FOR EMPLOYERS · POLICY

The H.R.1 Employer Readiness Checklist

triad

Reviewed September 2026

triadhq.com/hr1-readiness-checklist

Three of H.R.1's Medicaid provisions land on the same date. Work and community engagement requirements, six-month redeterminations for expansion adults, and a retroactive coverage window cut to one month all take effect **January 1, 2027**, and some states are already operating earlier. Revenue pressure has a predictable next stop, the workforce budget, and that instinct is backwards: billable capacity *is* licensed workforce. Twenty-four items, six sections, in the order they matter.

January 1, 2027

Work and community engagement requirement live in every state (earlier in some; later where HHS grants a good-faith effort exemption, to no later than Dec 31, 2028). Six-month redeterminations apply to expansion-adult renewals initiated on or after this date. Retroactive coverage narrows to one month for expansion adults, two for traditional Medicaid.

Federal FY2028 (from Oct 1, 2027)

Provider tax safe harbor begins stepping down in expansion states, 0.5 points a year until it reaches 3.5% in FY2032. Nursing facilities and ICFs excluded.

January 1, 2028

Grandfathered state directed payments step down 10 percentage points annually until they reach the allowable limit.

October 1, 2028

New cost sharing begins for expansion adults at 100-138% FPL, up to $35 per service. MH, SUD, primary care, and FQHC/CCBHC/RHC services exempt.

01 KNOW YOUR EXPOSURE

- [ ] **1. Quantify your Medicaid expansion-adult mix**

  DO NOW · Finance / revenue cycle

  Census by payer, then by eligibility category. Separate expansion adults from traditional Medicaid, and flag clients with a documented SUD or SMI.

- [ ] **2. Confirm whether your state implements early**

  DO NOW · Policy / gov affairs

  No later than Jan 1, 2027, but may start sooner (Nebraska May 1, 2026; Montana July 1, 2026) OR later: HHS can grant a good-faith effort exemption delaying a state to as late as Dec 31, 2028. Log each state's actual date.

- [ ] **3. Read the federal rule, not the summaries**

  DO NOW · Compliance

  CMS-2454-IFC, Federal Register June 3, 2026. Pull the exemption list and verification triggers into your own written policy.

- [ ] **4. Model the one-month retroactive window**

  BY JAN 1, 2027 · Finance / revenue cycle

  Pull 12 months of claims paid retroactively, count what falls outside one month, and carry the dollar figure into FY2027 as a named assumption.

02 PROTECT CLIENT COVERAGE CONTINUITY

- [ ] **5. Build an exemption-flagging workflow**

  BY JAN 1, 2027 · Clinical operations

  Categorical: treatment-program participants, caretakers of children 13 or under or a disabled individual, TANF/SNAP-compliant, pregnant and postpartum, AI/AN, totally disabled veterans, inmates, former foster youth to 26. SUD and mental illness are NOT categorical: they run through medically frail, a two-part test of condition AND significant impairment, and 5+ years stable recovery is not automatic. Your own clinicians can document it; states may also use 12 months of claims data. Route SUD data through 42 CFR Part 2.

- [ ] **6. Own the 30-day cure window**

  BY JAN 1, 2027 · Care coordination

  States must notice noncompliance and allow 30 calendar days to cure. Ask whether providers get notice; add a mail question to every clinical contact.

- [ ] **7. Prepare for six-month renewals**

  BY JAN 1, 2027 · Front office / eligibility

  Expansion-adult renewals initiated on or after Jan 1, 2027 run every six months. Report who is due in the next 60 days, monthly.

- [ ] **8. Decide who staffs eligibility support, and how it is paid for**

  DO NOW · Executive team

  Name the role before FY2027 budget lock. Check CCBHC PPS, current grants, and state RHTP; peer support and CHW roles are a common fit.

03 PROTECT THE REVENUE CYCLE

- [ ] **9. Shorten time from first contact to submitted application**

  BY JAN 1, 2027 · Revenue cycle

  Measure median days from first service to application. Set a target inside the retroactive window and report it monthly.

- [ ] **10. Track your state's provider tax exposure**

  ONGOING · CFO / policy

  Expansion-state safe harbor steps 6% to 5.5% on Oct 1, 2027 (federal FY2028), then 0.5 points a year to 3.5% in FY2032. NF and ICF taxes excluded where effective by Oct 1, 2026 and not above 6%. NOTE: published summaries differ by a year on the start; confirm with your state association before forecasting.

- [ ] **11. Understand the state directed payment limits**

  ONGOING · CFO / policy

  New SDPs capped at 100% of Medicare in expansion states, 110% elsewhere. Grandfathered arrangements drop 10 points a year from Jan 1, 2028.

- [ ] **12. Know what stays exempt from the new cost sharing**

  REFERENCE · Compliance / billing

  From Oct 1, 2028, up to $35 per service for expansion adults at 100-138% FPL. MH, SUD, primary care, and FQHC/CCBHC/RHC services are exempt.

04 PROTECT BILLABLE CAPACITY

- [ ] **13. Inventory your associate-level pipeline**

  DO NOW · HR / clinical leadership

  Count pre-licensure clinicians by discipline and exam (ASWB, NCE/NCMHCE, EPPP, MFT, BCBA, addictions). Flag anyone stalled at the exam step over six months.

- [ ] **14. Set and measure a time-to-licensure target**

  DO NOW · Clinical leadership

  Baseline median months from hire to independent licensure. Name an owner, review it with the financials, and clear supervision and exam blockers first.

- [ ] **15. Close the CE compliance gap**

  ONGOING · Compliance / HR

  Confirm you can produce centralized completion records per clinician per board on demand, and check state mandated topics. Records in inboxes are the gap.

- [ ] **16. Defend the professional development line in FY2027**

  BEFORE BUDGET LOCK · Executive team

  Bring the pipeline report into the budget conversation. Frame it as billable capacity and turnover cost, then show what can be funded elsewhere.

05 FUND IT FROM SOMETHING OTHER THAN OPERATING MARGIN

- [ ] **17. Map training costs into your CCBHC PPS rate**
  DO NOW · Finance (CCBHCs)
  PPS is cost-based. Check whether exam prep, CE, and supervision time are captured in the cost report at all; confirm treatment before recoding.
- [ ] **18. Get on your state's RHTP subrecipient list**
  DO NOW · Executive / grants
  RURAL money: $50B over FY2026-FY2030, half split equally among states. Workforce is supported, but several uses carry a 5-year rural service commitment. If you do not serve rural communities, skip to items 17 and 19.
- [ ] **19. Audit current grants for allowable training lines**
  DO NOW · Grants / finance
  Workforce and capacity-building awards often allow training, licensure prep, and CE. Redirect unspent authority before the period of performance closes.
- [ ] **20. Package it as one benefit with centralized records**
  ONGOING · HR / compliance
  One trackable program, one export that satisfies a licensing board, an accreditor, and a grant monitor without three reconstructions.

06 GOVERNANCE

- [ ] **21. Name one owner for H.R.1 readiness**
  DO NOW · CEO
  Director level or above, with a standing agenda slot. Work that crosses five functions and belongs to none does not get done.
- [ ] **22. Put the four dates on the leadership calendar**
  DO NOW · Executive team
  Each date, each owning function, a 90-day pre-brief. An earlier state go-live overrides the federal dates.
- [ ] **23. Brief the board once, in operational terms**
  BY Q4 2026 · CEO / CFO
  Lead with your expansion-adult share and retroactive exposure. Show the pipeline as mitigation and the funding map as how it gets paid for.
- [ ] **24. Subscribe to one source of truth**
  ONGOING · The item 21 owner
  National Council's free H.R.1 Hub for federal tracking, your state Medicaid agency for state specifics. Review monthly against this checklist.

Where to track implementation

The National Council for Mental Wellbeing's free H.R.1 Hub (hub.thenationalcouncil.org) consolidates guides, webinars, toolkits and an implementation timeline, including work requirements, redeterminations, the Rural Health Transformation Program, and provider taxes and state directed payments. The National Council is one of Triad's preferred partners. For anything state-specific, go to your state Medicaid agency directly, because that is where the variation lives.

The fill-in version

Owner, due date, status and evidence for all 24 items, a multi-state variation grid, and a funding-source map covering CCBHC PPS, active grants, and state RHTP pathways.

triadhq.com/hr1-readiness-worksheet

Reference: exemptions that map onto a behavioral health caseload

Categorically excluded. Participants in a drug addiction or alcohol treatment and rehabilitation program; parents and caretakers of children aged 13 or under or of a disabled individual; people already meeting TANF or SNAP work requirements; pregnant and postpartum individuals; American Indians and Alaska Natives; veterans with a total disability rating; inmates of public institutions; and former foster care youth up to age 26.

SUD and mental illness are not categorical. They run through the medically frail route, a two-part test: the condition must exist AND significantly impair the ability to comply. A diagnosis alone is not the exemption, and five or more years of stable recovery is not automatically excluded. Your own clinicians can document it, states may also verify from 12 months of claims data, and 42 CFR Part 2 governs any SUD records you share.

State-elected short-term hardship exceptions. States *may* except people in a medical institution or receiving intensive outpatient services; people travelling outside their community for an extended period to treat a serious or complex condition; residents of areas where unemployment runs at least 50 percent above the national average; and areas under a declared emergency or disaster. These are elections, not federal guarantees, so confirm your state's.

The operational point. The 80 hours can also be met by community service, a work program, half-time education, or monthly income of at least the federal minimum wage times 80 hours. Check the SNAP and TANF overlap first: it needs no documentation from you. After that, the proof for most categories is a clinical record you hold and your client does not, and an exemption that exists but is undocumented functions exactly like no exemption at all. That is item 5.

Sources. Work requirement, exemptions, hardship exceptions, verification and the 30-day cure: CMS, Medicaid Program; Community Engagement Requirement for Certain Individuals, interim final rule with comment period (CMS-2454-IFC), Federal Register, June 3, 2026, and the accompanying CMS fact sheet. State timing and six-month renewals: Center on Budget and Policy Priorities, Timing of State Implementation of H.R. 1's Medicaid Policies. Retroactive coverage: Justice in Aging, H.R. 1 Reduces Medicaid Retroactive Eligibility Starting in 2027. Cost sharing: KFF, Understanding Medicaid Cost Sharing and Policy Changes from the 2025 Reconciliation Law. Provider taxes and state directed payments: HHS ASPE, An Overview of State-Directed Payments and Medicaid Provider Taxes, and KFF, 5 Key Facts About Medicaid and Provider Taxes (0.5-point step-down from federal FY2028; Medicare caps). AMA, Summary of Changes to Medicaid Financing (10-point annual reduction for grandfathered SDPs from Jan 1, 2028; conditions on the NF/ICF exclusion; dates the provider tax phase-down a year later than the others). Rural Health Transformation Program: AMA program summary; Bipartisan Policy Center, Addressing Workforce Challenges through the RHTP. Good-faith exemption, the two-part medically frail test, stable-recovery carve-out, acceptable documentation sources, claims-based verification and 42 CFR Part 2: National Council for Mental Wellbeing, Interim Final Rule Summary: CMS Community Engagement Requirements. Ongoing tracking: National Council for Mental Wellbeing H.R.1 Resource Hub (hub.thenationalcouncil.org).