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Preparing for CMS's New Medicaid Section 1115 Budget Neutrality Review Process

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SUMMARY

The Centers for Medicare & Medicaid Services (CMS) State Medicaid Director Letter (SMDL) #26-003 issued on June 11, 2026, outlines the agency's intended approach to implementing new statutory requirements governing budget neutrality for Section 1115 Medicaid demonstrations. The SMDL notes that Section 1115(g) of the 2025 budget reconciliation legislation, P.L. 119-21, requires the CMS Chief Actuary to certify that any new Section 1115 Medicaid demonstration, amendment, or renewal will be budget neutral; that is, will not increase federal Medicaid expenditures relative to the amount that would have been spent absent the demonstration.

For states pursuing new demonstrations, renewals, or amendments, the standard for demonstrating budget neutrality is likely to become significantly more rigorous. Rather than focusing primarily on aggregate budget neutrality projections, states will need to provide more detailed evidence supporting the projected financial impact of individual demonstration activities.

Wakely and HMA are available to help states and stakeholders navigate the new 1115 Medicaid demonstration budget neutrality requirements, including planning, actuarial analysis, development of supporting documentation, and submission.

A SHIFT FROM AGGREGATE BUDGET NEUTRALITY TO ACTIVITY-LEVEL REVIEW

Distinguishing Medicaid Authorizable Populations and Services (MAPS) and Section 1115-only activities. Under the new framework, CMS is requiring that states identify and classify demonstration activities as either MAPS activities or Section 1115-only activities. MAPS activities generally represent populations and services that would otherwise be covered under a state Medicaid plan or another Title XIX authority. Section 1115-only activities are those that could not otherwise be implemented through existing Medicaid authority and therefore drive the demonstration's incremental federal financial impact.

Moving beyond traditional budget neutrality calculations. Historically, Section 1115 budget neutrality has relied on a comparison of projected with waiver (WW) and without waiver (WOW) expenditures. Under the new framework, CMS intends to move toward a prospective assessment of the financial impact of individual demonstration activities, with the Chief Actuary certifying budget neutrality before approval. As a result, the distinction between MAPS and Section 1115-only activities is likely to become a key component of both demonstration development and actuarial review.

EMERGING FRAMEWORK FOR ACTUARIAL REVIEW AND CERTIFICATION

Potential parallels with Medicaid managed care rate review. CMS has yet to release detailed guidance regarding the Chief Actuary's certification process, although the Medicaid managed care rate review process may offer insights into the types of actuarial documentation and supporting analyses that CMS could require. For managed care rates, states submit actuarial certifications and supporting documentation, CMS reviews the submission against applicable regulatory and rate-development requirements, and CMS may issue questions or requests for additional information. States and their actuaries respond to those questions and, when necessary, revise assumptions or supplement supporting documentation. CMS's 2026–2027 Medicaid Managed Care Rate Development Guide provides the documentation CMS needs to evaluate compliance. Insufficient documentation may result in additional questions and requests.

Guidance continues to evolve. CMS has yet to issue complete guidance, and it is unlikely new directives will replicate managed care rate review procedures exactly. The SMDL notes that additional guidance, technical assistance, and future regulations are forthcoming. If final rules take effect after January 1, 2027, CMS intends to apply the approach described in the SMDL on a provisional basis.

Implications for budget neutrality submissions. Although the final review process remains in development, the practical takeaway is clear: states should anticipate greater scrutiny of the data, assumptions, methodology, and rationale underlying budget neutrality projections. Demonstration submissions will likely require significantly more supporting documentation than has historically been included in budget neutrality submissions.

QUESTIONS STATES WILL NEED TO CONSIDER

What is the financial impact of Section 1115-only activities? CMS expects states to provide a financial impact analysis for Section 1115-only activities, including both direct expenditures and changes in utilization or costs attributable to those activities. For example, increased preventive care, reductions in emergency department utilization, or shifts to alternative sites of care should all be reflected in the analysis where applicable.

CMS anticipates that these analyses will generally be developed on a per member per month (PMPM) or percentage of cost basis, with enrollment projections used to translate estimated impacts into aggregate expenditures.

Are they building on existing actuarial practices? Many of the core analytical components will already be familiar to state Medicaid agencies and their actuaries. Trend assumptions, utilization projections, enrollment forecasts, program-change adjustments, and analyses of comparable programs are common elements of current budget neutrality analyses. The difference is likely to be the level of detail and support required to demonstrate why projected impacts are reasonable.

Can they support key assumptions? For example, a statement that an initiative is expected to reduce hospital utilization by 2 percent may now be insufficient. States may need to explain:

- Historical or external evidence that supports the assumption
- How the assumption was translated into projected expenditure impacts
- Whether impacts are expected to vary over time
- What portion of the impact is attributable specifically to the Section 1115 activity
- Any data limitations
- How uncertainty surrounding the assumption affects the projections

Existing actuarial methods may provide a foundation. From a modeling perspective, the underlying actuarial framework may not be fundamentally different. States will still need to establish a baseline, estimate incremental impacts on enrollment, utilization, and unit costs, and project the resulting financial effects over the demonstration period. Based on the SMDL, states may be expected to provide more explicit support and documentation for those estimates than has historically been required.

SUPPORTING ASSUMPTIONS AND ADDRESSING UNCERTAINTY

Using comparable experience. The SMDL allows states to use modeling, simulations, estimates, and experience from comparable Medicaid or healthcare programs. This flexibility can be valuable, particularly when evaluating new initiatives with limited historical experience.

However, supporting evidence will become increasingly important. If a state relies on experience from another state or program, it should be prepared to explain why that experience is applicable and what adjustments were made to account for differences in population characteristics, program design, provider environments, implementation approaches, or other relevant factors.

Recognizing uncertainty. Forecasting the financial impact of new Medicaid initiatives inevitably involves uncertainty. States should identify the major sources of uncertainty, explain how assumptions were selected, and, where appropriate, assess how results change under alternative scenarios.

Using sensitivity analyses. Actuarial analyses frequently evaluate a range of reasonable assumptions and outcomes rather than a single point estimate. Sensitivity analyses and ranges of reasonable results may become increasingly valuable tools for informing discussions with CMS regarding projected costs and savings.

WHY EARLIER PLANNING MATTERS

Integrating actuarial analysis earlier. The new framework reinforces the value of beginning budget neutrality analyses early in the policy-development process. Waiting until a proposal is fully developed may limit a state's ability to gather supporting evidence, refine assumptions, or modify program design based on anticipated financial impacts.

Key planning questions. As states prepare demonstrations, renewals, or amendments, key questions may include:

- Which proposed activities qualify as Section 1115-only activities versus MAPS?
- What data and historical experience will support the actuarial analysis?
- How will costs, savings, and utilization changes be attributed to individual activities?
- What uncertainties and limitations should be documented?
- What additional analyses may be required if CMS challenges key assumptions?

Implications for demonstration timelines. CMS has stated that the Chief Actuary's certification must occur before approval. As a result, states should anticipate that actuarial review may add additional iterations to an already complex demonstration approval process. A reasonable planning assumption is that actuarial questions, supporting analyses, and assumption refinement may become a significant component of demonstration application, renewal, and amendment timelines.

THE BOTTOM LINE

The new Section 1115 budget neutrality framework represents a meaningful shift in how CMS evaluates demonstrations and the role actuarial analysis plays in the approval process.

More documentation, but not necessarily new methods. Although additional guidance is still forthcoming, the overall direction is clear. States will likely need to build a more detailed and transparent evidentiary record supporting the projected financial impact of Section 1115-only activities. For actuaries and Medicaid agencies, the change may be less about developing entirely new modeling approaches and more about strengthening the documentation, justification, and validation of assumptions.

Preparing now can reduce future delays. States that integrate actuarial analysis early in demonstration design, develop clear methodologies, and proactively address uncertainty will likely be well positioned to navigate Chief Actuary review and avoid delays in demonstration approval.

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ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.