FOR EMPLOYERS · POLICY · WORKSHEET

The H.R.1 Readiness Worksheet

Twenty-four items, six sections, one date that carries most of the weight. Fill this in with your own numbers and owners, and it becomes the H.R.1 section of your FY2027 operating plan rather than a policy summary you read once.

ORGANIZATION	COMPLETED BY
STATES OF OPERATION	DATE COMPLETED
EXPANSION-ADULT SHARE OF SERVED POPULATION (ITEM 1)	ACCOUNTABLE OWNER (ITEM 21)

How to use it

- Work sections 01 through 03 with finance and compliance, sections 04 and 05 with clinical leadership and HR.
- Fill the owner and target date columns before you fill status. An item without an owner is not a plan.
- The evidence column is what an accreditor, a grant monitor, or your board will ask for. Name the artifact, not the intention.
- Re-run the whole thing whenever your state publishes new implementation guidance.

The four dates

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.	OWNER
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.	OWNER
January 1, 2028	Grandfathered state directed payments step down 10 percentage points annually until they reach the allowable limit.	OWNER
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.	OWNER

An earlier state go-live overrides every federal date above. Confirm your state's commitment before you plan against this page.

SECTION 01

Know your exposure

1. Quantify your Medicaid expansion-adult mix

DO NOW

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

Usually owned by Finance / revenue cycle

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

2. Confirm whether your state implements early

DO NOW

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.

Usually owned by Policy / gov affairs

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

3. Read the federal rule, not the summaries

DO NOW

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

Usually owned by Compliance

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

4. Model the one-month retroactive window

BY JAN 1, 2027

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

Usually owned by Finance / revenue cycle

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

NOTES, BLOCKERS, AND OPEN QUESTIONS FOR SECTION 01

SECTION 02

Protect client coverage continuity

5. Build an exemption-flagging workflow

BY JAN 1, 2027

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.

Usually owned by Clinical operations

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

6. Own the 30-day cure window

BY JAN 1, 2027

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

Usually owned by Care coordination

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

7. Prepare for six-month renewals

BY JAN 1, 2027

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

Usually owned by Front office / eligibility

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

8. Decide who staffs eligibility support, and how it is paid for

DO NOW

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

Usually owned by Executive team

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

NOTES, BLOCKERS, AND OPEN QUESTIONS FOR SECTION 02

SECTION 03

Protect the revenue cycle

9. Shorten time from first contact to submitted application

BY JAN 1, 2027

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

Usually owned by Revenue cycle

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

10. Track your state's provider tax exposure

ONGOING

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.

Usually owned by CFO / policy

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

11. Understand the state directed payment limits

ONGOING

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

Usually owned by CFO / policy

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

12. Know what stays exempt from the new cost sharing

REFERENCE

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.

Usually owned by Compliance / billing

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

NOTES, BLOCKERS, AND OPEN QUESTIONS FOR SECTION 03

SECTION 04

Protect billable capacity

13. Inventory your associate-level pipeline

DO NOW

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.

Usually owned by HR / clinical leadership

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

14. Set and measure a time-to-licensure target

DO NOW

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

Usually owned by Clinical leadership

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

15. Close the CE compliance gap

ONGOING

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

Usually owned by Compliance / HR

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

16. Defend the professional development line in FY2027

BEFORE BUDGET LOCK

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

Usually owned by Executive team

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

NOTES, BLOCKERS, AND OPEN QUESTIONS FOR SECTION 04

SECTION 05

Fund it from something other than operating margin

17. Map training costs into your CCBHC PPS rate

DO NOW

PPS is cost-based. Check whether exam prep, CE, and supervision time are captured in the cost report at all; confirm treatment before recoding.

Usually owned by Finance (CCBHCs)

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

18. Get on your state's RHTP subrecipient list

DO NOW

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.

Usually owned by Executive / grants

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

19. Audit current grants for allowable training lines

DO NOW

Workforce and capacity-building awards often allow training, licensure prep, and CE. Redirect unspent authority before the period of performance closes.

Usually owned by Grants / finance

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

20. Package it as one benefit with centralized records

ONGOING

One trackable program, one export that satisfies a licensing board, an accreditor, and a grant monitor without three reconstructions.

Usually owned by HR / compliance

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

NOTES, BLOCKERS, AND OPEN QUESTIONS FOR SECTION 05

SECTION 06

Governance

21. Name one owner for H.R.1 readiness

DO NOW

Director level or above, with a standing agenda slot. Work that crosses five functions and belongs to none does not get done.

Usually owned by CEO

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

22. Put the four dates on the leadership calendar

DO NOW

Each date, each owning function, a 90-day pre-brief. An earlier state go-live overrides the federal dates.

Usually owned by Executive team

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

23. Brief the board once, in operational terms

BY Q4 2026

Lead with your expansion-adult share and retroactive exposure. Show the pipeline as mitigation and the funding map as how it gets paid for.

Usually owned by CEO / CFO

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

24. Subscribe to one source of truth

ONGOING

National Council's free H.R.1 Hub for federal tracking, your state Medicaid agency for state specifics. Review monthly against this checklist.

Usually owned by The item 21 owner

OWNER	TARGET DATE	STATUS	EVIDENCE RETAINED

NOTES, BLOCKERS, AND OPEN QUESTIONS FOR SECTION 06

APPENDIX A

State variation grid

One row per state you operate in. Item 2 fills the first three columns; item 5 fills the fourth. Nebraska went live May 1, 2026 and Montana July 1, 2026, so a multi-state operator may already be past a deadline in one state while planning for it in another.

What varies by state, and what does not

Categorical, everywhere. 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: a two-part test. These run through the medically frail route. The state must verify the condition AND that it significantly impairs the ability to comply; a diagnosis alone is not the exemption, and five or more years of stable recovery is not automatic. Documentation may come from your own physicians, NPs, PAs, psychologists, counselors and therapists, or clinical social workers, or from 12 months of claims and encounter data. 42 CFR Part 2 applies.

State-elected, so fill the grid below. States *may* adopt short-term hardship exceptions for people in a medical institution or receiving intensive outpatient services; for people travelling outside their community for an extended period to treat a serious or complex condition; for areas where unemployment runs at least 50 percent above the national average; and for areas under a declared emergency or disaster.

How the 80 hours can be met. Work, community service, a work program, half-time education, or monthly income of at least the federal minimum wage times 80 hours. Seasonal workers may average over six months.

STATE	GO-LIVE DATE	VERIFICATION CADENCE	EXEMPTION PROCESS	YOUR CONTACT AT THE AGENCY

APPENDIX B

Funding-source map

Sections 04 and 05 describe real spend. This page is where you decide what pays for it. Fill in what applies, then bring the page into the FY2027 budget conversation rather than after it.

CCBHC prospective payment (PPS)

Cost-based, so workforce and training costs captured in the cost report are reflected in the rate. Check first whether exam prep, continuing education, and supervision time are captured at all.

ARE THESE COSTS IN THE CURRENT COST REPORT?

WHO PREPARES IT, AND WHEN IS THE NEXT SUBMISSION?

ESTIMATED EFFECT ON RATE

Active grants and cooperative agreements

Workforce and capacity-building awards frequently allow training, licensure preparation, and continuing education as eligible costs, and that authority often goes unused.

AWARD NAME AND PERIOD OF PERFORMANCE

ALLOWABLE TRAINING LINE? AMOUNT UNSPENT

DEADLINE TO REDIRECT

State Rural Health Transformation Program (RHTP)

Rural money: $50 billion over FY2026-FY2030, half split equally among approved states. Workforce is a supported category, including recruitment and retention, career pathways, residencies, ongoing clinician training, and CHW and peer support certification, though several uses carry a five-year rural service commitment. States award through RFAs; CMS caps direct provider payments at 15 percent annually. If you do not serve rural communities, this line is not your funding source.

WHICH OFFICE ADMINISTERS RHTP IN YOUR STATE?

ARE YOU ON THE RFA NOTIFICATION LIST?

NEXT ROUND AND SUBMISSION DATE

Operating budget

The residual. Whatever the three sources above do not cover is what you defend at budget lock, using the pipeline report from item 13.

CURRENT FY PROFESSIONAL DEVELOPMENT LINE

PROPOSED FY2027 LINE

BILLABLE-CAPACITY JUSTIFICATION

APPENDIX C

Board brief outline

Item 23. If the worksheet is filled in, this writes itself. Five slides, fifteen minutes, your numbers rather than the national ones.

1. **Our exposure.** Expansion-adult share of served population, split from traditional Medicaid (item 1). One number, stated plainly.
2. **What changes and when.** The four dates, with your state's actual go-live date if it differs from January 1, 2027 (items 2 and 22).
3. **What it costs us.** Retroactive-window exposure in dollars from twelve months of claims (item 4), plus the re-baselined bad debt assumption.
4. **What we are doing about it.** The exemption workflow and renewal support (items 5 to 8) as coverage protection; the licensure pipeline and time-to-licensure target (items 13 and 14) as capacity protection.
5. **How it gets paid for.** The funding map from Appendix B, ending with the residual you are asking the board to protect in the FY2027 operating budget (item 16).

Be explicit about what remains uncertain, particularly anything waiting on unreleased state guidance. A brief that admits its open questions survives contact with the next update.

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).

General operational guidance about federal legislation, not legal, tax, or reimbursement advice. H.R.1's Medicaid provisions phase in over several years and states retain meaningful discretion in how they implement, so the specifics that apply to your organization will differ from the federal baseline described here. Confirm with your own policy, finance, and compliance advisors and with official CMS and state guidance. Reviewed September 9, 2026.

Triad helps behavioral and mental health employers protect billable capacity through change: exam prep through AATBS, accredited continuing education through CE4Less and NurseCE4Less, and centralized completion records for compliance and accreditation. triadhq.com/employers