DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

SMD # 24-003
RE: Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects

August 22, 2024

Dear State Medicaid Director:

This letter describes the Centers for Medicare & Medicaid Services' (CMS) current approach to determining 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 information on how CMS calculates and applies budget neutrality in demonstration approvals. Until September 2022, CMS and states generally applied an approach to calculating budget neutrality described in the 2018 State Medicaid Director Letter (SMDL) available at link https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf. Since issuing the 2018 SMDL, CMS has recognized that the approach described in that SMDL could limit states' future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid. To address this, in recent approvals, CMS has updated its methodology to better support state innovation while continuing to promote fiscal integrity. The updated methodology has been applied as appropriate in demonstration special terms and conditions (STCs) starting in September 2022.[1] Accordingly, this SMDL updates and supersedes the 2018 budget neutrality SMDL.[2]

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 generally lists what elements the Medicaid state plan must include, such as provisions relating to eligibility, beneficiary protections, benefits, services, and premiums.

[1] See, for example, Oregon's Oregon Health Plan section 1115(a) demonstration (September 2022 approval), available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf, Massachusetts' MassHealth section 1115(a) demonstration (September 2022 approval), available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-ca1.pdf, and Arkansas' Health and Opportunity for Me (ARHOME) section 1115(a) demonstration (December 2022 approval), available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-demo-appvl-12282022.pdf.
[2] The 2018 SMDL will remain publicly available for reference through the CMS website.

Additionally, section 1903, "Payments to States," generally describes expenditures that may be "matched" with federal title XIX dollars, allowable sources of non-federal share, and managed care requirements.[3]

Budget Neutrality Overview

Currently CMS will not approve a demonstration project under section 1115 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.[4] The overarching goal of CMS's approach to budget neutrality is, therefore, to limit federal fiscal exposure resulting from the use of section 1115 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 period. The budget neutrality test assesses whether demonstration spending is over the established limit. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit, and it is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration.[5]

The essential parameters of a demonstration's budget neutrality test are specified in the demonstration's STCs. As a condition of each section 1115 demonstration approval, the STCs require that state officials attest to the accuracy of the data provided to CMS. CMS's determination that a demonstration is expected to be budget neutral is based on forecasts, using reasonable projections which could include future spending, enrollment trends, or both. CMS monitors budget neutrality throughout the demonstration period to determine if a state has exceeded the budget neutrality expenditure limit or is at risk of exceeding it in the future. Any irregularities that CMS finds are shared with the state, and the state provides explanations or adjustments to the budget neutrality formulation. A final determination of budget neutrality is made by CMS for every demonstration at the conclusion of each approval period— irrespective of length of the approval period.[6] Another condition that CMS currently places on section 1115

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[3] CMS reviews state requests for waiver or expenditure authority under section 1115 on a case-by-case basis to determine whether each such request is consistent with the requirements of section 1115 and other applicable laws.

[4] What the federal government's Medicaid costs would likely have been absent the demonstration may also include costs for populations or services 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. See discussion of various types of "hypothetical" expenditures below.

[5] 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 STCs 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.

[6] Generally, section 1115 demonstrations are approved for an initial five-year period and can be extended for additional demonstration periods. In general, CMS uses the terms "renewal of an existing demonstration" and

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.[7] In rare circumstances, CMS may determine that a budget neutrality test is not necessary for other reasons. For example, in light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's declaration of a national emergency on March 13, 2020 – and the time-limited nature of COVID-19 section 1115(a) demonstrations – CMS did not require states to submit budget neutrality calculations for such demonstrations.[8,9] In general, CMS determined that the costs to the federal government under these time-limited COVID-19 demonstrations were likely to have been otherwise incurred and allowable. States with COVID-19 demonstrations are required to track demonstration expenditures and are expected to evaluate the connection between those expenditures and the state's response to the COVID-19 public health emergency (PHE), as well as the cost-effectiveness of those expenditures.

For demonstrations with authorized expenditure authority under section 1115(a)(2)(A), 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

"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.

[7] See, for example, Wisconsin's "BadgerCare" section 1115(a) demonstration (11-W-00125/5)—January 1, 2011, through December 31, 2013, approval period.

[8] See the COVID-19 Public Health Emergency Section 1115(a) Opportunity for States SMDL #20-002, available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.

[9] See, for example, the COVID-19 PHE 1115 demonstrations in Arizona, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-cms-approval-covid-19-phe-amendment-01192021.pdf, and Delaware, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/de-dshp-covid19-amend-appvl.pdf.

authority, such as a waiver under section 1915[10] 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 adjusts the budget neutrality test, which effectively treats these expenditures as if they were approved Medicaid state plan services or approved section 1915 waiver 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 Calculations

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.[11]

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 or natural disasters. To obtain projected PMPM expenditure limits, projected WOW PMPM costs are multiplied by the state's actual member month caseload.[12] Therefore, the state is at risk only for increases to the PMPM cost growth—not for the increases in its caseload. This per capita, or PMPM, budget neutrality test is the most common model used in Medicaid section 1115(a) demonstrations.

The formula to calculate PMPM expenditure limit for a Medicaid Expenditure Group (MEG) in demonstrations is as follows:

(BN expenditure limit) = (projected WOW PMPM) x (actual Member Months)

CMS has also approved demonstrations with 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

[10] https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/index.html

[11] The terms "With Waiver" and "Without Waiver" mean with and without, respectively, the section 1115(a) demonstration, including both waiver and expenditure authorities.

[12] In calculating the cost for a PMPM limit, states are encouraged to utilize 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 limit and should work closely with their CMS contact for the best avenue for system support.

spending under the state plan. One such alternative is an aggregate limit model, which places a fixed total dollar ceiling on state expenditures for the demonstration, or a portion of 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.

The formula to calculate aggregate expenditure 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.[13] 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 demonstration's budget neutrality limit at initial approval[14] and at extension,[15] states currently provide CMS with historical expenditure data. The historical expenditure data may include member months of eligibility and expenditures for Medicaid populations that are to be included in, or affected by, the demonstration or proxy data for comparable services. The expenditure data might be categorized by MEGs—such as MEGs for adults, children, individuals eligible based on disability, or dually eligible beneficiaries. These MEGs represent the populations and projected cost of services included in or affected by the demonstration, and they could be aggregated or disaggregated to identify

[13] 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.

[14] 42 CFR 431.412(a)(1)(iii) requires states to submit with each application for initial approval of a demonstration an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable.

[15] 42 CFR 431.412(c)(2)(v) requires states to submit with each application for a demonstration extension financial data demonstrating the state's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the state.

appropriate trend rates over the lifetime of the demonstration[16] and effectively monitor expenditures. 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. Prior to September 2022, CMS requested five years of complete historical expenditure data as part of an initial Medicaid section 1115(a) application. That data was used to develop a historic trend rate for expenditures by MEG for comparison against the President's Budget trend rate. As discussed in further detail below, under its updated approach to determining budget neutrality, CMS is no longer comparing the state's historic trend rate against the President's Budget trend rate and is no longer using the lower of the two trend rates. Therefore, under its updated approach, CMS is no longer requesting five years of historic expenditure data in order to calculate the trend rate.

Trend Rates – Under the approach described in the 2018 SMDL, CMS would use the lower of the state's historical trend rate or the President's Budget trend rate to trend forward projected demonstration expenditures associated with each MEG in the WOW baseline. Under its post-September-2022 approach, CMS uses only the President's Budget trend rate. The future spending projections for each demonstration's MEGs are currently based on an extrapolation using the most recent year's Medicaid 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 (i.e., disabled, aged, child, or adult) that most closely correspond to the populations represented by each demonstration's MEGs. 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.

Before September 2022, as discussed in the 2018 SMDL, CMS applied a zero percent trend rate if a MEG's historical trend rate had negative growth. Under CMS's pre-September-2022 approach of applying the lower of the state's historic trend rate or the President's Budget trend rate, a negative percent trend rate would always be the lower of the two compared trend rates. Under the approach described in the 2018 SMDL, zero percent would be the default trend rate applied when a MEG's historical trend rate was negative. CMS updated this approach beginning in September 2022 to allow growth consistent with national trends as reflected in the President's budget for health care related expenditures, particularly over the five year period that is typical for most demonstration approvals. Demonstrations approved before September 2022 that have previously approved trend rates that differ from the President's Budget trends will continue to use those trend rates until the end of the approved demonstration period, but at the next (post-September 2022) extension approval, CMS expects to trend all MEGs in such a demonstration at the President's Budget trend rate. Under its current (post-September-2022) approach, CMS does not accept alternative trend rates proposed by states.

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"

[16] 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.

expenditures for the purposes of budget neutrality. In these cases, CMS adjusts 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 demonstration projects.

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 with 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 or state plan HCBS authorities (e.g., section 1915[i]);[17]
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;[18]
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;[19]
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), serious mental illness (SMI) or serious emotional disturbance (SED) — which would have been otherwise allowable under Medicaid were it not for the IMD exclusion—as described in State Medicaid Director Letter #17-003, *Strategies to Address the Opioid*

[17] See, for example, Washington's Medicaid Transformation Project section 1115(a) demonstration, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-ca-06302023.pdf.

[18] See, for example, Alabama's Plan First section 1115(a) family planning demonstration (11 -W-00133/4). Available at https://www.medicaid.gov/section-1115-demonstrations/downloads/al-family-planning-cms-temp-exten-aprl-ca.pdf.

[19] 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/section-1115-demonstrations/downloads/fl-mma-ca-10122022.pdf.

Epidemic[20] and State Medicaid Director Letter #18-011, *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*;[21] and

5. Expenditures for pre-release services furnished to certain incarcerated individuals who are soon-to-be former inmates of a public institution during a specified pre-release period – which would have been otherwise allowable under Medicaid were it not for the inmate payment exclusion – as described in the State Medicaid Director Letter #23-003, *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.[22]

Supplemental HRSN Aggregate Ceiling (SHAC) Expenditures – Beginning in September 2022, CMS has treated certain health-related social needs (HRSN) expenditures that are authorized under section 1115 authority as "hypothetical" expenditures in demonstration approvals. Some of these HRSN expenditures are for services that the state could otherwise cover under other title XIX authority, such as tenancy and nutrition supports for certain beneficiaries. Treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. However, there are other approved HRSN expenditures that could *not* otherwise be covered under title XIX authority, such as expenditures for section 1915(c) and 1915(i) services for beneficiaries who would *not* otherwise be eligible for these services under section 1915, and there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures.

Based on robust academic-level research, it appears likely that these HRSN expenditures could improve the quality and effectiveness of downstream services that can be provided under state plan authority.[23] Covering evidence-based HRSN services might improve beneficiary health,

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[20] See State Medicaid Director Letter #17-003, Strategies to Address the Opioid Epidemic. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[21] See State Medicaid Director Letter #18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[22] See State Medicaid Director Letter #23-003, Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated. Available at https://www.medicaid.gov/sites/default/files/2023-12/smd23003.pdf.

[23] Lipson, D. J. *Medicaid's Role in Improving the Social Determinants of Health: Opportunities for States*. National Academy of Social Insurance; 2017; https://www.nasi.org/wp-content/uploads/2017/06/Opportunities-for-States_web.pdf; Whitman, A., De Lew, N., Chappel, A., et al. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Assistant Secretary for Planning and Evaluation; 2022; https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf. (NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, the U.S. Department of Health & Human Services (HHS), or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.)

reducing the future downstream costs of medical care for these beneficiaries. At the same time, predicting these downstream effects on overall Medicaid program costs of covering certain evidence-based HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these HRSN expenditures on demonstration budget neutrality or on the state's overall Medicaid program. Treating demonstration HRSN expenditures as hypothetical gives states the flexibility to test these worthy innovations, especially as CMS anticipates that they could result in overall reductions in future Medicaid program costs.

To ensure that treating certain HRSN expenditures as hypothetical does not have a significant negative fiscal impact on Medicaid, CMS is applying a budget neutrality ceiling to HRSN services expenditures and an additional sub-ceiling to HRSN infrastructure expenditures. CMS is referring to these ceilings on HRSN expenditures collectively as the "Supplemental HRSN Aggregate Ceiling (SHAC)," also known as, "capped hypothetical expenditures." The SHAC currently cannot exceed 3 percent of the state's total computable Medicaid spending, and the sub-ceiling for infrastructure costs cannot exceed 15 percent of total HRSN expenditure authority.

The SHAC differs from the usual limit CMS places on hypothetical expenditures under the "supplemental test" discussed above in several respects. First, ordinarily, if a state exceeds the hypothetical expenditure limit, it can offset the additional costs with savings from the rest of the demonstration. That is not permitted with the HRSN expenditures. However, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. Second, the expenditures subject to the SHAC are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects, as discussed above. Third, the upper limit on the SHAC is based on a range of estimates of the likely cost of these expenditures over the course of a five-year period and set at a mid-point in that range, and it cannot exceed the 3 percent and 15 percent thresholds discussed above. While this SHAC deviates from the traditional approach to hypothetical expenditures, it is consistent with CMS's historical approach to maintaining budget neutrality in Medicaid demonstrations and it does not alter the underlying financing structure of the Medicaid program. This SHAC ensures that the state maintains its investment in the state plan benefits to which beneficiaries are entitled while testing the benefit of the HRSN services described above. CMS does not apply this SHAC to any other benefits or services.

DSH Diversion – CMS has approved section 1115 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[24,25]

To calculate budget neutrality for expenditures associated with an extension of a section 1115 demonstration, which provides an additional period of performance under the demonstration, CMS currently conducts a comprehensive review of state-reported expenditure data for the prior demonstration period's budget neutrality test to ensure the accuracy of each state's expenditure reporting, and to confirm that the state has not exceeded its budget neutrality limits. 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.[26] 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 adjustments based on those data, where appropriate.[27]

The following methodologies, further described below, are incorporated into CMS's current approach to budget neutrality for demonstration extensions:

1. Savings rollover from prior approval periods to the new extension approval period is permitted, subject to certain limitations.
2. The WOW baselines are rebased.
3. The growth of upper payment limit (UPL) diversionary spending is limited.

Limiting Savings Rollover and Savings Cap– Under the budget neutrality approach described in the 2018 SMDL, states were permitted to roll over savings to a demonstration extension period only from the most recently-approved five years, and there was a transitional phase-down of accrued savings. 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. To address this, in approvals since September 2022, CMS has updated its methodology to better support state innovation while continuing to promote fiscal integrity.

Beginning with demonstration extension approvals in September 2022, CMS began applying a revised approach to limiting the extent to which demonstration "savings" can be "rolled over" to a new approval period. Under this revised approach the "savings" amount available for extension approval periods is limited to the lower of:

1. "Savings" available to the state in the current extension approval period plus carryover "savings" from up to 10 years of the immediately prior demonstration approval period(s); or

[24] For additional discussion and definition of section 1115(a) "extensions," see footnote 6 above.
[25] For a more detailed discussion of CMS's pre-September 2022 approach to budget neutrality (including for demonstration extensions) please see the 2018 State Medicaid Director Letter (SMDL) available at link https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf.
[26] On a quarterly basis, states report 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.
[27] For additional information related to T-MSIS, see https:// https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html

2. Fifteen percent of the state's projected total Medicaid expenditures in aggregate for the demonstration extension period.

The first part of this updated approach permits states to access more "savings" from prior approval periods than they would otherwise be able to do under the approach described in the 2018 SMDL, and thus better permits states to fund program innovations. At the same time, the second part of the updated approach limits the "savings" states can access, thereby preserving the Medicaid program's fiscal integrity. These adjustments to the previous approach improve the balance between the availability of expenditure authority to support program innovation and the need for fiscal restraint. CMS expects these updates will continue to ensure fiscal integrity by limiting "savings" rollover from one approval period to the next. They are also expected to give states access to more funding than they would otherwise have been able to access, and thus a greater ability to implement demonstration projects that are likely to assist in promoting the objectives of the Medicaid program, than states would have had under the previous approach.

Under the pre-September-2022 approach, the newest savings accrued in the current demonstration approval period were used first, before savings accrued in a prior demonstration approval period, when applying savings to demonstration expenditures that required savings offset. Under the current approach to savings rollover, the oldest savings available are used first when applying savings to demonstration expenditures that require savings offset. Furthermore, demonstration savings that are not available for the current approval period due to the 15 percent limit discussed above may still be used to offset expenditures in the next approval period as long as those savings were accumulated in the 10-year period prior to approval of the extension. In addition, CMS is allowing savings to be transferred between a state's demonstrations. For example, if a state has a demonstration that is not generating savings but needs savings to offset a particular cost in that demonstration (e.g., a SUD demonstration under which all other expenditures are hypothetical and cannot generate savings), the state may be permitted to use savings from another demonstration to offset that cost.[28] Mechanically, the amount of savings necessary to offset such a cost would be removed from one demonstration (i.e., the one that generated the savings) and applied to the other demonstration (i.e., the one that includes the cost).

Rebasing WOW Baselines – Under the approach described in the 2018 SMDL, with each new extension taking effect on or after January 1, 2021, CMS expected to adjust WOW PMPM cost estimates to match recent *actual* PMPM costs experienced during the prior demonstration approval period. Effectively, this meant that the WOW limit for the new extension would have been the same amount as the state was spending in the current, pre-extension approval period. So, under that approach, states would have had to continue to reduce spending to generate savings on top of already implemented cost efficiencies. This could have resulted in states no longer generating savings and thus, ultimately, in limiting states' future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid..

[28] See for example, Montana's Healing and Ending Addiction through Recovery and Treatment section 1115(a) demonstration (11-W-00395/8), available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-heart-cms-amendment-approval-20240226.pdf

For demonstration extension periods approved in or after September 2022, CMS has been applying an updated approach to calculating the WOW baseline. Under its current approach, CMS calculates each rebased WOW PMPM baseline by using a weighted average of the state's historical WOW PMPM baseline and its recent actual PMPM costs. In practice, this has been a weighted average of eighty percent (80%) of the state's recent actual PMPM costs during the most recent demonstration approval period and twenty percent (20%) of the historical WOW PMPM for the most recent demonstration period. This updated approach is expected to reduce historical savings accumulated to preserve fiscal integrity, while crediting the state for recent historical savings achieved through innovation under the demonstration. CMS trends the rebased WOW PMPM using the President's Budget as described above.

The formula to calculate the rebased WOW PMPM is as follows:
*(0.8*Actual WW PMPM cost) + (0.2*Historical WOW PMPM cost)*

Limiting UPL Diversionary Spending – As was the case under the approach described in the 2018 SMDL, under CMS's current approach to determining budget neutrality states with approved UPL diversionary spending continue to 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, opportunities to request mid-course correction adjustments, and corrective actions if 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 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.[29]

[29] 42 CFR 431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary and the state to implement a demonstration project, and 42 CFR 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.

Mid-Course Correction Adjustments – Previously, changes to approved budget neutrality limits were allowed only if CMS approved an amendment to the demonstration, or, when data indicated the state was likely to exceed its budget neutrality limit and CMS thus approved a corrective action plan (CAP). Currently, to provide flexibility and stability over the life of a demonstration, CMS permits budget neutrality modifications during the course of a demonstration approval period under certain circumstances. No more than once per demonstration year, if a state has exceeded its budget neutrality limit during a demonstration period, a state may request that CMS make an adjustment to its budget neutrality agreement based on certain changes to the state's Medicaid expenditures. If the request is approved, the demonstration WOW baselines may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). Per the demonstration STCs, the state must include actual expenditure data and other information to support its request for an adjustment. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate.

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 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 demonstrations. 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. If you have any questions or would like to schedule a state-specific technical assistance call, please contact your project officer in the State Demonstrations Group, or the section 1115 applications mailbox at 1115demorequests@cms.hhs.gov.

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

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director