Class 4: The Future of NYS Medicaid

August 5, 2026

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Introduction

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- Welcome to the fourth session of FPI's "Medicaid Boot Camp"!
- Slides and recordings will be shared.
- Organization of the class:
  - **Session 1:** Medicaid in General
  - **Session 2:** Long-term care
  - **Session 3:** Hospital finance, supplemental payments and provider taxes.
  - **Session 4:** The 1115 waiver and the future of Medicaid in New York
- Email me!
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Agenda for Today

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- New York's 1115 Waiver:
  - 1115 waivers in general
  - How 1115 waivers generate money
  - New York's 1115 Waiver
    - Health-related social needs (HRSNs)
    - Hospital global budgets
    - Health Equity Regional Network (HERO)
  - Other NYS waiver programs
  - H.R. 1 impacts:
    - The Essential Plan
    - Work requirements
    - Funding cuts

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The 1115 Waiver

Waiving for Money

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Most people in New York politics think of “the 1115 waiver” as a mysterious way for the state to get billions of dollars from the federal government.



In this section we’ll discuss why that’s pretty much right.

1115 “Demonstration” Waivers

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- Section 1115 of the Social Security Act gives CMS very broad authority to change how Medicare and Medicaid work for “demonstration” purposes.
- For decades this was used narrowly and occasionally for demonstration programs.
- Beginning in 1994, states started reworking their Medicaid programs in major ways using 1115 waivers.
- Today there are ~65 active 1115 waivers:
  - Some for narrow purposes
  - Some (like New York’s) “comprehensive” waivers affecting the state’s entire Medicaid program.

What might you want to waive?

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- Federal Medicaid law imposes lots of requirements on states. For example:
  - **Comparability:** Different groups have to be eligible for comparable services.
  - **Freedom of choice:** An enrollee must be allowed to choose any Medicaid provider.
  - **Statewideness:** All Medicaid benefits must be available on a statewide basis.
  - **Benefits:** Only specific benefits are eligible for a Medicaid match.
  - **Eligibility:** Federal law imposes requirements and restrictions on eligibility.

What might you want to waive?

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- Federal Medicaid law imposes lots of requirements on states. For example:
  - **Comparability:** Different groups have to be eligible for comparable services – what if we want special services for HIV patients?
  - **Freedom of choice:** An enrollee must be allowed to choose any Medicaid provider – what if we want to put people in managed care?
  - **Statewideness:** All Medicaid benefits must be available on a statewide basis – what if we want to try an experiment in a specific area?
  - **Benefits:** Can we add benefits?
  - **Eligibility:** Can we expand (or restrict) who's eligible?

Medicaid Waivers

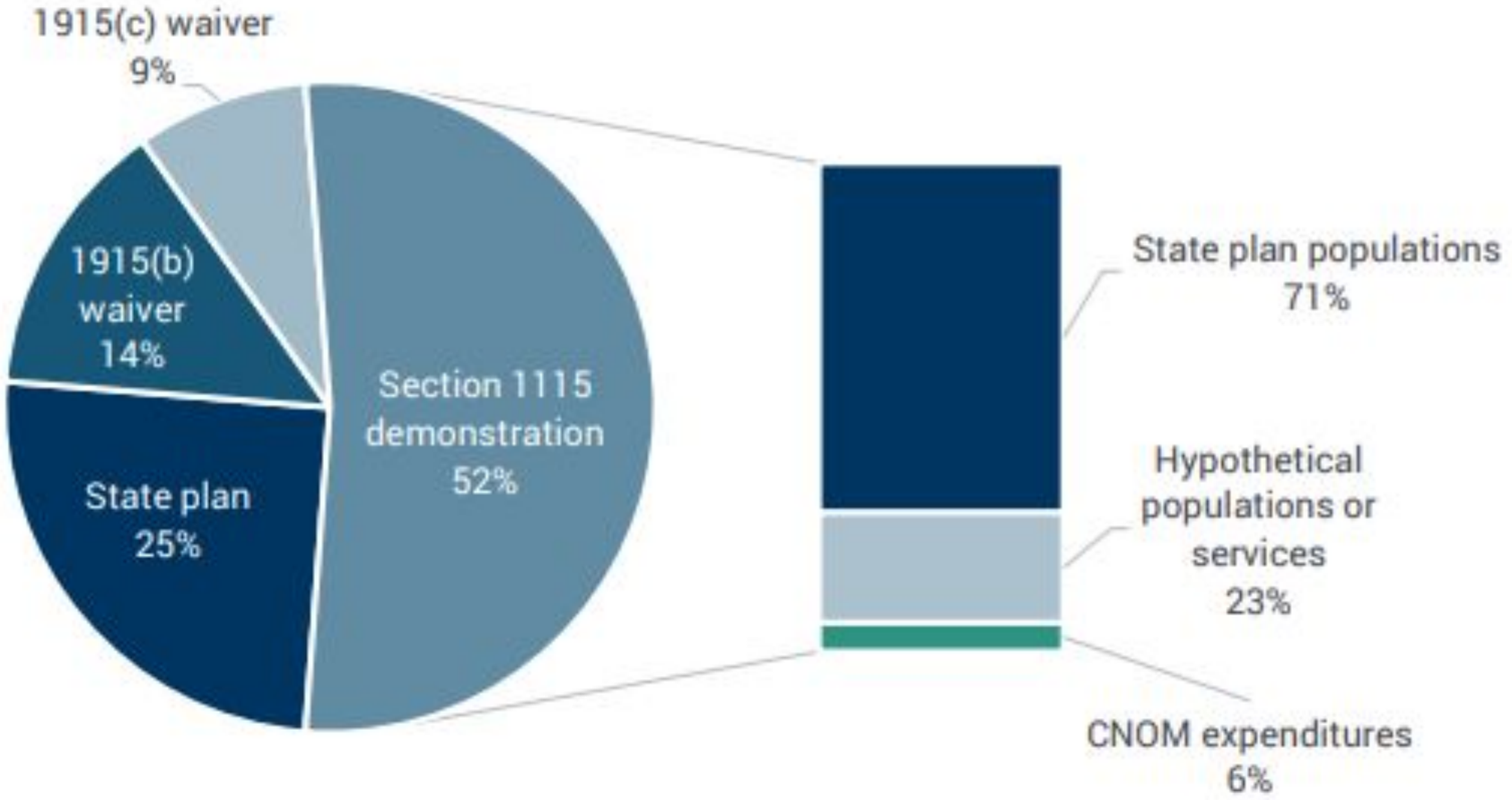
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- Waiver authorities allow states to experiment.
- Some waiver authorities are specific:
  - 1915(b) waivers are used to implement managed care.
  - 1915(c) waivers are used to offer HCBS, usually to specific populations.
- 1115 is the *broadest* waiver authority – CMS can choose to waive all sorts of provisions as long as CMS thinks it advances the goals of the program.
  - **Lots and lots** of federal discretion is involved.

Waivers are a Big Deal

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



Source: MACPAC 2021

1115 Waivers and Budget Neutrality

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- So could you use an 1115 waiver to just make everyone eligible for Medicaid? Medicaid for All!
- Not really: 1115 waivers must be **budget neutral** for the federal government, meaning the federal government won't spend more than it would without the waiver.
- But how do we know how much it would spend without the waiver?
  - That's where the fun begins.

Per Capita Budget Neutrality

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- This is an extremely complex and technical topic! Here's the cartoon version of how it might work.
  - State and feds agree that **without** the waiver, the state would spend $5,000 per enrollee.
  - The state can't spend **more** than $5,000 per enrollee.
  - If the state spends **less** than $5,000 – say, $4,800 – it has budget neutrality savings.
  - For example, if 1 million people enroll then it has $200 million in budget neutrality savings.
  - The state can then **spend those savings** on Costs Not Otherwise Matchable (CNOM)
  - Nice!

1115 Waiver Uses

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- 1115 waivers can be used to, like, **waive stuff**:
  - Implement managed care.
  - Do regional rollouts
  - Offer new benefits.
  - Charge copays or premiums or do work requirements.
- 1115 waivers can also be used to **generate money**:
  - Get budget neutrality savings
  - Spend it (with CMS approval) on stuff that wouldn’t ordinarily be matched.

How to Spend It

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- How can states spend the extra money on “CNOM”?
- Always:
  - Coverage expansions (broad before 2010, now usually continuous eligibility).
  - Inpatient substance use disorder treatment
  - Various benefit expansions.
- Trends:
  - Before 2010: 1115 was a great way to expand Medicaid eligibility to low-income otherwise-ineligible people.
  - 2010-2020: 1115 for supplemental payments to hospitals (“Delivery System Incentive Reform Program” or DSRIP)
  - Biden administration: Social determinants of health.

Where to Get the Money: DSHPs!

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- If a state has (say) $1B of budget neutrality savings, it still needs to find $500M of state-share spending to use them.
- In the 1115 process, the state can apply to “designate” some NON-Medicaid spending as Medicaid-matchable.
- So if a state is spending $100M on, like, anti-smoking ads, it can apply to make that a Designated State Health Program that is Medicaid-matchable.
- Now it has $50M extra money!

State-Federal Negotiations

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- There is *lots* of discretion and *lots* of negotiation in 1115 approval.
- Both **how much** money a state can get and **what programs** it can spend it on are up for grabs.
- Waiver approvals reflect presidential priorities and state-federal give and take.
- Negotiations result in an approval with a (long) list of **Special Terms and Conditions (STCs):** Requirements the state needs to meet to get the money.

New York's 1115 Waiver

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- Waivers are approved for 5 years.
- New York's was approved with few changes in 2022, while the state continued to negotiate with the federal government.
- Apparently the negotiations were rough because NYS received approval only on January 9, 2024 – and only for an "amendment," not a 5-year extension.
- So our current waiver expires on March 31, 2027.

New York's 1115 Waiver

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Program	1115 Approved Spending
Health-Related Social Needs	**$3.673B**
• Infrastructure	$500M
• Services	$3.173B
Health Equity Regional Organization	**$125M**
Hospital Global Budget Initiative	**$2.2B**
Workforce Initiatives	**$694M**
• Loan Forgiveness	$48M
• Career Pathways Training	$646M
Total	**$6.7B**

Funding the Waiver

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- The state got $4B of DSHP (so ~$2B of federal money)
- Dozens of programs were designated DSHP
- The largest by far was VAPAP ($2B)
- In effect this means that the federal government is funding a large share of the state-share of New York's CNOM!
  - Good for us.

1115 Spending Initiatives

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- **Health-related social needs (HRSN):**
  - Provides non-medical services (like food, housing, and transport – but honestly mostly food).
  - $3.173B for **services** and $500M for **infrastructure.**
- **Health Equity Regional Organization (HERO):** United Hospital Fund will convene stakeholders and stuff.
- **Hospital Global Budget Initiative:** Funding to support a new payment model for hospitals.
- **Workforce:** A little funding for student loan forgiveness and a lot of funding for training.

Health-Related Social Needs (HRSN)

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- **One way to think about it:** Social needs determine health, yet doctors can't prescribe food and shelter. Wouldn't it be good if they could? Wouldn't that save the healthcare system money?
- **Another way to think about it:** The state does some things that are not Medicaid-matched. What if they were?
- HRSN system:
  - Regional **Social Care Networks** coordinate CBOs to deliver nutrition and stuff.
  - CBOs learn to bill Medicaid
  - 96% of all services are nutrition (home-delivered meals etc.)

Hospital Global Budgeting: In General

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- Hospitals are paid to do stuff – appendectomies, ER visits, whatever.
- Arguably we would rather have hospitals be paid to keep people healthy.
- A hospital-level "global budget" means the hospital's revenue is **fixed in advance,** regardless of what services it provides.
- This can be good because it can:
  - Incentivize preventive care
  - Offer stability
  - Allow transitions in care settings
- Think of how public schools are funded!
- This system works well in Maryland, and CMS wants to encourage it elsewhere.

Hospital Global Budgeting: In New York

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- A handful of *downstate, safety net* hospitals are going to have global budgets.
- The state is getting an extra $550M/year to support them.
- A typical 1115 tradeoff:
  - CMS wants states to experiment with global budgets
  - The state wants $550M/year
  - Now, everyone can win!

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Other Waivers

1915(c) Waivers

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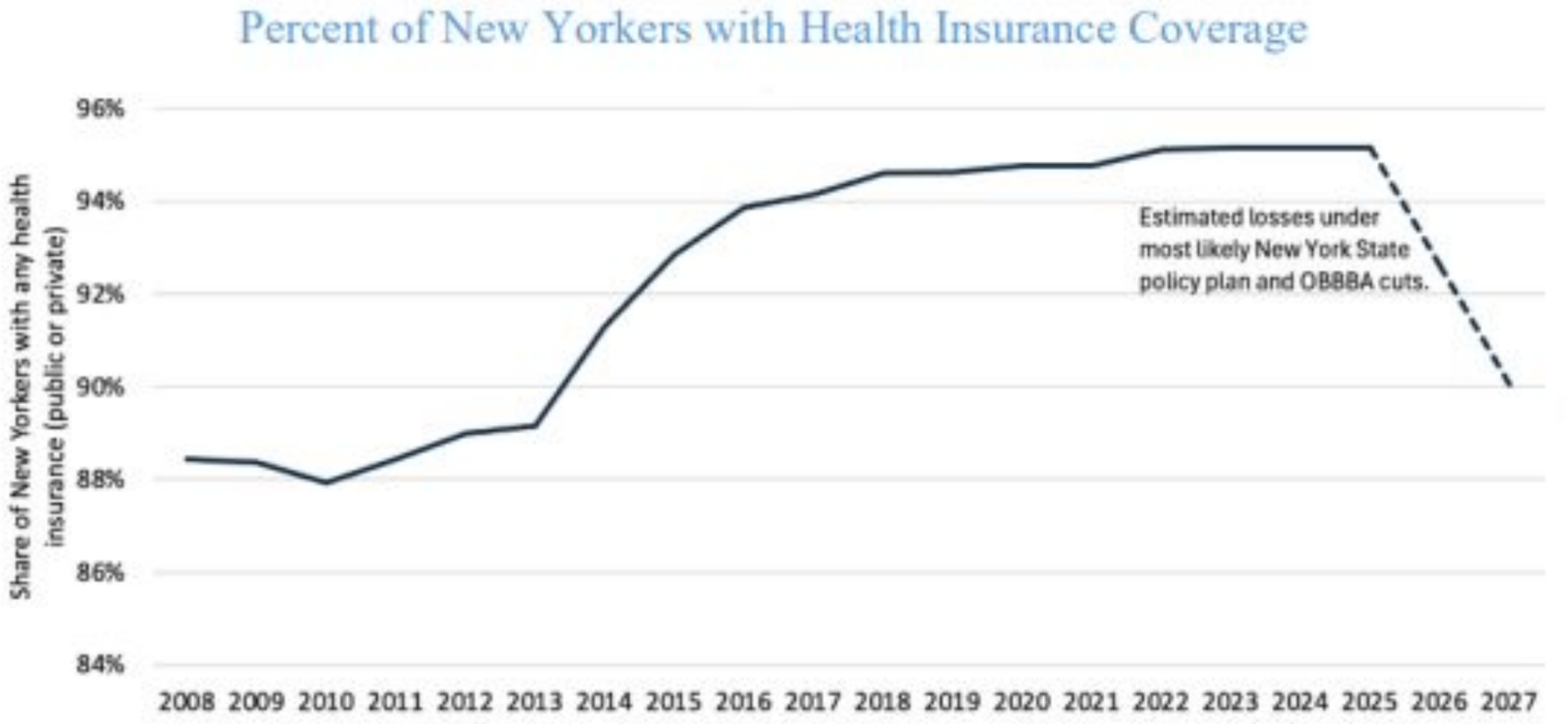
- Waiver authority created to encourage state HCBS
- Many states have a bunch of 1915(c)s
- New York has:
  - Nursing Home Transition and Diversion (NHTD)
  - Traumatic Brain Injury (TBI)
  - Office of People with Development Disabilities (OPWDD)
  - Children's Waiver
- OPWDD waiver:
  - $8.2B in spending for 104k participants ($80k/participant)
  - All sorts of supports for ID/DD population.

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Work Requirements

Where We're Headed

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OBBBA Work Reporting Requirements

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- Conservatives have long dreamed of imposing “work requirements” on Medicaid
- OBBBA finally achieved it, for the “ACA Expansion” population (low-income adults).
- Work requirements may cause 500k-1 million people to lose Medicaid, beginning 1/1/27.
  - No one knows the impact!
- The same population will be subject to six-month redeterminations

Figure 2

Proposed Qualifying Activities and Exemptions

Qualifying Activities

- 80 hours per month of work, community service, and/or "work program" participation
- Enrolled in education at least half time
- Any combination of the above totaling 80 hours per month
- Monthly income of minimum wage multiplied by 80 hours
- Seasonal workers with an average monthly income over 6 months of minimum wage multiplied by 80 hours

Mandatory Exemptions

- Parent/guardian/caretakers of dependent children under age 13 or disabled individuals
- Pregnant or receiving postpartum coverage
- Foster youth/former foster youth under age 26
- Medically frail
- Participating in SUD program
- Meeting SNAP/TANF work requirements
- American Indians and Alaska Natives
- Disabled veterans
- Incarcerated or released from incarceration within 90 days
- Entitled to Medicare Part A/enrolled in Medicare Part B

Optional Hardship Exceptions

State option to allow short-term hardship exceptions, for an individual who…

- was in an inpatient hospital, nursing facility, intermediate care facility, or inpatient psychiatric hospital
- resided in a county with a federally-declared emergency or disaster
- resided in a county with a high unemployment rate (above 8% or 1.5x the national unemployment rate), subject to a request from the state to the Secretary
- traveled outside of the individual's community for an extended period for medical care for themselves or for their dependent

Why Work Requirements Create Coverage Loss

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- Most people subject to work requirements either work or qualify for an exemption
- Red tape, confusion, missed letters will mean that many lose coverage anyway.
- The city's experience with SNAP so far is that *young adults* are most likely to lose coverage.

Special Issues

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- **Ex parte verification:**
  - NYS will work to use data sources (tax data, payroll data, etc.) to automatically verify that people are meeting work requirements
  - No one knows how well this will work.
- **Medical frailty:**
  - There was hope that the federal government would interpret the “medical frailty” exemption broadly
  - Unfortunately the standard is high – only people with a diagnosis that prevents them from being able to work.
  - For the first year people can “self-attest” but they will eventually need a doctor’s note.

Work Requirements, Conceptually

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- The vast majority of healthcare spending is on the **seriously ill.**
  - 80/20 rule – 80% of spending is on the highest-cost 20%.
  - It costs almost nothing to provide healthcare for a healthy adult
- A healthy adult who gets hit by a cab will become eligible (due to inpatient hospitalization)
  - Work requirements enormously increase the complexity, confusion and administrative overhead of Medicaid
  - But they don't meaningfully save money.
- A stupid and cruel policy.

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The Essential Plan

The Essential Plan: Background

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- EP provides coverage for 1.7 million New Yorkers earning less than 250% FPL
- EP is an extraordinarily efficient way to provide coverage
  - Less than $7k per person for high-quality, zero-deductible coverage
  - Private employer insurance costs ~$11k for coverage with a $2k deductible
- Sources of EP efficiency:
  - Regulated provider rates (originally 125% Medicaid, now 225%)
  - Good risk pool

The Essential Plan: Background

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- EP is funded with PTC, which in other states subsidize private exchange insurance
- *Because* EP is so efficient, it produces a significant surplus
- By 2023, EP had accumulated a $10B “trust fund.”
- In 2023-24, the state used that surplus to:
  - Increase provider rates from 125% to 225% Medicaid (significantly increasing costs)
  - Cover enrollees between 200-250% FPL (450k joined)
- This involved shifting from original federal authority (“Basic Health Program”) to Section 1332 waiver
- Basic Health Program “trust fund” still has $10B in it.

The Essential Plan: Federal Cuts

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- ~750k EP enrollees were (lawfully present) immigrants
- OBBBA cut off PTC and EP funding for immigrants
  - Effect **outside** NYS: Immigrants will be forced off the exchanges
  - Effect **here in NY:** massive loss of EP funding, forcing changes
- OBBBA led to a massive loss of funding for EP (~$7.5B of $14B)
- Options for keeping EP sustainable:
  - Put state money in
  - Access the trust fund
  - Reduce provider rates to their original level
  - Cut coverage

Executive and Enacted EP Changes

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- EP will return to its pre-2024 Basic Health Program authority
  - This will allow the state to maintain coverage for everyone below 200% FPL (regardless of immigration status)
- **450k people** between 200-250% will lose EP coverage **on July 1, 2026**
  - The most rapid and sudden loss of coverage in NYS history
- EP provider rates will remain at their high level
- EP coverage will be partly subsidized by “spending down” the BHP trust fund – meaning in 3-4 years we’ll need to revisit.

What will happen to people who lose EP?

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- 450k people who gained EP coverage in 2024 are set to lose it in 2026.
- Those people could:
  - Find a way onto employer coverage
  - Enroll in the individual market
  - Become uninsured
- The Executive predicts that perhaps 200-300k will find other insurance, while FPI predicts <100k
- Even those who find alternative coverage will face:
  - Increased premiums of $250/month
  - Deductibles of $3k+
  - A catastrophe of healthcare access

EP, ESI and “Crowding Out”

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- The Executive and others appear to believe that EP 200-250 “crowded out” ESI
- A more accurate view is that EP 200-250 responded to the growing crisis in New York ESI – dramatically rising premiums and declining quality, falling enrollment.
  - You can’t expect employers paying $40k/year to buy a health plan costing $11k/year!
- Small and low-wage employers are unlikely to re-enter the ESI game once they are out.
- And why would we want that? EP is:
  - Much better insurance than ESI
  - At a much lower cost

Reflecting on the EP Outcome

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- The state didn't spend a dime to protect EP – only federal funding will support EP 0-200.
- Policymakers doubled down on a broken policy framework (ESI for anyone who can get it, social insurance as "safety net").
- Policymakers prioritized provider rates over maintaining coverage.
- In the long term, we know that EP worked well and should revisit it.