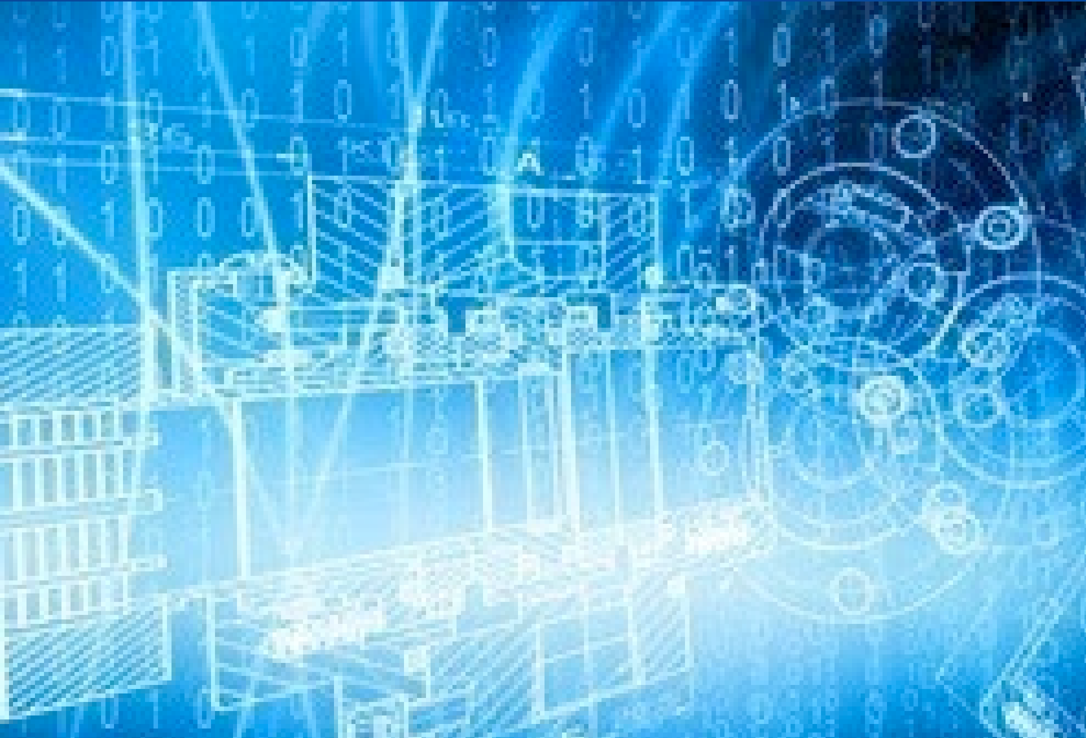
Budget Neutrality for Section 1115(a) Medicaid Demonstrations



Updated Approach to Determining Budget Neutrality

June 2024

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Purpose

- This slide deck discusses certain updates to CMS's approach to determining budget neutrality that CMS has applied when approving Medicaid section 1115 demonstrations beginning in September 2022.
- Other aspects of CMS's approach to determining budget neutrality, as discussed in the August 22, 2018, State Medicaid Director Letter (SMDL) # 18-009, "Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects,"[1] have not changed.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf

Background

- CMS has long required, as a condition of demonstration approval under section 1115 of the Social Security Act (“the Act”), that demonstrations be “budget neutral,” meaning the federal costs of the state’s Medicaid program with the demonstration cannot exceed what the federal government would have otherwise expended absent the demonstration.
- In recent years, CMS and states generally applied an approach to calculating budget neutrality described in a 2018 SMDL.
- Since issuing the 2018 SMDL, CMS has recognized that this approach could limit states’ future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid.

Background (Continued)

- To address this, in recent approvals, CMS has updated its methodology to better support state innovation while continuing to promote fiscal integrity.
- The updated approach to budget neutrality discussed in this slide deck has been implemented in all relevant demonstration special terms and conditions (STCs) starting in September 2022.[2]

[2] See, for example, Massachusetts' MassHealth section 1115(a) demonstration, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-ca1.pdf, and Oregon's Oregon Health Plan section 1115(a) demonstration, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf

Comparison of Budget Neutrality Approaches

The following tables compare the budget neutrality approach described in the 2018 SMDL to the updated approach that was first applied in September 2022, and the related rationale and/or effects of the adjustments.

	2018 SMDL Approach	2022 Updates	Rationale/Effect
Calculating Without Waiver (WOW) per member per month (PMPM) baseline costs	• CMS calculated using recent actual PMPM costs (beginning with demonstration extensions effective on or after 1/1/2021).	• Calculate using a weighted average of the state's historical WOW PMPM baseline and recent actual PMPM costs (in practice, this has been a weighted average of 20% of the historical WOW PMPM baseline, and 80% of recent actual PMPM costs).	• Similar to the 2018 SMDL, this updated approach aims to reduce historical savings accumulated to preserve fiscal integrity, while crediting the state for recent historical savings achieved through innovation under demonstrations.
Trend rates for setting WOW baseline costs	• Use the lower of the state's historical trend rate or the President's Budget trend rate.	• Use the President's Budget trend rate.	• Using the President's Budget trend rate aligns with federal budgeting principles and assumptions.

Comparison of Budget Neutrality Approaches (continued)

	2018 SMDL Approach	2022 Updates	Rationale/Effect
Savings rollover	• Permit states to roll over savings to a demonstration extension approval period from up to 5 years of the most recent demonstration approval period(s). • Apply Transitional Phase-Down of Accrued Savings (this applies to demonstration extensions approved prior to 1/1/2021).	• Permit states to roll over savings to a demonstration extension approval period from up to 10 years of the immediately prior demonstration approval period(s), subject to the limit described below.	• The updated approach continues to reduce historical savings accumulated to promote fiscal integrity, while allowing states to utilize more of the savings achieved through innovation under prior demonstration approval period(s).
Limit on the use of savings in the extension approval period	• The savings amount available for use by the state in the current demonstration extension approval period is limited to the savings available to the state in its current extension approval period plus savings from up to 5 years of the most recent demonstration approval period(s) (as described above).	• The savings amount available for use by the state in the current demonstration extension approval period is limited to the lower of (1) the savings available to the state in its current extension approval period plus savings from up to 10 years of the immediately prior demonstration approval period(s) (as described above); or (2) 15% of the state's projected total Medicaid expenditures in aggregate for the demonstration extension approval period.	• This adjustment, along with the savings rollover update described above, improves the balance between the availability of expenditure authority to support program innovation and fiscal integrity.

Comparison of Budget Neutrality Approaches (cont.)

	2018 SMDL Approach	2022 Updates	Rationale/Effect
Mid-course corrections to budget neutrality calculation	• Allowed only if CMS approves an amendment to the demonstration, or, when data indicate the state is likely to exceed its budget neutrality limit, if CMS approves a corrective action plan (CAP).	• May be approved without an amendment or a CAP in certain circumstances outlined in standard STCs (see appendix). • The state may request a mid-course adjustment no more than once per demonstration year (see Appendix for conditions). The state must provide a description of the expenditure changes and data demonstrating that actual costs have exceeded the budget neutrality cost limits established at demonstration approval. • Adjustments can be applied retroactively to when the state began incurring the relevant expenditures, if appropriate.	• This update provides stability for the state over the life of a demonstration by permitting adjustments to reflect certain costs not related to the state's demonstration and/or that are outside of the state's control, or that are likely to further strengthen access to care. • This update allows the state flexibility to make certain changes without needing to wait for renewal of the demonstration or an amendment to the demonstration. • This update is a more rational, transparent, and standardized approach to permitting budget neutrality modifications during a demonstration. • CMS will evaluate each request based on its merit and will determine whether to approve it or whether the state needs to submit an amendment instead.

Comparison of Budget Neutrality Approaches (cont)

	2018 SMDL Approach	2022 Updates	Rationale/Effect
Hypothetical Expenditures	• Generally limited to demonstration expenditures that are (1) for populations or services that the state could otherwise have covered under its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act; or (2) when a WOW spending baseline is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates.	• Expanded to certain expenditures to address health-related social needs (HRSN). • CMS applies a budget neutrality ceiling to HRSN services expenditures and an additional sub-ceiling to HRSN infrastructure expenditures. • These expenditures are referred to as "capped hypothetical expenditures" in the demonstration's STCs.	• Some of these HRSN expenditures are for services that the state could otherwise cover under other title XIX authority, for certain beneficiaries, while other HRSN expenditures have insufficient or inconsistent data to calculate a WOW baseline cost. Treating these HRSN expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. • Evidence indicates that these HRSN expenditures could improve the quality and effectiveness of downstream services that can be provided under state plan authority, improve the health of beneficiaries, and reduce their future downstream costs of medical care. HRSN demonstration evaluations will assess whether the demonstration is having these effects, and costs will be monitored as part of fiscal oversight. • At the same time, predicting the downstream effects on overall Medicaid program costs of covering certain HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these expenditures on demonstration budget neutrality or on a state's overall Medicaid program. • The ceilings on HRSN expenditures will ensure the Medicaid program's fiscal integrity. Also, the ceilings differ from the usual limit CMS places on hypothetical expenditures. For example, states cannot offset spending above the ceiling with savings from the rest of the demonstration.

Appendix

Budget Neutrality Mid-Course Corrections

- CMS might approve mid-course correction adjustments to budget neutrality if a state experiences changes to its Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- Examples could include:
  - Provider rate increases that are anticipated to further strengthen access to care;
  - CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual Medicaid Eligibility Groups (MEGs);
  - Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
  - State legislated or regulatory change to Medicaid that significantly affect the costs of medical assistance;
  - When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
  - High-cost innovative medical treatments that states are required to cover; or,
  - Corrections to coverage/service estimates where there is no prior state experience (e.g., substance use disorders [SUD]) or small populations where expenditures may vary widely.