FACT SHEET

Summary of CMS State Medicaid Director Letter on Medicaid 1115 Waivers

July 2026

The federal Medicaid program provides health insurance for nearly 70 million people and is a shared responsibility between states and the federal government. Federal law allows states to "waive" certain Medicaid eligibility requirements and cover care for people who might not otherwise be eligible for Medicaid. While there are several types of these "waivers," this fact sheet focuses on 1115 waivers, which give states additional flexibility to design and improve their programs, and demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

Many states use 1115 waivers to cover housing support services in supportive housing (aka tenancy supports) and medical respite care programs, which are especially critical for people with the experience of homelessness and the health care providers who depend on Medicaid reimbursements to deliver those services.

Federal law now requires a Chief Actuary at the Centers for Medicare and Medicaid Services (CMS) to approve Medicaid 1115 waivers and certify the entire demonstration is budget neutral under a stricter methodology. On June 11, 2026, CMS issued a "Dear State Medicaid Director letter" to outline changes to the 1115 waiver process effective January 1, 2027.

This fact sheet outlines upcoming changes to 1115 waivers, outstanding questions, and recommended actions for health center and medical respite care leadership as they navigate the future of waivers that impact their patients/clients and programs.

Takeaway messages: The changes CMS outlined in the letter will likely reduce state innovation through section 1115 demonstration authority and make the 1115 demonstration application, amendment, and renewal process more data-intensive and time-consuming, with states needing to develop more complete program designs and cost impact analyses before getting approval. Most importantly, the changes will significantly limit states' ability to expand Medicaid populations or services through section 1115 demonstrations, affecting both existing and new initiatives.

These changes come as most states are implementing other new federal Medicaid policies such as work requirements and more frequent redeterminations, plus responding to ongoing and time-consuming federal requests for information amid accusations of fraud, waste, and abuse. State leaders will have limited bandwidth to dedicate to 1115 waivers, but the availability of services in supportive housing/tenancy supports and medical respite care programs is imperative to the health and stability of people experiencing homelessness and the health care providers who serve them.

Three Key Changes

1. **How budget neutrality is determined:**

   - **Current:** States assess costs with and without the waiver based on state data, with budget neutrality established at the end of the demonstration.
   - **New:** CMS Chief Actuary must certify the entire demonstration is budget-neutral before approval.
     - States must provide very detailed implementation information plus data on the financial impact of each activity, which now includes administrative and other indirect costs not previously included.
     - Activities are now separated into two new categories: "Medicaid Authorizable Populations and Services (MAPS)" and "Section 1115-only activities" where MAPS activities may not be approved as expenditures because they can be covered elsewhere in Medicaid authorities—thus making subsequent savings more difficult to demonstrate and giving states less flexibility to test new initiatives.
     - Each activity must be assessed individually for cost savings and budget neutrality as well as have an analysis for any increase/decrease in cost (details subject to negotiation with CMS).

Additional resources:

Summary of CMS letter (Sellers Dorsey)

New Budget Neutrality Guidance for Medicaid 1115 Demonstrations (SHVS)

Trump Administration Issues Section 1115 Medicaid Wavier Financing Guidance Which Again Goes Far Further Than H.R. 1 (Georgetown Children and Families)

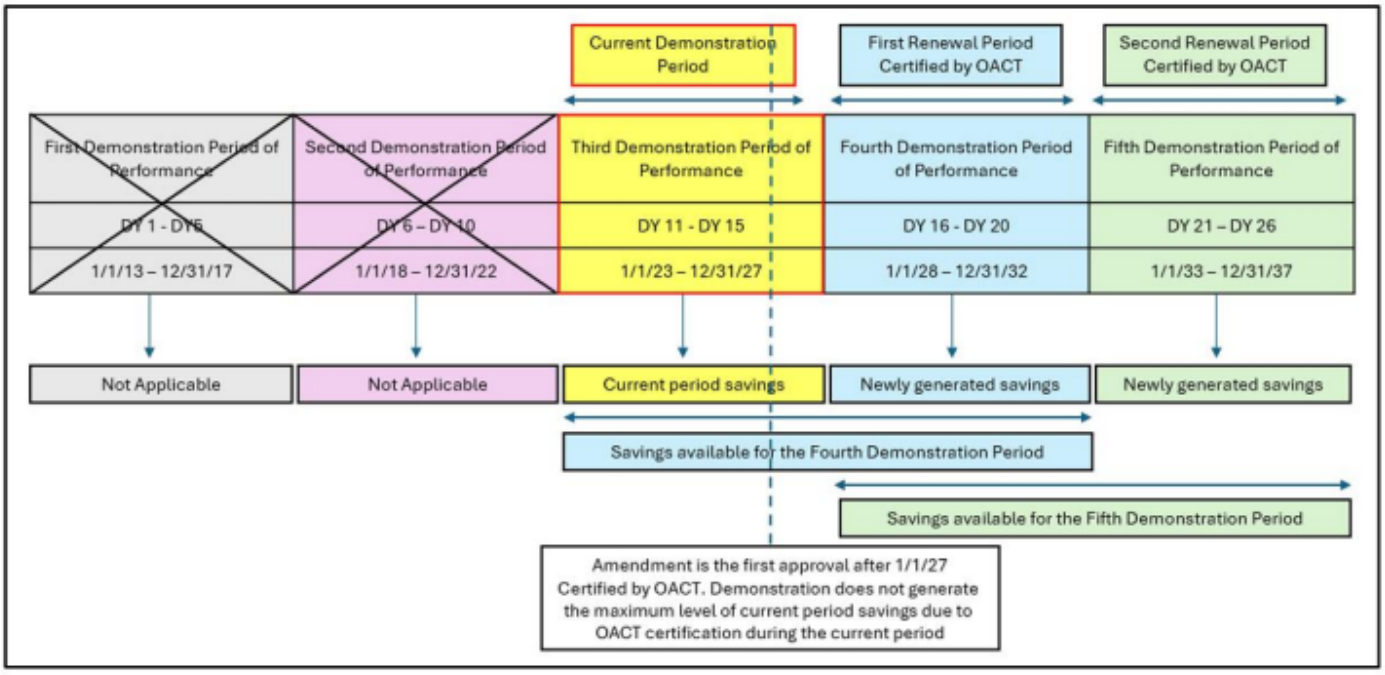
2. **How budget neutrality will be monitored:**

   - **Current:** Quarterly and annual reporting
   - **New:** New special terms and conditions will be defined to monitor key indicators, program outcomes and expenses.
     - CMS reserves the right to decline a renewal if policy goal/objectives are not being met or are unlikely to further the objectives of Medicaid.
     - There will be ongoing monitoring of expenditures, corrective actions for deviations, and new terms and conditions.

3. **How savings roll over into subsequent renewals:**

   - **Current:** Current and rollover of legacy savings beyond 10 years allowed to offset costs.
   - **New:** Waiver savings are only able to roll over into first renewal, not subsequent renewals—limited to 5 years (see figure below with more details in the CMS letter).

Figure 1: Overview of Demonstration Savings by Demonstration Period, SMDL 26-003



Source: CMS letter to states

Other Notes

- 1115 Amendments: States that make no changes to their waiver should see no changes; however, any state seeking to amend their waiver before January 1 must comply with new rules, which likely forfeits full accrued savings. The entire waiver must be certified as budget neutral before an amendment can be approved.
- The guidance discourages states from putting activities in an 1115 when they can be covered under another authority.
- This guidance does not apply to CHIP 1115 demonstrations.
- CMS will provisionally apply these changes and may request additional info from states.
- Ends adjustments to baseline costs if they rise (current practice allows re-baselining).
- Non-expansion states that use an 1115 waiver to cover uncompensated care pools will now have to include those costs in their budget neutrality calculations—further incentivizing formal Medicaid expansion.
- Under new guidance, states with 1115 waivers that add premiums, co-pays, healthy behavior requirements or other restrictions on coverage will easily demonstrate savings—making them prime policy incentives; however, waivers that add new services designed to save costs and improve health over time will have a harder time getting approved.
- On July 7, 2026, CMS rescinded the "fast track" federal review process for 1115 waivers to allow greater time to evaluate waivers for budget neutrality.

Outstanding Questions

- How will health-related social needs activities like tenancy supports and medical respite care be treated?
- What level of risk will states incur if actual costs exceed projected costs?
- How long and difficult will the CMS negotiation process be and is there the possibility of not getting approval in time to prevent gaps in services?
- How will states be treated differently based on political factors?
- Will CMS reject or cancel 1115 waivers if they are deemed not to meet policy goals?

States with 1115 Waivers for Supportive Housing or Medical Respite Care

As stated above, many states use 1115 waivers to cover tenancy supports in permanent supportive housing (PSH) and/or medical respite care (MRC) though states may be in various stages of planning, implementation, or negotiations with CMS over amendments (hence different "pending" and "approved" waiver status; see Table 1).

Table 1. States with 1115 Medicaid Waivers for PSH or MRC

State (links to waiver materials)	Status of Waiver (as of June 30)	Expiration Date	Covers PSH or MRC or Both?
CO	pending	6/30/2026	PSH
CA	pending	12/31/2026	Both
MD	pending	12/31/2026	PSH
ME	pending	12/31/2026	MRC
CT	approved	3/31/2027	PSH
NY	pending	3/31/2027	Both
MT	approved	6/30/2027	PSH
UT	pending	6/30/2027	Both
AZ	pending	9/30/2027	PSH
OR	approved	9/30/2027	PSH
MA	pending	12/31/2027	Both
VT	approved	12/31/2027	Both
NJ	approved	6/30/2028	PSH
WA	approved	6/30/2028	Both
IL	approved	6/30/2029	MRC
NC	approved	12/9/2029	Both
HI	approved	12/31/2029	Both
KY	approved	12/31/2029	MRC
NM	approved	12/31/2029	Both
FL	pending	6/30/2030	PSH
NE	pending	6/30/2030	MRC
RI	approved	12/31/2030	PSH

Recommended Actions

- Talk with your Medicaid director and other health care leaders who work on the Medicaid waivers and to ensure they are aware of these changes and the challenges they pose.
- Engage your state legislative Budget Committee leadership and staff analysts to raise concerns about the impact on the budget and key goals for the state (e.g., access to health care, housing, reducing hospital/ED burden, etc.).
- Assess what data your program may have that can help demonstrate savings for specific waiver services (see our data guide for medical respite care here).
- Evaluate whether other Medicaid authorities—such as the 1915b waiver—can be used to cover existing 1115 services (noting these authorities often do not allow room and board expenses).
- Request state leaders create a waiver task force (if one does not already exist) to proactively discuss options.
- Model the budgetary impact to your program of possible loss of 1115 waiver services and ability to bill for these services.
- Talk with your hospital partners about the impact to inpatient/ED use if supportive housing and/or medical respite care capacity should diminish in your community.

Conclusion

CMS changes to the 1115 waiver process will likely make it more difficult for states to keep or add services such as tenancy supports in supportive housing and medical respite care to state Medicaid programs. These services are vital to the health and stability of people with the current or former experience of homelessness. The HCH Community leadership should actively work with their state to help demonstrate savings as they negotiate with federal officials on a path forward to ensure ongoing services.