November 2025

EXECUTIVE SUMMARY

A View of Medicaid Today and a Look Ahead: Balancing Access, Budgets and Upcoming Changes

Results from an Annual Medicaid Budget Survey for State Fiscal Years 2025 and 2026

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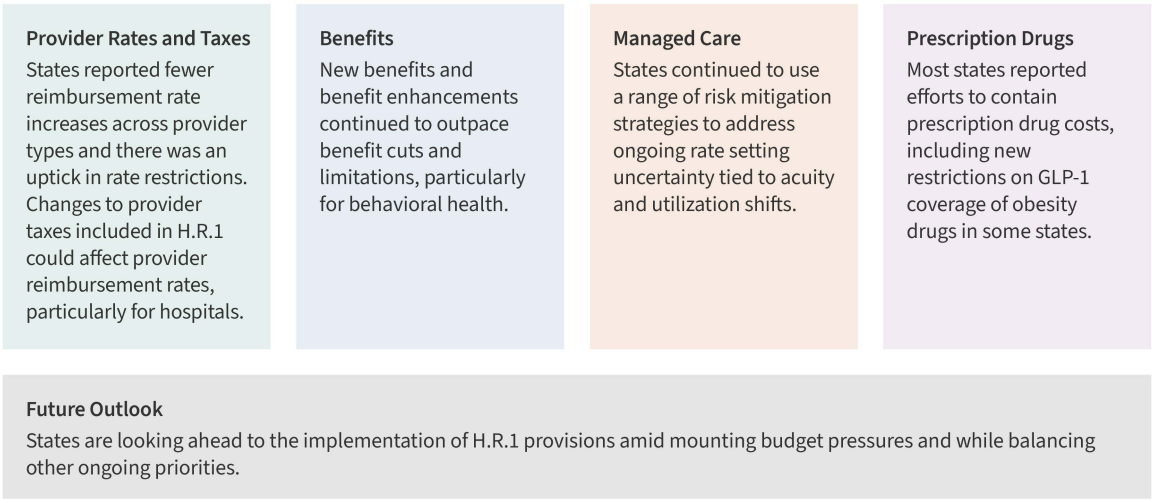
Executive Summary

Following years of significant changes in Medicaid spending, enrollment, and policy during the COVID-19 pandemic and the subsequent Medicaid unwinding period, state Medicaid programs returned to more routine operations in state fiscal year (FY) 2025 and were focused on an array of other priorities, including improving access to care or addressing social determinants of health. However, heading into FY 2026, states were facing a more tenuous fiscal climate and beginning to prepare for another major set of changes to the Medicaid program. The 2025 federal budget reconciliation law (H.R.1) includes substantial Medicaid policy changes and reductions in federal funding, though the impacts vary by state. While many of the provisions do not take effect until FY 2027 or later, states are anticipating the upcoming changes, assessing budgetary and programmatic impacts, and preparing for the implementation of multiple and complex policy changes. Serving over one in five people living in the United States and accounting for nearly one-fifth of health care spending (and over half of long-term care spending), Medicaid represents a large share of state budgets and is a key part of the overall health care system.

This report highlights certain policies in place in state Medicaid programs in FY 2025 and policy changes implemented or planned for FY 2026, which began on July 1, 2025 for most states.[1] The findings are drawn from the 25th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by KFF and Health Management Associates (HMA), in collaboration with the National Association of Medicaid Directors (NAMD). The survey was sent to states in June 2025 and 48 states responded by October 2025, although response rates for specific questions varied.[2] The District of Columbia is counted as a state for the purposes of this report, and due to differences in the financing structure of their programs, the U.S. territories were not included in this analysis.

Figure 1

Key Themes Revealed in the 2025–2026 Medicaid Budget Survey



Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, November 2025

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Key Take-Aways

- **Provider Rates and Taxes.** At the time of the survey, responding states had implemented or were planning more fee-for-service (FFS) rate increases than rate restrictions in both FY 2025 and FY 2026; however, across many individual provider types, notably fewer states reported rate increases in FY 2025, or planned for FY 2026, compared with recent years. States continue to target rate increases for nursing facilities and home and community-based services (HCBS) providers more often than for other provider types. There was a notable uptick in states reporting provider rate restrictions in FY 2025 (6 states) and FY 2026 (6 states), compared with the number of states reporting provider rate decreases for FY 2024 (1 state) and FY 2023 (2 states). Trends in provider reimbursement rates typically reflect state fiscal conditions. All states except Alaska continue to rely on provider taxes to fund a portion of the non-federal share of Medicaid, and taxes on hospitals (47 states) and nursing facilities (45 states) are most common. States report that provider tax revenue is most often used to increase FFS or managed care organization (MCO) payment rates or fund supplemental payments to providers. H.R.1 imposes significant new restrictions on states' ability to generate Medicaid provider tax revenue, including prohibiting all states from establishing new provider taxes or from increasing existing taxes and reducing existing provider taxes for states that have adopted the Affordable Care Act (ACA) Medicaid expansion.
- **Benefits.** The number of states reporting new benefits and benefit enhancements continues to greatly outpace the number of states reporting benefit cuts and limitations; however, state

Medicaid agencies could face increasing pressure to cut or limit optional benefits to reduce Medicaid costs as states face a more tenuous fiscal climate and start to prepare for the impact of H.R.1. Consistent with trends in recent years, many states reported expanding services across the behavioral health care continuum, particularly community-based behavioral health services.

- **Managed Care.** States and plans faced heightened rate setting uncertainty when the Medicaid continuous enrollment provision expired on March 31, 2023, resulting in acuity and utilization shifts within the remaining population that were difficult to predict. While states have continued to use a range of risk mitigation strategies to address this uncertainty, half of responding MCO states reported seeking Centers for Medicare and Medicaid Services (CMS) approval for a capitation rate amendment to address unanticipated shifts in acuity and/or utilization for a rating period beginning in FY 2025. Most states reported that the changes were applied retrospectively. Beyond rate setting, this year's survey also asked states about requirements related to MCO use of artificial intelligence (AI) to automate parts of the prior authorization process. As of July 1, 2025, less than one-quarter of responding MCO states reported requiring MCOs to disclose the use of AI in prior authorization processes. Several states reported implementing new or expanded oversight activities or adopting other safeguards in FY 2025 or 2026 to support appropriate use of AI in MCO prior authorization processes.
- **Prescription Drugs.** Sixteen state Medicaid programs reported covering GLP-1s (glucagon-like peptide-1s) for obesity treatment as of October 1, 2025, and some states reported plans to restrict coverage in the future. While states must cover nearly all Food and Drug Administration (FDA) approved drugs for medically accepted indications, a long-standing statutory exception allows states to choose whether to cover weight-loss drugs under Medicaid. As a result, Medicaid coverage of GLP-1 drugs for the treatment of obesity remains optional for states, while coverage is required for other indications (diabetes, cardiovascular disease, and sleep apnea). High costs continue to be the key consideration in state Medicaid program obesity drug coverage decisions, and given recent state budget challenges, state interest in expanding Medicaid coverage of obesity drugs is waning, though the landscape continues to evolve. Rising prescription drug costs (and the costs of new specialty drugs in particular) are an ongoing concern for states. Most responding states reported at least one new or expanded initiative to contain prescription drug costs in FY 2025 or FY 2026, with many states reporting initiatives that specifically target high-cost specialty drugs such as cell and gene therapies or other physician-administered drugs.
- **Future Outlook.** Now that the pandemic-era unwinding process has ended, many states are confronting more difficult fiscal conditions and facing fiscal uncertainty driven, in part, by H.R.1.

States reported managing Medicaid cost growth, especially growth driven by higher acuity, increased long-term care demand, and high-cost drugs and treatments, as significant challenges facing the program. Although many Medicaid provisions in the reconciliation law do not take effect until FY 2027 or later, states are assessing budgetary and programmatic impacts and preparing to implement policy changes required by the law. States expressed concern about the scope and complexity of the required changes, the compressed implementation timeframes for certain provisions, and the need for timely federal implementation guidance. States highlighted process and systems challenges that they must address to operationalize the new requirements, including work requirements. In addition to navigating state budget challenges and implementing H.R.1 provisions, states cited a continued focus on other varied Medicaid program priorities including expanding access, implementing initiatives that target specific populations (e.g., pregnant individuals, justice-involved), continuing delivery system efforts, and improving administrative systems and functions.

Endnotes

[1] State fiscal years begin on July 1 except for these states: New York on April 1; Texas on September 1; Alabama, the District of Columbia, and Michigan on October 1.

[2] Florida, Kansas, and Mississippi did not respond to the 2025 survey. In some instances, publicly available data or prior years' survey responses were used obtain information on Medicaid programs in these states. However, unless otherwise noted, these states are not included in counts throughout the survey.

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