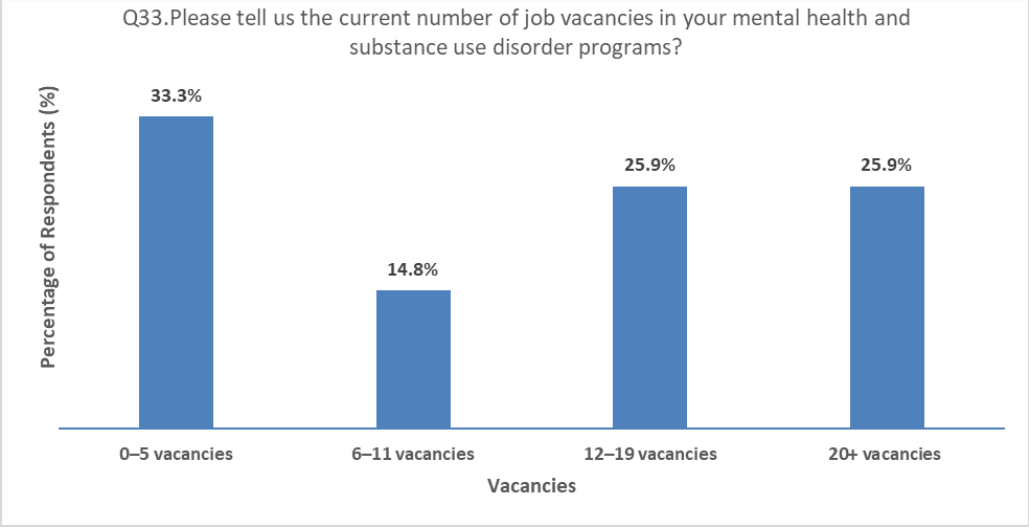
NYS Council for Community Behavioral Healthcare

New York State Council for Community Behavioral Healthcare
SFY27 Executive Budget Requests

PRIORITY #1: INCREASE AND STABILIZE OUR WORKFORCE

BUDGET REQUESTS

- Targeted Inflationary Increase (2.7% consistent with July 25 CPI-U) for behavioral health (BH) workforce recruitment and retention, to address significant and persistent job vacancies and workforce shortages in mental health (MH) and substance use disorder (SUD) programs across New York.
- Amend State Education Department (SED) laws and regulations that restrict access to care by prohibiting certain practitioners from working at the top of their scope, and that do not take into consideration program models that may/may not offer staff the opportunity to acquire the clinical hours they need to obtain the license or permit they seek.
- Create an online portal so practitioners with license/permit applications in process can see, in real time, the status of their application, and if there is information missing.
- Hire additional SED staff to work in the applications review department, to speed up the process of approvals for licenses and permits.
- Implement universal background check 'passport system.'
- Establish a Medicaid and commercial insurance reimbursement rate for services provided by certified peer specialists.
- Allow Psychiatric Nurse Practitioners and Physician Assistants to serve in professional roles that are currently limited to physicians.



DISCUSSION AND RECOMMENDATIONS

In a recent statewide survey of OMH and OASAS provider organization agencies, responses revealed job vacancy rates between **20-30%**, and annual turnover rates hovering around **35%**. This is a persistent crisis as a result and waiting lists for access to services in OASAS and OMH programs persist. Over 40% of the agencies surveyed report that they cannot currently meet agency standards for the provision of culturally competent staff due to these shortages.

Current background check requirements do not extend across programs, or across similarly situated agencies. Pre-employment screening is time consuming and expensive, and it can result in prospective staff abandoning the pre-employment process in favor of positions that do not require them to wait for clearance. NYS should take immediate steps to implement a 'background check passport system' and accompanying expedited process. (For example: Staff employed in one program of an agency should be able to work in another program in the same agency without having to complete the background check process a second time. Similarly, staff employed by one agency should be permitted to work in a different agency where the job requirements and pre-employment requirements are similar.

Recent changes to New York State Education Laws and specifically, changes related to practitioner scope of practice, and requirements for obtaining licenses, permits, and other credentials have left agencies high and dry as they grapple with gaping holes in their workforce, while New Yorkers linger on waiting lists. NYS Council member agencies are unable to recruit and retain the staff they need, and they are not competitive in the job marketplace.

To make matters worse, SED requirements for licensure, permits, etc. do not consider the program models associated with what can be seen as more 'non-traditional' OMH and OASAS programs and services that have significantly expanded their footprint across the state, to include ACT and Mobile Crisis Services. Both programs have seen exponential growth across the state however recent SED changes impacting scope of practice and how practitioners can obtain clinical hours to secure credentials, do not take these newer programs and services into account in terms of the nature and frequency of the services being delivered and the impact this has on practitioners ability to gain the clinical experience they need to secure their desired credential. Staff are leaving our employment so they can work in settings where they can gain the clinical horse they need quickly.

Finally, SED/Office of the Professions application processing times are slow. This creates situations where potential employees awaiting approval are forced to abandon their plans to work for these agencies, or they are required to leave their jobs due to lack of credentials necessary to be able to offer the full range of services.

RECOMMENDATIONS RELATED TO CURRENT SED LAWS/REGULATIONS

Practitioner types in high demand should be moved through an 'expedited waiver' process so they can work at the top of scope while awaiting SED final approvals. Additional recommendations include:

- Expand the definition of direct contact hours to explicitly include clinical encounters with collateral contacts and coordination of care that directly influences a therapist's ability to attempt to locate and contact patients.
- Consider allowing the use of the telehealth modality, and audio / telephone interventions to count toward direct contact hours for ACT and Mobile Crisis services. Provide written clarification to ensure that limited permit therapists in ACT and Mobile Crisis programs can accurately count these hours toward licensure.
- Engage stakeholders including ACT and Mobile Crisis providers, supervisors, and professional associations in shaping standards that reflect the realities of these services in New York State.

PRIORITY #2: INCREASE ACCESS TO CARE THROUGHOUT NYS PUBLIC MENTAL HYGIENE SYSTEM

BUDGET REQUEST

Carve out OMH and OASAS mental health and substance use disorder outpatient, residential, and rehabilitation services from NY's Medicaid managed care program.

DISCUSSION

NYS is currently throwing away a minimum of $400M/year as it continues to pay mostly for-profit insurance companies and their hired guns to 'manage' these services. Insurer and MCO tactics to delay/deny care result in life threatening obstacles to on-demand MH and SUD care throughout New York's public mental hygiene system (OASAS and OMH service delivery systems). Insurers pocket a minimum of 11% of the funds they are paid to 'manage' services; however, year after year these same insurers fail to meet contract requirements that require them to spend the vast majority of the funds they receive from the state on actual services for Medicaid members with MH and SUD conditions, depriving our systems of care of hundreds of millions of dollars each year, and resulting in interest bearing windfalls for the insurers. State regulators demonstrate little interest in monitoring, surveilling, and enforcing critical protections such as Network Adequacy standards, resulting in wait lists and delayed access to care. Insurers fail to follow the numerous state laws, regulations and contract provisions in place to protect vulnerable New Yorkers and the providers that serve them.

BEHAVIORAL HEALTH EXPENDITURE TARGETS / STATE'S ONGOING FAILURE TO ADEQUATELY OVERSEE CARVE IN OF BH SERVICES TO MEDICAID MANAGED CARE

In 2022, the NYS Council retained legal counsel to issue 25 FOIA requests on our behalf across six state agencies/regulators to confirm what we already knew - that the state was not enforcing a contract provision on insurers/MCOs that holds them to a high threshold for spending the funds received from the state on **actual care for Medicaid members with BH conditions.** Eventually, NYS Council leaders met with the Governor's Counsel to advise that we would litigate unless the state began to enforce the recoupment of funds MCOs had been paid but did not earn, depriving our systems of care of scarce resources amid two public health crises. Thanks to the Hochul Administration's swift action, the initial two-year enforcement (18-19, 20-21) returned $220M, and to date **over $500M** has been recouped.

These funds were sitting with insurers rather than being reinvested during the height of the Overdose Epidemic as suicide rates continued to climb in certain populations. However, the problems associated with insurers sitting on funds that belong to providers while they delay and deny care for some of New York's most vulnerable residents, is a problem that requires a fundamental move away from use of third-party vendors where the primary motivation (of the for-profit insurer) is profit.

The failure of MCOs to implement person-centered policies and to manage services in a manner that supports New York's goals of decreasing youth mental health suicide and other serious problems facing our youth is evidenced by a recent statistic from the CDC that found **youth suicide rates in NYS have risen +9.9% between 2014 and 2024 – *dates that coincide with the implementation of Medicaid managed care for children and youth mental health services.* At best, insurer management of these hard-to-find services has failed to deliver lasting change as we consider the ongoing youth mental health crisis in our state and across the country.**

A new October 2025 Report, issued by People's Action Institute (funded by Robert Wood Johnson Foundation), found that in NYS, patients with diagnoses relating to SUD in Medicaid Managed Care plans are having their external appeals overturned **64%** of the time, which is **24%** higher than the average overturn rate in Medicaid Managed Care. And this is only on a tiny percentage of appeals that are overturned overall.

ADDITIONAL SERIOUS & PERSISTENT PROBLEMS ASSOCIATED WITH CARVE IN OF BH SERVICES TO NY'S MEDICAID MANAGED CARE PROGRAM

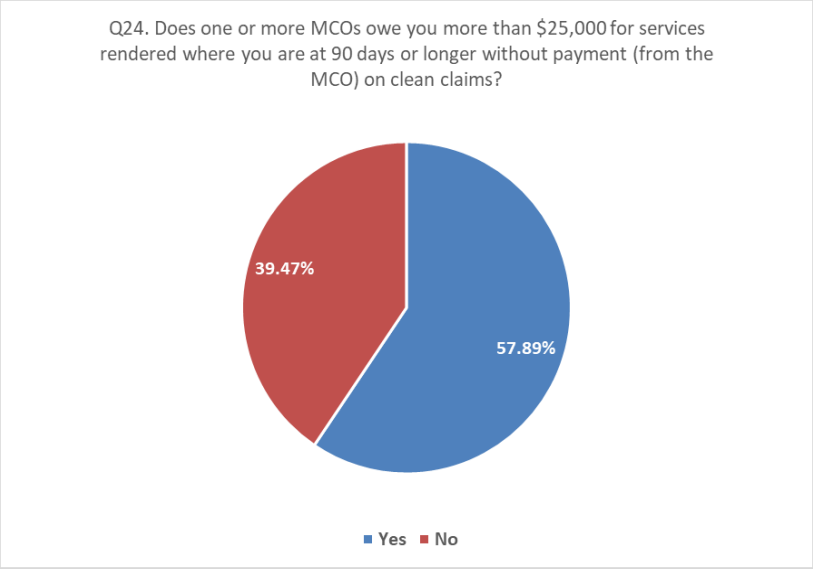
- Persistent **wait lists** for treatment and support provided by OASAS and OMH agencies across the state.
- Since 2019, over **300 citations** have been issued by state regulators; however, many of these citations have not resulted in meaningful change in the behavior of insurers, and most took years to resolve (if they have been resolved at all).
- Insurers and their middlemen have **failed to deliver on contractual commitments to increase alternative payment arrangements** (VBP, shared savings, etc.), to **increase the use of 'In Lieu of' services,** and **increase the penetration of integrated care for New Yorkers living with co-occurring conditions.** In fact, the only expansion of integrated care penetration has resulted from the expansion of the CCBHC Demonstration Program – a federal model adopted by NYS in 2018, where BH services are carved out of Medicaid managed care.
- Retroactive denials and retroactive takebacks occur on a seemingly arbitrary basis without explanation. The burden is entirely on the provider to try and figure out why the payments are being taken back, and then to assess whether the takebacks were legal and accurate.
- Most MCOs **do not respond to providers' requests for assistance** in a timely manner if at all. Further, they fail to acknowledge emails and calls from desperate providers. Numerous insurers now have semi-automated or fully automated provider relations functions.
- Most insurers contract with the state and then **use subcontractors** to perform all the tasks the insurer has agreed to, with little to no oversight by the insurer. This adds layers of complexity and additional middlemen who take their share of already scarce resources that should be available to OASAS and OMH systems of care. Use of BHOs as middlemen confounds any

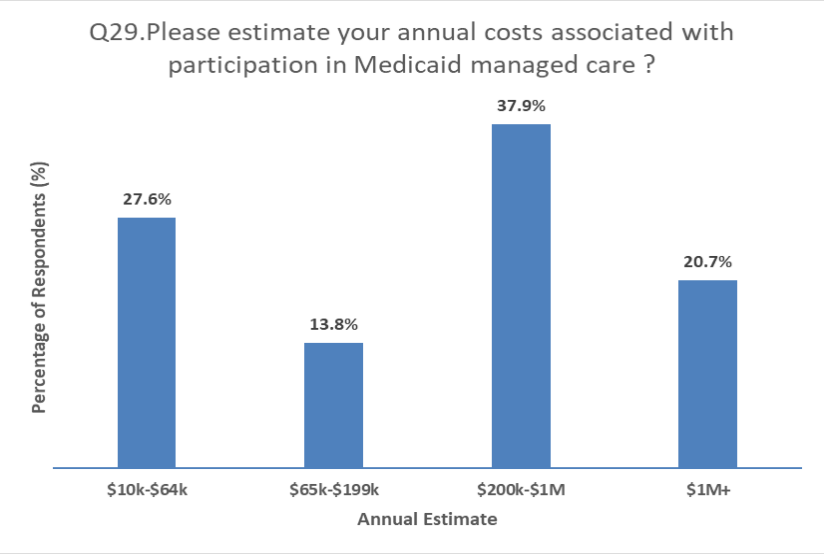
comparisons between physical health and BH benefits for purposes of analyzing MH and SUD parity compliance.

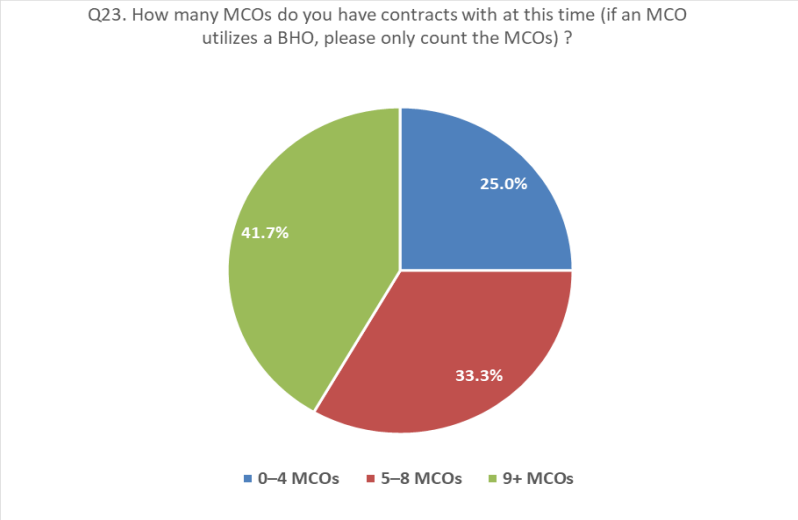
- Little to no evidence that insurers are doing any type of case management, as required.
- Fidelis, United, and HealthFirst recently implemented a concurrent review requirement on some providers that offer CFTSS services without adequate prior notice to network providers. The result is a major resource drain on impacted providers that appear to be impacting continuity of care for children, youth, and families.

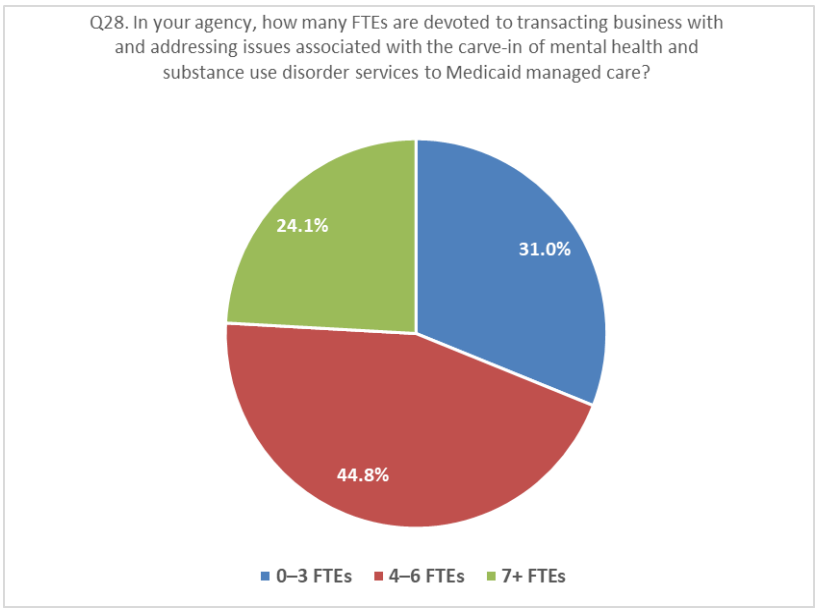
BENEFITS OF CARVING OUT BH SERVICES FROM THE MEDICAID MANAGED CARE PROGRAM

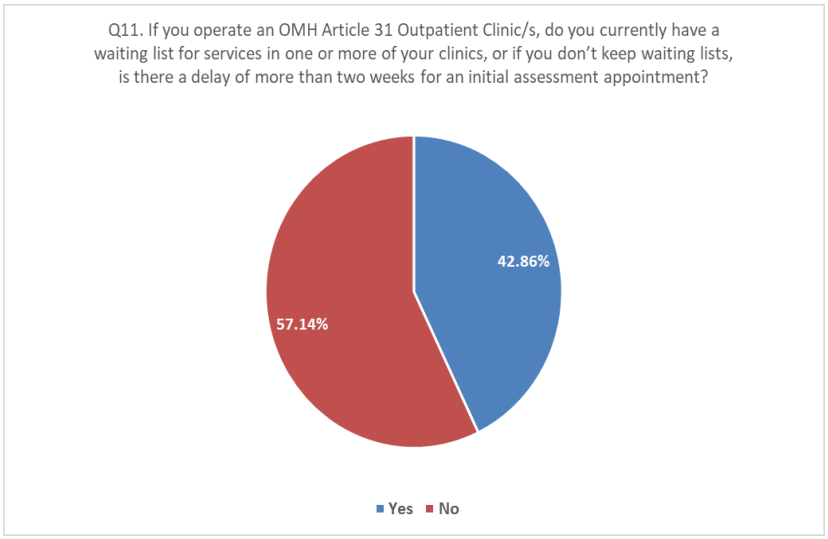
1. Savings at a minimum of $400M/year (insurer profit + admin overhead).
2. Opportunity to streamline New York's Medicaid Program, demonstrate New York's continued focus on creating efficiencies, and preserving scarce resources in our Medicaid Program.
3. Relieve state of responsibility to surveil, monitor, and enforce laws, regs, contract provisions related to BH MMC carve. They are failing in this responsibility. (BHET, hundreds of citations, Ghost Networks as proven by AG.)
4. Will provide massive regulatory relief for providers who spend millions chasing insurers and hiring back-office staff (that could be re-tasked) to do other critical jobs.
5. Increased access to care for Medicaid members with significant BH conditions - care recipients will no longer be limited to the in-network providers associated with their health plan. This significantly impedes access to care.
6. Increase opportunities for the state to contract with provider networks / healthcare and behavioral healthcare providers, to implement alternative payment arrangements (VBP, etc.) through the FFS Program.




Q29.Please estimate your annual costs associated with participation in Medicaid managed care ?
Percentage of Respondents (%)
27.6%
13.8%
37.9%
20.7%
$10k-$64k
$65k-$199k
$200k-$1M
$1M+
Annual Estimate


Q23. How many MCOs do you have contracts with at this time (if an MCO utilizes a BHO, please only count the MCOs) ?
25.0%
41.7%
33.3%
0–4 MCOs
5–8 MCOs
9+ MCOs





PRIORITY #3: INCREASE ACCESS TO CARE throughout OASAS and OMH service delivery systems, and substantially enhance Commercial Insurer Oversight

BUDGET REQUESTS

- Expand NYS CCBHC Program to permit any eligible provider to offer these services at the agency-based Medicaid cost-based PPS rate.
- Fix commercial insurer non-compliance with Part AA, New York's new commercial insurance rate reimbursement mandate.
- Increase and expedite enforcements against non-compliant commercial insurers.
- Expand the range of MH and SUD services available to children, youth and families with commercial benefits.

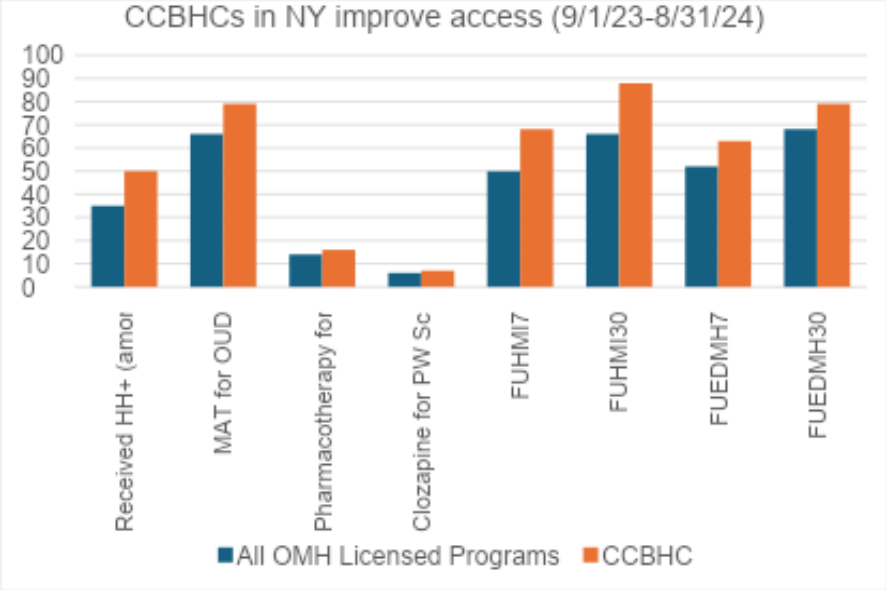
- Prohibit retroactive prior authorization denials, and retroactive audits that result in recoupments for services dating back beyond one year.

DISCUSSION

The NYS Council (in consultation with Health Management Associates or HMA) performed an analysis of vital signs data from September 1, 2023, through August 31, 2024, that are made available by OMH.[1] Based on those data we were able to determine that CCBHCs are, in fact, making a difference with respect to key measures of access.

When compared to the universe of OMH licensed providers,[2] New York CCBHCs demonstrates better outcomes on all major measures of access reported:

- Received Health Home Plus (among clients eligible for Health Home Plus)
- Utilization of Medication Assisted Therapy (MAT) for opioid use disorder
- Utilization of pharmacotherapy for alcohol abuse and dependence
- Utilization of Clozapine among potential Clozapine candidates with schizophrenia
- Seven day follow up after a hospitalization for a mental illness (FUHMI7)
- Thirty day follow up after a hospitalization for a mental illness (FUHMI30)
- Seven day follow up after a mental health emergency department visit (FUEDMH7)
- Thirty day follow up after a mental health emergency department visit (FUEDMH30)



DISCUSSION

Although Part AA, the new (and hard fought) commercial insurance rate mandate took effect on January 1, 2025, as of September 2025, 34 providers reported that they were owed over $6.8 million from

[1] https://omh.ny.gov/omhweb/tableau/vital-signs.html

[2] NYSCCBH recognizes that the appropriate comparison group is all OMH and OASAS licensed providers, but data regarding these performance indicators for OASAS programs are not publicly available.

commercial plans that are either paying the wrong rate, not following the mandate at all, or that have failed to implement system changes required to pay the correct rates on time and in full. We have seen no enforcement actions against non-compliant insurers to date by DFS, and the wait for assignment of a DFS complaint manager to address a provider's formal complaint is currently around 6 months (before a DFS complaint manager is assigned to address the complaint). As such, there is no recourse for providers that are entitled to the commercial rate for services provided to commercial clients insured under fully funded insurance plans.

RECOMMENDATIONS

1. Expand the current benefit package offered by commercial insurers and require a full range of benefits (similar to those required for Medicaid members) to be available to children, youth and families.
2. Establish a consistent, evidence-based definition of "medical necessity"; state should conduct quarterly audits of insurers to ensure compliance with same, and this audit schedule should also apply to Network Adequacy compliance audits (insurers should NOT be permitted to self-audit and merely attest to compliance).
3. Prohibit post-payment claw backs for services that were already approved and paid, beyond one year.
4. Assign additional DFS staff to expedite provider complaints against insurers that have failed to comply with the commercial rate mandate.

PRIORITY #4: ENSURE CONTINUITY OF CARE FOR NEW YORKERS RECEIVING SERVICES THROUGH THE OMH AND OASAS SERVICE DELIVERY SYSTEMS

BUDGET REQUESTS

- Increase funds available to Article 31 Outpatient Clinics through current OMH Uncompensated Care/CCBHC Indigent Care Pools.
- Seek authorization from CMS to implement a new OASAS Article 32-822 Uncompensated Care Pool.
- Permit OASAS net deficit funded agencies to retain excess funds and utilize them to support other OASAS programs and services flexibly.

DISCUSSION

In light of new federal work requirements and anticipated coverage losses/churning, the Trump Administration's intention to repeal federal parity laws, escalating health insurance premiums, and likely cuts to the Medicaid Program, New York State must act today to ensure existing pools of resources for mental health and substance use disorder providers serving New Yorkers without insurance are adequately funded and in the absence of such a pool. State agencies should immediately file a State Plan Amendment (SPA) to establish a pool – to ensure access to care and continuity of care for any New Yorker in need of services.

RECOMMENDATIONS

New York State can carve out MH and SUD services (see previous recommendation) from the state's Medicaid managed care program saving a minimum of $400M/year. These funds should (in part) be utilized to fund or increase funding for new and existing Uncompensated Care Pools to ensure New Yorkers who may lose their health insurance as result of draconian federal policy changes, can get the care they need and deserve.

New York State should permit OASAS net deficit funded agencies to retain excess net deficit funds and apply to other OASAS programs, as needed.

Given incoming (federal) threats associated with federal Work Requirements that are sure to create increased churning where longstanding Medicaid beneficiaries are thrown off Medicaid insurance rolls, New York State must immediately invest additional resources that will ensure community-based providers can continue to serve increased numbers of uninsured New Yorkers in a timely fashion.

NYS should immediately invest in the deployment of additional insurance navigators and financial liaisons to help care recipients learn about insurance options, fill out appropriate paperwork and avoid losing coverage.

ADDITIONAL REGULATORY REFORM/ADMINISTRATIVE STREAMLINING RECOMMENDATIONS (BEYOND THOSE PROVIDED EARLIER IN THIS DOCUMENT)

Remove unnecessary barriers to service expansion for service providers in good standing**,** such as eliminating duplicative requirements and revisiting limits that delay expansion and, in turn, access to care (14 NYCRR § Part 551).

Streamline grant contracting and reporting through umbrella contracts, acceptance of demonstration or request-for-proposal (RFP) information for subsequent licensure when the same data is requested again, and technology that eliminates duplicate reporting.