MHANYS
Mental Health Association
in New York State

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Report on Enacted FY 2026-27 New York State Budget

Aid to Localities Budget (New Appropriations enacted as proposed by Governor):

- $17.5 million for the expansion of Teen Mental Health First Aid
- $1,750,000 for services and expenses of school mental health programs including up to $750,000 to support the School Mental Health Resource and Training Center
- $1 million for First Responder Behavioral Health Center of Excellence
- $28.6 million for SROs and $38 million for scattered-site housing

Aid to Localities Budget adds (above the Governor's budget):

- For services and expenses of grants or reimbursement of expenses supporting the expansion or creation of community behavioral health crisis response pilot programs consistent with the Daniel's Law Task Force Behavioral Health Crisis Response report established pursuant to chapter 57 of the laws of 2023 - $8,000,000
- Mental Health Association of Erie County - $250,000
- For services and expenses of the Mental Health Association in New York State, Inc. (MHANYS) - $ 100,000
- 22 other legislative adds totaling $3.925 million for various local mental health programs and initiatives

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Health and Mental Hygiene Budget Legislation

Below the summary of the relevant provisions of the Health & Mental Hygiene Article VII bill as a result of negotiations between the Governor, the Senate, and the Assembly.

Part A: Medicaid Global Cap Extender:
The Governor proposed to extend the Medicaid global cap for an additional year, through fiscal year 2027–28.
- Assembly: agrees with Governor's proposal.
- Senate: proposes to repeal Global cap authority.

Final budget agreement: The Medicaid global cap is extended through fiscal year 2027–28.

Part B: Various Health-related Extenders:
Sections 1-15. Medicaid managed care authority extended: The Governor proposed to extend the sunset of the Medicaid managed care program for a six-year period, until March 31, 2032.
- Assembly: would extend the sunset of Medicaid managed care until March 31, 2029.
- Senate: agrees with Governor's proposal.

Final budget agreement: Extends Medicaid managed care authority until March 31, 2029.

Section 20. Telehealth Parity: Would extend New York's telehealth payment parity law, which applies to Medicaid and commercial insurers and health plans regulated by New York State Department of Financial Services for two more years through April 1, 2028.
- Assembly: agrees with Governor's proposal.
- Senate: agrees with Governor's proposal.

Final budget agreement: Extends the telehealth parity law through April 1, 2028.

Part E: Proposed Elimination of the Adult Home EQUAL Program

The Governor proposed to discontinue the Enhanced Quality of Adult Living Program (EQUAL Program). This program is designed to enhance the quality of life and living conditions of persons residing in adult care facilities, including adult homes. It is designed to improve and expand services and enhance the physical environment of these homes. Among the services and benefits funded by EQUAL include: providing needed clothing allowances, training to support independent living skills, food quality, outdoor leisure, recreation and other leisure events, and capital improvements to enhance the physical environment and quality of life. (This proposal would save an estimated $3.3 million annually.)

- Assembly: intentionally omitted.
- Senate: intentionally omitted.

Final budget agreement: The final agreement rejected the Governor's proposed elimination of the EQUAL program.

Part F (section 4): Prescription drugs: preferred drug list

The Governor proposed to amend requirements regarding the ability of prescribers to prescribe a drug that is not on the Medicaid "preferred drug list." It would require prescribers to consider "other clinical indications" identified by the "Drug Utilization Review Board," rather than the "committee for the patient's use of the non-preferred drug." Under this section of law "other clinical indications" include considerations of the medical needs of special populations, including persons with mental health conditions, and persons with an opioid use disorder. (The Governor's memorandum in support states that these are technical amendments, however, it is not clear to what extent there may be clinical implications from these amendments.)

- Assembly: intentionally omitted.
- Senate: intentionally omitted.

Final budget agreement: The Governor's proposed amendments impacting the ability of prescribe drugs that are not on the Medicaid preferred drug list were rejected.

Part L (Section 2): Medicaid Buy-In

The Governor proposed to amend the Medicaid Buy-In Program for working persons with disabilities who earn net income of at least 150% of the federal poverty line, by amending the monthly premium structure that they must pay. The current premiums for such persons is $25 per month for an individual, and $50 per month for a couple (when both are eligible for Medicaid). The new premium structure, would be up to 3% of net earned income and 7 ½% of net unearned income, subject to federal approval.

- Assembly: intentionally omitted.
- Senate: agrees with the Governor's proposal.

Final budget agreement: The Governor's proposal to amend the monthly premium structures of Medicaid Buy-In program were rejected.

Part M: Medicaid Managed Care Proposals

Section 1. This proposal would amend payments made to dually eligible individuals who have Medicaid/Medicare crossover claims, by eliminating exceptions for services provided by licensed psychologists and ambulance services.

- Assembly: intentionally omitted.
- Senate: intentionally omitted.

Final budget agreement: Agrees with Governor's proposal.

Sections 4-9: Presumptive Medicaid eligibility for children: These provisions would repeal subdivision 4 of section 364-i of the Social Services Law, to eliminate presumptive Medicaid eligibility for children under age 19 who reside in lower income households, until a full Medicaid application review can be completed.

- Assembly: intentionally omitted
- Senate: intentionally omitted

Final budget agreement: Agrees with Governor's proposal.

Section 13: Medicaid eligibility for children under age 6: The Governor proposed to repeal continuous Medicaid and Child Health Plus eligibility for children under the age of six. (Currently, children under the age of six, who are determined to be eligible for Medicaid, shall continue to be eligible for 12 months after the initial eligibility determination or renewal, or until the last day of the month in which the child reaches age of six. Such eligibility continues without a redetermination of eligibility, to the extent consistent with applicable federal requirements.)

- Assembly: intentionally omitted
- Senate: intentionally omitted.

Final budget agreement: Rejects Governor's proposal to repeal continuous Medicaid and CHP eligibility for children under age 6.

Part N: Expanded scopes of practice for certain healthcare aides

The Governor proposed to expand the scopes of practice of medical assistants, certified medication aides, nurse practitioners, and physician assistants, under certain circumstances. This proposal also would transfer the authority to enforce medical misconduct, as well as certifying the qualifications of professionals who own and operate medical entities, from the State Education Department to the Department of Health.

- Assembly: intentionally omitted.
- Senate: intentionally omitted

Final budget agreement: Part N was intentionally omitted.

Part P: Targeted inflationary increase (TII) for community-based human services providers

The Governor proposed to increase the targeted inflationary increase (formerly known as COLA) for mental hygiene and other human services providers for the 2026–2027 fiscal year by an additional 1.7%. This increase is unrestricted and applies to state payments, contracts, or "any other form of reimbursement for programs and services," including Medicaid rates. (The total cost for this TII is $176 million.)

- Assembly: Increases TII to 4%, with 2.3% targeted for certain staff.
- Senate: Increases TII for a total of 4%, with 1.3% targeted for certain staff.

Final budget agreement: A flexible targeted inflationary increase of 2.7% is included, without any increases targeted for certain staff.

Part Q: Integrated Behavioral Health Services Programs

The Governor proposed to authorize the Commissioners of OMH and OASAS to jointly license "integrated behavioral health services programs."

- Assembly: intentionally omitted
- Senate: includes the Governor's proposal

Final budget agreement: The Governor's proposal was intentionally omitted.

Part R: Addictive Disorder insurance coverage (includes gambling addictions)

The Governor proposed amendments to the state Insurance Law to require biennial reporting by insurers on addictive disorder services (such reports are already required for mental health and substance use disorder services), as well as adding penalties for parity noncompliance for addictive disorder services. Further, the

Governor proposed to provide the same level of health insurance coverage and protections for persons with gambling addictions as are currently provided for those with substance use disorders.

- Assembly: intentionally omitted.
- Senate: includes the Governor's proposal

Final budget agreement: Includes all of the Governor's proposed addictive disorder insurance reporting, parity and insurance coverage requirements.

Part S: Eliminate the Adult Home and Residence for Adults Resident Advocacy Program

The Governor proposed to repeal section 553 (10) of the Executive Law, to eliminate the Adult Home Advocacy and Adult Home Resident Council, which provides legal assistance and protection of rights for persons residing in impacted adult homes, i.e., those with large numbers of persons with mental health needs or histories. This program is currently located within the Justice Center for the Protection of People with Special Needs. (This proposal would save $230,000 annually.)

- Assembly: intentionally omitted
- Senate: intentionally omitted

Final budget agreement: This proposal was intentionally omitted from the final budget agreement.

Part U: Extend "government rates" for Medicaid managed care outpatient behavioral health services

The Governor's 30-day amendments added this Part to extend for a 4-year period until March 31, 2031, the reimbursement rates for ambulatory patient group (APG), or so-called "government rates," to ensure that Medicaid managed care, outpatient behavioral health service rates are at least as high as corresponding APG fee-for-service rates.

- Assembly: includes Governor's proposal
- Senate: includes Governor's proposal

Final budget agreement: Extends ambulatory Medicaid managed care behavioral health service "government rates" until March 31, 2031.

Part Y: Managed care organization (MCO) provider taxes

This new Part will require the Commissioner of Health to levy a provider tax on MCO's prior to January 1, 2027, and to apply to CMS for an amendment to the MCO provider tax, to impose a new assessment upon health plans of 0.35% of the health plans total premium revenue by January 1, 2027.

Part AA: Permanent carve out of school-based health centers from Medicaid managed care

This new Part permanently carves out school-based health centers from the Medicaid managed care program.

Note: A proposal to carve out mental health services from Medicaid managed care (as proposed in S8309A/A8055A) was not included in the final budget agreement. However, advocates are still advocating for such a provision before the end of the legislative session.

Other Noteworthy Article VII Provisions

Prior Authorization Reforms: The enacted reforms include the following:

- Require insurers and health plans to annually submit the following information to the Department of Financial Services: the number of pre-authorization requests, the number of pre-authorization requests for which an authorization was issued, the number of pre-authorization requests for which an adverse determination was issued, the number of pre-authorization requests for which an adverse determination was reversed, the 25 current CPT codes with highest number of pre-

authorization requests and the percentage of authorizations for these requests, the 25 current CPT codes with highest number of pre-authorization requests for which an adverse determination was issued in whole or in part but was reversed by an appeal in whole or in part, and the 25 current CPT codes with highest number of pre-authorization requests for which an adverse determination was issued. This information would be reviewed, analyzed and published as part of the Department of Financial Services annual guide to health insurance for consumers starting in September 2027.

- Extends the period of time for which a newly insured individual can continue to receive treatment if the health care provider is not in-network from 60 to 90 days (transitional period). This provision also extends this protection to those pregnant at time of enrollment and the transitional period shall cover care for the duration of the pregnancy and postpartum.
- Require insurers to publish formulary prescription drug lists on their public websites without having to create or access an account and make it clear which formulary applies.
- Limits the number of utilization reviews that can be conducted against an insured individual when experiencing a chronic health condition, which is defined as "a condition that is expected to last for at least one year and requires ongoing treatment to effectively manage the condition or prevent an adverse health event." The provision prohibits utilization review more than once per year for an outpatient course of treatment for a chronic health condition starting from the date of pre-authorization approval "unless the enrollee's attending provider recommends a change to the course of treatment, then utilization review may be conducted for the new course of treatment. Any new treatment, testing or procedures related to the specific medical problem, condition, or illness being managed but not already included in the approved course of treatment may be subject to a separate pre-authorization."