The 2025 Presidential Transition

Potential Health Care Impacts in New York under the Second Trump Administration

January 2025

Presentation Overview

- Key Stakeholders
- Medicaid
  - National Initiatives
  - NY-Specific Concerns
- ACA/Exchange
- Medicare

Key Stakeholders

Executive Appointees

Health and Human Services	Nominee	Confirmation
Secretary	Robert F. Kennedy, Jr.	PENDING
Deputy Secretary	Jim O'Neill	PENDING
CMS Administrator	Mehmet Oz	PENDING
Other Relevant Agencies		
OMB	Russ Vought	PENDING
FDA	Marty Makary	PENDING
Surgeon General	Janette Nesheiwat	PENDING
NIH	Jay Bhattacharya	PENDING
CDC	Dave Weldon	PENDING

119th Congressional Leadership

House of Representatives	
Speaker	Mike Johnson (LA)
Energy and Commerce Chair	Brett Guthrie (KY)
Ways and Means Chair	Jason Smith (MO)
Budget Chair	Jodey Arrington (TX)
Senate	
Leader	Sen. John Thune (SD)
Finance Committee Chair	Sen. Michael Crapo (ID)
Health, Education, Labor and Pensions Committee Chair	Bill Cassidy (LA)
Budget Committee Chair	Lindsey Graham (SC)

Medicaid

Potential Medicaid Priorities

- Medicaid cuts have been discussed as a policy goal and source of funding for Republicans' first 2025 legislative package.
- Specific proposals include:
  - Cap on federal matching funds for Medicaid (FMAP)
  - Work requirements as part of Medicaid eligibility
  - Block grants or per capita caps for Medicaid
  - Review of Medicaid financing mechanisms
- Targeted, state-specific administrative actions are also possible:
  - Review of Medicaid waivers
  - Review of Medicaid supplemental payments

FMAP Caps

Impact:

- Reduce federal Medicaid funding – specifically, for enhanced FMAP components
  - Many individual parts of statute would have to be modified to achieve a universal 50% FMAP
    - E.g., administrative and technology spending
  - However, most enhanced funding in New York is contained in two components
    - 90% FMAP for ACA Expansion population (childless adults <138% FPL)
    - Community First Choice Option (6% enhancement for community-based long-term services like home care)
- State responses will vary, based on size of the population and internal politics
  - Some may roll back Medicaid coverage of this population
  - Others (likely including NY) would spread the cost impact across the Medicaid program

Timing

- First legislative opportunity would be to include as part of an initial reconciliation package
  - Aggressive timeline could result in passage in 6-8 months
- FMAP changes could be implemented rapidly if passed

Likelihood

- Medium; changes to ACA enhancements more likely than to administrative and other enhancements

NY Impact

Targeted Category	Federal Funding Loss
ACA Expansion Populations up to 138% FPL (both new population and do-gooder funding)	$ (6,500,000,000)
1915(k) eFMAP Home and Community Choices Waiver	$ (663,000,000)
Medicaid Administrative Spending (either 90% or 75% eFMAP)	$ (148,000,000)
Other Miscellaneous Categories*	$ (100,000,000)
Total Loss Using 50% FMAP	**$ (7,430,000,000)**
Already Expiring:	
COVID-19 6.2% eFMAP	$ (6,070,000,000)

Work Requirements

Impact

- Authorize, or require, that States implement work requirements as part of Medicaid eligibility
- Likely to reduce enrollment nationwide, particularly in states with broad eligibility for working-age adults
- Likely to increase administrative burden, particularly if not aligned with TANF or WIC work requirements
- CBO estimate from 2023
  - Savings of about $11 billion per year
  - About 1.5 million would lose coverage (states possibly picking up some)
  - Actual impact might be much higher, based on GA experience
- In NY, *ex parte* (no paperwork) represented 2.4 million (55%) of renewals during most recent 12 months of unwind – most likely to be at risk of noncompliance with work requirements

Timing

- First legislative opportunity would be to include as part of an initial reconciliation package
  - Aggressive timeline would result in passage in 6-8 months
- Likely would require rulemaking prior to implementation, meaning unlikely to take effect prior to 2027
- Legal challenges would be likely

Likelihood

- High likelihood of option; low likelihood of mandate

Block Grant/Per Capita Cap

General Impact:

- Cap, at either current or reduced level, on total federal matching funds (block grant) or matching funds per capita (per capita)
- May be accompanied by additional State flexibility in implementing the program
- Impact on any particular state will depend on how the cap is set

Timing

- First legislative opportunity would be to include as part of an initial reconciliation package
  - Aggressive timeline would result in passage in 6-8 months
- Given nature of the change, could be implemented rapidly
- Unclear if flexibility in state administration could be passed as part of reconciliation

Likelihood

- Low

Review of Financing Mechanisms

General Impact:

- CMS may conduct a comprehensive and/or rolling review of Medicaid financing tools used by states:
  - Intergovernmental transfers
  - Provider taxes and fees (including MCO taxes)
  - Designated state health programs
  - State-directed payments
- CMS approval *will* be needed to renew state-directed payments or use new financing mechanisms
- Recent and unused financing could be rescinded easily; other financing approaches are more embedded

Timing

- Varies depending on tactic
- Approvals and renewals would be necessary within 1 year period for most state-directed payments (March 2025)
- Reversal of accepted mechanisms or comprehensive review would require new regulation (e.g., first Trump Administration's MFAR rule which was ultimately withdrawn); unlikely prior to 2027

Likelihood

- High

Potential New York-Specific Actions

- 1115 waiver
  - Non-renewal in 2027
    - Highly likely; put pressure on NY to spend down immediately
  - Revocation prior to 2027 – possible, although likely not until 2026
    - [See subsequent slide on impact]
  - Adding HRSN into capitation rates; HRSN-based risk adjustment
    - TBD – depends on Trump Administration’s approach to in-lieu services
- NY-specific Medicaid financing
  - State-directed payments for FY 2024-25 totaled $3.29 billion (all funds)
    - Largest payment was $1.86 billion Financially Distressed Hospital payment
  - Recently-approved MCO tax potentially subject to retraction

New York Waiver Funding Timeline

	DY 0	DY 1	DY 2	DY 3	Total
	04/1/2023-03/31/2024	*04/01/2024 - 03/31/2025*	*04/01/2025 - 03/31/2026*	*04/01/2026 - 03/31/2027*	
HRSN: Infrastructure	SCN RFA due 04/11/2024	$260,000,000	$190,000,000	$50,000,000	$500,000,000
HRSN Services		$695,000,000	$1,250,000,000	$1,420,000,000	$3,365,000,000
HERO		$50,000,000	$40,000,000	$35,000,000	$125,000,000
Medicaid Hospital Global Budget	$550,000,000	$550,000,000	$550,000,000	$550,000,000	$2,200,000,000
Primary Care Delivery System Model		$147,000,000	$147,000,000	$197,000,000	$492,000,000
Workforce: Student Loan Repayment		$12,080,000	$24,150,000	$12,080,000	$48,300,000
Workforce: Career Pathways Training		$175,770,000	$310,480,000	$159,500,000	$645,750,000
Continuous Eligibility for Children 0 to age 6		$23,000,000	$45,000,000	$45,000,000	$112,000,000
	$550,000,000	$1,912,850,000	$2,556,630,000	$2,468,580,000	$7,488,050,000

Essential Plan / Basic Health Plan / Exchanges

Exchange / ACA Subsidies

- Enhanced ACA subsidies currently authorized through the end of 2025
  - ~93% of people enrolled in an Exchange plan currently receive a subsidy – up from ~71% in 2019
- Trump administration unlikely to extend the subsidies
  - CBO estimates that loss of subsidy will drop national exchange enrollment from 21.3M to 15.7M in 2026
  - NY enrollment is much lower than average due to Essential Plan—213,000 as of the start of January 2025
- Loss of tax credits may be accompanied with other, private-market options
  - Expansion of HSAs
  - Expansion of limited-scope plans

New York – 1332 Essential Plan Waiver

- New York's Essential Plan now operates under a 1332 waiver
  - Covers a larger population under 1332 than under previous 1331 structure
  - Key aspects include eligibility up to 250% FPL; coverage of DACA population; fully-funded with federal dollars
- NY's Essential Plan waiver is highly vulnerable
  - NY-specific; high federal cost; includes immigrants (DACA)
  - Revocation would:
    - Revert NY's structure to the Basic Health Plan (1331)
    - About 350,000 people would lose coverage (as of November 2024)

New York – 1331 Basic Health Program for EP

- Authorized by federal statute (1331) as an alternative to ACA-based exchanges
- Although requiring statute to eliminate, 1331 remains vulnerable
  - Only adopted in blue states (New York before 1332, Minnesota, and – new in 2024 – Oregon)
  - Statutory formula of 95% of silver benchmark plan results in nearly $10 billion of funding for NY
- Would affect remaining 1.25 million New Yorkers
  - About 500,000 would be moved to State-only Medicaid (*Aliessa*), resulting in budgetary impact of up to $2-3 billion
  - Remainder would be split between Exchange coverage, other coverage, or becoming uninsured

Medicare

Medicare Advantage – Recent Policy Trends

Risk Adjustment

- Ongoing and relatively bipartisan focus
  - 2022 shift from RAPS → Encounter Data System
    - Emphasis on significantly more detailed encounter data
  - Ongoing shift from HCC model v24 → v28
    - Projected 3% decrease in risk scores
    - Changes or removal of weights for diabetes, mental health diagnoses, etc.
  - Overall coding scrutiny
    - Heightened level of audits (RADV)

- OIG 2024 report highlighted continued use of diagnoses obtained without a visit
  - $7.5 billion in payments associated

Medicare Advantage – Recent Policy Trends

Quality Scores

- Increased weight on CAHPS under Biden Administration
- Star rating controversies have significantly increased
  - E.g., Aetna $1 billion estimated loss in 2023 due to star rating drop (recovered the following year)
  - CMS recalculated 2024 star ratings for all plans due to successful Elevance appeal
  - UnitedHealth, Humana, and Centene all filed lawsuits regarding 2025 Star Ratings judgments
    - Lawsuits over counting of specific secret shopper calls
    - E.g., Centene argued that one failed call cost $73 million in quality payments
- 2028 planned introduction of health equity index in doubt

Medicare Advantage – Recent Policy Trends

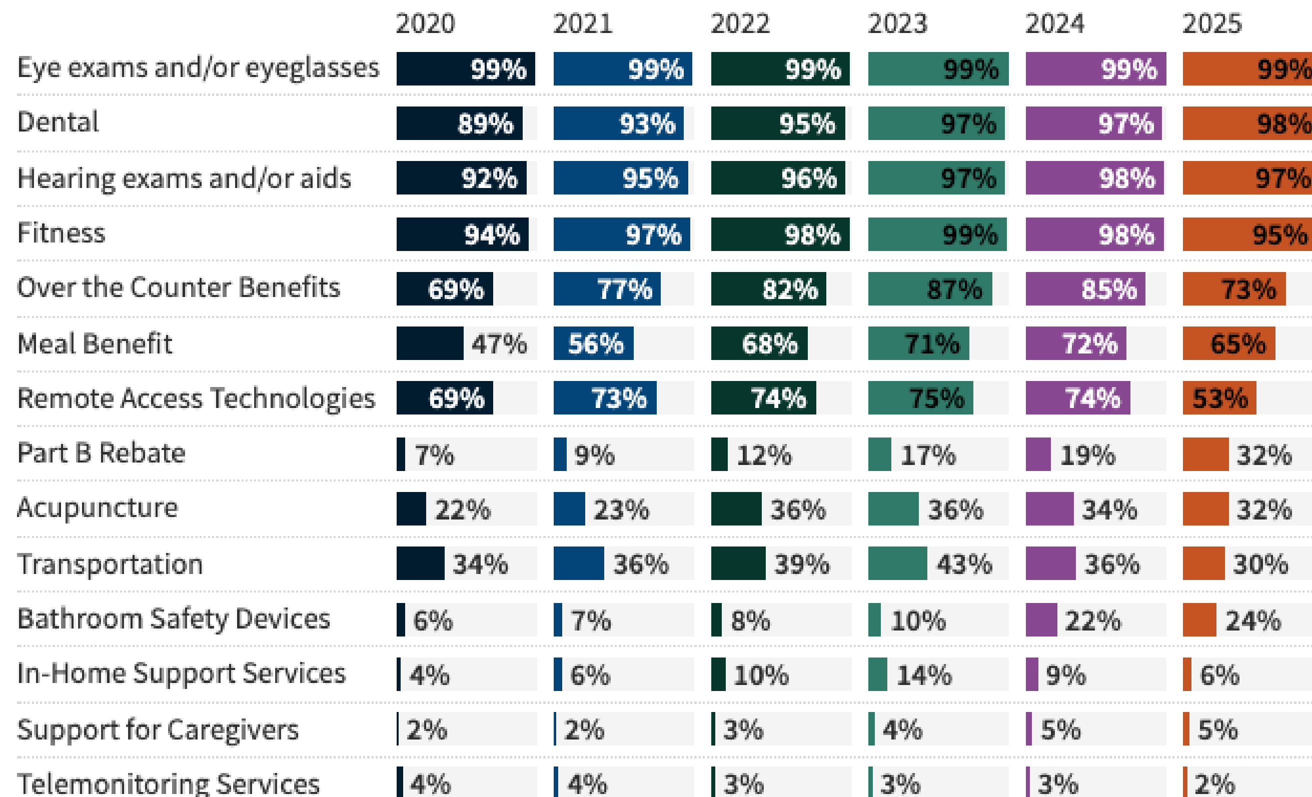
Supplemental Benefits

- Overall growth likely to slow due to headwinds
  - Uptake and outcome results still unclear
- Almost all plans offer vision/dental/hearing benefits, although scope varies
- Significant decrease in offerings of LTSS services (in-home support services, caregiver supports)
- Moderate increases in offerings of HRSN services (food, transportation, housing)

Medicare Advantage – Recent Policy Trends

Figure 2

The Share of Individual Medicare Advantage Plans Offering Vision, Hearing, and Dental Benefits Stayed Stable in 2025, But Declined for Some Benefits, Such as Over the Counter, Meal, Remote Access Technologies, and Transportation Benefits



Medicare Advantage – Policy Projections

- No detailed policy proposals have been released
- Strong Republican support for Medicare Advantage generally
  - Dr. Oz has proposed "Medicare Advantage for All"
- Traditional Republican approaches have included:
  - Policies that enable low cost sharing and a large number of plan options
  - Focus on Medicare costs
  - Lower oversight of plan operations (e.g. marketing tactics; network adequacy)
- Project 2025 advocated for making Medicare Advantage the default enrollment option

Medicare FFS

- No detailed policy proposals have been released
- Trump 1.0 included:
  - Administrative activities to reduce administrative burden (e.g. allowing X-rays to be transmitted electronically)
  - Expanding site neutrality
  - Drug pricing reform
- Broad bipartisan support for continued telehealth flexibilities
  - Currently extended through March 31, 2025
  - Statutory flexibilities include – permitting patient care at home; removing geographic restrictions; allowing telephonic telehealth; hospital @ home model

TEAM Model

- CMS's current proposal to create bundled payments for hospitals that extend to post-discharge care.
- **Key Features:**
  - **Implementation Date:** January 1, 2026.
  - **Mandatory Participation:**
    - Hospitals in covered geographies, including New York City and surrounding counties
  - **Scope of Bundles:**
    - Includes inpatient or outpatient procedures and 30 days post-discharge care for designated conditions:
      - Certain orthopedic procedures.
      - Coronary artery bypass graft (CABG).
      - Major bowel procedures.
- **Builds On:**
  - Bundled Payments for Care Improvement Advanced (BPCI Advanced).
  - Comprehensive Care for Joint Replacement (CJR) models.

TEAM Model

- **Financial Scope**
  - TEAM bundled payments estimated to represent **1.9%** of Medicare FFS hospital payment spending
  - By comparison, in 2021, 90-day bundled payment episodes under BPCI Advanced accounted for **2.1%** of spending for participating hospitals
- **Medicare Savings**
  - CMS expects the TEAM Model to generate **$705 million** in Medicare savings over five years