H.R. 1 Eligibility Changes for Non-U.S. Citizen Adults Frequently Asked Questions (FAQs)

Questions and answers from the August 13, 2026 Town Hall

Frequently Asked Questions

1. If a non-U.S. citizen is going to lose Medicaid coverage, how much advance notice will they have?

Answer: Letters were sent on August 2, 2026, to notify individuals who were identified as potentially at risk of losing full-benefit Medicaid coverage and who may need to update their immigration status information. Members have 30 calendar days to provide additional information about their immigration status to the state. After the 30-day period, the state will review information provided and redetermine the individual's eligibility using the new rules. Individuals who are determined to no longer be eligible for full-benefit Medicaid under the new rules will receive a Notice of Adverse Action explaining the change. Depending on their individual circumstances and eligibility, they may transition to Emergency Medicaid, or their Medicaid coverage may end. No one will have their coverage reduced or ended based on the new rules before October 1, 2026, and without first being provided written notice of the change.

2. Do individuals have to wait until an emergency occurs to apply for Emergency Services Medicaid, or can they apply earlier if they have a complex medical history that puts them at risk for hospitalization?

Answer: Anyone can apply for Medicaid at any time. When an application is submitted, eligibility is reviewed for full-benefit coverage categories as well as limited-benefit coverage, including Emergency Services Medicaid. Medical acuity or a specific medical event is not reviewed to determine enrollment in Emergency Services Medicaid. However, services are covered only when the service provided, as verified by a review of the claim once it is submitted, meets the emergency services criteria. Generally, the condition must be one that could reasonably be expected to result in serious disability or death. Ongoing dialysis is also covered through Emergency Services Medicaid.

3. What resources are available to help individuals find affordable medications, including prescription assistance programs, discount programs, low-cost pharmacy resources, and state or community supports?

Answer: Resources are available through the Virginia Department of Social Services (https://www.dss.virginia.gov/) and DMAS (https://www.dmas.virginia.gov/for-members/benefits-and-services/) public-facing webpages, with additional resources expected to be added. The Federal Marketplace also provides information related to these changes.

4. Will Medicaid waiver enrollment be automatically terminated on October 1, 2026, for members affected by the new noncitizen eligibility rules, or is there a redetermination process?

Answer: The Medicaid eligibility process and rules are the same for individuals receiving waiver services and those who are not. A lawful permanent resident who meets the applicable requirements, including the five-year waiting-period rules when applicable, may remain eligible. A waiver recipient with a status that no longer qualifies for full-benefit Medicaid will be redetermined and may be moved to Emergency Services Medicaid. Because waiver services require Medicaid eligibility, an individual who loses full-benefit Medicaid eligibility would also lose Medicaid-funded waiver services.

5. Will non-U.S. citizens still be eligible for SNAP benefits, help paying power bills, or subsidized housing?

Answer: Eligibility depends on the individual's immigration status. H.R. 1 made changes to SNAP eligibility for noncitizens that are similar to the Medicaid changes. For example, refugees, asylees, Special Immigrant Visa holders, and certain other groups generally need lawful permanent resident status to remain eligible for SNAP, while Cuban/Haitian entrants and COFA migrants remain eligible. Virginia began implementing the SNAP changes at recertification beginning December 1, 2025. Specific eligibility guidance for energy assistance or subsidized housing and other related resources are available through the VDSS website.

6. Will children of adults who become ineligible for Medicaid on October 1, 2026, also become ineligible?

Answer: No change was made to the noncitizen eligibility rules for children under age 19 or for pregnant individuals who are lawfully residing. Children and pregnant individuals who meet the applicable lawful-residence and other Medicaid eligibility requirements remain eligible.

7. Will the FAMIS Prenatal program continue, or will undocumented pregnant women lose prenatal coverage?

Answer: There are no changes to the FAMIS Prenatal program.

8. Will the H.R. 1 eligibility changes affect refugees?

Answer: Yes. Adult refugees must meet the new eligibility requirements to qualify for full-benefit Medicaid on and after October 1, 2026, unless they are under age 19 or pregnant. This means they must be a Lawful Permanent Resident (LPR), Cuban or Haitian Entrant, or Compact of Free Association (COFA) migrant. Unlike other LPRs, individuals who previously held refugee status, and certain other humanitarian statuses, do not have a 5-year waiting period to be eligible for Medicaid.

Newly arrived refugees or individuals with newly granted qualifying humanitarian status may be eligible for Refugee Medical Assistance (RMA), which has an eight-month time limit. RMA is available when an individual is not eligible for Medicaid and is determined through the application process by the local Department of Social Services.

9. How can providers determine whether a member is eligible for Medicaid after the noncitizen eligibility changes take effect?

Answer: Providers should verify Medicaid eligibility each time they provide services to ensure the individual is covered and the type of coverage that they have. Traditional Medicaid providers who use aid-category information should pay particular attention to aid categories 112 and 113, which indicate coverage for Emergency Services Medicaid.

10. If an undocumented member's coverage ends before the end of the 60-day postpartum period, who should the member contact for assistance?

Answer: FAMIS Prenatal provides coverage to pregnant individuals through the pregnancy and for 60 days after the end of the pregnancy. If coverage is ended early, the member can contact their eligibility worker at the local Department of Social Services or the Cover Virginia Call Center. Individuals can also find local enrollment assistance at Find Help in Your Area | CoverVA. Additional health, food assistance and legal resources are available through Virginia Department of Social Services public-facing resources (https://www.dss.virginia.gov/).

11. Will individuals screened and diagnosed through Every Woman's Life remain eligible for Medicaid coverage for cancer treatment?

Answer: Individuals screened and diagnosed through Every Woman's Life must still meet Medicaid's nonfinancial eligibility criteria, including the new noncitizen eligibility requirements. The Every Woman's Life program requirements themselves are not changing; however, eligibility for the Medicaid coverage category associated with a diagnosis through the program remains subject to Medicaid eligibility rules.

12. How many Virginia Medicaid members are expected to lose or have their coverage reduced because of the October 1, 2026, changes?

Answer: The state identified approximately 5,800 individuals who may not be eligible for full-benefit Medicaid after October 1, 2026 due to these eligibility changes. These individuals were sent a letter with information about the changes and give a 30-day period to send in updated immigration status information. Because members were still within the period to report updated information, not all of these individuals may lose or have their coverage reduced.

13. Do lawful permanent residents (i.e. green card holders) qualify for Medicaid?

Answer: Lawful permanent residents (LPRs) may qualify for Medicaid, but eligibility depends on several factors. LPR children and pregnant individuals are eligible for full-benefit Medicaid if they meet all other eligibility requirements. Under longstanding federal law, non-pregnant adult LPRs are generally subject to a five-year waiting period from the date they obtain LPR status unless they meet an exception, such as having previously held certain humanitarian statuses (such as refugee or asylee status), having entered the United States before August 22, 1996, or being an active-duty military personnel, veterans, or their spouse or child.

14. What happens when a child covered under the more flexible noncitizen rules ages out of children's Medicaid?

Answer: Children's Medicaid coverage continues through the month in which the child turns age 19. At that point, eligibility is reevaluated under the adult rules, including the lower adult income limit and more restrictive adult noncitizen eligibility requirements. For example, a child with refugee status who previously qualified for Medicaid would, upon turning 19, only be eligible for Emergency Services Medicaid.

15. How do the changes affect adults with Temporary Protected Status (TPS) who have U.S.-born children?

Answer: An adult with TPS is not eligible for full-benefit Medicaid under the current rules unless the individual is pregnant, so there is little change for those adults. Children born in the United States are U.S. citizens and are evaluated based on their own citizenship and eligibility circumstances. A parent's immigration status is not used to determine the child's Medicaid eligibility.

16. Does a member's noncitizen eligibility status appear in the Virginia Medicaid eligibility portal as a specific enrollment or plan code?

Answer: Information about a member's citizenship or immigration status is not available to providers. Medicaid shares member information only to the extent necessary for providers to furnish services and bill appropriately. A member's eligibility should always be confirmed prior to providing services.

17. If an individual wins a Medicaid appeal and eligibility is reinstated, can coverage be retroactive for services provided during the appeal process?

Answer: Coverage may be reinstated retroactively depending on the outcome of the appeal. Members who file an appeal within certain timeframes may also request to keep their coverage while the appeal it is pending, but may have to repay the cost of any care provided during the appeal process if they lose their appeal. When coverage is reinstated retroactively, the member is placed in fee-for-service. The provider will need to file a claim for services provided during that time period. For more information please go to DMAS Appeals page (https://www.dmas.virginia.gov/appeals/).

18. How and where should a member report an address change or updated immigration status information?

Answer: Members can contact their eligibility worker at the local Department of Social Services, call the Cover Virginia Call Center, or through their member account on CommonHelp.virginia.gov. Individuals who received a letter and need to report updated immigration-status information, such as proof of LPR status, can use the contact information provided in the letter.

19. What happens to nursing facility coverage for an older adult who loses full-benefit Medicaid solely because of the new immigration-status requirements?

Answer: Medicaid coverage of long-term services and supports (LTSS), such as nursing facility care, is based on the person being eligible for full-benefit Medicaid and meeting Medicaid LTSS level of care requirements. When a person loses their eligibility for full-benefit Medicaid, the state is no longer able to pay for their LTSS care. For a specific member in this situation, we recommend utilizing the Contact Us process (https://www.dmas.virginia.gov/for-members/benefits-and-services/long-term-care/) so the individual case can be reviewed and available resources or options can be explored with the member and provider.

20. Will an Iraqi or Afghan Special Immigrant Visa (SIV) holder lose Medicaid coverage?

Answer: Many Iraqi and Afghan SIV holders entered the U.S. with documentation also establishing LPR status, including a temporary I-551. These individuals will continue to meet Medicaid noncitizen eligibility rules for full-benefit coverage. If an SIV does not have LPR status, they will no longer be eligible for full-benefit Medicaid coverage unless they are a child under age 19 or pregnant.

21. For Emergency Services Medicaid, does an eligibility worker need to verify that an emergency occurred before enrolling the individual?

Answer: No. Eligibility workers do not review medical services, charts, or other medical documentation to verify an emergency before enrollment. An individual may be enrolled based on meeting the applicable eligibility criteria. Whether a service qualifies for payment under Emergency Services Medicaid is determined after the provider submits a claim for the services provided.

22. Is substance use disorder treatment considered an emergency service under Emergency Services Medicaid?

Answer: Substance use disorder treatment is not covered under Emergency Services Medicaid because it is typically considered ongoing treatment for a chronic condition rather than an emergent event as defined for Emergency Services Medicaid. However, treatment for an acute substance-related medical emergency, such as a drug overdose, may be covered if the individual's condition meets Emergency Services Medicaid criteria. This means the condition must involve acute symptoms severe enough that, without immediate medical attention, the individual's health could be placed in serious jeopardy, bodily functions could be seriously impaired, or an organ or body part could suffer serious dysfunction. Coverage is limited to services necessary to treat the qualifying emergency medical condition and is subject to review by DMAS.