New Medicaid work requirements begin in 2027

Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan (EP) members. Please note, this information is specific to the MMC, HARP, CHPlus, and EP programs only.

Starting January 1, 2027, new federal community engagement/work requirements will apply to certain Medicaid members and may affect their eligibility for coverage. For some Medicaid members, these changes may affect their eligibility or require additional documentation to maintain their Medicaid benefits.

Medicaid community engagement/work requirement FAQ

Q. What's changing?
A. Beginning January 1, 2027, some adults on Medicaid will need to report their work or community engagement hours to keep their health coverage under a new federal law. Members will also be required to renew their benefits more often.

Q. Who will be affected, and what are the new requirements?
A. Adults between the ages of 19 and 64 who do not have a disability, a qualified medical condition, or young children will need to work, go to school, volunteer for community service — or a combination of these activities — for an average of 80 hours each month to qualify for or keep their Medicaid coverage. Members who meet the new requirements will need to report an average of 80 hours per month of work, school, or volunteer hours, or a mix of all three, to Medicaid. **Most Medicaid members will not be affected**.

Q. How will members be contacted?
A. Medicaid will notify impacted members several months before the effective date of the change to allow them time to prepare:

- To make reporting easier, Medicaid will use reliable information the state already has, such as employment and Social Security records, to determine whether members meet the requirements. Medicaid estimates that this will allow it to confirm that about half of the impacted members meet eligibility requirements without requiring additional paperwork.
- For members whose eligibility cannot be determined using data sources, a manual process will be required. Medicaid will send letters to these members when they need to take action or provide information.
- Members should keep their contact information up to date with Medicaid so they do not miss these important updates or requests for information. Failure to respond to Medicaid requests may result in the closure of health coverage, even if the member remains eligible.

Q. Is anyone exempt from these changes?
A. These changes will not impact the majority of Medicaid members through one of the following exemptions:

- **Foster care youth** under the age of 26.

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- **Indian Health Service members**: people recognized as American Indians or Alaska Natives and eligible for health services through the Indian Health Service.
- **Caregivers** (defined as parent, guardian, caretaker, relative, or family caregiver) of a dependent child 13 years of age and under or a disabled individual.
- **Disabled veterans**: Defined as a veteran "with a disability rated as total under section 1155 of Title 38, United States Code" (section of law that establishes the schedule for rating veterans' disabilities and governs how compensation is determined).
- **Medically frail people**: Including people who are blind or disabled, have a substance use disorder, a disabling mental disorder, a physical, intellectual, or developmental disability, or have a serious or complex medical condition.
- **People already meeting work requirements** under Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program (SNAP)
- **Members participating in a qualifying substance use disorder treatment program**: Defined as SUD programs that meet SNAP-related federal requirements, run by nonprofit organizations or public community mental health centers.
- **Justice-involved populations**: This includes those who are incarcerated or have left incarceration within the prior three months
- **Pregnant and postpartum women:** Defined as "pregnant or entitled to postpartum medical assistance under paragraph (5) or (16) of subsection (e)" (the 12-month Medicaid continuous postpartum extension).

Additional temporary exemptions may apply for short-term hardship or certain extenuating circumstances, including:

- Members receiving care in hospitals, nursing facilities, psychiatric facilities, or other intensive care settings.
- Members living in a federally declared disaster area.
- Members living in counties with high unemployment rates (1.5 times the national unemployment rate, pending permission from the HHS secretary).
- Members or their dependents who are required to travel outside their home for medically necessary care for an extended period of time.

Q. How can care providers help?

- Remind members that these changes will not begin until **January 1, 2027**.
- Many members will be exempt from these work requirements:
- Help them identify whether they may qualify for an exemption and encourage them to contact the state so their **exemption can be confirmed**, if applicable.
- Be sure their contact information is up to date so they don't miss any notices; exemptions must be verified every six months.
- If the state can't verify compliance, they must send a notice and give them a chance to respond. Remind members that if they receive a notice of non-compliance, they have 30 days to show compliance before disenrollment.

For further questions, please refer to your state Medicaid site at **Changes to Medicaid Coverage | NY State of Health**.