

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850



DATE: October 19, 2026

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Programs for All-Inclusive Care for the Elderly (PACE), Medicare Providers, and Other Interested Parties

FROM: Jennifer Smith, Acting Director, Medicare Enrollment and Appeals Group, Center for Medicare

Nishamarie S. Mills, Deputy Director, Medicare-Medicaid Coordination Office

SUBJECT: **Impact to Medicare Enrollment, Disenrollment, and Cost Sharing Requirements Upon Implementation of section 1903(v)(5) of the Social Security Act (the Act)¹ for Dually Eligible Individual's Loss of Medicaid Coverage**

Beginning October 1, 2026, section 1903(v)(5) of the Act, as added by section 71109 of Public Law (P.L.) 119-21, known as the "Working Families Tax Cut" (WFTC) legislation, will limit, with some exceptions, federal financial participation for Medicaid to noncitizens who are: lawful permanent residents (LPRs or "green card holders"); Cuban/Haitian entrants; and Compacts of Free Association (COFA) migrants. The statute made similar changes to Medicare eligibility requirements for non-citizens which have not been implemented to date.

The purpose of this memo is to remind Medicare Advantage Organizations (MAOs), Medicare Prescription Drug Plans (PDPs), PACE Organizations, Medicare providers and suppliers, and other interested parties of the applicable Medicare enrollment, disenrollment, and cost sharing requirements when an individual dually eligible for both Medicare and Medicaid (dually eligible individuals) loses Medicaid coverage, including full Medicaid benefits and Medicaid coverage of Medicare cost sharing/premiums (e.g., through enrollment in a Medicare Savings Program (MSP)). Current dually eligible individuals may include noncitizens whose Medicaid coverage²

¹ On September 30, 2026, the U.S. District Court of the Western District of Washington entered a preliminary injunction in *Neighborhood House v. U.S. Dep't of Health & Hum. Services*, No. 2:26-cv-03006 (W.D. Wash.), enjoining HHS from (a) enforcing, implementing, or otherwise giving effect to the April 8, 2026, CMS State Health Official letter and the related State Implementation Tool as to all qualified noncitizen supplemental security income (SSI) recipients in the State of Washington, and/or (b) terminating Medicaid healthcare funding for any qualified noncitizen SSI recipients in the State of Washington.

² For purposes of this correspondence, Medicaid coverage includes full Medicaid benefits and partial or limited Medicaid benefits (e.g., MSP coverage, family planning services). The term does not include Medicaid payment for

may be reduced or terminated when section 1903(v)(5) of the Act is applicable on October 1, 2026, due to no longer having a satisfactory immigration status or for whom satisfactory immigration status cannot be verified.³

Additional information regarding section 71109 of the WFTC legislation (titled “Alien Medicaid Eligibility”) is available in the State Health Official letter, dated April 8, 2026, and available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf>.

As mentioned above, Section 71201 of the WFTC also limits Medicare entitlement and/or enrollment to the categories of noncitizens noted above, but terminations for Medicare based on the new entitlement and enrollment categories will occur after implementation of section 71109. Information regarding CMS’ proposals to implement the statutory changes made by section 71201 of the WFTC legislation (regarding Medicare eligibility and terminations) are available in the Calendar Year (CY) 2027 Medicare Physician Fee Schedule Notice of Proposed Rulemaking (CMS-1848-P), available at <https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other>. Additional information and guidance regarding section 71201 will be forthcoming.

Disenrollment from a Medicare Dual Eligible Special Needs Plan (D-SNP)

Some individuals whose Medicaid coverage is reduced or terminated by a state in accordance with section 1903(v)(5) of the Act may be enrolled in a D-SNP. Medicare Advantage (MA) special needs plans (SNPs), including D-SNPs, may apply eligibility deeming periods when an enrollee no longer meets the special needs status required for enrollment “if the individual can reasonably be expected to again meet the special needs criteria within a period of time not to exceed six months.” For more information regarding deeming period requirements, see also 42 CFR §§ 422.52(d) and 422.74(b)(2)(iv) and section 60.2.4 of the CMS [Medicare Advantage and Part D Enrollment and Disenrollment Guidance for contract year 2026](#) (“C/D enrollment and disenrollment guidance”). Noncitizens who lose Medicaid coverage as a result of section 1903(v)(5) of the Act are not reasonably expected to regain Medicaid coverage. Therefore, the eligibility deeming periods to maintain D-SNP enrollment **do not apply** for a noncitizen who loses Medicaid coverage as a result of section 1903(v)(5) of the Act.⁴

Additionally, as explained in section 60.2.4 of the C/D enrollment and disenrollment guidance, the D-SNP should provide the enrollee a notice of disenrollment a minimum of 30 days before the disenrollment effective date, regardless of the date of the loss of special needs status and within 10 days of learning of the loss of special needs status. In addition, the D-SNP should provide an involuntary disenrollment confirmation notice within 3 business days following the

the limited coverage of an emergency medical condition (“emergency Medicaid”) authorized under section 1903(v)(2) of the Act.

³ This memo focuses on these noncitizens losing Medicaid coverage, including full Medicaid benefits and limited Medicaid coverage of Medicare cost sharing/premiums. For information regarding noncitizens who may retain Medicaid coverage, including full and limited Medicaid benefits, please see the April 8, 2026, State Health Official letter.

⁴ If such a noncitizen regains Medicaid coverage later (for example, if their immigration status changes to a satisfactory immigration status), refer to section “MA Plan Special Election Periods (SEPs)” of this memo regarding MA SEPs that may be available to the individual.

disenrollment effective date. Section 20.8.4 of the C/D enrollment and disenrollment guidance includes information on D-SNP options for verification of Medicaid eligibility. Plans should refer to “MA Exhibit 32: Model Notice for Loss of Special Needs Status” and “MA Exhibit 33: Model Notice for Loss of SNP Status – Notification of Involuntary Disenrollment” for examples of the two notices that should be provided to the enrollee. Plans should modify the example notices to remove any inapplicable language regarding a deeming period.

For individuals whose Medicare premiums were covered by Medicaid, including through enrollment in an MSP, the beneficiary will be responsible for Medicare premiums when State payment of those premiums ends.

Programs for All-Inclusive Care for the Elderly (PACE)

Medicaid eligibility and enrollment is neither an eligibility nor enrollment requirement for participation in PACE. Participants who are enrolled in a PACE plan as Medicaid beneficiaries and who lose Medicaid eligibility are not involuntarily disenrolled from a PACE plan for loss of Medicaid. Additional information regarding PACE eligibility requirements is available at 42 CFR § 460.150, <https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment>, and <https://www.cms.gov/medicare/medicaid-coordination/pace>. Upon loss of Medicaid coverage, however, the PACE enrollee, or other payer, will be responsible for a monthly premium for the PACE services that Medicaid would have covered if the participant were enrolled as a Medicaid beneficiary, including long-term care services and supports. Additional information regarding Medicare-only payments for PACE participants may be found in the “Clarification of Enrollment of PACE Participants for Medicare Payment” memo, dated August 28, 2025, and available in the [CMS Health Plan Management System \(HPMS\) Memos-Archive Weekly section of the CMS HPMS website](#). Under 42 CFR § 460.164(b)(1) and (b)(2), a PACE organization is permitted to involuntarily disenroll the participant after a 30-day grace period if the participant fails to pay, or make satisfactory arrangements to pay, any premiums that are due to the PACE organization, and any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process. The State Administering Agency (SAA) must approve involuntary disenrollments (42 CFR § 460.164(f)).

MA Plan Special Election Periods (SEPs)

Individuals who lose special needs status are eligible for a Special Election Period (SEP) to make a new MA plan election (42 CFR §§ 422.62(b)(11)(i) and 423.38(c)(27)). See section 30.6.13 of the C/D enrollment and disenrollment guidance for more information. The SEP for an individual who loses special needs status begins the month the individual’s special needs status changes. In addition, individuals who continue to have Medicare Part D Low-Income Subsidy (LIS or “Extra Help”)⁵ are eligible for the SEP for dual- or other LIS-eligible individuals, which permits enrollment once per month in a standalone PDP but does not permit enrollment into an MA Prescription Drug (MA-PD) plan or a change between MA-PD plans (42 CFR § 423.38(c)(4)). If an individual who remains Medicare eligible does not elect a different MA plan or PDP, the individual will return to Original Medicare and CMS will automatically enroll the individual in a PDP, as applicable (42 CFR § 423.34(d)(1)).

⁵ Deemed LIS eligibility continues for the applicable period specified in 42 CFR § 423.773(c)(2).

If a dually eligible individual loses Medicaid coverage and then regains Medicaid later (for example, if their immigration status changes to a satisfactory immigration status), that individual can use an SEP to re-join their prior MA plan, as long as they remain otherwise eligible for Medicare and for the plan, or to join a new MA-PD (including D-SNPs) or PDP (42 CFR § 423.38(c)(9)). Information about SEPs is available in section 30.6 of the C/D enrollment and disenrollment guidance.

Loss of Cost Sharing Protections and Medicaid as Secondary Payer

The Qualified Medicare Beneficiary (QMB) group is a Medicaid eligibility group through which states pay Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. The QMB group is one of the MSPs. If a dually eligible individual's loss of Medicaid coverage includes removal from the QMB eligibility group, the individual will no longer be eligible for the cost sharing protections required for QMBs. Additionally, loss of Medicaid coverage due to section 1903(v)(5) of the Act would affect Medicaid coverage as the secondary payer. Providers should verify the individual's current Medicaid eligibility status, QMB eligibility status, and applicable coverage before billing or assessing cost sharing. Original Medicare providers and suppliers can identify Medicaid eligibility in the HIPAA Eligibility Transaction System (HETS), while MAOs inform the MAO's providers regarding any applicable enrollee billing protections. Information about QMB Billing Protections is available in the [Medicare Learning Fact Sheet: Prohibition on Billing Qualified Medicare Beneficiaries](#).

Questions about the information related to D-SNPs included in this memo can be submitted to MMCO_DSNPOperations@cms.hhs.gov. For questions about the information related to PACE, PACE Organizations should contact their PACE account manager. Medicare enrollment questions can be submitted to enrollment.lmi.org.