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The Trump Administration Just Cut Hundreds of Millions of Dollars a Year from New York's 1115 waiver – and that could be just the beginning

Cuts won't take effect until 2027 – but they could still pinch. Here's how.

On April 10, 2025, the federal Center for Medicare and Medicaid Services (CMS) sent a letter to state Medicaid directors announcing that it would no longer approve new Designated State Health Program (DSHP) expenditures by states.[1] This obscure administrative change will have a significant impact on New York State's Medicaid program, cutting off a nearly $1 billion funding stream New York is currently using to address social determinants of health, including homelessness and drug use, as well as critical healthcare workforce shortages across the state. This action by CMS is likely just the first step in a broader renegotiation of New York's Medicaid program. Over the coming months, we can expect to see more funding cuts and restraints on Medicaid spending.

The following brief describes how New York's 1115 waiver works and how the Trump administration has sought to cut it.

Medicaid Waivers and the Politics of the Federal Match

Medicaid is administered by the states, but it is jointly funded by the state and the federal government. Specifically, the federal government provides a "match" on state Medicaid spending by picking up the tab for between 50 and 90 percent of total spending in the state, depending on the state and the program area. New York's Medicaid program, for example, is projected to cost $103.1 billion in State Fiscal Year 2025, of which the federal government will pay $56.8 billion, or 55 percent.

This structure gives the federal government a significant voice in how states set up their Medicaid programs, since it can decide what kinds of spending it is willing to match. For example, the federal government can and does require states to provide a specific minimum set of benefits to Medicaid enrollees, to offer the same services to all enrollees statewide rather than favoring specific areas or demographics, to reimburse providers adequately but not excessively, to submit program changes to public comment, etc. Over time, a complex body of federal law and regulation has developed, shaping

[1] https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf

what states can and cannot do while receiving the Medicaid match. Just as importantly, federal rules determine what counts as Medicaid spending (i.e. eligible for a federal match) and what doesn't; state policymakers can't claim the Medicaid match for just any kind of spending.

These rules provide important guardrails for states – but they can also restrict state experimentation and innovation. For example, when Medicaid was first enacted in 1965, it did not allow states to claim any Medicaid federal match for home care for the elderly and disabled. This rule created a perverse incentive encouraging states to push people with disabilities into nursing home care, since nursing home care *was* Medicaid-eligible.

Other examples of federal rules which might pose an obstacle to good policy abound. For example, federal rules require that Medicaid services be offered on a statewide basis to all enrollees – a provision intended to avoid discrimination against racial minorities. But those same rules would also prevent a state from, for example, piloting a new service in a specific geography before deciding on whether to roll it out statewide, or targeting services to a specific population such as people with HIV or chronic conditions. The federal government may want to encourage such experimentation – but the rules won't allow it.

Medicaid *waivers* are designed to address these inflexibilities. Over time, Congress has granted CMS authority to waive a variety of Medicaid rules if CMS sees this as advancing the broader aims of the program. A state can apply for a waiver requesting exemption from some of the standard Medicaid rules, and CMS has substantial (although not total) discretion about whether and under what conditions to grant the waiver. Such waivers have now become extremely common; the CMS website lists 455 approved or pending waivers across all 50 states.[2] Waivers fall into three broad categories: 1915(c) waivers, which allow states to offer home and community-based services, 1915(b) waivers, which allow managed care, and 1115 demonstration waivers, which give CMS very broad authority to suspend Medicaid rules if doing so advances the goals of the program and doesn't cost the federal government more money.

The fact that there are hundreds of approved waivers may seem surprising: If the federal government is going to *waive* the rules so often, why not just *change* the rules? In some instances, Congress has done just that, changing the rules to allow states to do things without a waiver that they once needed a waiver for. But in other instances, policymakers are happy with the waiver system, because it allows CMS significant *discretion:* CMS can grant states flexibility when doing so advances its policy goals while retaining oversight powers to ensure that the flexibility is not misused..

Because of this discretionary dynamic, the waiver process often involves significant behind-the-scenes negotiation between CMS and the state seeking a waiver.

New York's 1115 Waiver

Like most states, New York operates several waivers, including four 1915(c) waivers allowing the state to offer home- and community-based services (HCBS) to specific populations.[3] However, by far the most significant New York waiver is its 1115 Medicaid Redesign Team (MRT) waiver, which has

[2] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list?f%5B0%5D=state_waiver_status_facet%3A1561&f%5B1%5D=state_waiver_status_facet%3A1591#content

[3] These waivers are: The Office for People with Developmental Disabilities (OPWDD) waiver, the Nursing Home Transition and Diversion (NHTD) waiver, the Traumatic Brain Injury (TBI) waiver, and the Children's waiver.

been operative since 1997. The vast majority of New York's Medicaid funding, including its funding for both mainstream Medicaid and long-term care, is spent under 1115 waiver authority. As described above, Section 1115 authority grants CMS broad discretion to allow states to restructure their Medicaid programs. New York's 1115 waiver originally allowed the state to shift its mainstream Medicaid program to managed care in the 1990s. Since then, the State has used 1115 authority for a number of purposes, including expanding coverage, addressing social determinants of health, and funding safety net hospitals.

An important requirement for 1115 waivers is *budget neutrality:* To receive waiver approval, a state must demonstrate to CMS that the waiver will not cost the federal government more money than the state would claim without the waiver. This means on the one hand that the state can't ask for more than it would have gotten without the waiver, but on the other hand that if the waiver is projected to *save* some money for the federal government, the state can use that federal savings for other purposes, as long as those purposes are healthcare-related and are approved by the federal government. If a state projects that the federal share of its Medicaid program would be $10 billion without the waiver but that it will only be $8 billion with the waiver, then the state can claim the remaining $2 billion of federal funds for other purposes, subject to federal approval.[4]

While this budget neutrality system may seem straightforward, in practice it is anything but. Demonstrating cost neutrality requires a state to project its Medicaid spending several years into the future under the waiver, project what its Medicaid spending *would* hypothetically be *without* the waiver, and then compare the two. Given the number of assumptions about enrollment, provider reimbursement, population health, and other issues involved in both projections, there is plenty of room for discretion on the part of both the state which seeks the waiver and the federal officials tasked with approving it. In general, the state will seek to select assumptions which generate large with-waiver savings while CMS will push for assumptions which lead to relatively smaller savings. The degree of flexibility CMS is willing to grant a state may depend on both how friendly the current presidential administration is to Medicaid spending overall and the extent to which CMS views the policy goals the state is pursuing through the waiver in a positive light.

If the state and the federal government agree that a waiver will save the federal government money, then the state may spend that freed-up federal money in several ways – by expanding the population or services covered by Medicaid, by directing supplemental payments to healthcare providers, or by spending money on healthcare-related programs that wouldn't ordinarily be eligible for a Medicaid match. This latter category is where Designated State Health Programs (DSHPs) come in (see below).

The result of these negotiations is an approved waiver application like the one New York State received in January 2024.[5] The approved waiver is in effect an agreement between the state and CMS, laying out how the state may change its Medicaid program, how much the changes will save, and how the state will spend the savings.

[4] https://www.macpac.gov/wp-content/uploads/2021/12/Section-1115-Demonstration-Budget-Neutrality.pdf
[5] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-appvl-01092024.pdf

Designated State Health Programs in New York's 1115 Waiver

This abstruse process entered the national spotlight last week because the Trump administration announced that it would change the rules of the game. CMS wrote a letter to states announcing that it would no longer approve or renew 1115 waivers that include Designated State Health Program funding. That's a big change, because New York's existing waiver gives the state nearly $2 billion over four years in extra funding through the DSHP mechanism, which the state has used to fund a variety of innovative programs; now we know that funding won't be renewed, and the state may need to make it up out of state tax dollars or cancel the health programs.

But how exactly does the DSHP mechanism work? Under DSHP, a state and CMS may agree to designate an *existing* state health program as Medicaid-matchable even if it wouldn't otherwise be. This allows the state to draw down federal match on the designated program, freeing up other state funds to support *new* programs.

For example the New York 1115 waiver approved in 2024 designated the following programs among others as match-eligible:[6]

- Doctors Across New York ($6.2 million), a program providing financial assistance to doctors to increase diversity in the medical profession.
- Newborn Screening ($38.9 million), a program to screen newborns for diseases so they can be treated.
- Tobacco Control ($162.6 million), a set of programs to discourage smoking.
- Vital Access Provider Assistance Program (VAPAP) ($2.4 billion), a program that supports financially distressed hospitals at risk of closure.

When these programs are "designated" under the 1115 waiver, they become eligible for the Medicaid match – so instead of New York paying the full $38.9 million for newborn screening, the federal government pays for half the program, freeing up $19.5 million in state funds to support other healthcare initiatives.

In total, CMS allowed New York to "designate" $3.9 billion worth of healthcare programs over four years, thus drawing down nearly $2 billion in new federal matching funds over four years. This was a significant contributor to the $7.5 billion over four years approved under New York's 1115 waiver.[7]

How New York is Using DSHP Funding

New York's DSHP funding is being used to support several significant programs:

- **Health Related Social Needs (HRSN) services:** Under the 1115 waiver, New York will use Medicaid funds to pay for non-medical services, like housing and healthcare, for specific high-need Medicaid populations. For example, New York may be able to provide nutritious meals and safe housing for people with mental illness who might otherwise seek care at an emergency room.

[6] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-appvl-01092024.pdf, Attachment N
[7] https://www.manatt.com/insights/newsletters/health-highlights/new-york-states-approved-health-equity-1115-waive

- **Health Equity Regional Organization (HERO):** New York was approved to set up a statewide entity to conduct regional research and planning to advance health equity.
- **Workforce initiatives:** New York will also provide training and loan forgiveness for a variety of healthcare providers, particularly those serving underserved populations.

None of these initiatives would be eligible for Medicaid matching under standard Medicaid rules, which require money to be spent on *medical* treatment for specific individuals. The waiver allows the state to spend federal funds on these initiatives.

It is important to note that the elimination of DSHP does not necessarily mean these programs will be cancelled. DSHP funding comprises only $2 billion of New York's $7.5 billion in 1115 waiver funding. And while the $2 billion in lost funding over four years – or about $500 million a year – will be significant, it is not a huge amount of money in the context of New York's $103 billion Medicaid program.

The Bigger Picture: A Rocky Road for New York's 1115 Waiver

The Trump CMS announcement reflects a larger debate over health equity, social determinants of health and aggregate Medicaid spending that could have a serious impact on New York's Medicaid program, even without Congressional action.

That debate centers on the issue of "social determinants of health" – all the non-medical factors that go into who gets sick and who remains healthy. Progressives have long argued that social determinants of health represent a key policy lever to improve health outcomes and lower costs. After all, if (for example) a homeless person repeatedly ends up in the emergency room because she can't access her medications because she's homeless, that can be very expensive for the state's healthcare system; doesn't it make better fiscal sense to use some funding to provide her with stable housing, rather than repeatedly pay for emergency care? On a broader level, if many patients are struggling to access healthcare because of language barriers or lack of providers, doesn't it make sense for the state to address this area-wide issue with workforce initiatives, culturally competent care, or other programs, rather than deal with the consequences on an individual level? New York's 1115 waiver is an effort to take this systemic approach, and under President Biden CMS was happy to approve it.

Conservatives, on the other hand, have remained skeptical of this approach, worrying that it represents a blank check for states to spend Medicaid funds on non-medical services, that it raises total Medicaid spending, and that it introduces issues of diversity, equity and inclusion into healthcare.

The issue hasn't always been partisan; social determinants of health approaches have sometimes found bipartisan support, and the DSHP mechanism was first used in 2005, under the George W. Bush administration. But during Trump's first term, CMS eliminated DSHP. President Biden restored it in 2021, and now Trump has cancelled it again.

The Trump administration's announcement that it will no longer accept DSHP is the opening shot in a larger battle about the purpose and limits of Medicaid spending, and the role of the federal government

in policing those limits. While media coverage of Trump's Medicaid policy so far has focused on legislative efforts to cut the program, administrative actions like these may be equally important in shaping the future of Medicaid. That's particularly true in New York, which operates one of the largest and most innovative Medicaid programs in the country. As the 2027 deadline for renewal of New York's 1115 waiver approaches, the Trump administration will likely take further action to reduce the amount of money New York receives from the federal government to fund its Medicaid program – and to constrain how it is allowed to spend the money it does receive.