AMERICA'S ESSENTIAL HOSPITALS

Nov. 18, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: Budget Neutrality Provisions of the Working Families Tax Cut Legislation

Dear Administrator Oz:

On behalf of our more than 400 member hospitals that serve many of the most vulnerable Medicaid patients, we share comments on the Centers for Medicare & Medicaid Services' (CMS') preliminary guidance about the Working Families Tax Cut (WFTC) legislation's budget neutrality provisions. Section 1115 demonstrations long have served as important tools for states to advance innovative care delivery and payment models, including investments in essential hospitals. We look forward to continuing to work with CMS to ensure that states can continue to use 1115 authority to support these investments and align payments with value.

America's Essential Hospitals is the leading association and champion for hospitals that fill a safety net role in their communities and are dedicated to high-quality care for all, including those who face social and financial barriers to care. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt, helping advance better outcomes and greater value across the health care system.

Essential hospitals serve a disproportionate share of Medicaid patients and provide access to essential care that few other hospitals provide. A disproportionate share of the patients essential hospitals serve are uninsured or covered by Medicare and Medicaid.[1] In addition, nearly two-thirds of essential hospitals provided services to rural patients and communities in 2022.[2] To meet the needs of the populations they serve, members of America's Essential Hospitals provide access to the full continuum of inpatient and outpatient care and engage in robust quality improvement initiatives to meet patients where they are.

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[1] Miu R, Kelly K, Nelb R. *Essential Data 2026: Building Healthy Communities—Results of America's Essential Hospitals 2024 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2026. essentialdata.info. Accessed Nov. 17, 2026.
[2] America's Essential Hospitals. Policy Brief: Essential Hospitals Ensure Access to Care in Rural Areas. March 2025. https://essentialhospitals.org/wp-content/uploads/2025/03/2025-Access-to-Care-in-Rural-Areas-Brief.pdf. Accessed June 5, 2026.

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Through Section 1115 authority, our members have partnered with states to invest in these services and test innovative ways to align Medicaid payment with value through delivery system reforms that improve quality and reduce downstream costs. These investments have been subject to CMS' long-standing budget neutrality guardrails that ensure that demonstration spending does not exceed what states could have spent without the waiver.

Section 71118 of the WFTC legislation was intended to codify CMS' long-standing budget neutrality policies and increase transparency by requiring the CMS Chief Actuary to review state budget projections. However, CMS' proposed implementation guidance appears to fundamentally alter the agency's approach to budget neutrality in ways not required by statute. As a result, it is unclear whether states can continue implementing proven payment reforms that support essential hospitals and the vulnerable patients they serve.

We look forward to working with CMS to understand how these changes will affect states' ability to align payments with the value of care provided. We offer the following comments to avoid unnecessary disruptions in care during the implementation of Section 71118 of the WFTC legislation.

1. CMS should not impose more restrictive policies than what the statute requires.

Nothing in the law requires CMS to adopt wholescale changes to its longstanding budget neutrality policies. The law only requires that, beginning Jan. 1, 2027, CMS may not approve a section 1115 demonstration application unless the CMS Chief Actuary certifies that it is budget neutral.

Considering the significant changes states already must implement under the WFTC legislation and the short time that CMS provided states to respond to its new budget neutrality policies, **CMS should limit implementation on Jan. 1, 2027, to only the changes required by statute.** In addition, CMS should clarify that current demonstrations receiving temporary extensions before a rule is finalized are not subject to the new requirements in H.R. 1 or to CMS' forthcoming rules.

If CMS does initiate changes beyond those required by the WFTC legislation, CMS should not apply them to demonstrations approved before the rule is finalized. A longer transition period is particularly important for existing demonstrations approved under CMS' prior budget neutrality framework. This approach would ensure that the new guidance does not interfere with the routine administration of state programs and provides more time for states to evaluate and adapt to the new changes.

2. CMS should provide more transparency about how the CMS actuary calculates budget neutrality limits.

To enable meaningful stakeholder feedback on CMS' new proposed budget neutrality guidance, the CMS actuary should be transparent about its methods and assumptions. The proposed guidance omits several key details that states need to determine how the new framework will apply to their existing Section 1115 demonstrations.

As CMS implements the new budget neutrality requirements, it should provide states and stakeholders with the data and calculations that the CMS actuary used to approve or reject

demonstration proposals. CMS also should provide more detailed guidance and technical assistance to help states replicate these calculations and reduce administrative burden. States are already subject to substantial transparency requirements under Section 1115. CMS should ensure its own guidance and implementation processes meet similarly high standards of transparency.

3. CMS' budget neutrality framework should not penalize states for efficient Medicaid program administration and should ensure that Section 1115 demonstrations can remain laboratories for innovation.

One of the key benefits of Section 1115 demonstrations is that they allow states to reinvest savings in delivery system reforms that improve access to quality care for Medicaid beneficiaries. Over time, these investments have helped reduce overall Medicaid spending below what it would have been without Section 1115 demonstrations, resulting in federal budget savings that states can reinvest for further innovation.

Unfortunately, CMS' proposed guidance would limit the period during which states can use accumulated savings from a 10-year budget window to a 5-year window. **This policy will make it harder for states to invest in new initiatives and unfairly penalize states that have demonstrated cost savings from prior Section 1115 demonstration initiatives.** It also incentivizes states to "use it or lose it," thereby increasing rather than reducing federal costs.

In addition, **CMS' new guidance does not provide enough clarity on how states can demonstrate Section 1115 savings moving forward.** Under the proposed guidance, states can demonstrate savings from exclusively Section 1115–only activities. This limitation could significantly constrain states' ability to finance new and innovative initiatives in the future. CMS should allow the use of non-waiver savings to pay for waiver expenditures because it will incentivize states to look for ways to redirect that spending to potentially more effective and efficient activities. For example, many states have financed Section 1115 demonstrations by redirecting disproportionate share hospital allotments to incentivize the provision of preventive care and chronic disease management services rather than simply directing payments based on costs incurred. To better manage overall Medicaid costs and incentivize states to better align payments with value, **CMS' budget neutrality approach should consider total Medicaid spending, including what could have been spent under the Medicaid state plan.**

4. States should also be able to use the MAPS framework to align payments with value and advance delivery system reforms.

Despite our concerns about the significant changes that CMS proposes to the long-standing budget neutrality framework, we appreciate that the guidance preserves states' ability to use Section 1115 demonstrations to pay for populations and services that could otherwise be covered under their state plans or other Title XIX authority. These expenditures were generally referred to as "hypothetical expenditures" in CMS' prior guidance and are now described as Medicaid Authorizable Populations and Services (MAPS). This policy has provided states greater flexibility to expand access to substance use disorder benefits, pre-release services, and care delivered by essential hospitals in nontraditional settings.

However, **we are concerned that the proposed list of MAPS is incomplete and unnecessarily ties payments to the rate that was approved under the Medicaid state plan or other title XIX authority.** This policy could limit states' ability to develop more efficient payment approaches for Medicaid services that improve care quality and reduce overall costs, such as global payments.

5. Section 1115 authority should continue to be a tool to advance the objectives of the Medicaid program, including pathways to coverage and economic mobility.

The new requirement for the CMS Office of the Actuary to review Section 1115 budget neutrality does not supersede the Secretary of Health and Human Services' overarching responsibility to certify that Section 1115 demonstrations advance federal program objectives. We appreciate the administration's efforts to improve chronic condition management, promote better health outcomes, and create pathways out of poverty. Accordingly, we urge CMS to implement its Section 1115 budget neutrality policies in a manner that preserves states' ability to advance these goals.

To ensure that Section 1115 demonstrations can continue to support efforts to manage chronic conditions and improve health outcomes, CMS should recognize the savings associated with essential hospitals' efforts to maintain continuity of care for Medicaid beneficiaries who experience temporary gaps in coverage due to enrollment churn. As the number of uninsured individuals is expected to grow in the coming years, essential hospitals are increasingly investing in strategies to maintain connections to care for these individuals, manage chronic conditions, and prevent avoidable, higher-cost health care utilization over time. CMS' budget neutrality framework should recognize the value and potential long-term savings of these investments.

Many essential hospitals have begun offering workforce training and employment programs for patients to support economic mobility and ensure that patients meet new community engagement requirements. CMS should allow states to support these efforts through Section 1115 demonstrations and recognize the potential long-term savings associated with helping Medicaid beneficiaries secure meaningful employment and access employer-sponsored health coverage. These investments can improve individuals' economic stability, strengthen access to coverage, and reduce reliance on Medicaid over time.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Robert Nelb, at 202-585-0127 or rnelb@essentialhospitals.org.

Sincerely,

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