Top 5 Restrictive CMS Changes That Could Reduce Medicaid Funding for States

CMS State Medicaid Director Letter SMD #26-003

Source document: CMS SMD #26-003 PDF

Bottom Line: The CMS letter would make Section 1115 demonstrations much harder to approve and finance by requiring prospective actuarial budget neutrality, narrowing the treatment of waiver expenditures, counting administrative costs, and limiting states' ability to rely on accumulated savings. The likely practical effect is less flexibility for states to finance expansions, delivery-system investments, uncompensated-care pools, and nontraditional Medicaid initiatives.

Five Most Restrictive Changes

1. New Chief Actuary certification before approval

Proposed change: Beginning January 1, 2027, CMS says it may not approve a new, amended, or renewed Medicaid Section 1115 demonstration unless the CMS Chief Actuary certifies prospectively that it will not increase federal Medicaid spending compared with what would have happened absent the waiver. Demonstrations projected to increase federal Medicaid expenditures would not be approved.

State funding impact: States may lose the ability to use 1115 waivers to finance new services, eligibility expansions, delivery-system pools, or supplemental initiatives unless they can prove actuarial savings up front.

2. Elimination of the current WW/WOW budget-neutrality cap model

Proposed change: CMS would move away from the traditional "with waiver/without waiver" expenditure-limit framework and instead require more rigorous, activity-specific financial analyses. CMS states that the new approach is expected to reduce savings available to states and ultimately reduce federal expenditures under Section 1115 demonstrations.

State funding impact: States may have less room to generate or rely on budget-neutrality savings that historically supported nontraditional Medicaid investments.

3. Stricter treatment of "hypothetical" expenditures through new MAPS rules

Proposed change: CMS would replace the current treatment of many "hypothetical" expenditures with a new category called Medicaid Authorizable Populations and Services, or MAPS. Some activities currently approved as hypothetical would no longer qualify as MAPS. MAPS activities would have a net financial impact of zero and could not generate savings; states also would have to show the activity could otherwise be covered under the state plan or other Title XIX authority, with payment terms no different from regular Medicaid authority.

State funding impact: This could sharply reduce the savings bank states use to support waiver-funded services, especially for populations or service combinations that do not neatly fit state-plan or 1915 authority.

4. Administrative costs must count against budget neutrality

Proposed change: CMS would now include all demonstration-related expenditures, including administrative costs, in the budget-neutrality analysis. CMS explicitly says this is a change from the current approach, where administrative costs are not considered as part of determining budget neutrality.

State funding impact: Waivers with significant start-up, IT, contracting, eligibility, care-management, evaluation, or oversight costs may become harder to certify as budget neutral.

5. Rollover savings would be sharply limited

Proposed change: CMS would limit rollover savings to the current demonstration period or the most recent five years, whichever is shorter, and those savings could be used only in the immediately following renewal period, not future periods. CMS says this approach is expected to give states access to less demonstration savings than under the current approach.

State funding impact: States with long-running waivers and accumulated savings would lose much of their ability to carry forward unused savings to finance future waiver costs.

Summary Table

Restrictive Change	Why It Matters	Potential State Funding Effect
Chief Actuary certification	Creates a front-end actuarial approval barrier.	New or expanded waivers may be denied if they increase federal spending.
End of current WW/WOW cap model	Limits use of broad waiver savings calculations.	Less savings capacity to support waiver investments.
MAPS limits on hypothetical expenditures	Prevents some activities from generating savings.	Fewer financing tools for nontraditional services and populations.
Administrative costs included	Adds start-up and operating costs to neutrality test.	Waivers become harder to certify as budget neutral.
Rollover savings restricted	Narrows carry-forward of prior savings.	Long-running waivers lose future financing flexibility.

Overall Takeaway for States

Taken together, these changes would shift CMS Section 1115 policy from a flexible demonstration-financing model toward a more restrictive, actuarially certified federal-spending-control model. The states most affected would likely be those relying on waiver-generated savings, hypothetical expenditures, delivery-system pools, or long-running accumulated savings to support Medicaid innovations and supplemental initiatives.

Source note: This document summarizes CMS State Medicaid Director Letter SMD #26-003. The original PDF is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf