February 6, 2026

New York State Senate
Standing Committee on Health

New York State Assembly
Standing Committee on Health
wamchair@nyassembly.gov
financechair@nysenate.gov

RE: Governor's Budget, Applied Behavior Analysis Medicaid benefit

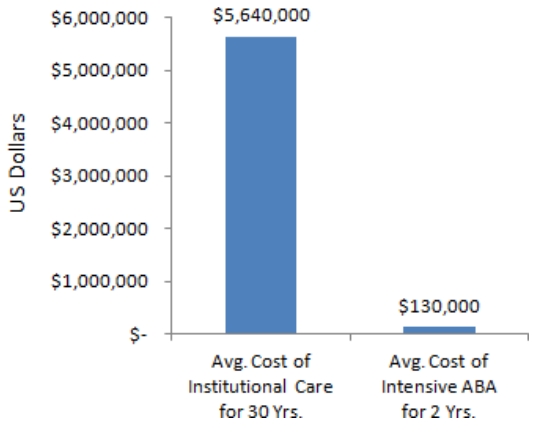
Dear Members of the Senate and Assembly Standing Committees on Health,

CASP is a non-profit trade association of autism service provider organizations, with a demonstrated commitment to promoting and delivering evidence-based practices for individuals with autism. CASP represents the autism provider community to the nation at large, including government, payers, and the general public. CASP provides information, education, and promotes the generally accepted standards of care for applied behavior analysis (ABA). CASP is committed to addressing barriers that impact access to quality services delivered by qualified providers.

On behalf of CASP member organizations providing services to more than New Yorkers diagnosed with autism spectrum disorder (ASD), including New York Medicaid beneficiaries, we are deeply concerned with Governor Hochul's proposed budget. CASP fears that the estimated 14 million dollar savings through the Medicaid ABA benefit for 2026 will have disastrous consequences for Medicaid beneficiaries in need of medically necessary ABA services. We respectfully request you reject the second, 12.5 percent rate reduction currently scheduled to go into effect on April 1, 2026. We also respectfully request that you thoughtfully evaluate the Governor's proposal to establish an Autism Center of Excellence program, loosely based on the Washington Medicaid model, which may have the unintended effect of further limiting access to care and creating inequity for Medicaid beneficiaries. This additional diagnostic requirement may also be a non-quantitative treatment limitation, violating the Mental Health Parity and Addiction Equity Act (MHPAEA) and is may be inconsistent with New York's obligation to ensure reasonably prompt access to diagnostic and treatment services through the Early, Periodic, Screening, Diagnostic and Treatment Program (EPSDT).

The costs associated with effective behavioral intervention pale in comparison to funding a lifetime of more restrictive care. Without effective treatment, a person with an autism spectrum disorder (ASD) will likely incur lifetime costs for specialized services of approximately $3.2 million (Ganz, 2007). The short-term cost of ABA therapy can result in a saving of an average of $2.8 million per person across a 55-year span (Jacobson, Mulick, &

Green, 1998).[1] Data from public schools showed an average savings of $208,500 per child across 18 years of education with access to early and intensive ABA, an investment that has proven to achieve cost savings (Chasson, Harris, & Neely, 2007).[2]



Average Cost Savings with Intensive ABA	
Through 18 yrs. education	$208,500
Through age 55	$2,800,000

We urge the Governor, New York Medicaid, and the standing committees on health to recognize the importance of appropriately funding medically necessary ABA. New York is spending millions of dollars on emergency room care, intensive partial hospitalization programs, and psychiatric hospitals and out of state placements that might be unnecessary if these same children had access to high quality ABA services. New York is also spending millions of dollars on restrictive educational placements which could be mitigated to some extent through appropriate access to ABA.

Until October 2025, NY Medicaid rates reflected a blended rate of $19.26 per 15 minute unit for one-on-one services and $3.31 per 15 minute unit per participant for group services. New York reimbursed the rate regardless of who was providing the service, or what service was being provided. We agree that this model made little sense and we urged NY Medicaid to redesign the reimbursement model to align with how services are commonly reimbursed, based on the service rendered and the individual rendering the service (Licensed Behavior Analyst, Certified Behavior Analyst Assistant, or unlicensed provider/ behavior technician) and establish reimbursement rates that were consistent with at least the publicly available national average for Medicaid rates across the country.

[1] Jacobson, J. W., Mulick, J. A., & Green, G. (1998). Cost-benefit estimates for early intensive behavioral intervention for young children with autism—general model and single state case. Behavioral Interventions, 13(4), 201–226. https://doi.org/10.1002/(SICI)1099-078X(199811)13:4<201::AID-BIN17>3.0.CO;2-R

[2] Chasson, G.S., Harris, G.E. & Neely, W.J. Cost Comparison of Early Intensive Behavioral Intervention and Special Education for Children with Autism. J Child Fam Stud 16, 401–413 (2007). https://doi.org/10.1007/s10826-006-9094-1

This committee, and members of both houses worked tirelessly to prevent a 50 percent rate reduction for 1:1 ABA (CPT code 97153), instead landing on a 25 percent rate reduction split into two-12.5 percent adjustments. Although we deeply appreciate the legislature's efforts, the second 12.5 percent rate reduction will still decimate access to care. According to a recent survey conducted by CASP and the New York State Association for Behavior Analysis, 73 percent of enrolled Medicaid providers may be forced to exit the network after the second rate reduction is implemented on April 1, 2026. We implore you to stop the second 12.5 percent cut scheduled for April 1, 2026 and leave the rate for 97153 where it is, at $16.85 per 15-minute unit, instead of further reducing it to 14.45 per 15-minute unit 13.7% below the national average for publicly available Medicaid rates.

New York rates for the benefit as a whole remain some of the lowest in the country, while the cost of living in the state is one of the highest. The mismatch between reimbursement and cost of living creates a tenuous situation where even the most fiscally responsible organization may simply be unable to remain part of the Medicaid network. The second 12.5 percent rate reduction may impact far more than Medicaid beneficiaries; it may impact all children in need of ABA, including those with commercial insurance, TRICARE, or other payers. If providers are unable to remain part of the Medicaid networks, and in some cases forced to close their doors entirely, all children suffer, not just those with Medicaid.

We deeply appreciate the steps DOH has taken to address concerns related to unlicensed providers, including mandating training and ongoing oversight requirements. We believe this is an important first step to address program integrity, utilization, and enhance clinical quality. We strongly believe there are additional policy revisions that DOH can make to ensure beneficiary eligibility, medical necessity, appropriate duration and intensity of services that will enhance oversight, ensure appropriate access, and address any unnecessary or wasteful spending. These changes will promote access to ABA services and ensure the provider network remains strong, ensuring children receive access to medically necessary services consistent with EPSDT expectations:

> *"...medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting."* [3]

According to SHO 24-005 Best Practices for Adhering to EPSDT Requirements issued in September 2024 by the Centers for Medicaid and Medicare Services (CMS):

> *"Although adequate payment rates are not, in and of themselves, enough to ensure a sufficient network, without them, any other steps a state might take to improve the provider workforce likely will be less effective."*[4]

We do not believe the proposed Autism Center of Excellence (COE) designation, loosely modeled after Washington state's Medicaid program, is the right approach to address eligibility concerns; it may not ensure equitable access to diagnostic services and therefore equitable access to care throughout NYS. The proposed model aims to address beneficiary eligibility by requiring a child to receive an autism diagnosis from a diagnosing and prescribing provider who has obtained a COE designation. On paper, this sounds like a reasonable approach, however, in reality, there are numerous questions left unanswered and this requirement may create significant

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-07-14.pdf
[4] https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

access to care concerns. One of the primary concerns from Washington state advocates is that some children, with complex medical and behavioral histories and unique symptomology, really need to be evaluated and diagnosed by a specialist (e.g., a psychologist, developmental behavioral pediatrician or neurologist). The Washington model allows all physicians to diagnose (with minimal training) this can lead to both over and under diagnosis, or false positive and false negative evaluations leaving some children without access to care.

Washington added ABA to its Medicaid program as the result of a lawsuit. The settlement agreement was finalized in early 2013. Washington developed its COE program the same year. The benefit and the eligibility requirements were established concurrently, not consecutively. New York established its ABA benefit in 2022 and fully implemented it in 2023, going back to establish an eligibility pathway three years later may interrupt access to care for children already receiving ABA services.

Washington requires all Medicaid beneficiaries to receive a diagnosis and prescription identifying medical necessity for ABA from a COE diagnosing and referring provider. If New York adopts this approach, what will happen to children who received a diagnosis and referral from a program that does not have this designation in New York? What will happen to children who were diagnosed out of state? Will children who are currently enrolled in ABA be grandfathered or will they be forced to get updated diagnoses and updated prescriptions for ABA? WIll a new diagnosis be required, or will the state accept an amendment or addendum to an existing diagnosis?

There are already lengthy waiting lists for diagnostics across New York. According to a 2023 survey related to diagnosing autism, nearly two-thirds of centers (61.26%) had wait times longer than 4 months, with 15.32% reporting waits of over one year, or waitlists that were so impacted they were no longer accepting new referrals. Most diagnosing providers are located in urban areas or the surrounding counties, only 12% of diagnosing providers are located in rural service areas.[5] Requiring updated diagnostic reports from a COE designated provider will only exacerbate wait times and access to care concerns for children waiting for an initial diagnosis. Early intervention is a critical variable leading to positive long term outcomes. Delaying access to care by any period of time means that some children will need more services for a longer period of time to make the same gains, ultimately costing the state more money.

Washington requires that the COE provider also refer or prescribe ABA. The COE provider can only evaluate a child and determine if ABA is an appropriate fit. Conducting the ABA assessment, developing the treatment plan, and determining the appropriate intensity and duration of services is left up to the authorized Licensed Behavior Analyst (LBA). The only utilization management and program integrity concern addressed through this model is beneficiary eligibility. This model does not ensure medical necessity for the specific duration or intensity of the ABA service requested, nor does it ensure appropriate clinical oversight, or promote quality clinical programming. According to advocates in Washington, the COE designation has done nothing to alleviate these concerns.

These are the same concerns NY DOH has shared with CASP during the interim session and we have provided recommendations to address. The Governor's proposal does nothing to address these concerns.

The Washington model was developed with the goal to allow primary care physicians to assess and diagnose children with autism, bill for the comprehensive diagnostic evaluation, and refer to applied behavior analysis (ABA) therapy that is covered by Medicaid. The goal was to expand access to diagnostic services in rural and

5 https://www.cms.gov/files/document/wait-times-and-processes-autism-diagnostic-evaluations-first-report-survey-autism-centers-us.pdf

underserved communities. However, in 2018, Washington had to revamp its program because although the COE designation had been available for five years, very few primary care providers had gone through the training or obtained the COE designation.[6] In reality, making this program available on its own did nothing to expand access to diagnostic services.

CASP supports any step the state may take to increase access to timely diagnostic services, there is no opposition to establishing a training model that expands access to rural and underserved communities and equips primary care physicians with the skills and tools they need to diagnose and refer children with autism to any and all medically necessary services assuming that this model does not impact individuals who have already been diagnosed or limit/ prevent access to ABA services that have already been authorized and demonstrated to be medically necessary.

Rather than advance the proposals in the Governor's budget related to the ABA Medicaid benefit, we respectfully request you:

1) Reject the previously announced 12.5 percent rate reduction scheduled for April 1, 2026.
2) Request additional details related to the Autism Center of Excellence designation, including how the designation addresses existing concerns related to beneficiary eligibility.

On behalf of CASP and our New York member organizations, thank you for considering our concerns and for your commitment to children and youth in need of medically necessary services. I am happy to answer any questions and look forward to serving as a resource in the future.

Respectfully Submitted,

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[6] https://mchb.tvisdata.hrsa.gov/Narratives/AnnualReport5/1b430743-bc1e-4566-b047-194103792281