spg SACHS POLICY GROUP

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.	**Hearing** – January 29th
Deputy Secretary	Jim O'Neill	PENDING
CMS Administrator	Mehmet Oz	PENDING
Center for Medicare	Chris Klomp?	N/A
CMMI	Abe Sutton?	N/A
Chief of Staff	Stephanie Carlton?	N/A
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	John Thune (SD)
Finance Committee Chair	Michael Crapo (ID)
Health, Education, Labor and Pensions Committee Chair	Bill Cassidy (LA)
Budget Committee Chair	Lindsey Graham (SC)

Policy Implications

- Most Republicans are industry-friendly—but different factions focus on different industries
  - Physician-friendly (e.g., Cassidy)
  - Pharma-friendly (e.g., Arrington)
  - Insurer-friendly (e.g., Crenshaw)
- Even where factions seem to have coalesced around some topics, the thin majority leaves no wiggle room:
  - Site-neutral payments (bipartisan framework)
  - PBM regulation (removed from December 2024 spending bill)

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)
  - Lower the FMAP floor
  - 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)

Lower the FMAP Floor

Impact:

- Reduce federal Medicaid funding across the board for high-income states
- CBO scored full elimination of the floor as saving $530 billion; Republican proposal estimated at $387 billion, so likely to be lowering to, e.g., 25%
- Cost impact on NY and CA would be extreme (tens of billions) and require immediate cuts

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

Likelihood

- Very low

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 – 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 – House Republican Proposals

- Implement site-neutral payments ($146 billion)
  - Savings level requires site-neutral payments for **all** HOPDs (off-campus and on-campus)
  - Cassidy/Hassan bipartisan framework suggested savings from should be reinvested
- Uncompensated care reform ($229 billion)
  - Cap growth at CPI and allocate based on share of charity care/non-Medicare bad debt
  - Savings level suggests this could also include GME reform:
    - Consolidation of Medicare/Medicaid GME
    - Substantial reduction of funding level
    - Trend at CPI (or CPI minus 1%) annually (by moving outside Medicare Trust Fund)

Medicare FFS – House Republican Proposals

- Bad debt ($42 billion)
  - Eliminate 65% bad debt reimbursement for non-rural hospitals
- Sequester extension ($62 billion)
  - Sequester currently extended through FY 2032
  - $62 billion likely represents extension through full ten-year window

- Of these proposals, site-neutral payments and sequester extension are most plausible

Medicare FFS – Other Policies

- Trump 1.0 included:
  - Patients over Paperwork initiative for administrative burden reduction
    - E.g., allowing X-rays to be transmitted electronically
    - Also included E/M reforms
  - Medicare Part B Most Favored Nation policy (lame duck period)
- 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
- No clear attitude towards Biden CMS coverage/service innovations
  - E.g., Advanced Primary Care Management, behavioral health crisis services, dental services, SDOH services

MSSP

- Trump Administration initiated Pathways to Success in 2018
  - More downside risk and faster glide path for ACOs
- Biden Administration retained basic structure but sought to attract more participation
  - Allowed 7 years (up from 2 years) of upside-only for new ACOs
  - Implemented (partial) fix for “rural glitch” through blend of administratively-set rate into benchmark
  - Contemplated but did not introduce new risk tier between Level E and Enhanced
- Likely to return to somewhere in the middle

CMMI – ACO REACH

- Trump Administration originally introduced program as Global and Professional Direct Contracting (GPDC)
  - Biden Administration launched GPDC for 2021-2022
  - Changed program to ACO REACH for 2023 and made relatively minor changes:
    - Adding health equity adjustments and a health equity plan
    - Requiring that REACH entities be governed at least 75% by participating providers
    - Enhanced monitoring
- REACH model scheduled to end in December 2026
  - Trump administration highly likely to extend REACH or transition to new version