# Federal and State Budget Medi-Cal Provisions

Updated as of July 16, 2025

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## Changes to How Medi-Cal is Funded

| Effective Date | Provision | Current Law | New Law | Resources |
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| July 4, 2025 | **HR 1: Provider Taxes (Freeze Provision)** | States can fund their share of Medicaid spending using taxes on healthcare providers. Federal rules require these healthcare provider taxes to be broad and uniform, meaning the tax cannot solely target Medicaid providers and states cannot guarantee providers will get their money back. However, if the tax revenue is 6% or less of providers' net patient revenue, the requirement doesn't apply. This is known as the "safe harbor" limit. | • States are prohibited from establishing any new provider taxes or from increasing the rates of existing taxes. | Which States Might have to Reduce Provider Taxes Under the Senate Reconciliation Bill?<br><br>5 Key Facts About Medicaid and Provider Taxes<br><br>Medicaid Budget Survey 2024-2025 - Provider Rates and Taxes |
| July 4, 2025 | **HR 1: State Directed Payments** | States are generally not permitted to direct how managed care organizations (MCOs) pay their providers. However, subject to CMS approval, states may use "state directed payments" (SDPs) to require MCOs to pay providers certain rates, make uniform rate increases (that are like fee-for-service supplemental payments), or to use certain payment methods.<br><br>A 2024 rule established the upper limit for SDPs as the average commercial rate for hospitals and nursing facilities, which is usually higher than the Medicare payment ceiling for other Medicaid fee-for-service supplemental payments. | • HHS must revise state directed payment regulations to cap the total payment rate for inpatient hospital and nursing facility services at 100% of the total published Medicare payment rate for states that have adopted the Medicaid expansion and at 110% of the total published Medicare payment rate for states that have not adopted the expansion.<br><br>• State directed payments approved prior to the legislation's enactment are grandfathered in but payments will be reduced by 10 percentage points each year (starting January 1, 2028) until they reach the allowable Medicare-related payment limit. | Reconciliation Language Could Lead To Cuts in Medicaid State-Directed Payments to Hospitals and Nursing Facilities<br><br>10 Things to Know About Medicaid Managed Care<br><br>5 Key Facts about Medicaid and Hospitals<br><br>Medicaid Budget Survey FY 2024-2025, Provider Rates and Taxes |

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| July 4, 2025* | **HR 1: Rural Health Funding** | No provision | • The budget bill establishes a rural health transformation program that will provide $50 billion in grants to states between fiscal years 2026 and 2030. These grants are to be used for payments to rural health care providers and other purposes.<br><br>• Uses of funds include promoting care interventions, paying for health care services, expanding the rural health workforce, and providing technical or operational assistance aimed at system transformation. | How Might the Reconciliation Bill's Medicaid Cuts Affect Rural Areas?<br><br>5 Key Facts About Medicaid Coverage for People Living in Rural Areas<br><br>10 Things to Know About Rural Hospitals |
| December 31, 2025 | **State Budget: Elimination of WQIP** | The Skilled Nursing Facility (SNF) Workforce & Quality Incentive Program (WQIP) provides performance-based directed payments for measurable improvements in quality of care, healthcare outcomes, and workforce investment. | • The health omnibus budget trailer bill eliminates the WQIP.<br><br>• All close-out activities will be required to occur prior to January 1, 2027 or when DHCS can attest it has been completed (January 2028 at the latest). | Medi-Cal Long-Term Care Reimbursement Act |
| July 1, 2026 | **State Budget: Nondesignated Public Hospital Supplemental Fund** | Existing law authorizes the state to retain 9% of each intergovernmental transfer (IGT) amount to reimburse the department, or transfer to the General Fund, for the administrative costs of operating the program. | • Nondesignated public hospitals participating in the program will be required to reimburse DHCS for specified administrative costs as a condition of receiving the supplemental payments. | |
| July 1, 2026 | **State Budget: Proposition 56** | On November 8, 2016, California voters approved the California Healthcare, Research, and Prevention Tobacco Tax Act (commonly known as Prop. 56) to increase the excise tax rate on cigarettes and tobacco products to help fund health care expenditures. | • Supplemental Medi-Cal provider payments for dental services will be eliminated.<br><br>• Supplemental payments for family planning and women's health services will be maintained. | Proposition 56 Supplemental Dental Payments |

*Funding not available until start of FY 2026 (October 1, 2025)

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| October 1, 2026 | **HR 1: Federal Medical Assistance Percentage (FMAP) for Emergency Medicaid** † | Undocumented immigrants and some lawfully present immigrants are not eligible for federally funded Medicaid coverage. Emergency Medicaid reimburses hospitals for the costs of emergency care provided to immigrants who would qualify for Medicaid except for their immigration status, which hospitals are required to provide under federal law. | • Federal matching payments for Emergency Medicaid will be limited for individuals who would otherwise be eligible for expansion coverage except for their immigration status to the state's regular FMAP. | Key Facts on Health Coverage of Immigrants |
| January 1, 2027 | **HR 1: Section 1115 Demonstration Waiver Budget Neutrality** | Under long-standing policy, Section 1115 demonstration waivers must not cost the federal government more than what would have been spent without the waiver. Costs are usually calculated per enrollee over the waiver period, typically five years. This means the spending per person cannot exceed the projected spending without the waiver. | • The Chief Actuary for CMS, rather than the HHS Secretary, must certify that 1115 waivers are not expected to result in an increase in federal expenditures compared to federal expenditures without the waiver. | Medicaid Section 1115 Waivers: The Basics |
| FY 2028* | **HR 1: Provider Taxes (Safe Harbor Reductions)** † | States can fund their share of Medicaid spending using taxes on healthcare providers. Federal rules require these healthcare provider taxes to be broad and uniform, meaning the tax cannot solely target Medicaid providers and states cannot guarantee providers will get their money back. However, if the tax revenue is 6% or less of providers' net patient revenue, the requirement doesn't apply. This is known as the "safe harbor" limit. | • States may only receive a waiver to implement provider taxes if that tax is broad-based and uniform - making some currently permissible taxes not permissible in future years.<br>• The safe harbor limit for states that have adopted the ACA expansion will be reduced by 0.5% annually starting in fiscal year 2028 until the safe harbor limit reaches 3.5% in FY 2032.<br>• The new limit applies to taxes on all providers except nursing facilities and intermediate care facilities, as well as to local government taxes in expansion states.<br>• States may have at most 3 fiscal years to transition existing arrangements that are no longer permissible. | Which States Might have to Reduce Provider Taxes Under the Senate Reconciliation Bill?<br>5 Key Facts About Medicaid and Provider Taxes<br>Medicaid Budget Survey 2024- 2025 - Provider Rates and Taxes |
| October 1, 2029 | **HR 1: Good Faith Waiver for Payment Reduction Related to Certain Erroneous Medicaid Payments** | Federal law requires CMS to recoup funds for payments made to ineligible individuals or over-payments to eligible ones if a state's error rate is over 3%. However, CMS may waive this recoupment if the state shows it has tried to lower its error rate. | • HHS will be required to reduce federal financial participation to states for identified improper payment errors related to payments made for ineligible individuals and overpayments made for eligible individuals. | 5 Key Facts About Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments |

* FY 2028 begins October 1, 2027 additional implementations through FY 2032

† Funding Allocated to Support State Implementation

| Updates to Covered Services | | | | |
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| **Effective Date** | **Provision** | **Current Law** | **New Law** | **Resources** |
| July 4, 2025 | **HR 1: Free Choice of Provider †** | States must generally allow beneficiaries to obtain Medicaid services from any provider that is qualified and willing to furnish services. Managed care organizations (MCOs) may restrict enrollees to providers in the MCO's network, except that such plans cannot restrict free choice of family planning providers. | • The payment of Medicaid funds are prohibited to providers that are nonprofit organizations, essential community providers primarily engaged in family planning services or reproductive services, provide for abortions outside of the Hyde exceptions and receive $800,000 or more in payments from Medicaid in 2023; this would affect Planned Parenthood and other Medicaid essential community providers.<br><br>• This provision is effective for only one year from enactment. | What's at Stake in the Supreme Court Case Medina v. Planned Parenthood South Atlantic?<br><br>The Impact of Medicaid and Title X on Planned Parenthood |
| July 1, 2026 | **State Budget: Dental for UIS** | Effective January 1, 2024, full scope Medi-Cal benefits were extended to unsatisfactory immigration status (UIS) individuals between the ages of 26 to 49. This included dental benefits. | • Individuals who are 19 years of age or older and do not have satisfactory immigration status will no longer be eligible for dental benefits under Medi-Cal.<br><br>• This includes legal qualified immigrants who have not been in the United States for a minimum of 5 years.‡<br><br>• Legal immigrants who are refugees or asylees are exempted from the reduction of dental benefits.* | |
| July 1, 2026 | **State Budget: Hospice** | Under existing law, prior authorization is not required for hospice services. | • Prior authorization for hospice services in Medi-Cal will be required. | |

*8 U.S.C.§ 1641(b)
‡ 8 U.S.C.§ 1613(a)
† Funding Allocated to Support State Implementation

| Updates to Covered Services | | | | |
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| **Effective Date** | **Provision** | **Current Law** | **New Law** | **Resources** |
| July 1, 2026 | **State Budget: Elimination of PPS for UIS** | A Prospective Payment System (PPS) is a method of reimbursement in which payment is based on a predetermined amount. California law mandates that the Department of Health Care Services (DHCS) pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) at PPS per-visit rates | • FQHC and RHC services eligible for PPS per-visit reimbursement will be limited to those eligible for federal financial participation, thereby eliminating PPS per-visit rates for individuals with unsatisfactory immigration status (UIS) services. | Eliminate Prospective Payment System Reimbursement for State-Only Services |
| July 1, 2028* | **HR 1: Home and Community Based Services (HCBS)** † | States must provide nursing facility care under Medicaid, but most home care services are optional. Many states offer home care through 1915(c) waivers, which restrict services to those needing institutional-level care. | • States will be allowed to establish 1915(c) HCBS waivers for people who do not need an institutional level of care.<br><br>• States' waiver submissions will be required to include a demonstration that the new waiver will not increase the average amount of time that people who need an institutional level of care will wait for services. | What is Medicaid Home Care (HCBS)?<br><br>A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024 |

*New waivers may not be approved until July 1, 2028
† Funding Allocated to Support State Implementation

## Changes to Medi-Cal Eligibility

| Effective Date | Provision | Current Law | New Law | Resources |
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| July 4, 2025 | **HR 1: Eligibility and Enrollment Final Rule** | The Eligibility and Enrollment Final Rule includes two main sets of rules issued by CMS. The first one makes it easier for low-income Medicare beneficiaries to enroll in Medicare Savings Programs (MSPs), which help cover Medicare costs. The second one simplifies how people apply for and enroll in Medicaid and aligns renewal processes for all Medicaid recipients. | • The Secretary is prohibited from implementing, administering, or enforcing certain provisions in both rules until October 1, 2034. | Medicaid Changes in House and Senate Reconciliation Bills Would Increase Costs for 1.3 Million Low-Income Medicare Beneficiaries<br><br>5 Things to Know: A Look at the Proposed Medicaid Eligibility & Enrollment Rule<br><br>What Does the Medicaid Eligibility Rule Mean for Low-Income Medicare Beneficiaries and the Medicare Savings Programs (MSPs)?<br><br>Potential Effects of the Proposed Medicaid Eligibility Rule for Newly Enrolled Medicare-Medicaid Enrollees |
| January 1, 2026 | **State Budget: Enrollment Freeze on UIS** | The federal Medicaid program does not provide funds for medical assistance to individuals who are not legal permanent residents in the U.S. However, state law allows individuals with unsatisfactory immigration status (UIS) to qualify for full scope Medi-Cal benefits if they meet otherwise meet eligibility requirements. | • New enrollment of undocumented individuals 19 years or older will be prohibited.<br><br>• If a member loses eligibility while pregnant, the individual shall remain eligible for full-scope Medi-Cal throughout the pregnancy and for 12 months after the pregnancy ends.<br><br>• Members will be allowed a 3-month cure period from the date of disenrollment.<br><br>• Those who've lost full scope benefits or individuals who would otherwise be eligible were it not for their immigration status are only eligible for pregnancy-related services and emergency medical treatment (with the exception of coverage loss during pregnancy noted above).<br><br>• Legal immigrants who are refugees or asylees are exempted from the freeze.* | Immigrant Healthcare |

*8 U.S.C.§ 1641(b)

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| **Effective Date** | **Provision** | **Current Law** | **New Law** | **Resources** |
| January 1, 2026 | **State Budget: Asset Test** | Current law prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries. | • Asset caps will be set at $130,000 for individuals and $65,000 for each additional household member, capping at 10 members. | California Assembly Bill No. 133 |
| October 1, 2026 | **HR 1: Immigrant Eligibility** † | Undocumented immigrants are not eligible for federally-funded Medicaid coverage. Emergency Medicaid pays hospitals for the costs of emergency department care for immigrants who would qualify for Medicaid if not for their immigration status. Many lawfully present immigrants must wait five years after obtaining qualified status before they may enroll in Medicaid; states may waive the five-year wait for children and pregnant individuals. | • Qualified immigrants for purposes of Medicaid or CHIP eligibility will be restricted to lawful permanent residents (LPRs), certain Cuban and Haitian immigrants, citizens of the Freely Associated States (COFA migrants) lawfully residing in the US, and lawfully residing children and pregnant adults in states that cover them under the ICHIA option. | 5 Key Facts About Immigrants and Medicaid |
| December 31, 2026 | **HR 1: Eligibility Determinations** † | States must renew eligibility every 12 months for Medicaid enrollees whose eligibility is based on modified adjusted gross income (MAGI). States are required to review eligibility within the 12-month period if they receive information about a change in a beneficiary's circumstances that may affect eligibility. | • States will be required to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults. | Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations Following the Unwinding of the Pandemic-Era Continuous Enrollment Provision<br><br>Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage |

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| **Effective Date** | **Provision** | **Current Law** | **New Law** | **Resources** |
| December 31, 2026* | **HR 1: Work Requirements** † | Medicaid eligibility cannot be tied to work or reporting requirements. During Trump's presidency, 13 states got approval for work requirements through special waivers, but most of these were canceled under Biden, leaving only Georgia with an active waiver. | • States will be required to condition Medicaid eligibility for individuals ages 19-64 on working or participating in qualifying activities for at least 80 hours per month.<br><br>• Federal law will mandate that states exempt certain adults, including parents of dependent children under 13 and those who are medically frail.<br><br>• States will be required to verify that individuals applying for coverage meet requirements for one or more consecutive months preceding the month of application and that individuals who are enrolled meet requirements for one or more months between the most recent eligibility redeterminations (at least twice per year).<br><br>• Seasonal workers meet the requirements if average monthly income meets the specified standard.<br><br>• These provisions cannot be waived including under Section 1115 authority. | 5 Key Facts About Medicaid Work Requirements<br><br>Understanding the Intersection of Medicaid and Work: An Update Implementing Work Requirements on a National Scale: What We Know from State Waiver Experience<br><br>Section 1115 Waiver Tracker Work Requirements<br><br>An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?<br><br>Medicaid Work Requirements: Implications for Low Income Women's Coverage<br><br>Different Data Source, But Same Results: Most Adults Subject to Medicaid Work Requirements Are Working or Face Barriers to Work Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders<br><br>A Closer Look at the Medicaid Work Requirement Provisions in the "Big Beautiful Bill" |

* Allows the Secretary to exempt states from compliance with the new requirements until no later than December 31, 2028, if the state is demonstrating a good faith effort to comply.
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| **Effective Date** | **Provision** | **Current Law** | **New Law** | **Resources** |
| January 1, 2027 | **HR 1: Retroactive Coverage †** | Under current law, states are required to provide Medicaid coverage for qualified medical expenses incurred up to 90 days prior to the date of application for coverage. | • Retroactive coverage will be limited to one month prior to application for coverage for expansion enrollees and two months prior to application for coverage for traditional enrollees. | |
| January 1, 2027*<br><br>October 1, 2029** | **HR 1: Verifying Enrollee Address and Other Information** | States are not required to take proactive steps to obtain updated enrollee contact information. The Eligibility and Enrollment final rule requires states to leverage reliable data sources to update enrollee address information, effective June 2025. | • States will be required to obtain enrollee address information using reliable data sources.<br><br>• The HHS Secretary will be required to establish a system to prevent individuals from being simultaneously enrolled in two states and states will be required to submit monthly enrollee information to the system.<br><br>• States must review the Death Master File at least quarterly to determine if any enrolled individuals are deceased. | Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations Following the Unwinding of the Pandemic-Era Continuous Enrollment Provision |
| July 1, 2027 | **State Budget: Premiums for UIS** | Effective July 1, 2022, the 2022-2023 state budget lowered Medi-Cal premiums to $0, including for pregnant persons and children. | • All unsatisfactory immigration status (UIS) populations, between the ages of 19-59, excluding pregnant women, shall be required to pay a premium.<br><br>• Premium costs will be $30 per individual per month.<br><br>• After 90 days of nonpayment and if coverage is not reestablished during the available 3-month cure period, members will only be eligible for pregnancy-related services and emergency medical treatment.<br><br>• Legal immigrants who are refugees or asylees are exempted from premiums.‡ | Proposition 56 Supplemental Dental Payments |

* January 1, 2027 for states to obtain contact information and to review Death Master File

** October 1, 2029 to establish system to prevent enrollment in two states simultaneously

‡ 8 U.S.C.§ 1641(b)

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| **Effective Date** | **Provision** | **Current Law** | **New Law** | **Resources** |
| January 1, 2028 | **HR 1: Home Equity Limits** | Most Medicaid enrollees who qualify for Medicaid because they need long-term care (LTC) are subject to limits on their home equity. In 2025, federal rules specified that states' limits on home equity must be between $730,000 and $1,097,000, and those amounts are updated each year for inflation. | • The maximum home equity limits will be reduced to $1,000,000 regardless of inflation.<br><br>• States will be allowed to apply different requirements for homes that are located on farms. | Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025 |
| October 1, 2028 | **HR 1: Cost Sharing** † | States have the option to charge premiums and cost-sharing for Medicaid enrollees. Out-of-pocket costs cannot exceed 5% of family income. | • Enrollment fees or premiums will be eliminated for expansion adults.<br><br>• States will be required to impose a copay of up to $35 per service on expansion adults. This explicitly exempts primary care, mental health, and substance use disorder services and limits cost sharing for prescription drugs.<br><br>• Services provided by federally qualified health centers, behavioral health clinics, and rural health clinics will be exempt.<br><br>• The 5% of family income cap on out-of-pocket costs is maintained. | Cost Sharing Requirements Could Have Implications for Medicaid Expansion Enrollees With Higher Health Care Needs<br><br>Understanding the Impact of Medicaid Premiums & Cost- Sharing: Updated Evidence from the Literature and Section 1115 Waivers |

† Funding Allocated to Support State Implementation

Federal Information Adapted from KFF (formerly: Kaiser Family Foundation) Summary