Upcoming District Health Coverage Changes

Biweekly DHCF Eligibility Meeting

Department of Health Care Finance

August 12, 2026

Presentation Overview

- **One Big Beautiful Bill (OB3) Eligibility Changes Overview**
- Medicaid Qualified Immigration Status Changes
- Work Requirements Overview
- Outreach and Next Steps
- Q&A

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DHCF Aims to Implement Eligibility Changes as a Result of Federal Legislation in a Customer Forward and Transparent Way

- Forthcoming changes we cover below are as a result of federal legislation in the One Big Beautiful Bill Act (OB3) are significant – spanning policy, operations, and outreach

- The District initiated a contract with a communications vendor (Market Me Consulting LLC) for services related to OB3 eligibility advertising, outreach, messaging, and related tasks

- DHCF intends to provide outreach and engagement materials like we did for the Public Health Emergency Unwinding/Medicaid Renewal
  - Communications Toolkit
  - Advertising campaign
  - On the ground outreach (participation in health fairs, other city events, etc.)
  - Attend your event or train your team

Changes to Medicaid Will Roll-Out Over the End of 2026 and Beginning of 2027

- **October 1, 2026:** Some persons with legal immigration statuses will lose Medicaid coverage, but may transition to other programs

- **January 1, 2027:**
  - Some adults will have to show work, volunteer or school hours (the “work requirement”) to be eligible for Medicaid
  - Some adults will have to recertify their eligibility every 6 months to keep Medicaid
  - Medicaid retroactive coverage will change from 3 months to either 2 months or 1 month
  - DHCF will allow for the deduction of moving expenses for eligibility for some people
  - DHCF will be required to take action to reduce duplicate or deceased enrollment

- **January 1, 2028:**
  - DHCF will cap the home equity allowed for eligibility from long term services and supports at $1 million

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OB3 Imposes Restrictions on Some Non-Citizens Eligible for Medicaid

- Non-Citizen Eligibility Changes - Effective 10/1/26
  - Definition of "Qualified Alien" eligible for Medicaid benefits and ACA Tax Credits amended to only include Lawful Permanent Residents (LPRs), certain Cuban and Haitian immigrants, and Compact of Free Association (COFA) migrants.

  - **What to Know**:
    - CMS provided written guidance clarifying that Lawful permanent residents (LPRs); Cuban-Haitian entrants; and Compact of Free Association (COFA) migrants are available for full-scope federal financial participation.
      - This means Medicaid eligibility ends for certain populations such as refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, trafficking victims, people granted conditional entry prior to 1980, individuals granted withholding of Deportation, and Amerasian entrants –*unless they gain a qualifying immigration status*

Noncitizen Eligibility Changes (Current and Future Groups)

Groups Covered	Currently Covered?	Starting October 1, 2026
U.S. Citizens	✓	✓
Lawful Permanent Residents (LPRs) aka Green Card Holders who meet the 5-Year Bar*	✓	✓
Cuban/Haitian entrants	✓	✓
Members of federally recognized tribes, COFA migrants, etc.	✓	✓
Refugees/Asylees	✓	☒
Victims of Trafficking	✓	☒
TPS and DED holders	✓	☒
Individuals paroled into the U.S. for at least one year	✓	☒

*Note: There are some exceptions to the LPR groups. For example, LPR generally face a 5-year waiting period before Medicaid eligibility, **however,** LPRs here under 5 years who are also refugees or asylees may access Medicaid without waiting if you hold LPR status.

Noncitizen Eligibility Changes Do Not Pertain to Children Under 21, Pregnant Women, and Emergency Medicaid

Beginning October 1, 2026:

- **Children under age 21 and pregnant women who are lawfully residing in the U.S. without meeting the five-year waiting period will continue to be eligible.**

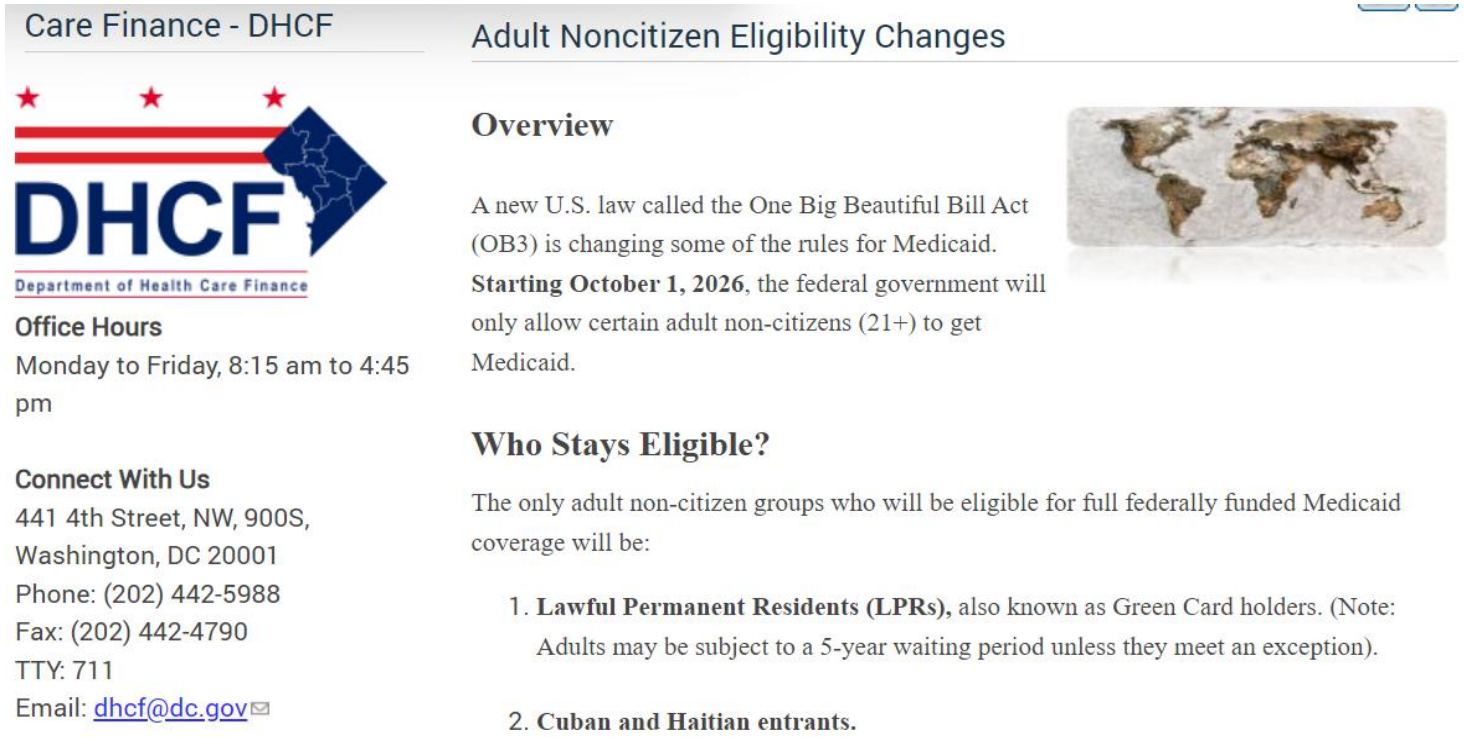
- Currently, **District does not expect impact to the FCEP/Unborn Child eligibility category**, but we are awaiting additional guidance from CMS on FCEP/Unborn impact of this OBBBA provision, if any.

- **Emergency Medicaid:** If you no longer qualify for Medicaid due to your immigration status after October 1, 2026, you can still get help for medical emergencies.

- **Health Care Alliance Program**: Individuals already enrolled in the Alliance Program are not impacted by these changes.

Noncitizen Eligibility Changes Website is Live With Key Information for Those Affected

- The District published a website at dhcf.dc.gov/non-citizen-eligibility with key information on the changes
- The District has sent notices to impacted residents and needs responses with their latest immigration information to ensure our records are accurate and individuals' Medicaid eligibility is being determined on updated information.



Care Finance - DHCF

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Adult Noncitizen Eligibility Changes

Overview

A new U.S. law called the One Big Beautiful Bill Act (OB3) is changing some of the rules for Medicaid. **Starting October 1, 2026**, the federal government will only allow certain adult non-citizens (21+) to get Medicaid.

Who Stays Eligible?

The only adult non-citizen groups who will be eligible for full federally funded Medicaid coverage will be:

1. **Lawful Permanent Residents (LPRs),** also known as Green Card holders. (Note: Adults may be subject to a 5-year waiting period unless they meet an exception).

2. **Cuban and Haitian entrants.**

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- Update: SSA Income Error
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- Medicaid Qualified Immigration Status Changes
- **Work Requirements Overview**
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Reminder: Work Requirements Do Not Apply to Everyone That Has Medicaid Coverage

- Medicaid **work requirements do not apply to:**
  - Children 18 or younger
  - Any Adult 65 and older
  - Adults enrolled in waiver programs like Elderly and Persons with Disabilities Waiver, Services My Way, the Individuals with Developmental Disabilities Waiver, or the Individual & Family Support Waiver
  - Adults who are disabled or have a health condition qualifying them for Medicaid (non-MAGI)
  - Adults in Long Term Institutional Care, like Nursing Facilities and Intermediate Care Facilities
  - Adults in the Program for All-Inclusive Care for the Elderly (PACE)
  - Adults in the Qualified Medicare Beneficiary (QMB) and QMB+ programs

  Those not affected are estimated to be just over 3/4 of current Medicaid enrollees (78%)

- **Work requirements do apply to**:
  - The Medicaid expansion population, meaning Adults (aged 19-64) without dependent minor children (i.e. not disabled, not pregnant, not enrolled in one of the waiver programs, in institutional care or in PACE, etc.)

  This is estimated to affect around ¼ of current Medicaid enrollees (22%)

Important Reminder: Work Rules Do Not Apply to Everyone!

Most People Are **Not** Affected: Nearly 8 Out of 10 People will not encounter new eligibility rules!

Medicaid work requirements do not apply to:

1. Children under 19
2. Adults 65 and over
3. Enrolled in Waiver Programs (EPD, Services My Way, IDD, IFS)
4. Individuals Receiving Long Term Care in Nursing Homes
5. Enrolled in PACE Program
6. Individuals with Disabilities or serious health conditions (Non-Magi)
7. Parents and Caretakers of minor children

A Small Group **Is** Affected: About 2 Out of 10 People Will Have to Follow the New Rules!

Medicaid work requirements do apply to:

1. Adults aged 19-64
+ 2. No Dependent Children
+ 3. Not disabled or pregnant
+ 4. Under 138% FPL
= 5. Medicaid Expansion Population (Childless Adults)

Reminder: Individuals Can Comply With Work Requirements Through 80 Hours of Work or Community Service in a Month, Half Time Educational Enrollment, More

- The new Law requires states to condition Medicaid eligibility for adults in the Affordable Care Act (ACA) Medicaid expansion group at application and following enrollment on meeting work requirements starting January 1, 2027

- An individual who is subject to work requirements can demonstrate compliance with work requirements for a one-month look back period if they meet one or more of the following criteria:
  - Work at least 80 hours
  - Complete at least 80 hours of community service
  - Participate in a work program for at least 80 hours
  - Is enrolled in an educational program at least half-time
  - Engage in any combination of the above for at a total of at least 80 hours
  - The individual has a monthly income that is not less than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours.
    - *For a household of one, someone earning near the District Living Wage could work ~33 hours a month and earn this amount*
    - This amount is equal to roughly 44% of the FPL for a household of one
  - The individual had an average monthly income over the preceding 6 months that is not less than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938 multiplied by 80 hours, ***and*** is a seasonal worker

Work Requirements Can Mean Working or Volunteering a Certain Number of Hours, Attending School or Training Half Time, Meeting Income Standards- or Combinations

The new Law requires states to condition Medicaid eligibility for adults in the Affordable Care Act (ACA) Medicaid expansion group at application and following enrollment on meeting work requirements starting January 1, 2027

How to Meet Work Requirements: At application, an individual must have met one or a combination of the requirements below one month prior to their application. At renewal, an individual must have met or a combination of the requirements one month in the past certification period:

80 Hour Requirement			Income		School
Work	Community Service (Volunteer)	Work Program	$580 (earned or unearned)	Seasonal income to equal at least $580 over the past 6 months.	Enrolled at least half-time.
					College, GED, High School, Adult Basic Education

For 80-hour requirement, if you have less than 80 hours in a single category, you can combine the above activities (school, work, volunteering, job training) to meet the requirement.

Work is Broadly Defined Under Work Requirements Rule; Volunteering is Defined More Narrowly

- **Community Services (Volunteering)** - Is unpaid work within a structured program that is completed for the *direct benefit of the community* under the supervision/direction of government or nonprofit (§501(c)(3)) organizations:
  - The public or nonprofit organization must provide oversight of the activity and have a process in place to track the community service (volunteering) completed by individuals
  - The applicant or beneficiary must submit a letter from the agency or organization to verify the completed service, including the dates and hours, a description of the work, the organization's name and address, and a point of contact who can confirm the details.

- **Work** - Is work in exchange for money, work in exchange for goods or services ("in kind" work), and unpaid work other than community service
  - Work includes self-employment
  - Unpaid work can include things like an internship
  - An example of "in kind" work would be serving as a building superintendent in exchange for rent

Reminder: Exempted Individuals Include Medicare, Foster Care, American Indians, Disabled Veterans, Medically Frail Individuals

- Many Medicaid populations are not subject to Medicaid Work Requirements through exemptions in statute
  - If exempted, the individuals won't be subject to work requirements (no need to fill out information, no "look back" period)

- Exempted Individuals:
  - Individuals who are Pregnant or Postpartum
  - Individuals who are already compliant with SNAP/TANF Work Requirements
  - Parent/Caretaker Relatives of a disabled child or a child 13 years or younger
  - Enrolled in or entitled to Medicare Part A benefits, or enrolled in Medicare Part B
  - Enrolled or eligible for Medicaid as a current or former foster care youth
  - American Indians and Alaskan Natives who are eligible to receive services via the Indian Health Service
  - Veterans with a disability rated as total under section 1155 of title 38, United States Code
  - Individuals who are medically frail in a way that significantly impacts their ability to meet work requirements including an individual:
    - ✓ Who is blind or disabled (as defined in section 1614);
    - ✓ With a substance use disorder;
    - ✓ With a disabling mental disorder;
    - ✓ With a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
    - ✓ With a serious or complex medical condition

Reminder: Some Exceptions Include Those in Rehab, Who Received Inpatient Hospital Services, Those Traveling for Medical Reasons

- For those subject to work requirements, States *may allow for individuals who request such an exception* to be considered as having met the community engagement requirement for a month if they have experienced a short-term hardship event during the look back period
  - This must be during the look back period, not in the month of application

- These events include:
  - ➢ The individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including outpatient care relating to other services specified in this subclause), as the Secretary determines appropriate
  - ➢ The individual resides in a county with an emergency/disaster declared by the President or a high local unemployment rate:
    - ✓ Permits states to request exemptions for individuals who reside in counties that have unemployment rates at or above 8% or below 8% but 1.5 or more times the national average unemployment rate.
  - ➢ The individual or their dependent must travel ***outside of their community*** for an extended period of time to receive medical services necessary to treat a serious or complex medical condition that are not available within their community of residence.

Compliance With Work Requirements Must Be for One Month of the Eligibility Verification Period for Those Enrolled or Applying

For currently enrolled applicable individuals:

- The District will require that currently enrolled individuals subject to work requirements meet them for **one** month during the individual's most recent eligibility determination and redetermination of eligibility. First renewal cohort subject to Medicaid work requirements will be those with March 2027 certification dates.

For new applicants:

- The District will "look back" **one** month prior to the month of application Medicaid to see if they met work requirements:
  - CMS directs states to use reliable information available to them (e.g. payroll data, payments, Medicaid claims, and encounter data) for verifying community engagement and exemptions

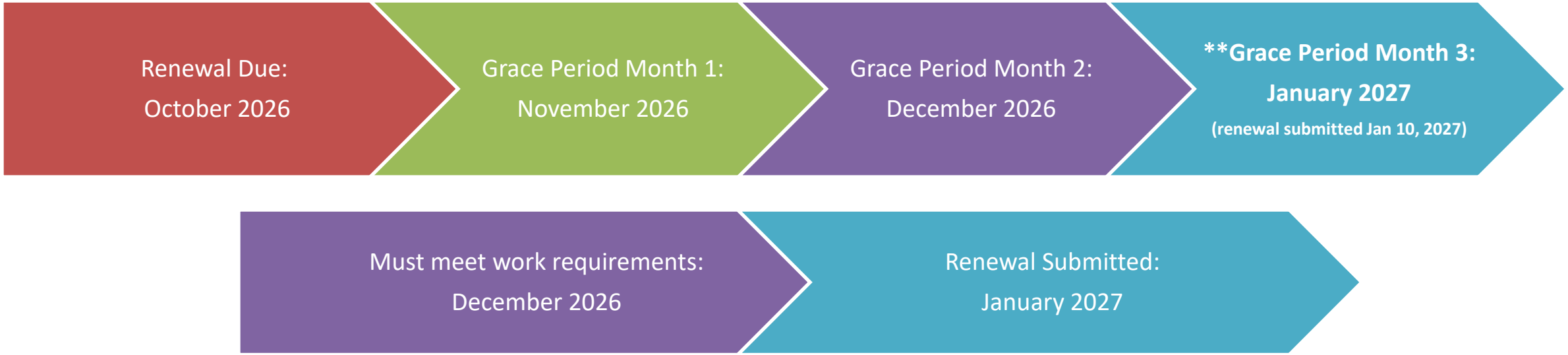
February	March (Look-Back Period)	April (Month of Application)	May

Renewals Submitted in the Grace Period in Early 2027 Will Be Subject to Work Requirements

New work requirements start with renewals due in **March 2027 and future dates**. However, this date changes if you turn in your renewal paperwork late. You have **90 days** after your coverage ends to turn your paperwork in late. This 90-day window is called a grace period.

If your Medicaid renewal is due between **October 2026 and February 2027**, and you send your paperwork during the grace period on or after **January 1, 2027**, it will be treated like a brand-new application. This means you will have to follow the work rules much earlier.

See example below for a client with at 10/2026 renewal submitted their renewal on January 10, 2026:



Reminder: Outreach Standards Include Notices to Beneficiaries with Specific Standards on How to Complete Engagement Requirements

- Prior to the implementation of the community engagement requirement (and periodically thereafter) states must notify applicable individuals enrolled in Medicaid expansion about the requirement, including:
  - How to comply with the requirement, including an explanation of the exemptions
  - The consequences of noncompliance with such requirement; and
  - How to report to the state any change in the individual's status that could result in exceptions or the end of a previously established exception.

- States must notify individuals:
  - By regular mail (or, if elected by the individual, in an electronic format); and
  - In one or more additional forms, which may include telephone, text message, an internet website, other commonly available electronic means, and such other forms as the Secretary determines appropriate;
  - States must begin outreach to notify individuals of the new requirements at least three months before the start of the first compliance "look-back"
    - ✓ District must perform outreach by September 2026 according to preliminary guidance

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- Refresher: Medicaid Qualified Immigration Status Changes
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- New: SSA Income Error, CMS Advertisements, OB3 Webpage
- **Outreach and Next Steps**
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DC Medicaid Has Multiple Ongoing Methods of External Outreach And Wants to Join Your Meetings Too!

- DC Medicaid is hosting regular Biweekly DHCF Eligibility Meetings such as this every 2 weeks- continuing every other Wednesday at 2:30 pm and the **next is Wednesday, August 26, 2026**.
  - Please email *Medicaid.renewal@dc.gov* to join the meetings and related mailing list if not on it already

- DC Medicaid is holding twice monthly Resident-Focused Eligibility Meetings on the 2nd and 4th Friday of every month– the meeting in the middle of the month features concurrent Spanish translation
  - The next is at 6:30 pm **Friday, August 14 @ 6:30 PM with concurrent Spanish language translation**
  - There will be a Resident Focused Meeting online **Friday, August 28 @ 6:30 PM**, which is likely to kick off a regular series with Spanish translation

- DC Medicaid is holding monthly District Direct (DCAS) Trainings for Human Services Benefits at 12:30 pm the 3rd Tuesday every month designed for stakeholders and anyone helping with eligibility– the next one is **Tuesday, August 18, 2026**.

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Questions and Comments

Learn More About Recent Federal Eligibility Changes to Medicaid: https://dhcf.dc.gov/page/federal-changes-medicaid

Learn more about Medicaid Program Changes: https://dhcf.dc.gov/page/non-citizen-eligibility

Contact DHCF on Eligibility Issues: Medicaid.Renewal@dc.gov

For Assistance Navigating Health Care in DC: Office of the DC Health Care Ombudsman and Bill of Rights: 202-724-7491

For information on your benefits or to take action: Public Benefits Call Center, 202-727-5355

For information on your Healthy DC Plan or Marketplace coverage or to take action: DC Health Link Contact Center, (855) 532-5465

Appendix: An Error in DCAS Double-Counted SSA Income and Affected Benefit Eligibility for Thousands of People –and is Being Fixed

- The District implemented an enhancement to read the BENDEX file from SSA in June and it mistakenly created duplicate SSA income evidence in the DCAS system
  - As a result of the error, DCAS started double-counting the SSA income for thousands of beneficiaries in Medicaid
  - Many beneficiaries' cases were set for termination by 7/31 because it appeared as though their income was over the eligibility threshold
  - This affected approximately 2,800 cases in SNAP and TANF, and approximately 3,000 in Medicaid

- This issue is being addressed, and the District is planning a comprehensive fix to resolve these issues before week's end (all corrections were reflected in MMIS by Monday 8/3 at the latest)

- The District is implementing a **recovery plan** for Medicaid clients affected
  - For Medicaid, the District is restoring Medicaid coverage in DCAS and MMIS for clients who incorrectly lost coverage, correcting program codes and retransmitting updates to MMIS , reversing and correcting the small number of downstream transitions impacted (Medicaid to TMA; Medicaid to BHP; Medicaid to QHP), and sending mail merge notices to affected clients.