What CMS' New Budget Neutrality Rules Mean for Section 1115 Reentry Demonstration Waivers

HARP
THE HEALTH AND REENTRY PROJECT

The Bottom Line

New CMS guidance establishes a rigorous new budget neutrality framework for all section 1115 demonstration waivers, effective January 1, 2027. Although the new guidance, which reflects federal law established in the One Big Beautiful Bill Act, is a substantial change for many services, **it does not materially change the budget neutrality treatment of Medicaid pre-release services in Medicaid reentry waivers**.

In June, the Centers for Medicare & Medicaid Services (CMS) issued new guidance[1] that substantially changes how states demonstrate and CMS reviews **budget neutrality** for Medicaid Section 1115 demonstration waivers (referred to as "waivers" throughout the paper).

"Budget neutrality" is the federal government's financial test for Medicaid Section 1115 waivers. State Medicaid Agencies (SMAs) must show that an 1115 waiver is not expected to cost the federal government more than Medicaid would cost without it—that is, a net change in federal spending of $0 or less. CMS has long applied this standard through agency policy when states test new approaches to coverage and care through waivers. Budget neutrality is now required by federal law, with more rigorous review requirements. HARP wrote this issue brief for State Medicaid Agency staff who work on waiver policy, though other audiences may also find it of interest.

A NEW STANDARD FOR 1115 WAIVER APPROVAL

The 2025 One Big Beautiful Bill Act (OBBBA), also known as H.R. 1, made budget neutrality a statutory requirement. Beginning January 1, 2027, CMS cannot approve a new Medicaid 1115 waiver, amendment, or renewal without certification by the CMS Chief Actuary. The Chief Actuary is CMS's senior official responsible for estimating the financial impact of federal health programs. The CMS Actuary has not previously played a significant role in assessing waivers. Using projected enrollment, service use, payment rates, and other cost assumptions, the Chief Actuary must for the first time independently determine whether a waiver is expected to keep federal Medicaid spending at or below what the federal government would otherwise have spent without it.

1 CMS, State Medicaid Director Letter (SMD) #26-003, June 11, 2026, pp. 1–7, 10–13, 25–27 and 30.

Under the prior policy, CMS and the U.S. Office of Management and Budget, reviewed projected costs before approval and set a budget neutrality spending limit. After approval, CMS monitored actual spending against that limit and could require corrective action. Final compliance was assessed after the waiver period, and states had to return excess federal funds when allowable savings did not cover an overage.

Under the new framework, the Chief Actuary must certify the waiver's expected financial impact before approval. This replaces the prior spending-limit test with a more detailed analysis of estimated costs and directly attributable savings. States should expect closer review of their data, assumptions, payment arrangements, and implementation plans. CMS will continue to monitor spending and may require corrective action if it differs substantially from projections.

The new guidance groups waiver activities into two categories with different requirements. Under the new framework, states must classify activities based on whether they could cover the same people and services under the Medicaid State Plan without a waiver. The "Medicaid State Plan" is the federally approved blueprint of how a state's program operates and the basis for a state to receive federal matching payments.

- Medicaid Authorizable Populations and Services (MAPS) refers to coverage a state could provide under its Medicaid State Plan or other federal Medicaid rules, including certain services provided in a different setting, such as a jail or prison. For budget neutrality, CMS treats this spending as equal to what Medicaid could spend without the waiver. This means states do not have to find savings elsewhere to cover MAPS costs, and MAPS cannot count as savings to pay for other waiver activities. States must show which Medicaid rules allow the coverage, estimate spending for each year—including the federal government's share – and formally confirm that their payment methods and amounts meet the applicable Medicaid requirements.
- Section 1115-only activities are waiver activities that cannot be covered under a state's Medicaid State Plan or other federal Medicaid rules. States must estimate the cost of each activity, including the cost of administering it, and identify any additional Medicaid costs or savings that result directly from it. These estimates must be based on a comprehensive, well-supported analysis that clearly explains the data, methods, and assumptions used.

WHAT THIS MEANS FOR ESTABLISHING BUDGET NEUTRALITY FOR MEDICAID 1115 REENTRY WAIVERS

The basic budget neutrality treatment of qualifying pre-release services remains similar to past policy, even though the terminology and documentation requirements change. Under the prior approach, CMS called pre-release service costs "hypothetical" because Medicaid could cover the services for eligible people in the community. States did not need savings elsewhere to pay for these services within the approved spending limit, and the services could not generate savings to fund other waiver activities.[2]

Under the new methodology, qualifying pre-release services fall under MAPS provided at a different site of service—a correctional facility. The reasoning remains similar: Medicaid could otherwise cover these services for the same eligible individuals in the community. CMS treats qualifying MAPS spending as equal to spending without the waiver, giving it a net financial impact of zero for budget neutrality. As before, states do not need offsetting savings, and these services cannot generate budget neutrality savings.[3]

2 CMS, State Medicaid Director Letter 24-003, August 22, 2024, pp. 7–8

3 CMS, State Medicaid Director Letter 26-003, pp. 9–12

Although MAPS receive budget neutrality treatment similar to the prior "hypothetical" approach, the new methodology makes the criteria for that treatment explicit. States must show that the services could otherwise be covered for the people receiving them. They must also formally confirm that their payment methods follow, or are consistent with, applicable Medicaid payment rules and do not pay more than Medicaid could pay for the same or comparable services in the community. These are the documentation and payment safeguards states must meet to retain this budget neutrality treatment.

HOW ADMINISTRATIVE AND INFRASTRUCTURE COSTS ARE TREATED

The new approach changes how administrative costs count toward budget neutrality. Prior to the new budget neutrality framework, states estimated the expenses of setting up and running their waivers, but CMS generally reviewed ordinary administrative costs separately, outside the budget neutrality spending limit. Under the new framework, administrative costs resulting from the waiver must be considered when determining whether it increases federal Medicaid spending.

CMS is also adopting a stricter posture on the budget neutrality treatment of waiver infrastructure spending. CMS previously treated reentry infrastructure and capacity-building funding authorized under Section 1115 as "hypothetical" spending, subject to an approved limit. The new guidance places this funding in the Section 1115-only category. States must analyze the investment's costs and any additional Medicaid costs or savings it directly causes. Any net added federal costs must be offset by allowable savings within the full waiver. This can make infrastructure funding harder to support when a waiver has no offsetting savings.[4]

Longstanding Medicaid authorities to support administrative funding remain available to states. States can still receive Medicaid administrative funding for allowable costs associated with their Section 1115 waivers, even without a separate upfront infrastructure funding allowance. For now, states without approved infrastructure funding should pursue eligible start-up and ongoing administrative costs through regular Medicaid administrative funding rules, such as Implementation Advance Planning Documents. Administrative costs attributable to the waiver must be considered in a state's budget neutrality analysis.[5]

States should continue to identify infrastructure and administrative costs separately from pre-release service costs. When staff, systems, or other resources support multiple programs, states should explain how they determined the share assigned to the reentry waiver. CMS has indicated that it will provide further guidance on how administrative costs should be handled.[6]

HOW CMS WILL DETERMINE BUDGET NEUTRALITY

The Chief Actuary must certify that the entire waiver is budget neutral. When qualifying pre-release services are part of a broader Section 1115 waiver, actuarial certification covers the full program, not just the pre-release services component. CMS combines the costs and savings across all Section 1115-only activities over the approval period and bases certification on the federal government's share. After counting any savings CMS allows the state to carry forward, the waiver must not be expected to increase federal Medicaid spending compared with what would have been spent without it. Added infrastructure costs can be offset by savings directly attributable to other Section 1115-only activities within the waiver.[7]

4 CMS, State Medicaid Director Letter 26-003, pp. 7, 13, and 30

5 Social Security Act § 1903(a)(7); 42 CFR §§ 433.15(b)(7) and 433.34; CMS, Medicaid Administrative Claiming.

6 SMD 26-003, pp. 7 and 13.

7 SMD 26-003, pp. 7–8, 13, 15–16 and Appendix B, p. 30. The letter separately addresses administrative costs generally and demonstration-authorized infrastructure funding.

WHEN THE NEW BUDGET NEUTRALITY REQUIREMENTS APPLY

Certification is required for new waivers, amendments, and renewals approved on or after January 1, 2027. Existing 1115 waivers generally continue under their approved Special Terms and Conditions (STCs) through the current approval period, but an amendment can trigger the new process earlier. If the Chief Actuary has not previously certified the waiver, CMS's review would cover all 1115 components, including those the state is not changing.

Waiver renewals will require both a look back at the current approval period and estimates for the next period. Under the new methodology, states must assess how Section 1115-only activities changed Medicaid spending, using actual experience to identify their costs and any directly related Medicaid savings or added costs. The findings help inform estimates for the next approval period and determine whether savings can be carried forward.[8]

CMS plans to establish the new budget neutrality methodology through formal rule-making. If a final rule is not in effect by January 1, 2027, CMS will apply the new guidance outlined in the new guidance on an interim basis and later adjust budget neutrality terms, as needed, to align with the final rule.

NEXT STEPS FOR SMAS AND CORRECTIONAL PARTNERS

States can prepare by reviewing the timing of their next waiver approval, renewal, or amendment and identifying any additional information they may need, building on existing implementation and reporting data. Correctional partners can support this work by providing data states may need to meet the new actuarial certification requirements, such as the number of eligible people expected to receive services, the types and frequency of services, and proposed staffing and infrastructure costs. This information can help states develop realistic spending estimates and explain the assumptions behind them.

8 SMD 26-003, pp. 14–15, 19–21 and 25–27. For the first renewal after January 1, 2027, CMS permits a one-time transition in calculating allowable carry-forward savings under the prior methodology, subject to the limits described in the guidance.