SFY 2026-27 New York State Executive Budget Testimony

The Northeast Medical Equipment Providers Association is a nonprofit organization advocating for increased access to durable medical equipment (DME) for our patients and the continued viability of providers across New York State. We respectfully submit this testimony in response to the Executive Budget proposal.

Include A.2520/S.8838—Reimbursement Parity for Durable Medical Equipment Providers

Durable medical equipment includes medically necessary items prescribed by physicians for home use, such as wheelchairs, hospital beds, oxygen systems, ventilators, and orthotics. For Medicaid members with disabilities or chronic health conditions, this equipment is not optional—it is essential to maintaining safety, dignity, and independence. Proper access to DME allows New Yorkers to live in their homes and communities, reducing hospitalizations and preventing costly institutional placements.

In recent years, Medicaid managed care plans have reduced reimbursement rates for DME to unsustainable levels—some at half of the Medicaid fee-for-service (FFS) rate for identical products and services. Given that approximately 75% of all Medicaid members are enrolled in managed care, this underpayment has had devastating statewide impacts.

During last year's legislative session, the Legislature unanimously passed A.2520/S.8838 to require Medicaid managed care organizations (MCOs) to reimburse DME providers at no less than one hundred percent of the State's Medicaid DME and complex rehabilitation technology fee schedule for the same services and supplies.

Unfortunately, this vitally important bill was vetoed by the Governor. In her veto message, the Governor claimed that the bill would cost the Medicaid program $145 million. However, this estimate fails to account for funding that is already being paid to managed care organizations to manage individuals' DME needs.

The State currently provides approximately $539.4 million in premiums to manage the DME portion of the Medicaid program. Yet the MCOs pay out less than half of that amount in actual DME claims—approximately $235 million. Even if DME claims increased to roughly $380 million by reimbursing at 100 percent of the fee schedule, health plans would still retain approximately $150 million in excess premium that is already designated for DME services.

In other words, the Governor's cost estimate assumes new spending that, in reality, has already been appropriated and is already being paid to the managed care plans.

Payment parity has already been implemented successfully in other areas of New York's Medicaid program, including behavioral health. Other states have enacted similar DME rate floor legislation with strong outcomes for access and provider stability.

To be clear: this bill will not increase costs to the State. It will reduce the profit margins of a select few insurance companies that have taken advantage of the State's Medicaid program at the expense of individuals who need access to durable medical equipment.

Include A.7357/S.8098—DME Third-Party Administrators as Pharmacy Benefit Managers

In addition to the fact that insurance plans retain substantial portions of funding intended to improve access to durable medical equipment, many plans also contract with third-party administrators (TPAs) to manage these benefits. These TPAs then take an additional administrative fee—often in the range of 15 percent—off the top of the amount the insurance company has already determined should be paid to the provider. As a result, resources that were intended for patient care are further reduced.

TPAs functionally perform the same role as Pharmacy Benefit Managers (PBMs)—they act as bureaucratic intermediaries and introduce an additional layer of inefficiency into an already intricate healthcare system. Despite this, TPAs in New York currently operate outside the state's PBM statute.

Bringing TPAs under the same regulatory framework by classifying them as PBMs and requiring licensing through the Department of Financial Services would shine a light on this opaque sector, ensuring accountability for cost-containment measures and fair reimbursement practices. Without such oversight, TPAs disrupt the continuum of care and offer no demonstrable benefit to ratepayers or patients, while eroding the financial viability of smaller providers and placing undue pressure on the system.