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**SMD # 18-009**  
**RE: Budget Neutrality Policies for**  
**Section 1115(a) Medicaid**  
**Demonstration Projects**

August 22, 2018

Dear State Medicaid Director:

This letter describes the Centers for Medicare & Medicaid Services' (CMS) current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Social Security Act ("the Act") and is intended to give states and interested parties insight into CMS's decision-making process. The letter also outlines recent changes that CMS made to its approach to budget neutrality for demonstration project extensions, in order to strengthen fiscal accountability and prevent the federal government's exposure to excessive expenditures under section 1115(a) demonstrations.

### **Section 1115(a) Medicaid Demonstration Projects**

Under section 1115(a) of the Act, the Secretary of Health and Human Services ("Secretary") or CMS, operating under the Secretary's delegated authority, may authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgment of the Secretary, are likely to assist in promoting the objectives of title XIX of the Act. The Secretary (1) may, under section 1115(a)(1), waive provisions in section 1902 of the Act; and/or (2) may, under section 1115(a)(2)(A), authorize federal financial participation (FFP) for state expenditures that would not qualify for FFP under section 1903 of the Act (i.e., provide "expenditure authority"). Section 1902 of the Act lists what elements the Medicaid state plan must include, such as provisions relating to eligibility, beneficiary protections, benefits, services, and premiums. Section 1903, "Payments to States," describes expenditures that may be "matched" with federal title XIX dollars, allowable sources of non-federal share, and managed care requirements.<sup>1</sup>

### **Budget Neutrality Overview**

Currently, CMS will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government. A budget neutral demonstration project does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration.<sup>2</sup> The

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<sup>1</sup> CMS reviews state requests for waiver or expenditure authority under section 1115(a) on a case-by-case basis to determine whether each such request is consistent with the requirements of section 1115(a) and other applicable laws.

<sup>2</sup> What the federal government's Medicaid costs would likely have been absent the demonstration may also include costs that could be federally matched if the state were to amend its Medicaid state plan or obtain waivers under certain title XIX authorities. These costs may be deemed "hypothetical" if the state could otherwise have covered these costs under a state plan amendment or a waiver under section 1915 of the Act.

overarching goal of CMS’s approach to budget neutrality is, therefore, to limit federal fiscal exposure resulting from the use of section 1115(a) authority in Medicaid.

Currently, budget neutrality for each demonstration project is determined as one key component of CMS and state negotiations over the specific terms and conditions of the demonstration project. To assess budget neutrality, CMS currently subjects each demonstration to a budget neutrality test, which results in limits that are placed on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration.<sup>3</sup>

The essential parameters of the budget neutrality test are specified in the demonstration’s Special Terms and Conditions (STC). CMS’s determination that a demonstration is expected to be budget neutral is based on forecasts, using reasonable projections of future spending and enrollment trends. CMS monitors budget neutrality throughout the demonstration period, and also performs a formal adjudication at the end of the demonstration period to determine whether the state’s actual spending has remained within the specified limit. As a condition of each section 1115(a) demonstration approval, the STCs require that state officials attest to the accuracy of the data provided to CMS. CMS performs an adjudication for every demonstration at the conclusion of each approval period—irrespective of length of the approval period.<sup>4</sup> Another condition that CMS currently places on section 1115(a) demonstration approval is that states agree to limit their receipt of FFP to the amounts indicated in the budget neutrality test, and to return any funds they receive in excess of those limits to CMS via the expenditure reconciliation process described below.

CMS currently applies a budget neutrality test to any section 1115(a) demonstration project, regardless of whether it involves use of section 1115(a)(1) waivers, section 1115(a)(2)(A) expenditure authority, or both. However, for demonstrations that include only waiver authorities under section 1115(a)(1) (i.e., only demonstrations *not* requiring authority for “costs not otherwise matchable”), CMS sometimes determines that the authorized waivers will not result in an increase in federal Medicaid spending, and deems the demonstration to be budget neutral without carrying out the calculations under the general approach described in this letter.<sup>5</sup>

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<sup>3</sup> In most cases, for convenience and ease of analysis, the budget neutrality test is specified in terms of total computable Medicaid expenditures (i.e., both the federal and non-federal shares of the total expenditure). The demonstration’s terms and conditions include conversion factors – known as Composite Federal Share Ratios – that are used to convert the total computable budget neutrality expenditure limits into federal share equivalents that can be used as a limit on actual federal expenditures.

<sup>4</sup> Generally, section 1115(a) demonstrations are approved for an initial five-year period and are extended for an additional three to five years. In general, CMS uses the terms “renewal of an existing demonstration” and “extension of an existing demonstration” interchangeably, and in this document, CMS uses the term “extension” to refer collectively to renewals and extensions approved under section 1115(a), 1115(e), or 1115(f). The CMS-approved expiration date indicates the end of the demonstration approval period, and each extension or renewal (whether approved under section 1115(a), 1115(e), or 1115(f)) initiates a new demonstration approval period. There are also instances when a “temporary extension” to the current period is provided to permit CMS and a state time to finish negotiating terms of a new period.

<sup>5</sup> See, for example, Wisconsin’s “BadgerCare” section 1115(a) demonstration (11-W-00125/5)—January 1, 2011 through December 31, 2013 approval period.

For demonstrations with authorized expenditure authority under section 1115(a)(2), determinations of budget neutrality currently involve calculating that the demonstration project will likely achieve federal Medicaid “savings” sufficient to offset the additional projected federal costs resulting from the expenditure authority. Under CMS’s current approach, offsetting savings are factored into the overall budget neutrality test for the demonstration and, if the total federal cost of the portion of the state’s Medicaid program affected by the demonstration plus the expenditure authority is less than or equal to the projection of federal Medicaid spending for that same portion of the state’s Medicaid program without the demonstration, the demonstration as a whole (including the expenditure authority), is determined to be budget neutral.

In cases where expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act, CMS considers these expenditures to be “hypothetical;” that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS currently makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS’s current view that states should not have to “pay for,” with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service.

### **Budget Neutrality Calculation**

Under its current approach, when calculating budget neutrality, CMS refers to the projected expenditures that could have occurred absent the demonstration as the “Without Waiver” (WOW) expenditures, or “baseline expenditures.” The baseline expenditures are the basis for the budget neutrality expenditure limit. CMS refers to the *actual* expenditures under the demonstration as the “With Waiver” (WW) expenditures.<sup>6</sup>

Generally, calculation of the WOW budget neutrality expenditure limit(s) is based on spending per eligible individual, per month. Using this per member per month (PMPM) approach, the state *is not at risk* for increased costs associated with increases in enrollment, and *does not accrue* savings from decreases in enrollment. Unexpected increases in enrollment could be a consequence of factors outside the demonstration and beyond the state’s complete control—such as changing economic conditions and natural disasters. To obtain projected PMPM expenditure limits, projected WOW PMPM costs are multiplied by the state’s actual member month caseload.<sup>7</sup> Therefore, the state is at risk only for increases to the PMPM cost growth—not for the increases in its caseload. This per

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<sup>6</sup> The terms “With Waiver” and “Without Waiver” are CMS shorthand for with, and without, the section 1115(a) demonstration, including both waiver and expenditure authorities.

<sup>7</sup> In calculating the cost for a PMPM, states are encouraged to leverage existing federal investments and data sources and utilize T-MSIS data as it becomes available. States may additionally need to use enhanced system support for calculating the PMPM and should work closely with their CMS contact for the best avenue for system support.

capita, or PMPM, budget neutrality test is the model most commonly employed in Medicaid section 1115(a) demonstrations.

*The formula to calculate PMPM expenditure limits for demonstrations is as follows:  
(BN expenditure limit) = (projected WOW PMPM) x (actual Member Months)*

On occasion, CMS has approved a demonstration under which the state deployed an alternative approach to budget neutrality calculation, depending on the type of waivers and expenditure authorities approved under the demonstration proposal, and the likely financial impacts of the initiative relative to Medicaid spending under the state plan. One such alternative is the aggregate limit model, which places a fixed total dollar cap on state expenditures for the demonstration for which FFP can be obtained—often referred to as an “aggregate cap.” With this model, the state *is at risk* for all increases in expenditures—including those due to increased enrollment or caseload partially outside of a state’s control. Unlike the PMPM model, the dollar limits are fixed with aggregate caps and do not vary by caseload. Aggregate expenditure limits can also be used for demonstrations to include categories of Medicaid expenditures that are not easily associated with particular beneficiaries, such as supplemental provider payments.<sup>8</sup>

*The formula to calculate aggregate limits for demonstrations is as follows:  
(BN expenditure limit) = (projected WOW total spending)*

Total budget neutrality expenditure limits (whether calculated as PMPM or in an aggregate model) are often made up of multiple sub-limits. Sub-limits can be defined based on Medicaid coverage expenditures for various Medicaid populations (e.g., children, adults, aged, or disabled), or other categories of Medicaid expenditures, such as supplemental provider payments. These sub-limits can be PMPM sub-limits, aggregate sub-limits, or both—and are determined based on the nature of the historical expenditures and/or state- and CMS-negotiated estimations of new sub-limits. Sub-limits are also differentiated by their applicable time periods, usually in terms of “demonstration years” (DY). The overall budget neutrality expenditure limit is, therefore, determined by adding the sub-limits together to create a single limit.<sup>9</sup> The single budget neutrality limit applies to all relevant categories of Medicaid expenditure as specified in the demonstration’s STCs—and is currently the *sole determinant* in assessing whether the demonstration is budget neutral.

## **Budget Neutrality Methodologies**

*Historical Expenditures* -- To facilitate calculation of a new demonstration’s budget neutrality limit, states currently provide CMS with five years of complete/continuous historical expenditure data as part of their Medicaid section 1115(a) demonstration applications. The historical expenditure data

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<sup>8</sup>The most recently approved comprehensive demonstration in which an aggregate cap model was employed is the “Virginia Governor’s Access Plan for the Seriously Mentally Ill (GAP)” demonstration (No. 11-W-00297/3, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=29032>).

<sup>9</sup>In other words, under CMS’s current approach, states sometimes exceed individual budget neutrality sub-limits, but if a state exceeds the overall budget neutrality expenditure limit the demonstration is no longer considered to be budget neutral.

include member months of eligibility and expenditures for Medicaid populations that are to be included in, or affected by, the demonstration. The expenditure data might be categorized by Medicaid Eligibility Groups (MEG)—such as adults, children, individuals eligible based on disability, or dual eligible beneficiaries. These MEGs represent the populations and services included in the demonstration, and they could be aggregated or disaggregated in order to develop appropriate trend rates over the lifetime of the demonstration.<sup>10</sup> Historical data might also include expenditure data related to prior years’ disproportionate share hospital (DSH) or supplemental provider payments when states propose to divert those payments toward demonstration-specific programs or goals that promote the objectives of title XIX.

*Trend Rates* – The future spending projections for each demonstration’s MEGs are based on an extrapolation of the historical trending discussed above. Under CMS’s current approach, after those historical trend rates have been calculated and submitted to CMS for review, staff compare the rates to the most recent year’s Medicaid baseline PMPM coverage cost trends from the annual President’s Budget. The President’s Budget trends that are employed under the current approach are for the Medicaid population categories that most closely correspond to the populations represented by each demonstration’s MEGs (i.e., disabled, aged, child, or adult). CMS then compares each MEG’s actual trend rate to a corresponding rate in the President’s Budget trends and applies a “lower of the two rates policy”—or zero in the event that a MEG’s historical trend rate is negative. Limiting per capita cost trends to no more than the President’s Budget trends reflects CMS’s effort to align its approach to budget neutrality with federal budgeting principles and assumptions.

States sometimes propose alternate trend rates to their historical trends, where doing so is supported by additional data and analysis. Approval of alternate trend rates might reflect acknowledgement of state-specific anomalies or non-recurring circumstances, which resulted in past trends not being representative of likely future Medicaid spending trends. CMS carefully analyzes states’ rationales for proposed alternate trend rates, and approvals of such adjustments are infrequent.

*The formula to calculate average PMPM cost trend rates across multiple years is as follows:*

$$\text{Average trend} = (\text{end PMPM}/\text{start PMPM})^{(1/\# \text{ of changes})} - 1$$

### **Budget Neutrality Additional Considerations**

*Hypothetical Expenditures* – Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which *could have otherwise been* covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as “hypothetical” expenditures for the purposes of budget neutrality. In these cases, CMS makes adjustments to budget neutrality in the manner discussed below to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115(a) demonstration projects.

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<sup>10</sup> States and/or CMS might aggregate or disaggregate MEGs to, for example, isolate population-specific trends or more easily compare trends to eligibility groups commonly utilized by the federal government, actuaries, and others.

To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality “supplemental test” for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state’s WW hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

CMS currently employs a variety of alternate estimation methodologies, based on evidence-based econometric principles, to determine the budget neutrality expenditure limits for hypothetical expenditures, because, often, there are no historical expenditures that can be used to establish a spending baseline. CMS therefore bases the budget neutrality expenditure limit for hypothetical populations or services on a reasonable and methodologically sound estimate of the program’s expected costs (e.g., expenditures for like-populations/proxies and/or actuarial analyses of expected costs).

Examples of hypothetical expenditures that CMS has previously approved include:

1. Expenditures for home and community based services (HCBS) that are similar to those that may be provided through section 1915(c) waivers;<sup>11</sup>
2. Expenditures for family planning services similar to what may be provided through the optional categorically needy group described in section 1902(a)(10)(A)(ii)(XXI) of the Act;<sup>12</sup>
3. Expenditures for medical assistance for aged and disabled individuals similar to what may be provided through the optional categorically needy group described in section 1902(a)(10)(A)(ii)(X) of the Act;<sup>13</sup> and
4. Expenditures for services furnished to beneficiaries who are residing in an institution for mental diseases (IMD) primarily to receive treatment for a substance use disorder (SUD)—which would have been otherwise allowable under Medicaid were it not for the IMD/settings prohibition—as described in State Medicaid Director Letter #17-003, *Strategies to Address the Opioid Epidemic*.<sup>14</sup>

For states that provide Medicaid coverage for “new adults” under section 1902(a)(10)(A)(i)(VIII) of the Act, CMS also currently counts section 1115(a) demonstration expenditures for this group as hypothetical expenditures if the state has not included this group in its Medicaid state plan. Additionally, even if the state has included this group in its Medicaid state plan, CMS currently treats demonstration expenditures for this group as if they were hypothetical expenditures, due to the high

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<sup>11</sup> See, for example, Tennessee’s TennCare II section 1115(a) demonstration, TennCare CHOICES (11-W-00151/4). Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tenncare-ii-ca.pdf>.

<sup>12</sup> See, for example, Alabama’s Plan First section 1115(a) family planning demonstration (11 -W-00133/4). Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/al/al-family-planning-ca.pdf>.

<sup>13</sup> See, for example, Florida’s Managed Medical Assistance section 1115(a) demonstration, MEDS-AD population (11-W-00206/4). Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf>.

<sup>14</sup> Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>.

degree of cost variability from one year to the next, which, due to that volatility, produced highly anomalous trend rates.

*DSH Diversion* – CMS has approved section 1115(a) demonstrations that include alternative uses for funds normally used to provide payment adjustments to Disproportionate Share Hospitals (DSH), if CMS determined that those uses were likely to further the goals and objectives outlined in title XIX of the Act. The budget neutrality expenditure limits that CMS currently applies to “DSH diversion” within demonstrations are aggregate limits based on a projection of the state’s DSH expenditures absent the demonstration. The diverted DSH limits reflect the state’s actual historical expenditures for DSH payments. CMS currently limits annual demonstration expenditures for DSH diversion, combined with any remaining DSH payments, to the state’s annual DSH allotment.

### **Budget Neutrality for Demonstration Extensions<sup>15</sup>**

To calculate budget neutrality for expenditures associated with an extension of a section 1115(a) demonstration, which provides a new period under the demonstration, CMS currently conducts a comprehensive review of the prior demonstration period’s budget neutrality test to ensure the accuracy of each state’s expenditure reporting. CMS also makes appropriate adjustments for any changes in waivers and expenditure authorities under the extended demonstration. Specifically, CMS staff compare the state’s data and analysis to CMS-64 reports in order to confirm that the state has not exceeded its budget neutrality limits, and has reported expenditures correctly under the prior approval period.<sup>16</sup> Now that states have begun submitting their utilization, claims and other Medicaid data to CMS via the Transformed Medicaid Statistical Information System (T-MSIS), CMS might also make appropriate adjustments based on those data, where appropriate.<sup>17</sup>

*Budget Neutrality Savings Accrual & Rebasing* – CMS’s approach to establishing budget neutrality parameters for the new approval period under a demonstration extension has been to extend the demonstration’s existing WOW baseline/limits for additional years. Until recently, CMS considered the budget neutrality savings from the prior approval period(s) to “roll over” into the next demonstration approval period.

Over time, CMS noted that states with long-running demonstrations accumulated substantial amounts of “unspent” budget neutrality savings due to this policy of permitting savings to “roll over” from one approval period to the next. Furthermore, as a result of CMS’s practice of extending WOW baselines for additional years without adjustment, the WOW baseline came to be based on antiquated historical data after multiple extensions, with little grounding in the state’s current health care environment and associated expenditures. Based on their unspent savings, states requested that CMS authorize additional demonstration expenditures through amendments and extensions, leading to increased federal Medicaid spending and putting the fiscal integrity of the program at risk.

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<sup>15</sup> For additional discussion and definition of section 1115(a) “extensions,” see footnote #3 above.

<sup>16</sup> On a quarterly basis, states report budgeted and actual Medicaid expenditures on the CMS-64 form which serves as the basis for the amount of FFP paid to states to fund their Medicaid programs.

<sup>17</sup> For additional information related to T-MSIS, see <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html>.

In 2016, CMS updated its approach to create a more accurate budget neutrality test based on recent state spending trends.<sup>18</sup> The following methodology adjustments have been incorporated into CMS’s current approach to budget neutrality and CMS expects to phase them in fully for demonstration extension approvals beginning January 1, 2021, with a transitional phase-in preceding this date as described below.

1. At most, savings from the most recent five years can “roll over” into an extension from prior approval periods.<sup>19</sup>
2. Beginning with the next demonstration extension approval period starting on or after January 1, 2021, WOW baselines are expected to be rebased to more accurately reflect recent state spending trends.
3. Beginning with the next extension of states’ demonstration projects, there is expected to be a transitional phase-down of the accrued savings which resulted from a continuation of the baseline trending from prior period(s).
4. The growth of upper payment limit (UPL) diversionary spending is limited.

Limiting Savings Rollover—Under CMS’s previous budget neutrality approach, states were permitted to roll over savings from older demonstration approval periods rather than limiting roll-over savings to recent years. Under CMS’s current approach to budget neutrality, states are permitted to roll over accumulated budget neutrality savings only from the most recently-approved five years. If expenditures from the most recent approval period are greater than or equal to that period’s budget neutrality limit, then no savings will roll over.

Rebasing WOW Baselines—Beginning with demonstration extension periods with effective dates on or after January 1, 2021, CMS expects to rebase the demonstration’s budget neutrality expenditure limits to better reflect the state’s most recent historical experience. At each new extension thereafter, CMS expects to adjust WOW PMPM cost estimates to match recent *actual* PMPM costs experienced during the prior demonstration approval period. CMS also expects to apply its current policy of trending PMPM costs using the lower of the state historical trend or the President’s Budget (including the “zero substitution” methodology described above) to the rebased WOW baseline. CMS expects to rebase all demonstrations which are approved for an extension with an approval period beginning on or after January 1, 2021. The transitional phase-down, discussed next, precedes rebasing.

Transitional Phase-Down of Newly Accrued Savings—Until CMS has rebased all current demonstrations (i.e., before January 1, 2021), at each demonstration’s next approved extension, CMS expects to apply a transitional phase-down percentage to the demonstration’s annual savings based on when the state implemented the policy that produced the savings. CMS anticipates that savings phase-down would apply only during the extension approval period; however, CMS expects that the *amount* of phase-down would be determined based on the length of time since the state originally

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<sup>18</sup> See CMS’s *Budget Neutrality for Section 1115(a) Medicaid Demonstrations—New Adjustments in Methodology* (May 12, 2016) presented during All-State State Operations and Technical Assistance Call; available at <https://www.medicare.gov/medicaid/section-1115-demo/downloads/about-1115/all-state-presentation.pdf>.

<sup>19</sup> See, for example, the most recent section 1115(a) approvals of Texas’ “Healthcare Transformation and Quality Improvement Program” (Project No. 11-W-00278/6) and Florida’s “Managed Medical Assistance Program” (Project No. 11-W-00206/4).

implemented the aspect of the demonstration that produced the savings. For the first five years post-implementation of the savings-producing policy, 100 percent of budget neutrality savings will accumulate and carry forward, but starting with the sixth year post-implementation of the savings-producing policy, savings will be phased down by 10 percent per demonstration year, until savings are reduced to no less than 25 percent of the amount of savings realized based on the original baseline. CMS expects to apply this transitional phasedown to demonstration extensions taking effect on or before December 31, 2020. For extensions taking effect later than that date, or for demonstrations that have already had a transitional phase-down period, CMS expects to conduct a full rebasing, as described above. This phase-down of savings aligns with the overall goal of budget neutrality tests—to limit federal fiscal exposure resulting from the use of 1115(a) authority in Medicaid.

*Limiting UPL Diversionary Spending* – States with approved UPL diversionary spending have the choice of either rebasing UPL diversion estimates based on their current levels of fee-for-service utilization, or of carrying forward UPL without growth at each extension (which means they would be limited to the capped annual amount in the final DY of the previous demonstration approval period).

### **Reporting and Monitoring on Budget Neutrality**

Each currently approved demonstration’s STCs include sections describing the monitoring of budget neutrality, general financial requirements, and corrective actions in the event that actual spending exceeds the specified limits. Together, these STCs describe the process by which the calculations described above are performed—as well as how the state reports expenditures to CMS and the reconciliation processes.

*Monitoring and Corrective Action Throughout Demonstration Period of Performance* – CMS regularly monitors states’ budget neutrality reports, including the expenditures reported on the CMS-64 quarterly expenditure reports. If demonstration expenditures are determined to be at risk of exceeding the budget neutrality limits based on specified thresholds in the STCs, states currently agree, as a condition of continued CMS approval of their demonstration project, to provide a corrective action plan in order to bring their expenditures in line with the pre-specified limits. CMS has also developed a monitoring tool to aid in timely identification of budget neutrality-related issues.<sup>20</sup>

*Exceeding Budget Neutrality and Return of Federal Funds* – As a condition of demonstration approval, states currently agree that if the state is found to have exceeded its budget neutrality expenditure limit at the end of its demonstration’s period of performance, it will return excess funds

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<sup>20</sup> 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and intends to include, in STCs governing budget neutrality reporting, language providing that states will agree to use the tool as a condition of demonstration approval.

to CMS. States return funds by entering a negative adjustment to expenditures claimed on their CMS-64 reports.

CMS continues to revise and improve its approach to budget neutrality for section 1115(a) demonstrations. While we do not envision deviating from these policies in the near future, CMS may issue additional information based on, for example, changes in federal legislation or regulations. CMS will remain available to provide technical assistance to states regarding all aspects of its current and ongoing approaches to budget neutrality and continues development of numerous templates and tools to facilitate those discussions. CMS will also be conducting a series of technical assistance webinars and all-state calls. If you have any questions, or would like to schedule a state-specific technical assistance call, please contact your project officer or Paul Boben, Senior Advisor, State Demonstrations Group at (410) 786-6629.

We look forward to continuing our work together on these important issues.

Sincerely,

/s/

Timothy B. Hill  
Acting Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health