



THE BASICS

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Medicaid Waivers and Budget Neutrality

All states operate one or more Medicaid waiver programs. Medicaid waiver programs, usually referred to by the section of the Social Security Act granting the waiver authority, generally fall into three main categories: section 1115 research and demonstration projects, section 1915(b) “freedom of choice” waivers, or section 1915(c) home and community-based services (HCBS) waivers.¹ The waivers, granted by the Centers for Medicare & Medicaid Services (CMS), allow states to pursue service delivery approaches like managed care or community-based care by “waiving” certain requirements of the Social Security Act (hereafter referred to as the Act). In order to gain approval from CMS for waiver programs, states must first show that the activities under the waiver will be “budget neutral,” meaning federal Medicaid expenditures over the waiver approval period must be no greater than they would have been without the waiver.

The term **budget neutrality** is used primarily with regard to section 1115 research and demonstration projects, which are usually approved for five years. Budget neutrality for 1115 demonstrations is not a requirement under the Act but rather is mandated by federal policy. However, with respect to 1915(b) freedom of choice waivers (which are approved for two years) and HCBS waivers (which are approved for three years), the Act does specify requirements regarding waiver costs. Section 1915(b) freedom of choice waivers must meet a **cost-effectiveness test**, whereas 1915(c) HCBS waivers must be **cost neutral**. Regardless of the differing terminology for each type of waiver, the basic concept is the same: federal expenditures may not increase more than they would have in the absence of the waiver program.

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CALCULATING BUDGET NEUTRALITY

Budget neutrality is calculated somewhat differently for each type of waiver because of the differences in program design.

Freedom of Choice waivers [1915(b)] permit states to use primary care case management systems or managed care organizations that restrict beneficiaries' choice of providers other than in emergency circumstances. Cost-effectiveness review for these programs traditionally is based on a comparison of the cost of payments under managed care to what fee-for-service (FFS) costs would have been without the waiver. In areas where there has been widespread use of managed care for a number of years and recent FFS service data are limited, cost effectiveness is based on managed care expenditures in the previous two-year period. Those two years' costs are used as the base, and then costs are projected forward using adjustments (such as for inflation) to determine the cost-effective amount for the current two-year approval period. The use of capitation payments in managed care provides a high level of predictability that helps ensure the cost-effective amount is not exceeded.

HCBS waivers [1915(c)] permit states to provide a set of home and community-based services to individuals who would otherwise be institutionalized in hospitals, nursing homes, or intermediate care facilities for the mentally retarded (ICFs/MR). Cost neutrality is determined by comparing the average per-capita HCBS costs to average per-capita costs in the institutional setting and determining how many persons would have been institutionalized in the absence of the waiver services. Similar to 1915(b) waivers, costs for the current approval period are projected using base costs determined from prior years' data and by applying certain adjustments. States use caps on (i) the number of people who can be enrolled in the waiver program and (ii) the average costs per person to ensure that they do not exceed the cost-neutrality limit.

Section 1115 demonstration budget neutrality calculations are more complex than for the other types of waivers because, under section 1115 authority, states can choose to expand their Medicaid program by covering populations and services that are not normally eligible for Medicaid reimbursement under existing federal rules (for example, non-disabled adults without children). In order to maintain budget neutrality, states need to identify sav-

ings in their proposed section 1115 demonstration that will offset the cost of any program expansion. States have used several key sources of savings to fund Medicaid program expansions:

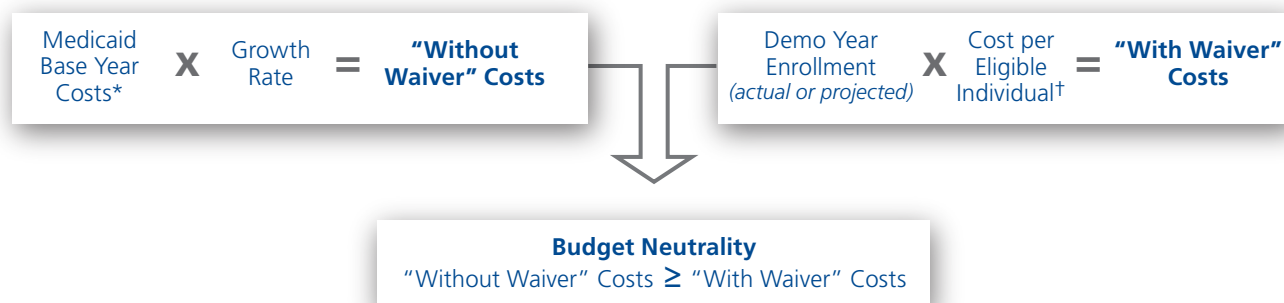
- **Managed care savings:** Statewide section 1115 demonstrations implemented during the 1990s most commonly projected savings generated by providing services to beneficiaries through the use of managed care capitation payments rather than through fee-for-service payments.
- **Redirecting Medicaid disproportionate share hospital (DSH) Payments:**² DSH funding is made available to hospitals that serve a “disproportionate share” of Medicaid and/or uninsured patients. The federal government distributes DSH funds to the states in the form of capped allotments that are specified in the statute. Some states have proposed to use their DSH allotments to offset expansion costs, on the premise that uncompensated care in hospitals for those who are uninsured will be reduced as Medicaid coverage is made available to additional populations.
- **Benefit and cost-sharing savings:** If a state offers more limited benefits than would normally be provided under Medicaid or charges increased cost sharing amounts to existing populations, the projected savings can be used to finance the expansion of services to new populations.

Doing the Math

Budget neutrality is calculated by first determining a state’s Medicaid costs in a base year, usually the 12-month period for which the most recent, complete program data are available. Growth rates are then applied to the base year data to project future expenditures to create the “without waiver costs” baseline. The growth rates are determined by using historical caseload and expenditure data over the prior five-year period. The lower of either this historical growth rate or the Medicaid growth rate in the President’s budget is used to set the budget-neutral expenditure limit for the demonstration. The “with waiver costs” estimate, including any new populations or services, is then compared to the “without waiver costs” estimate to establish that the project is budget neutral. (See Figure 1, next page, for a simplified illustration of how the budget neutrality cap may be calculated.)

The budget neutrality cap is usually calculated on either a per-member per-month or a per capita basis. This eliminates financial

FIGURE 1 | Illustrative Example of Calculating Budget Neutrality



* Medicaid Base Year Costs include the number of enrollees (in member months) and costs per eligible individual for a given year.

† Cost per Eligible Individual is fixed based on the base-year costs and growth rate that have been negotiated for the "without waiver" costs.

risk for the state should enrollment growth exceed projections. However, aggregate caps have occasionally been used.³ In a budget-neutrality agreement with a **per capita cap**, the cost per eligible individual is fixed during negotiations; however, total expenditures over the life of the demonstration will vary based on actual enrollment. In a budget-neutrality agreement with an **aggregate cap**, the total expenditures, as determined during negotiations between CMS and the state, form an overall cap on expenditures for the demonstration, usually in return for greater state flexibility to operate its program. States that exceed their budget neutrality caps are at risk for the excess costs and would either need to use state-only funds to cover those costs or scale back their programs.

ENDNOTES

1. More information about the different types of waivers can be found in Cynthia Shirk, "Shaping Medicaid and SCHIP through Waivers: The Fundamentals," National Health Policy Forum, Background Paper, July 22, 2008; available at www.nhpf.org/library/details.cfm/2635.
2. For more information on Medicaid DSH, see "Medicaid Disproportionate Share Hospital (DSH) Payments," National Health Policy Forum, The Basics, June 15, 2009, available at www.nhpf.org/library/details.cfm/2745.
3. For example, Vermont's Global Commitment to Health uses an aggregate cap on spending to finance its program.

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