COLORADO
Department of Health Care Policy & Financing

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Budget Neutrality Overview

Fact Sheet May 2024

1115 Waiver Overview

Section 1115 of the Social Security Act (the Act), which established the Medicare and Medicaid programs, authorizes state Medicaid programs to conduct experimental, pilot, or demonstration projects that promote the objectives of Medicaid. Certain provisions of the Act are waived so states can receive federal financial participation (FFP) match, the portion of the Medicaid budget paid by the federal government, for previously ineligible services.

The Centers for Medicare and Medicaid (CMS) will only approve these demonstrations if the project is determined to be budget neutral over the five-year implementation period of the demonstration. This means there would be no net increase in costs to the federal government when the demonstration is implemented.

In addition, as directed through HB 24-1322, the Department of Health Care Policy and Financing (Department) can only submit a waiver if that waiver is General Fund neutral. The Department will need to demonstrate that on a state fiscal year basis, unlike the federal requirement that the waiver be budget neutral to the federal government over the five-year waiver demonstration period.

Therefore, the Department will need to identify and leverage programs that use existing General Fund investment that will be eligible for a federal Medicaid match under the waiver. The Department will present options to make the waiver General Fund neutral to the state through feasibility studies due in November 2024. If General Fund neutrality cannot be achieved the Department will delay submission of the waiver until future action by the General Assembly to appropriate the necessary funding.

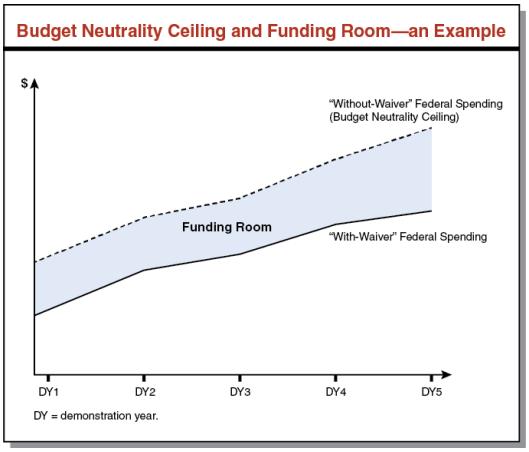

Illustration of the Budget Neutrality Funding Room Concept, California Legislative Analyst's Office, 2015

Calculating Budget Neutrality and Reporting to CMS

General Information about budget neutrality calculations

CMS has specific requirements for budget neutrality calculations. CMS-provided calculations include a variety of components such as:

- "Without Waiver"(WOW) or "baseline expenditures" are the projected costs that could have occurred in absence of the demonstration and is the budget ceiling for demonstrations.
- Calculation of the WOW budget neutrality expenditure limit(s) is based on spending per eligible individual, per month (PMPM), multiplied by the state's actual member month caseload.
- States must calculate savings occurring as a result of the demonstration, resulting in funding room under ceiling, satisfying budget neutrality requirements and creating federal match opportunities.

See federal guidance in the 2018 State Medicaid Director letter "SMD # 18-009 RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects".

CMS Reporting Requirements

All 1115 demonstration waivers require state budget neutrality reports (CMS-64) to CMS to demonstrate budget neutrality over the five year period it is active for, as well as year by year. States must provide quarterly reports which may include:

- Budgeted and actual Medicaid expenditures on the CMS-64 form, which CMS uses to confirm that the state has not exceeded its budget neutrality limits, and has reported expenditures correctly under the prior approval period. This is the basis for the amount of FFP paid to fund their state Medicaid programs.
- CMS conducts a comprehensive review of the prior demonstration period's budget neutrality test to ensure the accuracy of each state's expenditure reporting.

Intergovernmental Transfers and Match

Through an 1115 waiver, Medicaid agencies may draw down federal match for certain state-funded programs, or designated state health programs (DSHP) by leveraging funds through intergovernmental transfers (IGT) to fund waiver activities. Government entities may transfer public funds to the state Medicaid agency so they can be used to draw down federal match. These entities might include:

- Any state agency.
- Any unit of local government (including, but not limited to, a public hospital, hospital district, county, city, or Local Mental Health Authority).

The entities must estimate the cost of the program they seek to supplement, determining the number of Medicaid members who are likely to receive services in order to calculate the amount of money per Medicaid member and the overall funding amount to be transferred. Then through the IGT, they can transfer funds to the state Medicaid program if appropriate and the federal match will support initiatives under the waiver demonstration that supplement, not supplant, the services provided by that government entity.

CMS has provided guidance through a number of letters to State Medicaid Directors that outline how any state savings can be reinvested. Generally, states must create a reinvestment plan, account for and report on the use of state savings, and ensure they go to improve access and quality of care for the population served.

Colorado State Budget

For HCPF to submit an 1115 waiver without the additional spending authority, we must identify General Fund that is currently being used to fund similar services as those covered in the waiver. Receiving a federal match would depend on the Medicaid member characteristics, as some members such as kids and disabled adults receive a 50% federal match while Affordable Care Act (ACA) expansion populations receive a 90% federal match. By matching existing General Fund already paying for these services, the state can expand the services to more Medicaid members.

As an example, if the Department of Local Affairs (DOLA) provides rental assistance that is 100% state funded, Medicaid could leverage DOLA's existing infrastructure and funding to support our 1115 waiver demonstration expansion by matching the state funds with federal funds. Once the funds have been identified, the Department can submit a technical budget request to the Joint Budget Committee to establish the necessary transfer of state funds or appropriate federal funds between entities. If the Department has any administrative cost related to the transfer of funds or programmatic/system costs, those costs can be included in the future technical budget request and can be offset by the new federal funds. This will allow the program to be budget neutral to the General Fund and gain a federal match on existing state and county funds.

As another example, the Department could use county funding (non-General Fund) that counties are using to fund these services as the state share. Medicaid is allowed to use county funding as the state share to receive a federal match. Then the Department could pass the federal funds directly to the county, which will offset that county's cost and allow them to expand services to additional members. There is currently a similar, long-standing practice in the Department's School Health Services Program. Colorado districts can claim a federal match for Medicaid covered services that are provided in schools. The school or county expenditure is used by the Department to draw a federal match, which is then transferred to the school district to offset their costs for providing Medicaid services in schools to Medicaid enrolled students. The Department retains a small percentage of the federal funds to cover administrative costs.

Pursuing new waivers - HB24-1322

If HCPF can demonstrate how we will leverage state and federal dollars year by year to the Joint Budget Committee to be budget neutral, we will then have authority through House Bill 24-1322 to pursue an 1115 waiver for those proposed housing service changes without having to seek additional authority from the state legislature or make an additional budget request.

For more information contact

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