

# Trump, Take 2

## Likely Policy Shifts for Children's Public Behavioral Health

### Three Strategies, Ten Tactics and a Trojan Horse

In this brief, we'll provide you with a concise overview of policy changes likely to occur, and how we identified them. We consider two sources as primary. The first source is the Heritage Foundation's '[Project 2025: Mandate for Leadership](#).' This tome walks through conservative policymakers' priorities for each Federal Department under the new Trump Administration. In lieu of a party platform or detailed position papers by the campaign, this volume serves as the clearest blueprint of the Administration's intentions.

**To prepare for the 2025 Trump Administration, we have to understand what it intends to do.**

The second source is the actions of CMS Administrators in the first Trump Administration. If people tell you what they are going to do, and have a track record of pursuing those very actions, we consider that strong evidence that they will pursue these actions (again).

We have identified three broad strategies the Administration is highly likely to pursue. We then identify ten tactics we expect to see used to realize those strategies. We'll close with a surprise: a seeming gift with a nasty kicker!

### Strategy I: Restrict Access to Medicaid

This first strategy is the most impactful. Access to care precedes all of the other healthcare characteristics that matter (timeliness, quality, periodicity). The number of uninsured families and children has dropped substantially since the Affordable Care Act (ACA) was enacted. Previously, many states only covered children in families with incomes up to 100% of the poverty line. The ACA required coverage to extend to families with incomes up to 133% of the poverty line (In 2025 this is \$20,029 for an individual and \$41,400 for a family of four).

# Trump, Take 2

## Likely Policy Shifts for Children's Public Behavioral Health

### Strategy I: Restrict Access to Medicaid (cont.)

*Tactic 01.* A [House bill](#) from the previous Trump Administration intended to roll back this extension, despite it likely ending coverage for more than 1 million children. Then Director of the Centers for Medicare and Medicaid Services (CMS), Seema Verma, supported this change.

*Tactic 02.* Also present in that bill was a clause that required redetermination of eligibility every six months, versus every year. As we have seen in dramatic fashion after the unwinding of Covid-era coverage protections, redetermination processes are [error-prone, substantially burden families and state Medicaid agencies](#), and [contribute to violations of federal regulations](#) protecting Medicaid-eligible children and youth. In one state that engaged in a particularly rapid redetermination process, only 11% of people disenrolled via redetermination purchased coverage on the ACA Marketplace.

### Strategy II: Reduce services available to children.

For persons who obtain access to care, a second strategy aims to limit what is required to be provided. The Project 2025 policy document lays out a set of potential tactics to limit the scope of care provided:

“Allow states to have a more flexible, accountable, predictable, transparent, and efficient financing mechanism to deliver medical services. This system should include a more **balanced or blended match rate, block grants, aggregate caps, or per capita caps**” (p. 466).

“CMS should also...[A]dd targeted **time limits** or **lifetime caps** on benefits to disincentivize permanent dependence” (p. 468) and,

“Benefits **increasingly involve nonmedical services** such as air conditioning and housing, many of which are already handled by departments other than HHS (p. 466).”

# Trump, Take 2

## Likely Policy Shifts for Children's Public Behavioral Health

### Strategy II: Reduce services available to children (cont.)

*Tactics Five and Six.* Per capita and lifetime caps are pernicious ways to eliminate access to care for persons who have the most severe conditions. Our experience with designing service arrays in multiple states is that their inadequate continuums of community-based care result in Medicaid-covered youth receiving unnecessary and costly care in inpatient and residential settings. Thus, the system itself may be responsible for an individual's high costs of care. Limiting access to care because of cost 'overruns' that the system itself fostered is a diabolical approach to care management.

*Tactic Seven.* It is particularly important to note the mention here of block grants. The previous Medicaid Administrator [championed block grants](#) as a way to deliver innovative care to Medicaid recipients. Yet block grants have a key difference from other Medicaid payment mechanisms: they cap funding for health care.

Medicaid's traditional model allows states to draw down as much federal reimbursement as needed, based on a state match rate. This allows states to have flexibility in spending – spending more when unexpected population health needs arise, and less when needs decrease. Block grants cap the federal contribution, leaving states on the hook when unexpected needs arise.

This makes it doubly difficult for states to address unexpected needs. First, states must carefully monitor spending so that there is a reserve available for any unexpected need. Second, should an unexpected need arise that exceeds that reserve, state health department officials must convince legislators to allocate new funding without any additional match from the federal government. This is unlikely to occur within a state fiscal year, meaning that health care is likely to be underfunded for a substantial period of time before adequate funding is provided (if it is provided at all).

# Trump, Take 2

## Likely Policy Shifts for Children's Public Behavioral Health

### Strategy II: Reduce services available to children (cont.)

*Tactic Eight.* The final quote indicates that a substantive portion of services provided by CMS are a) non-medical and b) covered by other programs. Thus, their inclusion in a Medicaid benefit is superfluous or just simply wasteful. Our experience is the opposite. There is very little flexibility in addressing well-established [social determinants of health](#) (SDoH) for children experiencing behavioral health problems. This can make effective treatment much more difficult to provide. For instance, frequent residential mobility or homelessness can exacerbate children's adjustment problems yet wait times for federal housing assistance programs [routinely exceed multiple years](#).

### Strategy III: Reduce administrative burden.

'Administrative burden' has become a catch-all term encompassing nearly any activity that is not direct patient care. When used in the context of Medicaid administration, we have identified two specific tactics that appear to fall under this heading.

*Tactic Nine.* First is the elimination of much of the federal oversight in the waiver and State Plan Amendment process. In the first Trump administration, there was a laudable emphasis on [tracking the time CMS staff took](#) to review and respond to waiver applications and State Plan Amendments. In the second Trump administration, the goal extends beyond timeliness and to the level of oversight itself. As stated in the Project 2025 policy manual (p. 468):

**Increase flexible benefit redesign without waivers.** CMS should add flexibility to eliminate obsolete mandatory and optional benefit requirements and, for able-bodied recipients, eliminate benefit mandates that exceed those in the private market. This should include flexibility to redesign eligibility, financing, and service delivery of long-term care to serve the most vulnerable and truly needy and eliminate middle-income to upper-income Medicaid recipients.

# Trump, Take 2

## Likely Policy Shifts for Children's Public Behavioral Health

### Strategy III: Reduce administrative burden (cont.)

The ability to redesign without waivers creates a situation in which many of the federal guardrails for ensuring the program adequately reimburses states and providers, and adequately safeguards eligibility and quality of care, are in jeopardy. As we have seen with the [Medicaid-Medicare reimbursement disparity](#), when states are given the 'flexibility' to design payment and eligibility processes they often act in ways that shortchange both care providers and Medicaid-eligible citizens. Because of this, we identify this tactic as a **'Trojan Horse,' reducing quality and accessibility of care for persons most in need.**

*Tactic Ten.* This last tactic involves shifting from process measures of performance to outcome measures of performance. Here's a relevant recommendation from Project 2025:

Finally, HHS should adopt metrics across the agency that can objectively determine the extent to which the agency's policies and programs achieve desired health and welfare outcomes (not agency outputs). What is not measured is not achieved.

Under Administrator Seema's tenure in the previous Trump administration, there was a similar emphasis on a shift to [Value-Based Care](#), particularly in Primary Care. We applaud the desire to focus attention on the outcomes of behavioral healthcare. However, we note two important cautions.

First, there is no federally designated outcome measure used across states to benchmark and track behavioral health outcomes. The Child and Adolescent Needs and Strengths (CANS) tool is likely the most widely used functional assessment measure in children's public behavioral healthcare. However, the items included on each state's version of the CANS tend to differ, sometimes dramatically. A practical methodology for tracking a core set of indicators across states and time has not been published or implemented.

# Trump, Take 2

## Likely Policy Shifts for Children's Public Behavioral Health

### Strategy III: Reduce administrative burden (cont.)

Barring this standardization, history indicates that CMS may opt for narrow-band measures of specific syndromes, such as depression, anxiety, or post-traumatic stress. Such an approach would increase the burden on providers by requiring the addition of several distinct outcome measures. Our experience is that these multi-measure measurement systems tend to collapse under the weight of their implementation.

### Summary

We have identified three strategies highly likely to be pursued under the incoming second Trump Administration. These strategies have in common that they reduce the responsibilities of states and the federal government to ensure that all children and youth in need receive adequate and effective behavioral health care. There is clear empirical evidence that robust enactment of these policies will lead to fewer children being insured, less access to care for chronic and costly conditions, and increased variation across states in the adequacy of provider payments and availability.