Testimony before the Joint Legislative Budget Committee
Topic: Health / Medicaid Executive Budget Proposals
January 23, 2024

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 150 community-based mental health and addiction prevention, treatment, recovery, and harm reduction agencies that provide a broad range of essential services in a variety of settings including freestanding nonprofit agencies, counties, and general hospitals.

While there is broad consensus on the fact that mental health and addiction conditions are no different from other medical conditions that require a robust and nimble continuum of services that is able to meet changing demand for care, there are long waiting lists for mental health and addiction services for children, families, and adults seeking care through the public mental hygiene system. This, combined with persistent workforce shortages up and down the organizational chart, has left our sector in a perpetual state of emergency, with little ability to respond to trends.

Our comments on executive budget proposals in the Health/Medicaid domain are through the lens of care recipients and the community-based providers that are struggling to meet demand for these essential services amidst increased rates of suicide and a lethal Overdose Epidemic. New York has not treated these crises as true public health emergencies worthy of the same laser focus and additional resources made available during the COVID-19 crisis. The response to the Overdose Epidemic is anemic at best and thinking of Opioid Settlement funds as New York's main source of investment to address what is clearly a public health emergency cannot stand. If we agree that mental health and addictions care is healthcare, where is the full-throated 'all hands-on-deck' mobilization we need to stop it?

2024-2025 EXECUTIVE BUDGET WORKFORCE PROPOSALS

The most urgent problem facing New Yorkers with mental health and/or addiction challenges is the lack of sustained investment and state leadership devoted to addressing the ongoing workforce shortages across the state. These shortages are exacerbated by low salaries, failure of insurers to reimburse on time and in full, and a lack of robust state and federal investments meant to increase successful recruitment and retention of the staff we need to provide access to care for all New Yorkers, to name just a few.

The NYS Council supports the workforce investments embedded in the Governor's executive budget and we appreciate the fact that the Executive has included a COLA proposal in the last three budgets, however, the proposed 1.5% cost of living increase **(Source: Article VII, HMH, Part FF)** for health and human services programs under OMH, OPWDD, and OASAS, is insufficient to address the increasing costs associated with operating these complex safety net programs. The current *employee vacancy rate* for our staff who have direct care responsibilities currently hovers around 21%. The Governor's proposal *must be increased to 3.2%* in recognition of widespread staffing shortages, and rising inflationary costs that result in long wait lists for services through the public mental hygiene system. New York cannot afford to wait for the federal government or any other entity to take aggressive action to address workforce shortages that continue to put New Yorkers at risk. Executive budget proposals including the Community Mental Health Loan Repayment Program (**Source: Article VII, HMH Part Y)** and the Career Pathways initiative embedded in New York's 1115 waiver will be helpful, but again, we do not see evidence of a full-throated 'all hands-on deck' response to what is a serious and debilitating workforce crisis.

The **Executive Budget Briefing Book** describes 5 new initiatives to expand the mental health workforce through job marketing, the creation of a job bank, and the creation of a Behavioral Health Fellowship Program. It states that OMH will also develop new ways to credential mental health paraprofessionals, and that rural governments will receive funding to develop targeted workforce investments. We support all of these initiatives, and we would like to see more information to include the proposed amounts for each.

SCOPE OF PRACTICE EXTENDERS

Proposals that would extend the scope of practice for Nurse Practitioners and Physician Assistants **(Source: HMH, Art. VII, Part P & Q)** are important reforms, however they do not go far enough to address workforce shortages in community-based agencies where licensing laws now require highly credentialed social workers and other practitioners to perform tasks including diagnosis. Psychiatrists are needed to authorize care and practitioners with credentials beyond the base requirements in their field can make far more money and enjoy a less stressful workload if they move to private practice. Our ability to recruit and retain LCSWs and LMHCs is dramatically reduced when the businesses around us including hospitals, state operated programs and services, and many if not most private businesses, are paying better salaries, and offering stepped up benefits to attract new employees. That's why we need the scope of practice extensions proposed in the Governor's budget to be expanded to include practitioners that typically work in community-based mental health and substance use disorder settings.

The NYS Council also supports the Governor's executive budget proposal allowing New York to join the Interstate Medical Licensure Compact and the Nurse Licensure Compact, enabling doctors and nurses to relocate to New York and use their existing license to practice in the state. **(Health/MH Article VII, Part R)** However, again the proposal does not go far enough and should also permit LCSWs, LMSWs, CASACs (or the equivalent credential in other states) and LMHCs (or the equivalent credential in other states) to relocate to NY and use their existing licenses to practice throughout the state.

In summary, we call upon the members of the NYS Legislature to make the ongoing workforce crisis in mental health and addictions care one of its' highest priorities. Without people power and specifically, without qualified staff who can both work in our programs and feed their families, we are nowhere. To date, we have not seen a well-organized and sustained response to the workforce challenges we face across New York and legislative champions are needed to correct this situation immediately.

COMMERCIAL INSURANCE RATE MANDATE PROPOSAL
(Source: Article VII, Health/MH, Part AA)

There are a number of executive budget proposals that would implement badly needed reforms that will open up access to New Yorkers seeking care for their mental health and/or addiction needs to varying degrees.

The NYS Council wholeheartedly supports the Governor's proposal **(Article VII, HMH, Part AA)** to ensure that New Yorkers with commercial insurance will no longer face disparate access to care due to a longstanding problem in which mental health and substance use disorder providers are reimbursed (on average) just 50% of the state mandated reimbursement rate paid for services for Medicaid beneficiaries. This situation may seem counterintuitive since in most areas of NYS healthcare it is the Medicaid rate that is the lower of the two rates, however, for mental health and addictions agencies the commercial rate remains largely unregulated and is abysmally low. As such, our members often cannot afford to serve many New Yorkers with commercial insurance and this situation has resulted in what we often refer to as state sanctioned discrimination in that the state has always had the ability to change this, but, to this point, has failed to do so.

Importantly, the Governor's proposal seeks to remedy this disparity by mandating commercial insurance plans to reimburse community-based providers (at a minimum) at the same amount as the state mandated Medicaid rate. **We implore you to support this critical proposal and include it in your one-house budget bills. Let's stand our ground and finally ensure New Yorkers with commercial insurance have an equal opportunity to access care throughout the public mental hygiene system.**

On a related matter, it is critical that we address a problem (not addressed in the executive budget proposals) that continues to create barriers to access to care. Ever increasing co-pays and high deductible insurance plans for New Yorkers with commercial insurance continue to create barriers to treatment for far too many New Yorkers who, while insured, are unable to pay cost share obligations and as such, are forced to forego needed care. The Governor's

commercial rate parity proposal should include a provision that requires insurers, rather than consumers, to bear the brunt of this mandate. The Department of Financial Services should be required to hold the line when it comes time to approve rate increases for insurers who would be required to pay the Medicaid rate or above for commercial care. Consumers should not bear this burden and we believe the Department has the ability to ensure this is not an unintended consequence of this proposal.

The NYS Council enthusiastically supports the Governor's proposal to waive cost share requirements for Insulin in the treatment of Diabetes (**Transportation, Economic Development and Environmental Conservation Art. VII bill, Part EE)** and we urge members of the NYS Legislature to expand this proposal to include additional cost share waivers for other essential treatments for chronic illnesses such as addiction and mental health conditions. Intervening early – at the beginning of a disease process – has been proven to save countless lives and scarce state resources, not just in the behavioral health arena but also in the physical health space. No New Yorker should have to choose between cost share obligations and putting dinner on the table. And so, the NYS Council requests that the NYS Legislature broaden the Governor's Insulin cost share waiver proposal to include co-pays and high deductibles for substance use disorder and mental health care – at least during the ongoing overdose and suicide public health crises.

PROPOSAL TO INCREASE OMIG AUDIT TARGETS
(Source: Medicaid Scorecard)

The NYS Council has been co-chairing an ongoing effort to secure reforms to the OMIG audit process where we seek nothing more than transparency, balance, and fairness in the audit process. We fully support OMIG's efforts to identify and address fraud and abuse in the Medicaid Program. However, there has been serious 'mission drift' with these audits in which recoupments are being used to balance New York's budget. Audit practices no longer focus on targeting fraud, waste, and abuse, but rather there is an increasing focus on clerical, technical, and administrative errors that do not impact clinical care or patient outcomes. Human errors that are unintentional and do not qualify as fraud or abuse are now a major focus of the audit process. OMIG takes punitive action in instances of clerical or technical errors and utilizes an aggressive audit extrapolation formula that takes a clerical error which may relate to a claim of a couple hundred dollars and demands recoupments of thousands or millions of dollars from the provider. This is untenable and unsustainable, and it threatens the safety net system of Medicaid providers and agencies that provide essential and often life-saving care to beneficiaries.

We commend both houses of the Legislature for passing meaningful OMIG audit reform legislation in 2022. But as you know, Governor Hochul vetoed that bill. In her veto message the Governor directed OMIG to "engage the healthcare provider community and Medicaid stakeholders to solicit input on the concerns… Perform a comprehensive review of the agency's program integrity process and identify areas for improvement… Commit to conducting program integrity activities in a responsible manner that includes consideration of financial impacts on providers and assured continuity of care for Medicaid recipients." We are unaware of any OMIG auditing reforms being enacted since this veto and based on feedback from members and other providers, unfair auditing activities are only intensifying.

On the Medicaid Scorecard for SFY 2024-25 we see the Executive has increased OMIG's "Audit Target" by $100 million. Now more than ever, we must ensure that OMIG is focusing on actual fraud, waste, and abuse, and not clerical errors made by honest providers who are providing essential services to Medicaid members. The OMIG Audit Reform legislation passed by the Legislature in 2022 has been amended to address many of the concerns with the previous version of our bill. We respectfully urge the inclusion of the 2024 legislation (S5329B, Harckham/ A6813A, Paulin) in your one-house budget bills and in the final state budget to protect access to critical healthcare services for those enrolled in Medicaid.

COMPETITIVE PROCUREMENT PROPOSAL / DISCUSSION OF NYS COUNCIL REQUEST FOR CARVE OUT OF BH OUTPATIENT SERVICES FROM MEDICAID MANAGED CARE
(Source: Article VII, Health/MH, Part H)

For the past 8 years, the NYS Council has been engaged in advocacy designed to fix serious problems associated with the Medicaid Redesign Teams decision to carve-in mental health and substance use disorder services into the state's Medicaid managed care program beginning in 2015. It should be noted that our first meeting with DoH officials to educate them regarding the problems with the carve in was just 6 months after it was implemented. At that time, we reported serious problems with timely payment, and use of prohibited contract language put forward by health plans to providers. Since then, we have appeared numerous times before this Committee, begging for relief from the now enormous problems we face when trying to transact business with MCOs most of which are large

for-profit corporations. We have argued vociferously for increased surveillance, monitoring, and enforcement efforts by the Office of Health Insurance Programs at DoH. However, the problems have only increased over time.

Since 2019, over 200 citations have been issued against numerous MCOs for three primary issues: failure to pay the government mandated Medicaid rate, failure to oversee the third-party vendors insurers that are currently permitted to hire outside vendors to act in their stead, and failure to comply with federal and state parity laws. A recent assessment of Medical Necessity criteria used by insurers to make life and death decisions about access to mental health care found that none of the insurers Medical Necessity criteria satisfied OMH standards. And in 2020, the NYS Council issued over 20 FOILs to six different state agencies/regulators and confirmed what we already knew – that DoH had failed to enforce an expenditure target requirement embedded in MCO contracts with the state that requires them to spend the vast majority of funds paid to them (by the state) on **actual services for Medicaid members**. As a result of this failure to enforce an important contract provision, the OMH and OASAS systems of care were deprived hundreds of millions of dollars that MCOs were permitted to hold on to despite not having earned it. DoH finally began to recoup overpayments made to MCOs that did not meet the targets in 2021, and $222M was returned to OASAS and OMH as the result of this action. Since then, another $220M has been or will be recouped from MCOs that continue to fail to meet these targets. The executive budget refers to these recouped funds as 'Reinvestment Funds' associated with the transition to Medicaid managed care and the '24-'25 executive budget for both OASAS and OMH includes proposals in the Aid to Localities bills that appropriate $74M to OMH and $37M to OASAS). Again, these are state funds that health insurers have been permitted to hold on to and presumably collect interest on while the Overdose Epidemic and increased rates of suicide continue to devastate our local communities. This is the clearest example we can share in which the state's failure to enforce a requirement resulted in two state agencies being deprived of desperately needed funds.

After 8 long years of intense advocacy, this year the NYS Council, along with 17 other statewide coalitions/ associations representing care recipients and providers of mental health and substance use disorder services, has been advocating for NYS to carve out mental health and substance use disorder outpatient services from the state's Medicaid managed care program. Our agencies are unable to transact business with MCOs in an efficient manner, health plans do everything they can to hold on to funds that they have not earned, and agencies across the state have been forced to hire small armies of staff who spend their days chasing payments. There are currently long waiting lists for care in many of the outpatient clinics across New York. When agencies spend too much of their time chasing MCOs who do not respond to provider inquiries, or fail to pay rates on time or in full, the result is an inability for these agencies to increase access to care. The clearest example of this problem is the 21-22 COLA. Despite the COLA being enacted in April of 2022, most providers did not receive the increased rates from many MCOs for a good seven months after it was enacted. This situation is unsustainable and would not necessarily be addressed by a Competitive Procurement of MCOs, since the majority of the insurers that will compete for a contract in the procurement are the same insurers that are perpetrating the problems I have described here.

We find the Governor's Competitive Procurement lacking in detail and far too permissive. And it is troubling that the new Report from Boston Consulting Group regarding MCO Services that was required to be completed and sent to the Legislature 1.5 years ago was only released to the lawmakers yesterday, giving state leaders and other stakeholders who are testifying today little to no time to digest the Report and discuss it during today's hearing.

The Competitive Procurement proposal does not list the specific standards MCOs will be required to meet in order to receive an award. The proposal also lacks potency. For instance, the Procurement being proposed appears to be a one-time event where the state can forego subsequent re-procurements. If this is the case, MCOs will feel little pressure to improve their performance since they may not have to face subsequent competitive procurements. And while the executive budget proposal includes a provision that would impose liquidated damages on MCOs that fail to comply with the Model Contract, the proposal limits fines to between $250 and $25,000 and in our experience, MCOs will see these fines as nothing more than the cost of doing business. On other words these fines are unlikely to change health plan behavior. And unfortunately, we have seen little evidence that the state will be willing to enforce at the high range of the fines when enforcement is required.

The NYS Council calls upon the members of this Committee to vigorously support our request for a carve out of outpatient mental health and substance use disorder services from Medicaid managed care, and include our proposed language in your one house budget bills. Please remember that we are talking about carving out a specific group of MH and SUD services – not people. No one would lose access to these and no one would lose their Medicaid eligibility. Furthermore, the staff that were employed to implement the carve in of our services are still employed by the responsible state agencies, and so NYS would not need to hire additional staff to return these services to FFS billing. We know how to do this, the state knows how to do this, the codes are in place, the forms are in place, and providers are already being reimbursed and transacting business with the Medicaid FFS Program.

EXTENSION OF TELEHEALTH RATE PARITY
(Source: Part B, Section 5, HMH Article VII)

Mental health conditions continue to make up the top five diagnoses of individuals seeking telehealth services and during the pandemic New York saw an approximately 130-fold increase in telehealth usage. According to FAIR Health's monthly regional tracker for the Northeast for December 2022, mental health conditions continued to lead, accounting for 70% of telehealth claims, followed by acute respiratory diseases and infections at 3%, COVID-19 at 2.8%, substance use disorders at 1.5%, and developmental disorders at 1.3%. The FAIR Health data further bolsters the urgent need to extend New York's parity reimbursement statute as the December 2022 study also showed that, in the Northeast, the use of telehealth continues to be strong, consisting of 6.3% of overall claim lines, an increase since December 2021. Evidence has shown that telehealth substantially reduces the rate of missed appointments, providing for greater adherence to a treatment plan, which is particularly important for those with mental health conditions. Audio-only or video-only telehealth has been critically important throughout the pandemic as well for many New Yorkers and will continue to be so as more than one million or 13.8% of households in New York State do not have access or a subscription to broadband services.

The significant value of telehealth has already been highlighted by the Department of Health as noted in the following **excerpt from its notice of adoption of regulations** in the *New York State Register* on September 14, 2022:

> *"Providers have reported that this expansion of telehealth has improved access to care, improved patient experience, and improved provider satisfaction. Telehealth also has the potential to improve patient outcomes… Furthermore, expanded use of telehealth during the pandemic has resulted in Medicaid program savings related to avoidance of emergency room and urgent care visits, and decreased utilization of Medicaid-covered non-emergency medical transportation services. Telehealth mitigates provider access issues by connecting patients in rural areas with needed specialist care."*

More recently, the Department of Health's 2023 telehealth consumer survey of over 8,700 consumers further demonstrates the importance of telehealth as means to addressing transportation barriers and disparities that otherwise inhibit access. The survey found 84% of those surveyed who are Medicaid members used telehealth service in the last two years, and 81% of those surveyed who are non-Medicaid members have used a telehealth service in last two years. The benefit of telehealth as found in the survey includes:

- 95% reported lowered travel time and costs
- More than 80% can easily use application or software provided for the visit
- 90% were comfortable sharing private health information and using the Internet

Reported rates for using telehealth as per the DOH consumer survey found mental health led with 41% followed by acute (new symptoms, rash, cold, flu etc.) at 40%, preventative (annual visit/physical examination etc.) at 40%, and chronic (diabetes, high blood pressure etc.) at 21%.

Without telehealth, some individuals may delay or forgo care, potentially disrupting medication, and treatment regimens, which can have serious consequences for those with mental health and substance use disorders. For all of the above reasons, the NYS Council urges that the current telehealth rate parity law be made permanent and in doing so, demonstrate full recognition of the treatment preferences of care recipients. Person-centered care begins with consumer choice as to how these individuals consume the care they need, and these decisions should be based solely on the unique needs of the individual.

OPIOID SETTLEMENT FUNDS
(Source: Aid to Localities – OASAS)

The Governor's Executive Budget proposal identifies deposits of $63.7 million from settlement agreements with opioid manufacturers and distributors in the Opioid Settlement Account (down by $148.5 million from $212.2 million in the SFY 2024 final budget). Unfortunately, the administrative requirements on providers that want to apply for the RFPs that are being rolled out by OASAS are onerous and often disincentivize providers from applying for these resources. This is not a problem that is rooted at OASAS but instead, an example of the quagmire of regulations and requirements required for the procurement of these and other funds due to complex regulations. New York State should immediately waive the vast majority of administrative and other requirements that are put on providers

shoulders when they compete for these resources. Also, we see no reason why these funds should be limited to nonprofit agencies when for profit providers are also struggling to address the ongoing overdose epidemic with the resources they currently possess.

OVERDOSE PREVENTION PROGRAMS FOR SCHOOLS
(Source: Aid to Localities – DoH)

Provides $272,000 for services and expenses of an opioid overdose prevention program for schools (same as level provided in SFY 2024 final budget). We support this proposal although we feel that, in total, the Executive Budget proposals included in the Governor's proposal are deeply insufficient given the epidemic numbers of overdoses across New York State. NYS should and must be a leader when it comes to investments in prevention programs in schools and really anywhere community members gather, rather than dedicating just $250,000 (as proposed in the Governor's budget) for one program.

PROVISIONS RELATED TO ENFORCEMENT OF MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY LAWS
(Source: Part HH, Transportation, Economic Development & Environmental Conservation Article VII Budget Legislation A8808/S8308)

The NYS Council strongly supports this proposal that authorizes the Department of Financial Services to levy a fine of up to $2,000 per offense against health plans and insurers after finding a "willful violation" of federal or state mental health and substance use disorder parity (MH/SUD) laws and/or regulations. The NYS Council has, for years, actively supported efforts to increase surveillance, monitoring, and enforcement of federal and state (MH/SUD) parity laws and regulations as critical means for sustaining access to high quality care and treatment.

A recent Milliman study found that non-compliance with federal and/or state parity laws is rampant, making the enactment of this provision critical for New Yorkers living with MH/SUD and their families to ensure they can access their benefits and coverage. Governor Hochul's State of the State rightly captures the need to raise the fine for non-compliance, however all of this relies heavily on the appetite of the Department of Financial Services (DFS) to act swiftly and exact significant fines that will make a strong impression on the insurers that fail to abide by the laws.

While not proposed as part of the FY 2024-25 Executive budget, the NYS Council also strongly supports the establishment of a private right of action, allowing individuals with grounds to sue insurers and health plans for violations of parity laws to recover "actual damages." Enactment of such would provide accountability and would mirror a private right of action that already exists under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The NYS Legislature must not allow this disparity to persist as we continue to face non-compliance with parity laws clearly evidenced by data and reports submitted to the Department of Financial Services pursuant to the Mental Health and Substance Use Disorder Parity Report Act of 2018. A state private right of action and the above provisions will take New York one step closer to achieving the full spirit and intent of the parity laws. As such, we hope the enacted budget will include such provisions.

In addition, recent evidence of non-compliance and challenges with access to care includes the investigation undertaken by New York Attorney General Letitia James. The investigation included a survey of nearly 400 mental health providers listed as in-network, which found 86 percent were in fact unreachable, not in-network, or not accepting new patients. NYSPA and stakeholders have long raised the issue of "ghost" networks.

Raising the amount of the fines the Department of Financial Services is authorized to levy is critical as DFS and Department of Health move forward the promulgation of network adequacy standards as required by the enactment of provisions in the FY 2024 budget, which the NYS Council has vigorously supported.

It should also be noted that SFY 2025 Executive budget authorizes NYSDOH to impose liquidated damages for Medicaid Managed Care plans that fail to comply with the state Model Contract which lays out the rules of the road for Medicaid managed care. Under the proposal, liquidated damages against managed care plans shall range from $250 up to $25,000 per violation based on the severity of noncompliance as determined by the Department. Importantly, the proposal states that plans may not pass such liquidated damages through to any provider or subcontractor. **(Source: Article VII, HMH, Part H)**

All of the proposed enforcement changes (described throughout this document) will rely almost entirely on the appetite of the regulator to enforce the fines and penalties to the maximum amounts permitted in order to send a clear message to health plans that current behavior in which MCOs often violate state laws, regulations, or contract provisions, will not be tolerated. It is our belief that the current fines being proposed are not sufficient to change behavior given the range of problems that continue to plague the mental health and substance use disorder systems of care, and the individuals seeking services from the same.

PROPOSAL TO ELIMINATE PRESCRIBER PREVAILS
(Source: Part I - A8807/S8307)

The NYS Council urges the Legislature to reject the proposed repeal of the authority of physicians and other qualified prescribers to make a final determination regarding medication prescribed to individuals covered under Medicaid Fee-for-Service and Medicaid Managed Care, commonly referred to as "prescriber prevails."

Repealing this critical care recipient protection would jeopardize patient care as well as undercut initiatives the State has undertaken to reduce unnecessary and avoidable hospitalizations. A key component in sustaining and accelerating such a trend is ensuring individuals can obtain the medications prescribed by their physician to alleviate the symptomatology of their physical and/or mental health conditions. We thank the Senate and Assembly for standing up for patients and rejecting this proposed change in previous budget years and urge you to do so again.

PROPOSAL TO INCREASE REIMBURSEMENT FOR MH SERVICES PROVIDED IN DOH LICENSED FACILITIES AND PRIVATE PRACTICES
(Source: Executive Budget Briefing Book)

Another executive proposal would appropriate $42.2M to increase reimbursement for mental health services provided in DoH-licensed facilities and private practices. While we certainly support this initiative for its' ability to expand access to care in FQHCs and other primary care settings, we must also point out that the budget **does not** simultaneously address the need for rate increases for community-based MH and SUD outpatient clinics and other core services that are best suited to meet the needs of New Yorkers with complex behavioral health and other conditions. To implement true collaborative care, New York must adequately reimburse both primary care and behavioral health specialty programs at an adequate reimbursement rate that covers the true costs of care, in order to create no wrong door for New Yorkers regardless of where they choose to seek treatment.

MENTAL HEALTH SERVICES PROVIDED TO CHILDREN IN INTEGRATED SETTINGS
(Source: Medicaid Scorecard)

While the NYS Council supports this proposal that would add $7.8M for MH services provided to children in integrated settings, the proposal as currently conceived is a one-way investment in integrated care in that it increases rates for mental health services in primary care settings, but it *fails to increase the rates in children's specialty programs such as the Article 31 Outpatient Clinic.* Given the increasing numbers of children and youth with complex mental health challenges, *an equal investment in the children's mental health continuum of care should be made to ensure New York's children and their families can get the focused care they need from mental health experts in a timely manner*. Across New York there are long waiting lists for services for children and youth across the state with too many children and youth having to board in Emergency Departments due to these waiting lists and the lack of an appropriate place for them to be referred to. We urge this Committee to review the Healthy Minds, Healthy Kids Rate Reform proposal: https://cccnewyork.org/coalitions/campaign-for-healthy-minds-healthy-kids/# that seeks to increase rates for children's mental health services – specifically for the OMH Article 31 Outpatient Program and HCBS services.

INDIGENT CARE POOL FOR CCBHCS
(Source: Aid to Localities, DoH)

The NYS Council also supports an executive proposal to establish an Indigent Care Pool at $22.5M to assist MH and SUD agencies that are currently participating in a federal demonstration program that requires them to meet 150 criteria and serve all New Yorkers without regard to their ability to pay. The Demonstration Program ensures access to high quality care for those New Yorkers who live close to one of the demo programs however the reimbursement method for these clinics does not contemplate care provided to New Yorkers with no insurance. And since there are

many non-Demo clinics across the state that struggle with losses associated with provision of care to New Yorkers with no insurance, the demonstration clinics are seeing an increase of referrals from other community agencies to provide services to individuals with no coverage. The CCBHC Indigent Care Pool will go some of the way towards ensuring that demo agencies can continue to meet the needs of this population regardless of their ability to pay.

We Support the following budget proposals:

Children and Youth

- Adds an additional 12 (new) Youth ACT teams. We support the additional programs *however at the present time the rates of reimbursement associated with the operation of these services are inadequate and caseloads are far too high to maximize effectiveness or to attract new providers to offer this care.* **(Briefing Book)**
- $4 million set aside from the Community Mental Health Loan Repayment Program for practitioners working in children's mental health settings. **(Aid to Localities – OMH)**
- **Briefing Book** pledges $45M to fund expansion of school- based mental health clinics for schools that need them.
- Extension of Medicaid coverage for individuals age 19 or 20 who are living with their parents who meet certain criteria through 5/1/29. **(Article VII, HMH, Part B)**
- $4 million in Medicaid funding to expand and provide a 25% rate enhancement for the Partial Hospital program (for children and adults). (**Aid to Localities bill – OMH)**
- Continuous Medicaid coverage for children from birth to 6 years old. **(Article VII, HMH, Part M)**
- $1.7 million for infant mental health consultations at regional infant and toddler mental health resource centers. **(Medicaid Scorecard)**
- $6.1 million for a 5% rate increase for Early Intervention Services and $500,000 for a rate modifier for rural and underserved community Early Intervention (EI) providers.
- Invests $6.2 million to provide mental health specialists and peers in mental health courts, $2.8 million to provide individuals with mental illness with housing and supports, and $9.6 to enhance and expand specialized Forensic Assertive Community Treatment (FACT) teams that support individuals in the community. **(Briefing Book)**

Addiction Prevention, Treatment, Recovery and Harm Reduction

- Opioid Stewardship: Deposits $63.7 million from settlement agreements with opioid manufacturers and distributors in the Opioid Settlement Account (down by $148.5 million from $212.2 million in the SFY 2024 final budget). **(HMH Article VII, Part U)**
- Aligns state law with revised DEA regulations that permit providers in hospital emergency departments to dispense up to a 3-day supply of schedule III-V narcotics (Buprenorphine) for the purpose of initiating maintenance or detox treatment while arranging for a patient referral. (**Article VII, HMH, Part U**)
- Continues funding for the Community Health Access to Addiction and Mental Healthcare Project (CHAMP), a joint program of OASAS and OMH that provides New Yorkers with assistance with behavioral health insurance related barriers that delay or prevent access to and continuity of care for New Yorkers seeking MH or SUD treatment. **(Aid to Localities bill – OASAS)**

Regulatory Flexibility

- Makes permanent the ability of OMH, OASAS and OPWDD to utilize flexibility to develop new methods of services through demo programs. (**HMH Article VII, Part Z**)
- Extends OMH and OASAS ability to waive regulations for DSRIP projects through 4/1/26. (**Article VII HMH, Part B**)

Hospitals

- Enables safety net hospitals meeting certain criteria to apply for funding (individually or with other partnering organizations) by submitting a Transformation Plan with a strategic 5- year vision, roles and flexibility needed. Total funding will be up to $500 million for program. **(Art. VII, HMH, Part S)**

Proposals we oppose:

Proposal to repeal Enhanced Quality of Adult Living (EQUAL) Program

The NYS Council strongly opposes the Executive Budget's repeal of the Enhanced Quality of Adult Living (EQUAL) Program. The budget ends the EQUAL grant program **by eliminating new appropriations in the Aid to Localities and Capital Projects budgets and repealing SSL 461-s, the program's statutory basis, in the Health Article 7 bill (Part L).** As a result, the elderly and persons with mental illness who comprise our adult care facility population will no longer benefit from the vital improvements to their quality of life that the program provides.

For more than 25 years, New York has provided additional state funds to aid low-income residents of Adult Care Facilities, who now number 13,000 people. In 1996, the New York State Legislature established the Quality Incentive Payment Program (QUIP), administered by the New York State Department of Health, to provide ACFs that housed SSI recipients with additional funds to support improvements in the residents 'quality of life, care and services. In 2018, the Department of Health replaced QUIP with the EQUAL Program. It is a small non-competitive grants program that has cost the state only $6.5 million annually for many years. Eligible facilities receive grant awards based upon their low-income populations.

These grants fund needed clothing allowances and recreational activities that directly benefit low-income residents and capital improvements to facilities that improve the physical plant beyond statutory minimums that benefit the common life of the entire resident community. The recent frigid temperatures we are now experiencing throughout the state underscores the need and benefit when a resident must replace a winter coat or winter boots that their monthly personal needs allowance is inadequate to cover. Or when residents need to replace their other garments lost or worn out in a facility's laundry.

EQUAL Program funds have been used to pay for air conditioners in resident rooms, non-Medicaid transportation and trips, staff training, and recovery & rehabilitative services to help residents become more independent. Residents use it to supplement their diets with fresh fruits and vegetables. Capital improvement projects have funded washers and dryers for resident use, ice machines, ramps and outdoor patios and gardens.

In addition to the quality of life improvements the EQUAL Program provides, it also restores autonomy and choice to residents. Resident Councils have important powers over adult homes' EQUAL applications because they identify residents' top priorities and decide how the funds will be used thereby giving them agency, power and community in deciding on the improvements they want for themselves and their facilities. This insures that EQUAL funding is utilized for the best interests of the residents. We urge the members of the Committee to reject this executive proposal to safeguard the basic human rights and dignities that all New Yorkers should have no matter where they live.

Thank you for this opportunity to share our thoughts regarding the Governor's Executive Budget proposal.

For more information regarding the content of this document, please contact Lauri Cole, Executive Director, NYS Council for Community Behavioral Healthcare at 518 461-8200 or lauri@nyscouncil.org. For more information regarding the NYS Council for Community Behavioral Healthcare, visit our website at: www.nyscouncil.org.