



# The One Big Beautiful Bill Act & California's Medicaid Program

The One Big Beautiful Bill Act (OBBBA) makes significant changes to Medicaid eligibility, financing, and provider payments. Expansion states, such as California, will face some of the steepest effects, especially around work requirements and stricter limits on provider taxes and hospital payment structures.

## Work Requirements

OBBBA creates a new community engagement (work) requirement for most adults. People enrolled in California's Medicaid (Medi-Cal) expansion group, the "New Adult Group," must complete at least 80 hours per month of work, education, job training, or qualifying community service to enroll and remain eligible.

Several groups are excluded from new work requirements, including adults with disabilities, pregnant people, parents and caretakers of children under 14, individuals with certain medical conditions, and American Indian and Alaska Native members.

## Cost-Sharing

Beginning October 1, 2028, California must charge cost-sharing of up to \$35 per service for certain New Adult Group members with incomes between 100% and 138% of the federal poverty level. Primary care, mental health, and substance use disorder services, and services received at Federally Qualified Health Centers (FQHCs), rural health clinics, and community behavioral health providers are exempt.

## Retroactive Coverage

Currently, Medi-Cal allows coverage for unpaid medical expenses incurred within the 3 months before the Medi-Cal application date for applicants who were eligible during those months. For most Medicaid programs going forward, OBBBA shortens retroactive coverage from up to 3 months before application to 2 months before the month of application, and to 1 month for New Adult Group members. This change takes effect on January 1, 2027.

## Eligibility Review

Starting January 1, 2027, New Adult Group members must complete eligibility renewals every 6 months, rather than every 12 months. American Indian and Alaska Native members are exempt from this requirement. California has already implemented an "ex parte" review process using existing data sources to speed up renewals and reduce the number of times people need to take action to maintain coverage. The law also delays federal streamlining rules intended to simplify Medicaid and CHIP renewals and adds new checks for duplicate enrollment, address changes, and death records.

## Qualified Immigrants

Under OBBBA, only lawful permanent residents, certain Cuban and Haitian immigrants, and migrants from the Compact of Free Association (COFA) remain in the “qualified immigrant” category. In states that choose to use this option, federal funds can also continue for lawfully residing children and pregnant people under the Legal Immigrant Children's Health Improvement Act (ICHIA) option. Beginning October 1, 2026, certain abused spouses and children, asylees, refugees, trafficking survivors, and humanitarian parolees will no longer qualify for Medicaid or CHIP.

## Provider Taxes and State-Directed Payments

The OBBBA makes significant changes to Medicaid funding with provider taxes and state-directed payment (SDP) programs. The changes begin in FY 2028 and will be phased in over a 10-year period.

**Provider tax rate:** OBBBA limits how California can use provider taxes, such as the Medi-Cal managed care organization (MCO) tax and the Hospital Quality Assurance Fee (HQAF), to finance Medi-Cal. Beginning in FY 2028, expansion states must gradually lower their maximum allowable provider tax rate each year until the cap reaches 3.5 percent in FY 2032. The Legislative Analyst's Office estimates that changes to the MCO tax could remove roughly \$4.2 billion in anticipated General Fund savings in 2025-26 and \$2.8 billion in 2026-27 that the state had planned to achieve through the tax.

**Hospital state-directed payments:** California uses state-directed payments in Medi-Cal managed care to increase hospital and other provider payments above base rates. Under OBBBA, expansion states like California will begin phasing down their commercial rate-based payment structure in FY 2028, reducing allowable payment ceilings by 10 percentage points of the commercial rate each year until they meet Medicare rate limits.

## Emergency Medicaid Match Reduction

Starting October 1, 2026, the federal match rate for Emergency Medi-Cal services provided to non-citizens who would otherwise qualify for the New Adult Group will drop to the regular Medicaid Federal Medical Assistance Percentage (FMAP).

## Federal Payments to “Prohibited Entities”

For one year following enactment (July 4, 2025 – July 4, 2026), federal Medicaid funds may not be paid to certain nonprofit family planning providers that offer abortion services and deliver family planning or reproductive health services to Medicaid members.

In California, a series of federal court orders has temporarily protected Planned Parenthood affiliates from this ban, and the California Department of Health Care Services (DHCS) has directed Medi-Cal managed care plans to continue paying those providers while the preliminary injunction remains in effect. Other providers that meet the federal “prohibited entity” definition may only be paid with state funds for most services, and abortion services at those clinics are already funded entirely with state General Funds outside federal Medicaid.

## Rural Health Funding

OBBBA creates a **\$50 billion Rural Health Transformation Program** to support rural healthcare access, infrastructure, and workforce. The program provides \$10 billion annually from FY 2026 through FY 2030, distributed to states with approved rural health transformation plans. States that applied are expected to receive about \$100 million per year in baseline funding, with the potential for additional competitive dollars based on rural needs and the strength of each state's plan.

The California Department of Health Care Access and Information (HCAI) has submitted its plan to CMS and is expected to receive an award notice by December 31, 2025. If approved, the state plans to invest in a hub-and-spoke “Transformative Care Model,” workforce development recruitment and retention, and technology and tools for health IT, telehealth, and data systems for rural providers.