

## Section 1115 Demonstration Budget Neutrality

Medicaid spending under Section 1115 demonstrations is required to be budget neutral, meaning that federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (referred to as the without-waiver baseline). If state spending under its demonstration is below the without-waiver baseline, the difference is considered savings. The state can use any accumulated savings to finance spending on populations or services that are not covered by Medicaid, referred to as costs not otherwise matchable (CNOM). The Centers for Medicare & Medicaid Services (CMS) establishes the methods that states must use to demonstrate budget neutrality and, as part of the Section 1115 demonstration approval process, must approve any spending of budget neutrality savings on CNOM expenditures.

This issue brief reviews the sources and uses of Section 1115 demonstration budget neutrality savings based on MACPAC's review of spending reported in fiscal year (FY) 2019. The brief concludes with a discussion of current policy issues related to Section 1115 demonstration budget neutrality.

### Background

Section 1115 of the Social Security Act (the Act) provides the Secretary of Health and Human Services (HHS) with broad authority to waive federal Medicaid requirements to allow states to make changes to their Medicaid programs as long as they are likely to promote the objectives of the Medicaid program. As of September 2021, there were 76 approved Section 1115 demonstrations in 47 states and the District of Columbia (CMS 2021a). As described below, these demonstrations vary greatly in size and scope.

Although each demonstration program has unique features, current demonstrations often do one or more of the following:

- change policies for existing Medicaid populations, such as testing premiums that exceed statutory limits and other alternative eligibility policies;
- expand coverage for certain groups or benefits, such as substance use disorder (SUD) treatment services in institutions for mental diseases (IMDs);
- authorize new types of Medicaid payments, such as uncompensated care pools or delivery system reform incentive payments (DSRIP).

Some Section 1115 demonstrations encompass most or all Medicaid beneficiaries in the states, while others target only a small subset of Medicaid beneficiaries or a discrete feature of the program. Some have been approved relatively recently, such as those providing SUD benefits in IMDs, while others are the current iterations of models that have been in place for decades, including the comprehensive managed care programs in several states.<sup>1</sup>



Some of these policies can be implemented only through Section 1115 authority while others can also be implemented under other authorities. For example, mandatory Medicaid managed care programs for most populations can be implemented through Section 1915(b) waiver authority or Section 1932 state plan authority. However, many states implement managed care under Section 1115 authority in order to show budget neutrality savings that can be used to finance other program changes.

## Methods for Establishing Budget Neutrality Limits

The requirement for Medicaid spending under Section 1115 demonstrations to be budget neutral is not defined by federal statute or regulations but has been in practice since the late 1970s (Lambrew 2001). CMS provides states with instructions for calculating budget neutrality and updated its budget neutrality guidance in 2018 (CMS 2018).

Most states demonstrate budget neutrality using a per capita method and so this method is the focus of this brief.<sup>2</sup> Under the per capita method, a state is at risk for the costs of individuals served by the demonstration but not for the number of individuals enrolled. CMS typically establishes different per capita limits for different eligibility groups, such as children, adults, and people with disabilities.<sup>3</sup>

For Medicaid populations that a state previously covered, CMS develops per capita limits based on historical spending. Specifically, the state's historic baseline spending per person is trended forward based on the lower of the state's historical growth rate or the trend rate assumed in the President's budget. The President's budget trend rate derives from CMS Office of the Actuary (OACT) projections.

The per capita limit is multiplied by the number of people enrolled in each eligibility group to establish the without-waiver baseline. If spending under for these eligibility groups is below this baseline, then a state accumulates budget neutrality savings that can be used to finance the federal share of CNOM expenditures. States must provide the non-federal share of CNOM expenditures, similar to other Medicaid expenditures. In addition, states must receive CMS approval prior to spending budget neutrality savings and agree to special terms and conditions negotiated with CMS.

Budget neutrality is enforced over the entire period of the demonstration, which is typically five years. As a result, if a state exceeds its budget neutrality limit in one year, it is not in violation of the waiver terms if it has offsetting savings in another year of the demonstration period. States can also exceed spending limits for one eligibility group as long as the demonstration overall is budget neutral.

Historically, states had been able to carry over unspent budget neutrality savings from prior years when a demonstration was renewed. However, CMS revised its policy in 2016 and began to phase-down accumulated savings and rebase per capita spending limits based on actual spending at the time of renewal, with a goal of fully rebasing all demonstrations approved after January 1, 2021 (CMS 2018). In addition, CMS will only allow a state to carry forward savings from the most recent five-year approval period.<sup>4</sup> For example, if a demonstration accumulated \$100 million in savings over the most recent five-year period based on an assumption that spending for children would be \$100 per person per month (PMPM) but actual spending on children was \$80 PMPM, CMS's new policy would require the state to



establish a new without-waiver baseline at renewal based on the actual spending amount (\$80 PMPM) rather than the previous projections. The \$100 million in savings from the previous approval period would be carried forward to the renewed demonstration, but any savings accumulated in prior approval periods would not.

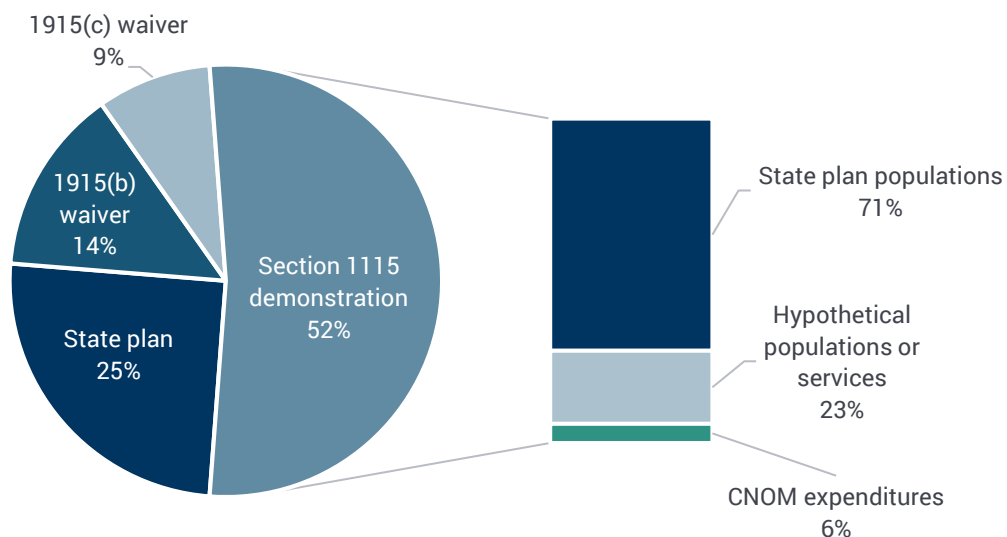
Some populations and services are excluded from budget neutrality calculations because there is no historical data to establish a baseline or because these services are similar to what could have been covered without a Section 1115 waiver. Costs for these populations and services are classified as hypothetical expenditures. Examples include spending for adults with incomes below 138 percent of the federal poverty level who are newly eligible for Medicaid as a result of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and spending for SUD services in IMDs that could have been provided in inpatient hospital settings. For these services and populations, states establish projections of what they expect to spend for purposes of developing waiver cost estimates, but they cannot generate budget neutrality savings if their costs are lower than expected. If costs are higher than expected, the state agrees to offset that spending elsewhere in the demonstration or refund the excess federal spending to CMS.

During the COVID-19 public health emergency, CMS has allowed states to apply for time-limited Section 1115 demonstrations that are exempt from budget neutrality requirements (CMS 2020). As of November 2022, CMS has approved 6 COVID-19 targeted demonstrations and 25 COVID-19 related amendments to existing demonstrations (CMS 2021b). The COVID-19 related amendments primarily make changes to the long-term services and supports programs that were previously authorized through existing Section 1115 demonstrations, such as allowing retainer payments for certain home and community-based services providers (MACPAC 2021a).

## Spending under Section 1115 demonstrations

In FY 2019, about half of Medicaid spending was authorized under Section 1115 demonstrations, but almost three-quarters of this spending was for populations or services that could have been covered under the Medicaid state plan without a waiver. Another 23 percent was for populations or services that the state had not covered under the state plan but hypothetically could have (Figure 1). About 6 percent (\$17.9 billion) of Section 1115 demonstration spending—about 3 percent of total Medicaid spending—was CNOM spending that could not otherwise be covered by Medicaid.



**FIGURE 1.** Medicaid Spending Under Section 1115 Demonstrations, FY 2019

**Notes:** FY is fiscal year. CNOM is cost not otherwise matchable. The Medicaid state plan covers Medicaid populations and services that do not require a waiver of statutory requirements. Section 1915(b) waivers authorize comprehensive managed care and Section 1915(c) waivers authorize home- and community-based services. Hypothetical populations or services are those that are similar to populations or services that could have been covered without a Section 1115 demonstration and are not included in the calculation of budget neutrality savings.

**Source:** MACPAC, 2021, analysis of Section 1115 demonstration special terms and conditions and the CMS Medicaid Budget and Expenditure System.

The share of Medicaid spending authorized by Section 1115 demonstrations varies widely by state. In FY 2019, Section 1115 demonstration spending was more than 90 percent of Medicaid benefit spending in 5 states (Arizona, Hawaii, Kansas, New York, and Vermont) and less than 1 percent of Medicaid benefit spending in 24 states and the District of Columbia.

## Uses of Budget Neutrality Savings

In FY 2019, 21 states reported CNOM expenditures (Table 2). Most of these expenditures were for supplemental payments that are not otherwise permitted in managed care, such as DSRIP and uncompensated care pool payments. Below we provide additional detail on the CNOM expenditures that CMS has approved to date and the extent to which states could make similar types of payments without a Section 1115 demonstration.

**TABLE 2.** Section 1115 Demonstration CNOM Expenditures Requiring Budget Neutrality Savings, FY 2019

Type of Section 1115 demonstration CNOM spending	Number of states	Total FY 2019 spending (millions)	Share of Section 1115 demonstration CNOM spending
<b>Total</b>	<b>21</b>	<b>\$17,885</b>	<b>100%</b>
Coverage expansion	13	\$1,401	8%
Supplemental payments	16	\$14,584	82%
Designated state health program	7	\$886	5%

**Notes:** FY is fiscal year. CNOM is cost not otherwise matchable. Analysis excludes CNOM expenditures for hypothetical populations and services, which do not require use of budget neutrality savings.

**Source:** MACPAC, 2021, analysis of Section 1115 demonstration special terms and conditions and the CMS Medicaid Budget and Expenditure System.

## Coverage expansions

Thirteen states used \$1.4 billion in Section 1115 demonstration budget neutrality savings to expand Medicaid coverage in FY 2019. In the 1990s and early 2000s, coverage expansions were the most common use of budget neutrality savings, but after the passage of the ACA, many states began covering low-income adults under the Medicaid state plan instead. However, some states that have not expanded Medicaid under the ACA still use Section 1115 demonstrations to provide limited coverage to low-income adults who do not otherwise qualify for Medicaid.

Some states also use Section 1115 demonstrations to fill in gaps in coverage with targeted eligibility policies that would not otherwise be permitted in the Medicaid state plan. For example, Maryland uses some of its budget neutrality savings to provide ongoing coverage to individuals who were receiving treatment through its breast and cervical cancer treatment program before the state changed eligibility criteria for the program in 2013. In Florida, the state uses some of its budget neutrality savings to provide expanded coverage for individuals diagnosed with HIV/AIDS who are not otherwise eligible for Medicaid. These types of eligibility expansions are typically not allowed in the Medicaid state plan because they do not provide comparable benefits to beneficiaries who do not have these specific health conditions (§1902(a)(10)(B) of the Act).

## Supplemental payments

In FY 2019, 16 states reported \$14.6 billion in supplemental payments authorized under Section 1115 demonstrations. These include 11 DSRIP or DSRIP-like programs making payments of \$6.3 billion to providers based on their achievement of various quality-related milestones, and 9 uncompensated care payment programs making \$8.0 billion in payments for uncompensated care costs that are not covered by other sources, such as disproportionate share hospital (DSH) payments. Additional information on DSRIP is provided in MACPAC's [issue brief on DSRIP programs](#) and additional information on how these payments relate to other types of supplemental payments to hospitals is provided in MACPAC's [issue brief on base and supplemental payments to hospitals](#) (MACPAC 2020a, 2021b).



## Designated state health programs

In FY 2019, seven states reported \$886 million in designated state health program (DSHP) expenditures, which provide Medicaid matching funds for non-Medicaid state health programs. Because DSHP expenditures reduce the amount of state funds that states would otherwise need to pay for these programs, DSHP is most often used as a financing mechanism to make available state funds for other types of Medicaid expenditures, such as DSRIP.

Massachusetts, Rhode Island, and Vermont currently use DSHP authority to lower premiums for qualified health plans offered on their states' health insurance exchanges (to levels equivalent to what low-income adults paid under the states' prior expansions of coverage to adults under their previous Section 1115 demonstrations). In FY 2019, these states reported \$148 million in payments on these programs.

## Policy Issues

Although a large share of Medicaid spending (52 percent) is authorized under Section 1115 demonstration authority, much of this spending is for populations and services that could otherwise be covered without a waiver. The advantage for states is that when these are included in Section 1115 demonstrations, any budget neutrality savings achieved can be used to finance CNOM expenditures. These CNOM expenditures, which are a better measure of new spending allowed under Section 1115 demonstrations, account for a small share of overall Medicaid spending (3 percent).

Budget neutrality policies are intended to limit increases in federal spending resulting from CNOM expenditure authority. However, the U.S. Government Accountability Office (GAO) has raised concerns that some methods for calculating budget neutrality, such as not rebasing budget neutrality limits at renewal, may result in limits that are higher than what states would have spent in the absence of the demonstration (GAO 2012; GAO 2013). These policies also created inequities between states in the amount of CNOM spending under Section 1115 demonstrations. In addition, GAO has raised concerns about specific uses of budget neutrality savings that CMS has authorized, questioning whether they best advance Medicaid goals (GAO 2015).

CMS's 2018 revisions to its budget neutrality methods address many of GAO's prior concerns about the calculation of budget neutrality limits. For example, CMS's new policy of requiring states to use more recent data when establishing budget neutrality baselines and to limit budget neutrality savings that can be carried forward when a demonstration is renewed will likely lower budget neutrality limits. CMS is still in the process of applying this new policy to demonstrations renewed after December 31, 2020. It remains to be seen how the lower budget neutrality limits under this policy affect states' ability to make similar levels of CNOM expenditures in the future.

In recent years, CMS has also taken steps to limit some CNOM expenditures, but GAO has expressed concerns that CMS does not use specific criteria for reviewing CNOM expenditure authority (GAO 2015). In 2017, CMS notified state Medicaid directors that it would phase out the use of DSHP and that it does not plan to renew existing DSRIP demonstrations (CMS 2017).



GAO concerns with the use of CNOM expenditure authority also extends to CMS policies for classifying some populations and services as hypothetical expenditures that are largely exempt from budget neutrality requirements. Much of the spending on hypothetical expenditures in FY 2019 was for adults who became newly eligible for Medicaid as a result of the ACA coverage expansions. Now that states have historical data on the costs of covering this population, it may be possible for CMS to develop a without-waiver baseline for this group and no longer classify this group as a hypothetical expenditure. Doing so would allow states to generate budget neutrality savings if costs are lower than expected.

CMS has encouraged states to use other authorities to sustain activities such as DSRIP, for example, by using managed care directed payments, a new way for states to require managed care plans to make directed payments to providers, which can be similar to lump-sum supplemental payments in fee for service (MACPAC 2020b). If a state makes additional payments to providers made through the directed payment option without a Section 1115 demonstration, then these payments are not subject to budget neutrality limits. However, directed payments are subject to several regulatory requirements and require prior CMS approval.<sup>5</sup> As such, it may be difficult for states to make the same amount of payments to providers that they made under Section 1115 demonstration authority and to target payments based on factors other than Medicaid utilization, such as unpaid costs of care for uninsured individuals (MACPAC 2020a, 2020b). In addition, some states with longstanding managed care programs authorized under Section 1115 may lack the administrative resources or capacity to reorganize their programs under a different authority.

## Endnotes

<sup>1</sup> States can mandate enrollment in comprehensive managed care without a Section 1115 demonstration.

<sup>2</sup> States can also demonstrate budget neutrality using an aggregate method, in which the state is at risk for both per capita costs and for the number of enrollees in the demonstration. For family planning and other targeted Section 1115 demonstrations, states have also demonstrated budget neutrality by estimating the avoided costs to the state achieved by the demonstration. These methods are outside the scope of this issue brief.

<sup>3</sup> The per capita limits used to develop Section 1115 budget neutrality do not change the current federal financing mechanism for Medicaid. Unlike proposals to replace the open-ended Medicaid financing structure with per capita caps, Section 1115 demonstrations are voluntary and do not require all states to limit spending based on federal standards (MACPAC 2017).

<sup>4</sup> If expenditures for the most recent five-year approval period are greater than or equal to that period's budget neutrality limit, then no savings will roll over.

<sup>5</sup> For example, directed payments must be tied to utilization and delivery of services, be distributed equally to specified providers under the managed care contract, advance at least one goal in the state's managed care quality strategy, and not be conditioned on provider participation in intergovernmental transfer (IGT) agreements (42 CFR § 438.6(c)).





## References

- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. State waiver list. Baltimore, MD: CMS. <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. E-mail to MACPAC, December 1.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Letter from Calder Lynch to State Medicaid Directors regarding "COVID-19 public health emergency Section 1115(a) opportunity for states." March 22, 2020. <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Letter from Timothy Hill to State Medicaid Directors regarding "Budget neutrality policies for Section 1115(a) Medicaid demonstration projects." August 22, 2018. <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18009.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Letter from Brian Neal to State Medicaid Directors regarding "Phase-out of expenditure authority for designated state health programs (DSHP) in Section 1115 demonstrations." December 15, 2017. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17005.pdf>.
- Lambrew, J. 2001. *Section 1115 waivers in Medicaid and the State Children's Health Insurance Program: An overview*. Washington, DC: Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/section-1115-waivers-in-medicaid-and-the/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. *Use of Medicaid retainer payments during the COVID-19 pandemic*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/use-of-medicaid-retainer-payments-during-the-covid-19-pandemic/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *Base and supplemental payments to hospitals*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. *Delivery system reform incentive payment (DSRIP) programs*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/delivery-system-reform-incentive-payment-programs/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. *Directed payments in Medicaid managed care*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Setting per capita caps: Differences between current methods and financing proposals*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/setting-per-capita-caps-differences-between-current-methods-and-financing-proposals/>.
- U.S. Government Accountability Office (GAO). 2015. *Medicaid demonstrations: Approval criteria and documentation need to show how spending furthers Medicaid objectives*. <https://www.gao.gov/products/gao-15-239>.
- U.S. Government Accountability Office (GAO). 2013. *Medicaid demonstration waivers: Approval process raises cost concerns and lacks transparency*. <http://www.gao.gov/products/gao-13-384>.





U.S. Government Accountability Office (GAO). 2012. *Opportunities for financial savings and program improvements in Medicare and Medicaid remain*. GAO-12-719T. <https://www.gao.gov/products/gao-12-719t>.

