement requirements that rely on the same eligibility systems. The unwinding demonstrated that coverage losses among eligible individuals during large-scale renewal efforts is driven substantially by implementation choices. Practices like minimizing administrative burden, investing in renewal navigation, and building strong data and monitoring systems can help states and clinics meet statutory requirements while preserving care continuity for people experiencing mental health and substance use challenges. The National Council stands ready to partner with CMS, states, providers and communities to assist in achieving these outcomes.

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