Recent and Upcoming District Health Coverage Changes: Alliance and Medicaid

Biweekly DHCF Eligibility Meeting

Department of Health Care Finance

February 25, 2026

Presentation Overview

- **Information on Recent Medicaid and Alliance Program Changes**
- New: Work Requirements and Other One Big Beautiful Bill (OB3) Eligibility Changes
- Outreach and Next Steps
- Q&A

Local Realities and Federal Actions are Leading to Changes to Medicaid That Will Be Implemented Between Now and January 2027

- Locally, changes in the District's revenues, increasing costs of health care, and increasing Medicaid enrollment challenge Medicaid program sustainability
  - Coverage options changing for some adults currently eligible for Medicaid
- Federally, the One Big Beautiful Bill Act (OB3) includes significant changes to the Medicaid program in the future, including:
  - Changes to eligibility for some legal immigration statuses (starting October 2026)
  - Work requirements for some adults enrolled in Medicaid (effective January 2027)
  - More frequent eligibility checks for some adults enrolled in Medicaid (effective January 2027)
  - Changes to retroactive Medicaid coverage (effective January 2027) and more...
- More details about these changes will be provided today

As of January 1, 2026, Many Adults Are No Longer Eligible for Medicaid

- Eligibility changes made effective January 1, 2026:
  - **No** changes to financial eligibility for Children (0-20), pregnant individuals, SSI individuals, those in the Aged, Blind and Disabled (ABD) group, or participating in long term care.
  - Effective January 1, 2026, the eligibility threshold for Parent/Caretaker Relatives and Childless Adults decreased to 138% FPL.
  - **Adults over this threshold have been disenrolled** from Medicaid effective December 31, 2025.
  - **These adults were sent an adverse action notice** in early December. An informational notice went to impacted individuals in early September.
  - Healthy DC Plan enrollment notices were sent to many transitioning adults on November 1.

Category	Current Childless Adult (Ending 12/31/2025)	Current Parent or Caretaker (Ending 12/31/2025)	**New** Childless Adult and Parent/ Caretaker (Effective 1/1/2026)
Threshold in Federal Poverty Level (FPL)	210% + 5% disregard	216% + 5% disregard	133% + 5% disregard
1 person household, monthly	$2,806	$2,884	$1,800
2-person household, monthly	$3,790	$3,896	$2,432
3-person household, monthly	$4,775	$4,908	$3,065
4-person household, monthly	$5,762	$5,923	$3,697

As of January 1, 2026, Many Adults Are No Longer Eligible for Medicaid

- Generally, adults (without dependent children in a household of one) with incomes around $1,800 / month or more are no longer eligible for Medicaid based solely on their income
- Parents and Caretaker Relatives (in a household with two adults & two children) making around $3,700 / month or more are no longer eligible
- Single Adults and Parents above these limits with Medicare can still have Medicaid pay monthly Medicare premiums and cost sharing under QMB program but lost their eligibility for full Medicaid benefits.
  - DHCF automatically transitioned these individuals to QMB-Only coverage on January 1, 2026.
- These Medicaid changes also have an impact on Emergency Medicaid coverage in the District:
  - After January 1, 2026, the majority of adults (21+) only qualify for Emergency Medicaid coverage if they are at or below 138% of the federal poverty level.
- DHCF has worked with DCHBX to automatically transition currently enrolled Medicaid enrollees who will be losing coverage to alternative coverage options.

As of January 1, 2026, Many Adults Are No Longer Eligible for Medicaid…And Most Became Eligible for the New Healthy DC Plan

- Options for coverage are available through the DC Health Benefit Exchange (DCHBX)
  - Most adults no longer eligible for Medicaid will qualify for the Healthy DC Plan
  - The remaining adults will be eligible for a Qualified Health Plan
- The Healthy DC Plan is a new option administered by DCHBX and offers no cost coverage to eligible adults
  - Many services covered by Medicaid are included except for non-emergency transportation, dental and vision coverage, long-term services and supports, and some community-based mental health and SUD services
  - About 15,000 Residents disenrolled from Medicaid and eligible for Healthy DC Plan were automatically enrolled for coverage starting January 1
- Residents can find more information regarding the Healthy DC Plan at: www.HealthyDCPlan.com

District Residents Shifting to the Healthy DC Plan Have to Start a New Online Account to Manage Benefits Online

- District Residents who moved to the Healthy DC Plan ***can use their District Direct Login and password on DCHealthlink.com to access Healthy DC Plan Information***
  - District Direct does **NOT** give access to information or allow residents to take action on Healthy DC Plan coverage, but the District Direct login does work on DCHealthLink.com
- If a resident moving to Healthy DC Plan does not have a log in for either system, they can call 833-432-7526/TTY: 711 to create an online account.
- Please note: Residents with an active DC Health Link account will continue to access the site with their current login and password.

REMINDER: Health Care Alliance Program Eligibility Standards Changed on October 1, 2025

- Eligibility changes made effective October 1, 2025:
  - Eligibility threshold for Adults decreased from 215% FPL to 138% FPL. **Adults over this threshold were disenrolled** from the Alliance Program effective September 30, 2025.
  - DHCF established an enrollment moratorium for new Alliance Adults who are age 26 and over.
    - Meaning if you are 26 or over at the date of application, **you are not eligible** to newly enroll in the Health Care Alliance Program after October 1, 2025; and
- Benefit changes effective October 1, 2025 –
  - Benefits for Adults will include primary care, generic-only prescription drugs, hospital services, emergency transportation, lab, and durable medical equipment. DBH provides locally-financed BH services to those who remain eligible. Coverage for Children will also include vision, dental, and podiatry
  - Reminder: Effective January 1st, 2026, your prescriptions will be filled with generic medications instead of brand-name versions
- Delivery System changes effective October 1, 2025 –
  - Alliance became a fee-for-service only program

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

- DHCF recognizes there are other program changes occurring as a result of federal legislation this year (e.g. SNAP) and we are collaborating with our sister agencies

- Limited guidance to date from CMS, which means what may not have answers to all your questions and there may be changes to what we expect
  - We will highlight changes in this meeting as we learn of them

- 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

DHCF Aims to Implement Eligibility Elements in a Customer Forward and Transparent Way

- Today, our focus is on the eligibility changes occurring between now and January 1, 2028
  - Overview of OB3 elements
  - Highlight policy decisions made by DHCF

- Generally, DHCF's work is focused on:
  - District Direct system design and implementation
  - Defining how exemptions work within Medicaid work requirements
  - Developing outreach and engagement plans
  - Redesigning application and renewal requirements to accommodate these changes
  - Training District staff, residents, and stakeholders on new requirements

- Going forward, OB3 updates & issues for discussion will be a standing item on this meeting's agenda

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

- **October 1, 2026:** Some persons with legal immigration statuses may lose coverage

- **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 2 months or 1 month for some people
  - 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

OB3 Imposes Restrictions on Some Non-Citizens Eligible for Medicaid, Pending Federal Guidance and Injunctions

- Non-Citizen Eligibility - 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 promised but not has yet provided written guidance clarifying whether 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
    - A Preliminary Injunction was issued related to this provision, suspending implementation of this OB3 provision, pending litigation in Federal court.

OB3 Imposes Cap on Deductible Home Equity and Allows for Moving Expenses to Be Deductible if Military or Intelligence Related

MAGI Moving Expense Income Deduction - Effective tax year 2026

- Extends the MAGI qualified moving expense income deduction (applicable to active-duty members in the U.S. Armed Forces/military who are ordered to move or change duty stations) to members of the intelligence community who move pursuant to a change in assignment which requires relocation.

LTCSS Home Equity Cap - Effective 1/1/2028

- Imposes cap of $1,000,000 on home equity for LTSS eligibility determinations; Cap is not waivable via asset disregards.
- The minimum will only continue to increase based on CPI-U increases until it reaches $1,000,000.

OB3 Requires DHCF to Check Addresses and Deaths Against Reliable Sources to Ensure Accurate Enrollment

Reduction of Duplicate Enrollment under Medicaid and CHIP - Effective 1/1/27

- DHCF must regularly obtain address information from "reliable data sources" meaning mail returned by USPS with a forwarding address; the USPS National Change of Address Database; MCOs; and other data sources as identified by DHCF and approved by the Secretary.
- MCOs under contract must promptly, at least once monthly, transmit information to DHCF identifying whether individuals enrolled or seeking to enroll are identified as also being enrolled under another state's program. If the system identifies these individuals, the state will be required to take appropriate action to determine whether that individual is a resident of the state and, if not, disenroll.
- By October 1, 2029, CMS must establish a centralized enrollment verification system that allows States to cross-check enrollment data and detect individuals enrolled in State plans or CHIP in multiple states

Ensuring Deceased Individuals Do Not Remain Enrolled - Effective 1/1/27

- DHCF must check the Social Security Administration's (SSA) Death Master File (DMF) or a successor system on at least a quarterly basis to determine whether Medicaid enrollees are deceased and disenroll such individuals.

- Optional use of other electronic data sources in addition to the DMF (e.g., vital statistics data on deaths available through State Health Departments and State Vital Statistics Offices).

OB3 Imposes 6 Month Certification Periods and Restrictions on Retroactive Coverage After a Successful Initial Applications

- 6 Month Certification Period for Renewals for Expansion Adults - Effective 1/1/27
  - A provision in OB3 shortens certification periods for expansion adults, requiring renewals every 6 months.
    - Previous: Every 12 months
    - This will be the same group subject to Work Requirements

- Retroactive Coverage - Effective 1/1/27
  - Shortens retroactive coverage (currently up to 3 months preceding month of application) to:
    - 1 month for adults in the Expansion category; and
    - 2 months for all other Medicaid and CHIP eligibility groups.

Medicaid Work Requirements are Required to Be in Place no Later than January 1, 2027

- *"Beginning not later than January 1, 2027, states must, as a condition of eligibility, require that applicable individuals (eligible or enrolled in a state Medicaid expansion program or state waiver program that provides Minimum Essential Coverage, ages 19-64, and not an inmate of a public institution during the three months prior) demonstrate community engagement."*

- This means work requirements must be in place for applications received on or after January 1, 2027 and renewals initiated on or after January 1, 2027.

Individuals Can Demonstrate Compliance 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 can demonstrate compliance with work requirements for a month 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

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.

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

Enrollees Found Not to Meet Work Requirements Get a Notice of Noncompliance and 30 Days to Address Before Termination

- If the District is unable to verify that an applicable individual has met the requirement to demonstrate community engagement, we will:
  - Provide the individual with the notice of noncompliance and give them 30 calendar days from to demonstrate compliance or that the requirement does not apply to them.
    - During this 30-day period, if the individual is already enrolled in Medicaid, they will continue to be enrolled.
  - If the individual cannot demonstrate compliance:
    - The District will deny their application; OR
    - Terminate current enrollment, no later than the end of the month following the month in which the 30-day period ends (two months after noncompliance notice).
  - Prior to termination the state must determine if the individual is eligible for medical assistance under the State plan (or waiver of such plan) or for another insurance affordability program.

Certain Groups Are Not Subject to Work Requirements and Exemptions Will Be Available to Those With Short-Term Hardships

- Many Medicaid populations are not subject to Medicaid Work Requirements:
- Exempted Individuals will include (more detail in following slides):
  - QMB Enrollees
  - Foster Care or Former Foster Youth
  - Individuals who are **Medically Frail**
  - Individuals who are Pregnant or Postpartum
  - Individuals who are already compliant with SNAP/TANF Work Requirements
  - Parent/Caretaker Relatives
- Many Medicaid enrollees may be exempt (more detail in following slides) from having to demonstrate compliance with work requirements during application or renewal based on temporary hardship:
  - Those that received inpatient treatment (NF, ICF, IMD) or treatment of similar acuity in an outpatient setting;
  - Those individuals who resided in a county with an emergency or disaster declared by the President OR reside in a county with a high local unemployment rate;
  - Those who had to travel for treatment of a serious medical condition

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
- Exempted Individuals:
  - 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 or otherwise have special medical needs (as defined by the Secretary), 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

Other Exemptions Include Those Meeting SNAP/TANF Work Requirements, Those in Rehab, Pregnant Individuals, Parents or Caretakers

- Other Individuals who are Exempted from Medicaid Work Requirements:
  - Individuals who are in compliance with work requirements from SNAP or TANF
  - Individuals participating in a drug addiction or alcoholic treatment and rehabilitation program
    - ✓ Any such program conducted by a private nonprofit organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act to provide treatment that can lead to the rehabilitation of drug addicts or alcoholics
  - Individuals who are inmates of a public institution or released in past 90 days
  - Individuals who are pregnant or entitled to postpartum Medicaid coverage
  - Parent, guardian, caretaker relative, or family caregivers (as defined in the RAISE Family Caregivers Act) of (1) a dependent child or (2) a disabled individual
    - ✓ In many other states, this only pertains to caregivers of children 13 years or younger, DC is special in this circumstance:
    - ✓ *For states that covered parents up to 138% FPL pre-expansion (CT, DC, MA, MN) none of the parents, guardians, or caretaker relatives are considered "expansion" so none of them would be subject to work requirements.*

Exceptions are Available for Short Term Hardships that Include Inpatient Stays, Disaster Declarations, or Travel for Health

- 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.
- 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 or 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.

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"
    - ✓ States must perform outreach by October 2026 according to preliminary guidance

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REMINDER: DHCF is Conducting Outreach About Alliance and Medicaid Changes to Beneficiaries and Stakeholders

- **Direct Outreach to Impacted Beneficiaries:**
  - DHCF sent notice of disenrollment to affected Alliance and Medicaid beneficiaries
- Ongoing communications will be provided in the Biweekly DHCF Eligibility Meetings such as this– next is Wednesday, March 11, 2025, at 2:30 pm.
- DHCF established dedicated webpages related to these program changes that provides an overview of changes and answers Frequently Asked Questions at https://dhcf.dc.gov/Alliance-Program-Changes and https://dhcf.dc.gov/medicaid-program-changes

NEW: DHCF Has Medicaid FAQs, a Resource Document, and a Medicaid Director Letter on its Website on Upcoming Changes to Medicaid

- DHCF will share out all information on Medicaid changes at https://dhcf.dc.gov/medicaid-program-changes
- DHCF shared the Medicaid Changes Resource Document last month:
  - Find the Resource Document at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Changes%20Resource%20Information.pdf
- DHCF shared information on the Medicaid changes' scope in a Medicaid Director Letter
  - Find the Medicaid Director Letter at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MDL_25-02-Medicaid_PCR_and_CA_Income_Change_Eff_01_01_26_1.pdf
- DHCF released Beneficiary FAQs on Medicaid Changes
  - Find Beneficiary FAQs at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Changes%202025%20Fact%20Sheet%20FAQ%2010.2025.pdf

The Healthy DC Plan Provider Webpage is Live

- The Healthy DC Plan Provider Webpage is live at https://www.dchealthlink.com/HealthyDCPlan-providers

- Providers can use the page to learn:
  - **Which insurance companies are offering Healthy DC Plan?**
  - **Where can I check enrollment for Healthy DC Plan members?**
  - **Where can I check benefits, provider networks, and prescription drug coverage for Healthy DC Plan members?**
  - **What does Healthy DC Plan cover?**
  - **Who is eligible for Healthy DC Plan?**
  - **And More!**

- Check out the Healthy DC Plan Provider Webpage today!

DC Medicaid Has Multiple Ongoing Methods of External Outreach And Wants to Join Your Meetings Too!

- DC Medicaid wants to join meetings of key stakeholders to explain changes to Medicaid and Alliance
  - DHCF staff would attend meetings hosted by your stakeholder group -or that you know about –*send invites to us via email at Medicaid.renewal@dc.gov.*

- DC Medicaid is hosting regular Biweekly DHCF Eligibility Meetings such as this every 2 weeks- continuing every other Wednesday at 2:30 pm and **next is Wednesday, March 11, 2026**.
  - Please email *Medicaid.renewal@dc.gov* to join the meetings and related mailing list if not on it already

- DC Medicaid is holding monthly Resident-Focused Eligibility Meetings the last Friday of every month– the next is this week at **6:30 pm Friday, February 27, 2026.**

- DC Medicaid is starting monthly District Direct (DCAS) Trainings for Human Services Benefits at 12:30 pm on Tuesdays designed for stakeholders and anyone helping others with eligibility– the next one is **Tuesday, March 17, 2026**.

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Questions and Comments

Learn more about Alliance and Medicaid Program Changes: https://dhcf.dc.gov/Alliance-Program-Changes and https://dhcf.dc.gov/medicaid-program-changes

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