NYS Council for Community Behavioral Healthcare

Written Testimony

SFY27 Executive Budget Proposals

Topic: Health/Medicaid

Hearing: February 10, 2026

Good morning. My name is Lauri Cole, and I am the Executive Director of the New York State Council for Community Behavioral Healthcare ("The NYS Council"), a statewide membership association representing the interests of 175 community based mental health and addiction prevention, treatment, recovery, and harm reduction agencies that provide a broad range of essential services in local communities across New York. NYS Council members operate these services in a variety of settings including freestanding nonprofit agencies, counties, and general hospitals.

Below please find our response to various proposals in the Governor's Executive Budget in the areas of Health/Medicaid.

NYS COUNCIL BUDGET REQUESTS ABSENT FROM EXECUTIVE PROPOSALS

ACCESS TO CARE CRISIS CONTINUES BUT CAN BE REVERSED WITH A CARVE OUT & REINVESTMENT OF $400M IN SAVINGS TO FULLY FUND TARGETED INFLATIONARY INCREASE

Request: We urge New York lawmakers to protect vulnerable New Yorkers with Medicaid managed care insurance who struggle with mental health and/or substance use disorders, by carving out most OMH mental health and OASAS substance use disorder services from the state's Medicaid managed care program. Carving out these services will remove insurer / middlemen that are deeply conflicted and should not be managing these benefits. It will immediately increase access to care, **and yield $400M in savings that can be reinvested to address service gaps, waiting lists and workforce shortages that are pervasive across New York's public mental hygiene system, and particularly, the OASAS and OMH systems of care.**

Background:

In 2015, NYS leaders made the decision to carve in OMH and OASAS mental health and substance use disorder services into the state's Medicaid managed care program. This decision was made under the Cuomo Administration and must be reversed. The Executive Budget is silent on this matter. This is an unacceptable outcome given the serious conflict of interest that faces care recipients and providers under the thumb of for-profit insurers who are focused entirely on profits – not people.

Despite 6 years of advocacy designed to fix the many serious problems associated with the carve in of our services, insurance middlemen (MCOs) are the only parties benefiting from this failed policy experiment that allows insurers to ration care, delay reimbursement to providers, and to pocket a minimum of $400M/year as profit and overhead. This is nothing more than a profit-making scheme in which insurers are gatekeeping care, while New York State pays them $400M/year that should be reinvested to address serious workforce shortages that result in long waiting lists for services, and an inability for providers to recruit and retain the valued workforce they need to meet demand for care.

The rules of the Medicaid managed care program for behavioral health domain services are not being followed. The current arrangement creates incentives for

MCOs to assertively gatekeep and create barriers to services for Medicaid beneficiaries. The tactics insurers utilize to delay or deny services, and to delay or deny payment to community-based providers, are often overlooked by state regulators, and where there is any enforcement, it is weak and does not deter insurers from continuing to game the system.

Insurers are paid to arrange care for Medicaid beneficiaries - and to promptly reimburse providers in full and at the appropriate rate. However, the commitments made by the insurers – to ensure adequate access to care, to ensure providers are reimbursed on time and at the appropriate rate, and to provide other value-added services, **have not materialized.**

The data speaks for itself – Medicaid managed care for behavioral health services is an abject failure and must be reversed:

- **9.9%** increase in NYS youth suicide rates over 10 years (corresponds with the implementation of Medicaid managed care for children/youth services)
- In situations where an insurer denies care and the beneficiary dares to appeal, **62%** of all denials for substance use disorder care are reversed upon appeal, by an outside medical expert
- OMH Article 31 waiting lists for outpatient care: In 2024 a NYS Council statewide survey found over **50%** of OMH clinic providers had extensive waiting lists for services; in 2024, **45%** of OMH clinics had extensive waiting lists, with virtually no change in 2025.
- A whopping **60%** insurer claims denial rates for mental health services and **320 citations** issued against insurers by the state (to date) of which close to **89 citations** were for inappropriate claims denials; failure to pay the correct (state mandated rates) and more.
- 2023 Attorney General secret shopper report found that **86%** of the provider directory entries published by insurers for beneficiaries, were profoundly inaccurate to include practitioners that do not accept Medicaid, no longer accept new clients, or simply don't exist.
- Providers are forced to hire between **3-6 additional staff** to perform functions that are solely focused on billing, chasing reimbursement from insurers, appealing claims denials and filing complaints with regulators
- In 2025, a statewide NYS Council survey found that providers were owed anywhere from **$25,000 to over $1M** from insurers who failed to reimburse on time and in full, and according to state laws.
- In 2022, the NYS Council was forced to inform the Hochul administration we would bring litigation against the state unless it began to enforce a MCO contract provision **that paid insurers for failing to meet a contractual requirement** designed to hold them to having to spend a high percentage of the funds they are

paid by the state, for ACTUAL SERVICES for Medicaid beneficiaries. To date over $500M has been recouped from insurers and returned to OASAS and OMH however, during the years when the state failed to recoup these funds, our systems of care were **deprived of hundreds of millions that belonged to taxpayers and to Medicaid beneficiaries** but instead, the funds sat with insurers, earning interest while insurers waited for the state to collect the funds.

As waiting lists for mental health and substance use disorder services persist, communities are left scrambling to address the unmet needs and negative consequences associated with vulnerable community members who are at risk or already suffering as a consequence of a serious mental health or addiction challenges, being unable to secure care. This results in increased rates of homelessness, incarceration, and unnecessary utilization of acute health services that are far more costly than community-based care.

New York State has experienced increasing rates of youth suicide (9.9% increase over the last 10 years according to the CDC), and sustained rates of overdose in communities of color, and in other underrepresented communities, and this is a recipe for disaster that sustains the ongoing emergency facing New Yorkers with few choices and increasingly complex needs.

NYS continues to pay mostly for-profit corporations for care coordination and other services designed to head off preventable crises through robust access to a broad range of services that can address a disease process before it becomes a full-blown emergency. However, when OMH and OASAS community-based providers are forced to wait for months if not years for reimbursement from insurers, their hands are tied as they are unable to use these funds to recruit the workforce they need and that New Yorkers deserve, resulting in delayed care, and delayed care is denied care.

Insurers will do anything to hold on to the funds the state pays them to pass through to providers. This leaves already fiscally vulnerable community agencies unable to utilize funds owed to them to compete in today's challenging job market. At the present time, **OMH and OASAS Programs have a job vacancy rate approaching 30% and these numbers have not changed substantially for several years. That makes the $400M** the state is paying insurers to gatekeep and block care and reimbursement, that much more confounding.

Over the last 4 years, and despite the fact that this body has worked with the Executive to enact COLAs for the human services sector, **insurers managing mental**

health and substance use disorder services that are responsible for reimbursing them based on state requirements, fail to pay the new rates that reflect the COLAs you have passed year after year – sometimes for years.

Perhaps all of this would be somewhat manageable if NYS regulators conducted robust surveillance, monitoring and enforcement of such violations, but robust enforcement does not exist for our carve in.

Our association has been offering solutions and escalating our advocacy to secure meaningful changes to this broken policy experiment for years, however the situation is worse than ever, and we need your help to fight for increased access to care and a return of $400M currently paid to insurers, to bolster our workforce and address care gaps.

We urge this committee to take action to return the responsibility for reimbursement of these services to the Medicaid Fee for Service system, and to reinvest the funds currently paid to for-profit insurers ($400M/annually) in our workforce and our systems of care. Using for profit insurers to manage services is a **massive conflict of interest,** one New York State taxpayers can no longer afford and New Yorkers with these challenges don't deserve. **Please include our carve out request in your one house bills, and pass our legislation, sponsored by Senator Brouk and Assemblywoman Simon, (S8309-A/A8055) as soon as possible.**

Address Anticipated Increase in Number of Uninsured New Yorkers Needing Mental Health and/or Substance Use Disorder Services; **Reallocate MCO tax revenues to include community-based mental health and substance use disorder providers**

(No executive budget proposal)

Unfortunately, Governor Hochul's executive budget proposal does not include a 'Plan B' for already fiscally challenged OASAS and OMH community-based providers in the likely event that the numbers of uninsured New Yorkers seeking mental health and/or substance use disorder services through New York's public mental hygiene system, grows as result of the implementation of federal work requirements and other draconian federal actions.

At the present time, OMH contributes some funds to an Article 31 Uncompensated Care Pool that gets some federal assistance. The Pool allows providers that are eligible for these funds to continue to serve a significant number of uninsured individuals; however, the Pool does not adequately subsidize the full costs of care.

OASAS provides some net deficit funds to some of its providers; however, neither of the existing resources mentioned here are in any way sufficient to address what may be significant increases in the numbers of uninsured New Yorkers seeking services through our systems of care once work requirements are imposed. Even with the most liberal regarding the conditions (diagnoses) that would exempt an individual from federal work requirements, the online filings required of Medicaid beneficiaries to remain insured, will be onerous and many will fall off Medicaid rolls.

The current annual process that requires New Yorkers with Medicaid to prove they are eligible for this insurance is changing, and will move to an every 6-months schedule. For individuals with cognitive impairments, those who cannot figure out how to enroll, stay enrolled, or renew their enrollment, these demands will certainly result in an increase in the number of uninsured New Yorkers seeking care. Uncompensated Care Pool resources and current OASAS Net Deficit resources have not increased in many years while the number of providers seeking a subsidy has increased. In the OASAS system of care, not all providers receive net deficit funds, the amount of funds they receive is often arbitrary, and the rules regarding how these funds can be used are challenging for many providers.

REQUEST: We urge this Committee and the members of the NYS Legislature to **make strategic investments to ensure access to care for uninsured New Yorkers.** This must include a second look at appropriations language that (at this point) does not allocate MCO Tax revenues to community-based organizations.

Many of the risks associated with implementation of federal Work requirements, are not addressed in the Governor's budget proposal when it comes to community-based services despite there being numerous proposals that increase resources for other types of providers. For instance, the executive budget document includes a proposal to appropriate an additional $750 million for hospitals and nursing homes to respond to an increasing number of uninsured patients. We agree with this investment AND we think NYS must also prioritize the needs of community-based agencies that are the safety net for millions of New Yorkers, many of which are likely to become uninsured in the months to come.

Without strategic investments in this area, providers may be forced to limit the amount of uncompensated care they can provide or worse yet, they may have to restrict care dramatically in order to keep their doors open.

New York State needs a final budget deal that includes emergency funds to contend with increased numbers of uninsured New Yorkers who want and deserve access to services regardless of their insurance status. These resources must be available to all healthcare providers – not just those that operate services in more institutional settings. **New York State must utilize a portion of the $1B in MCO Tax Revenue it now knows it can appropriate in the SFY27 enacted budget, to include community-based providers, and specifically, OASAS and OMH community-based providers.**

Increase Certified Community Behavioral Health Clinic Indigent Care Funding

In 2017, New York was one of eight states selected to participate in a federal demonstration program that opened the door to federal funding and the implementation of a new model of care for New Yorkers with significant mental health and/or substance use disorder challenges. The model is a game changing reform designed to remove siloes, enhance client outcomes, reduce hospitalizations and re-hospitalizations, and to open up access to care. However, the rates paid to participating providers do not cover costs associated with serving New Yorkers with no insurance (Indigent Care), or those with commercial insurance.

In 2023, Governor Hochul and the members of the NYS Legislature expanded the number of agencies participating in this evidence-based model of care from 13 to 39 agencies. The final enacted budget also included the implementation of an **Indigent Care Pool** where eligible CCBHC providers can seek some (limited) funds for services provided to these New Yorkers.

The SFY27 Executive Budget appropriates $22.5M to continue to fund the CCBHC Indigent Care Pool – a critical component in light of coming federal Work Requirements that will likely result in increased numbers of New Yorkers with mental health and/or substance use disorder challenges who have no insurance.

REQUEST: *Unfortunately, the Executive Budget does not seek to further expand the number of agencies that can participate in this Program. It also does not increase the amount available in the CCBHC Indigent Care Pool for these agencies despite the fact*

that we anticipate greater need for these resources as more New Yorkers find themselves uninsured.

We greatly appreciate the investment NYS has made in the CCBHC Program to date, and we are sure to re-visit the topic of further expansion of the Program in future budget requests. We fully support continued funding for this Program, and for the Indigent Care Pool (discussed above) however, we caution lawmakers that, without further strategic investments in the number of resources available in the Pool, providers will face serious financial challenges serving uninsured New Yorkers who need and deserve this care.

Ensure Community Health Centers Receive Full Telehealth Reimbursement

Telehealth is a critical access point to healthcare and behavioral healthcare, for care recipients. For many, it removes barriers that would otherwise prevent them from accessing care, including lack of transportation, childcare challenges, weather emergencies, and inflexible work schedules. It allows patients to connect with their providers when they need care most, maintain continuity of treatment, and access specialty services that may not exist in their community.

Yet, New York's telehealth statute creates an inequitable regulatory framework that disproportionately harms CHCs. Under the State's interpretation of a 2022 statutory prohibition on telehealth facility fees, CHCs receive only one-third of their full bundled Medicaid reimbursement rate for many telehealth services – even though they do not bill facility fees. This limitation only applies to CHCs.

Reduced reimbursement has made telehealth financially unsustainable for many CHCs, despite a growing demand from consumers. To comply with the State's policy, providers are required to be onsite for virtual visits. The impact is most pronounced in behavioral health, where telehealth has proven to reduce no-show rates and improve continuity of care. Many behavioral health providers are leaving CHCs for jobs offering remote flexibility (many of which do not accept Medicaid patients). This leads to decreased patient access and undermines CHCs' ability to fully meet patient needs.

REQUEST: The New York State Council urges the New York State Legislature to adopt Community Health Center Telehealth Payment Parity (A.1691 Paulin/S.3359 Rivera) as part of the FY26-27 budget, before the April 1, 2026 expiration of the existing telehealth statute, to ensure CHCs receive their full reimbursement.

Continuous Medicaid & CHP Eligibility for New Yorkers 0-6

The Governor proposes to repeal continuous eligibility in Medicaid and Child Health Plus from birth to age six effective July 1, 2026 (HMH Part M, sections 13 and 14). Unfortunately, the federal government is no longer allowing states to provide multi-year continuous eligibility. New York's waiver approval for this expires March 31, 2027.

REQUEST: ***We ask that the provision remain in effect until the end of the current waiver period (or at least until a date that allows for a smooth unwinding of the provision).***

The NYS Council enthusiastically supports the following executive budget proposals:

- Governor's proposal to make dental and vision benefits in the Essential Plan permanent.
- Funding for the Community Health Access to Addiction and Mental Healthcare Project (CHAMP)

The NYS Council opposes the following proposal:

Elimination of funding for and repeal of the Enhanced Quality of Adult Living (EQUAL) program, which funds quality of life enhancements (like clothing, other personal items, room air conditioners, etc.) for people who live in adult care facilities, the majority of whom are people with low or no income who are covered by Medicaid. (HMH Part S)