Mary's Center

Frequently Asked Questions on Medicaid Changes Effective January 1, 2026

1. What changes are happening in the Medicaid program?

- Income limits for **parents/caregivers** will decrease from **221% to 138% of FPL** (See the income table below)
- Income limits for **childless adults** will decrease from **215% to 138%** of **FPL**
- The current categories of **adults without children** and **parents/caregivers** will be in effect through **December 31, 2025**
- Starting **January 1, 2026**, a **new combined category** will go into effect (income **138% of FPL**)

Household Size	**Current Adult without children (210% + 5%)** ***Valid until 12/31/2025)***	**Current Parent/Caregiver (216% + 5%)** ***Valid until 12/31/2025)***	**New (138%)** ***Valid from 01/01/2026)***
1 person	$2,806	$2,884	$1,800
2 people	$3,790	$3,896	$2,432
3 people	$4,775	$4,908	MX$3,065
4 people	MX$5,762	MX$5,923	MX$3,697
5 people	MX$6,747	$6,935	$4,330
6 people	MX$7,731	MX$7,947	MX$4,962
7 people	$8,718	MX$8,962	$5,595
8 people	MX$9,703	MX$9,974	MX$6,227

These **Federal Poverty Level (FPL)** guidelines for eligibility based on household size are updated annually. Exact dollar amounts may change as **of January 1, 2026.** These amounts reflect the maximum monthly income allowed to qualify based on household size.

2. What happens if my income exceeds the new income limits (138% FPL) as of January 1, 2026?

If your income exceeds the eligibility limit, your Medicaid coverage will end on **December 31, 2025**. You will receive a termination letter in early December.

If your income exceeds **138% of FPL** and you are a **parent/caregiver** or **childless adult** applying after January 1, 2026, other health coverage options will be evaluated for you.

3. What other health care options are available in addition to Medicaid?

The DC Health Benefit Exchange, officially known as DC Health Link, is the District of Columbia's online health insurance marketplace for residents and small businesses, created under the Affordable Care Act.

DC Health Benefit Exchange offers:

- **Qualified Health Plans** (with or without assistance)
  - The income limit is **greater than 200% of FPL**
- **Healthy DC Plan** (Basic Health Plan), new program effective **January 1, 2026**
  - The income limit is **138% to 200% of FPL**

4. Are there any out-of-pocket costs for Qualified Health Plans?
Qualified Health Plans: (Assisted or Unassisted): "Assisted" and "Unassisted" refer to whether a person receives financial help from the government to pay for their health insurance premiums and out-of-pocket costs when enrolling in a Qualified Health Plan (QHP) through a Health Insurance Marketplace. There are out-of-pocket expenses that can be reduced through advance premium tax credits for those who qualify.

- 27 medical plans
- Income: The income limit is greater than 200% of the Federal Poverty Level (See table below).

Category	DC Health Link (200% of FPL)
1-person household, annual income	**Over $31,300**
2-person household, annual income	**Over $42,300**
3-person household, annual income	**Over $53,300**
4-person household, annual income	**Over $64,300**

DC Health Link Call Center: 833-432-7526

- Monday – Friday: 8:00 a.m. – 8:00 p.m.
- Saturday: 10:00 a.m. – 5:00 p.m.

5. Does DC Health Benefit Exchange programs have out-of-pocket costs?
Yes, most DC Health Benefit Exchange (DC Health Link) programs have out-of-pocket costs, such as copayments, deductibles, and co-insurance, which vary by plan type, except Healthy DC Plan.

6. What does the Healthy DC Plan cover?
The **Healthy DC Plan** covers a wide range of health care services, including:

- Primary care physician visits
- Visits to specialist doctors
- Urgent care visits
- Hospitalizations and emergency care
- Laboratory services
- Prescription drugs
- Behavioral health
- Substance use disorder treatment
- Preventive care

7. Who is eligible for the Healthy DC Plan?
DC residents are eligible for the Healthy DC Plan if:

- They are between 21 and 64 years old
- Are U.S. citizens or are in the country legally
- They are not eligible for Medicaid
- They are not eligible for employer or other coverage, and
- They have an annual income between 138% and 200% FPL

For more information, see the Income Eligibility Chart for the Healthy DC Plan below.

Household Size	Annual income
1-person household	$21,597 – $31,300
2-person household	$29,187 – $42,300
3-person household	$36,777 – $53,300
4-person household	$44,367 – $64,300

Special eligibility for lawfully present residents with an annual income of up to 138% of FPL: If a lawfully present resident is not eligible for Medicaid due to their immigration status, the resident is eligible for the Healthy DC Plan.

8. Are there any out-of-pocket costs in the Healthy DC Plan?
No. **The Healthy DC Plan** has no monthly payments (also called premiums) or out-of-pocket costs for covered services. When you receive care from participating doctors, hospitals, and community health centers, there is no out-of-pocket cost to you.

9. When does the Healthy DC Plan open during the enrollment period?
The **Healthy DC Plan** opened enrollment on **November 1, 2025,** for coverage effective **January 1, 2026**. If you select a plan between **December 16, 2025,** and **January 1, 2026**, your coverage will begin on **February 1, 2026**.

10. What insurance companies offer the Healthy DC Plan?
There are 3 insurance companies that offer the Healthy DC Plan:

- AmeriHealth Caritas District of Columbia Healthy DC Plan
- CareFirst BlueCross BlueShield Healthy DC Plan
- MedStar Family Choice Healthy DC Plan

All three insurance plans cover the same services. The main differences are provider networks and prescription drug coverage.

11. What measures should I take during this transition period?

If your income exceeds 138% of the FPL (see income chart on page #1), your Medicaid record and information will be automatically transferred to the DC Health Care Benefit Exchange (HBX). No further action is necessary.

12. How do these changes affect prenatal and postpartum care for parents/family caregivers or recently pregnant childless adults?
If a mother, caregiver, or childless adult with an income greater than 138% enrolled in the DC Health Benefit Exchange becomes pregnant, they must report immediately. Once notified, and if you qualify, you will be transferred back to Medicaid, which grants you a right to **prenatal care** and **12** months of **postpartum care after pregnancy.**

13. I currently have transitional medical assistance (TMA), will my coverage end early?
Your TMA will continue until the end of your certification period. At the end of that certification period, you will be evaluated to continue Medicaid or move to HBX.

Note: When a parent/caregiver reports a change in income due to increased hours or income from employment, they will be granted TMA coverage for 12 months. Please note: The TMA is only available to parents/caregivers.

14. Will there be any changes to Elderly and Persons with Physical Disabilities (EPD) Waiver Program services under Medicaid My Way or other long-term care programs?
There are no changes to the financial eligibility criteria for Medicaid long-term care services.

Medicare beneficiaries
1. If I am a childless adult with Medicare and my income exceeds 138% of FPL (about $1,800 for an individual), what happens to my coverage?

- **Childless Adults and Parents/Caretaker Relatives** who currently are enrolled in both Medicare and Medicaid are members of the District's **Qualified Medicare Beneficiary Plus (QMB+)** program (these individuals are also known as "dual eligible")

    - **Definition:** QMB Plus applies to individuals who qualify for both QMB and full Medicaid.
    - **Benefits:** These individuals receive all the benefits of the QMB program, plus any additional benefits available through their state's Medicaid program, such as coverage for services Medicare does not.
    - **Income limits:** Monthly Income Limit 138% of FPL

- **Qualified Medicare Beneficiary (QMB)**
    - QMB health coverage is limited to payment Medicare premiums, co-payments and deductibles and does not offer full scope health insurance
        - Part A (Hospital)
        - Part B (Medical Insurance)
        - Part D (Prescription Drug Coverage)

Category	QMB	QMB Plus (Full Duals)
2026 Federal Poverty Level (FPL)	**Monthly Income Limit 300% of FPL**	**Monthly Income Limit 138% of FPL**
1 person	Max. $3,913.00	Max. $1,800.00
2 people	Max. $5,288.00	Max. $2,432.00

2. If I am a parent/caregiver or adult without children, will I keep my Medicaid coverage, even if I have Medicare?

It depends... Here are some cases:

- If you are a parent/family caregiver, your income must be at or below 138% of the FPL.
- If you are an adult without children and receive Medicare, you will need to move to another Medicaid group

Examples of options for other Medicaid groups:

- **Aged, Blind, or Disabled (ABD):** To be eligible for this group, your income must be at or below 100% FPL ($1,305 per month for an individual), be over 65, blind, or disabled, and meet the resource requirements, $4,000 or less.
- **Long-term care (LTC):** To qualify for this group, you must need long-term care and have an income at or below 300% of the supplemental security income benefit rate ($2,901).

3. What if I am an adult without children with an income below 138% FPL and I have just qualified for Medicare?

You should report your Medicare eligibility immediately. A Department of Human Services caseworker may ask you for additional information to make sure you belong to the current eligibility group. Also, in some cases, DC Medicaid will find out that you have Medicare and send you a supplemental application, which you will need to return by the deadline listed on the notice.

Note: You cannot remain in the childless adult category if you have Medicare or are 65 years of age or older. You must be evaluated for another Medicaid program.

4. I am an adult without children; I am almost 65 years old, and I do not have Medicare. Do I need to do anything to keep my Medicaid?

Since you are almost 65 years old, you should receive a notice from DC Medicaid asking you to complete a supplemental application so that you can be evaluated in another Medicaid category.

Beneficiaries who are approaching age 65 and not receiving Medicare are encouraged to apply for Medicare, but it is not a requirement to qualify for Medicaid.

Application Process

1. **How do I apply for Medicaid coverage and what is required?**

You can apply for Medicaid in the following ways:

- Online through District Direct: districtdirect.dc.gov
- District Direct mobile app: Compatible with Android (Google Store) and iPhone (Apple Store)
- Fax: 202-671-4400
- By visiting or mailing to the Department of Human Services/Economic Security Administration (ESA) Centers (see addresses in the following table)

Service Centers	Address in Washington, DC	Telephone:	Fax:
Anacostia	2100 Martin Luther King Avenue, SE	(202) 645-4614	(202) 727-3527
Congress Heights	4049 South Capitol Street, SW	(202) 645-4525	(202) 654-4524
Fort Davis	3851 Alabama Avenue, SE	(202) 645-4500	(202) 645-6205
H Street	645 H Street, NE	(202) 698-4350	(202) 724-8964
Taylor Street	1207 H Street, NW	(202) 576-8000	(202) 576-8740

Applications will not be considered complete until all financial and non-financial verifications have been received.

- You must provide proof that you reside in DC
- If you are a U.S. citizen, you must present your Social Security card
- If you have a green card, you must provide your alien number or Social Security card
- You must prove your income revenue
- Resources like Qualified Medicare Benefits (QMB) and Long-Term Care (LTC)

2. How long will it take to know if I am eligible?

It takes 45 business days to determine eligibility, 60 business days if you need to prove a disability. If you meet all program requirements, your eligibility begins on the first day of the month you applied. If you applied on April 28 and were approved for health coverage, your eligibility begins on April 1.

3. How long does eligibility last?

Eligibility is valid for 12 months. At the end of the 12 months, you must complete a renewal form and submit all updated income and residency documents.

Renewal Process

1. Are personal interviews required?

- No, personal interviews are not required

2. How often should you renew your coverage?

- Once every 12 months

3. How will I know if it is time to renew my coverage?

The Department of Human Services, Economic Security Administration (ESA) will send you a letter informing you of your upcoming renewal period 60 days before your certification period ends.

Aspects to consider for the renewal:

- At the time of renewal, beneficiaries must check certain eligibility factors

4. What tests are needed for the renewal?

Recipients will need to provide proof of District residency and income.

Type of check **Acceptable Testing**

Income

- Recent pay slips (last 30 days)
- Self-Employment: Latest Tax Return
- Retirement Income Statement
- Disability Income Statement
- Workers' Compensation
- Pension or Annuity Declaration
- Unemployment Benefits Statement

Residence

- Valid DC driver's license or ID card
- Current rental agreement, lease agreement, or rent receipt
- Utility or phone bill
- Payroll or income statement issued within the last 30 days that includes the person's name and DC address
- Property tax bill issued within the last 60 days for a property located in DC
- Completed residency form

Beneficiaries must verify their residency and income in each renewal period.

5. When should I file my renewal?

Renewal must be submitted on the last day of the certification period. For example, if the renewal expires in May, you must file it by May 31.

6. What happens if I don't file for renewal before the end of the certification period?

90 Days' Grace Period:

- If you don't submit your renewal form by the end of your certification period, you still have **up to 90 days** afterward to turn it in. This is called the **grace period**
- If you submit the form within those 90 days and still qualify, your coverage will restart **retroactively** from your certification end date
- If you do not submit it within 90 days, you will need to **submit a new application** for medical coverage