Note: This letter has been updated since an earlier version was sent to state leaders on September 30.

Addiction Treatment Providers of New York
Alliance for Rights and Recovery
Association for Community Living
Citizens Committee for Children
Coalition of Community Services
Coalition of Medication Assisted Treatment Providers & Advocates
Families Together in New York State
Federation of Mental Health Services
HealthyMinds, HealthyKids Campaign
InUnity Alliance
Legal Action Center
National Alliance on Mental Illness - New York State
NYS Council for Community Behavioral Healthcare
New York State Psychiatric Association
Therapeutic Communities Association of NY

October 15, 2025

The above listed membership associations and advocacy coalitions collectively represent thousands of community-based mental health and substance use prevention, treatment, recovery and harm reduction providers, family members and millions of New Yorkers they serve each day. We are writing today to urge New York State leaders to remove OMH and OASAS community-based behavioral health (mental health and substance use) services, including outpatient, residential and rehabilitation services, from the state's Medicaid managed care program and in doing so, restore the availability of essential services to New Yorkers fighting for access to care, and to preserve scarce resources.

Medicaid managed care has proven detrimental to the ability of New Yorkers to secure the mental health and substance use disorder care they need in a timely fashion. Insurers and MCOs continue to employ tactics that result in months and sometimes years of reimbursement delays as well as persistently inaccurate payments. These barriers prevent providers from hiring and retaining staff, launching needed programs, and competing in a workforce market already strained by shortages. Instead of investing in care, agencies are forced to expend scarce resources chasing reimbursement. By removing managed care organizations, the middlemen in this equation, New York State will finally remove unnecessary and serious barriers to care while simplifying and streamlining the reimbursement process, and returning vital resources to the OASAS and OMH systems of care to address workforce shortages and gaps in care.

Given the change in leadership in Washington, we have grave concerns for the future of the NYS Medicaid Program. We stand ready to assist the Hochul Administration as it continues to face down and plan for draconian policy changes that threaten the viability of New York's public health insurance programs. Streamlining Medicaid reimbursement to create a direct transaction between the FFS Medicaid system and providers will protect Medicaid beneficiaries from some of the most draconian policy and fiscal changes we face in the days ahead that threaten continued access to care.

State leaders must ask themselves what value is this model providing for New Yorkers with serious behavioral healthcare needs? Managed care plans/insurers are able to keep at least 11% of Medicaid funds for administration and profit, yet they fail to meet contractual requirements, claims denials rates are hovering at around **60%,** and some providers have been forced to suspend new intakes due to their inability to recruit and retain a workforce that can meet actual demand. When we consider the

total amount of premiums paid to MCOs to pay for care and manage behavioral health benefits (approximately $4 billion/year), the hard fact is that MCOs add no value, and they continue to employ tactics that delay or deny payment. As such, **we must ask ourselves whether we are spending taxpayer resources wisely?**

We know there is a better way, and we need to act now in light of the ongoing incidence of rates of deaths of despair that continues to claim the lives of so many New Yorkers. By carving out behavioral health from Medicaid managed care, the State can save hundreds of millions which can be reinvested into much-needed mental health and addiction care and a well-trained workforce to provide these lifesaving services.

We must foundationally fix what is broken in our behavioral healthcare system. This begins with eliminating the largely for-profit middlemen (health insurance plans), returning reimbursement to New York's fee for service system as was the case over a decade ago, and reinvest finite resources in services, our workforce challenges where job vacancy rates for positions that are client-focused are hovering between 20-30% (depending on the Program), with and annual turnover rates over 30%.

Now is the time for New York State to take managed care middlemen out of the equation and move behavioral health services back to Fee for Service in Medicaid, as Senate bill 8309 / Assembly bill 8055 sponsored by Mental Health Committee Chairs Senator Brouk and Assemblymember Simon would do.

For more information regarding this request, please contact Lauri Cole, Executive Director, NYS Council for Community Behavioral Healthcare, at (518) 461-8200 or lauri@nyscouncil.org.

cc: Karen Persichilli Keogh, Secretary to the Governor
Kathryn Garcia, Director of State Operations and Infrastructure
Angela Profeta, Deputy Secretary for Health
Peter Hatch, Deputy Secretary for Human Services and Mental Hygiene
Blake Washington, New York State Budget Director
Dr. James McDonald, Commissioner, NYS Department of Health
Amir Bassiri, Medicaid Director, NYS Department of Health
Dr. Chinazo Cunningham, Commissioner, NYS Office of Addiction Services & Supports
Dr. Ann Sullivan, Commissioner, NYS Office of Mental Health

Additional Background to Support the Need for Medicaid Managed Care Carve Out of Outpatient Behavioral Health Services in NYS

In 2015, NYS began carving-in most outpatient mental health and substance use disorder / addiction) services available through New York's public mental hygiene system, into managed care.
The decision to carve in these services was made by the Medicaid Redesign Team and was not presented as a choice for Medicaid beneficiaries or system stakeholders, nor was it a decision made by the current Administration. With this action, *New York effectively handed over day-to-day management of Medicaid benefits to insurers (most of which are for profit companies) and their Managed Care Organization proxies.*

The result of this failed experiment has been disastrous for care recipients who are sitting on waiting lists around the state, desperate for access to services while providers on the ground fight to remain viable with one hand tied behind their backs.

Since 2019, over 300 citations have been issued by state regulators against many MCOs for their failure to comply with state laws, regulations, and guidance – actions that perpetuate barriers to care and force providers to waste scarce resources chasing health plans for reimbursement. These citations are rooted in three core areas:

- failure to pay the state mandated fee for service (APG) government rates.
- inappropriate claims denials (the rate of claims denials in 2023 was approximately 60%)
- failure to oversee the proxy company that is employed by many of the insurers to manage the benefits.

In August 2025, a provider survey of mental health and substance use disorder agencies revealed the following:

- Nearly 50% of community-based providers had waiting lists for outpatient clinical services to include Medication Assisted Treatment and psychiatric services, while New York's children with behavioral health conditions continued to live in emergency rooms across the state due to a lack of appropriate community-based services.
- 58% of respondents are spending between $200k – $1M+ to employ staff in their back offices whose primary responsibly is to chase MCOs, file complaints with regulators, upgrade billing systems, hire attorneys to threaten legal action against MCOs for failure to pay, re-process claims that are paid at the wrong rate by MCOs many months after they are required by law to do so, and to manage what appears as intentionally complicated and opaque tactics in which MCOs take back payments without notifying the provider first, and where the provider is left to try and piece together why the health plan/MCO took the funds back and then pursue the insurer. Many providers are unable to sustain this advocacy for the many months and often years it takes to get a resolution from the insurer.
- 75% of responding organizations currently have between 5 to 9 contracts with various insurers/MCOs, each with their own rules, requirements, and administrative demands.
- 58% of providers responding told us they are owed more than $25k for over 90 days for clean claims submitted to insurers/MCOs.
- MCOs often fail to reimburse providers based on new/existing state laws. As an example, the COLA that was enacted as part of the 24-25 enacted budget had yet to be paid by most insurers as of February 2025.
- In 2022, Milliman Consulting Firm completed an analysis and concluded that most insurers participating in the carve-in fail to comply with federal and state parity laws and regulations and/or New York's requirements around self-monitoring of compliance with the same.
- In 2020, the Office of Mental Health conducted an analysis of Medical Necessity criteria used by MCOs to make critical decisions around authorizations for care only to find that there were no MCOs that met the Office's Medical Necessity criteria standards.

- Finally, in 2022, NYS began recouping hundreds of millions of taxpayer dollars paid by the state to MCOs they had not earned due to their not meeting a contract requirement that holds them to a high threshold for how much the insurer/MCO must spend on **actual services for Medicaid beneficiaries.** To date, the enforcement of this requirement has resulted in over $500M being returned to OASAS and OMH where the majority of funds have been reinvested in provider reimbursement rates and other high priority needs.

A recent analysis conducted by Boston Consulting Group for NYS found serious problems associated with the ongoing carve in of behavioral health services writing "…*MCOs have shown little innovation to improve upon workforce challenges. Additionally, there have been no applications for in-lieu-of services (i.e., medically appropriate, cost-effective substitutes to a covered service), despite this being an option available to plans. Furthermore, OMH has struggled to entice MCO participation in quality-improvement initiatives. According to stakeholder interviews, OMH tried to engage MCOs in Critical Time Intervention for high-need BH populations but did not secure participation, even with a $400 incentive per member engagement visit. Likewise, stakeholder interviews indicate that MCOs did not participate in an OMH-led Performance Opportunity Project to increase adoption of evidence-based practices for high-risk/high-need populations. Lastly, despite network requirements, managed care has relied on additional government funding to bring inpatient psychiatric beds online*." **It should be noted that Guidepoint Consulting recently completed a report commissioned by NYS that recommends services for individuals receiving care through the OPWDD system of care should not be carved in or managed through a managed care model. As such we are left to wonder why mental health and substance use disorder services remain carved in and in jeopardy while the state protects other vulnerable populations from the same fate.**

For more information, contact Lauri Cole, Executive Director, NYS Council for Community Behavioral Healthcare, (518) 461-8200