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Response to NYS Health Plan Association Comments on Call for Medicaid Managed Care Carve Out of Behavioral Health Services

In recent weeks, representatives for NYS Medicaid health insurance plans have issued statements in the media attempting to pour water on the urgent call by organizations representing New Yorkers on Medicaid, their families, and community providers. The call: for the state of New York to fix the broken Medicaid system of care by carving outpatient, residential, and rehabilitative mental health and substance use disorder (SUD) services out of Medicaid managed care (MMC).

For more than a decade, there's been a crisis felt by so many New Yorkers, their families, and schools throughout the state struggling to respond to the serious mental health and addiction care needs of our residents. Children and adults are facing long wait times for care, service deserts, and health insurance denials, which hinder their ability to get the care they need and deserve in a timely manner.

The fact is, millions of New Yorkers would benefit from the managed care carve out by streamlining the program and making the care provided to those enrolled in Medicaid patient-centered and available without barriers put up by insurers with a profit motive. Here are more details on the myths being told by the insurance companies and the facts.

MYTH: Health Plans Pat Themselves on the Back for "Surpassing National Benchmarks in Behavioral Health"

FACT: The Health Plan Association appears to be pointing to a 2023 State Health Department (NYSDOH) Managed Care (MC) report, which compares New York health plans of all types to national averages **and to their own rankings** from 2021-2023 for certain benchmarks in physical and behavioral health. *On page 8 of the DOH MC report it says that the results of the metrics are purely a comparison of 2021 performance and 2023 performance*. This is obviously a very flawed approach for several reasons: 1) it is simply comparing old performance against new performance and 2) COVID 19 was at its height during this period of time.

Importantly, the Report looks at a minimal number of metrics related to mental health and substance use disorder, and does not account for the realities experienced by clients on the ground for more than a decade, and that continues during a period of time when hundreds of thousands of New Yorkers are struggling to secure the services and support, they need and deserve:

- New York ranks third in the nation for teen suicide rates. And, according to an October 2025 analysis of Center for Disease Control (CDC) data analysis performed by Stateline, youth suicide

rates in New York **increased by 9.9% between 2014-2024.** (Note, the carve in of children's mental health services was implemented in 2017, leaving health plans with 7 years to bring these numbers down, however rates continue to rise.)

- New York's **opioid death rates** have consistently exceeded the national average, with black and brown communities hit the hardest.
- Health plans seemingly use a "deny first" policy. **In NYS, when New Yorkers with substance use disorders file an external appeal of a decision made by their insurer denying care, the denial is overturned 64% of the time by an independent medical expert.**
- Many providers across the state continue to report waiting lists. The improvement has been marginal at best, certainly nothing to brag about. Specifically, a statewide provider survey performed in 2023 found that 45% of OMH mental health outpatient clinics had prolonged waiting lists, while the same survey administered in 2025 found 43% still had waiting lists.
- A 2023 Report commissioned by state NYSDOH and performed by Boston Consulting Group identified a myriad of serious problems associated with the carve in of these services to include access to care issues and insurer performance issues when it comes to administering the BH benefit.
- A damning 2023 Attorney General's Report that focused on access to care, network adequacy and health plan directories found that 85% or more of BH provider networkers insurers use are not real, the BCG report which highlights a myriad of managed care access problems and insurer performance issues when it comes to administering the BH benefit.

The 2023 NYSDOH Managed Care report also fails to speak to the over three hundred citations issued by NYS against numerous Medicaid managed care plans since 2019 for a range of serious violations. Health plans continue to state that there is no proof that they delay payment to providers however 87 citations issued by the state were for **delayed payments**. The citations also include violations related to noncompliance with state mental health parity requirements. In 2021, an OMH root cause analysis found a claims denial rate in the 60%. Inappropriate claims denials and underpayment of mandated government rates for behavioral health services has severely impacted provider financial solvency.

The NYSDOH report also does not speak to the fact that many managed care plans have repeatedly failed to meet a contractual requirement to spend the vast majority of the funds they receive from the state on **actual services for Medicaid members with mental health and SUD conditions**. These failures led to advocacy that pressured the state to recoup over $500 million, to date, from the plans that held onto these dollars rather than spending them on this essential care in a timely manner and as required by their contracts with the state. This starved the system of resources and ultimately starved New Yorkers of the care they needed during the height of the COVID-19 pandemic, a raging overdose epidemic, increasing suicide rates, and exacerbating a crisis with children's mental health. **Despite these recoupments, managed care plans are continuing to violate these requirements by failing to meet these established thresholds. "behavioral health expenditure targets or BHETs."**

MYTH: Health Plans Assert that they take an Integrated Approach and Provide Oversight, Accountability, and Coordination of Care

FACT: When the Cuomo Administration proposed the shift to Medicaid managed care for behavioral health services a decade ago, there were big promises of integrated care, value-based payments, and improved coordination of care. The reality is that none of these promises has materialized.

Value-based payment arrangements are extremely rare for behavioral health, and primary care and behavioral healthcare remain highly fragmented under managed care. In actuality, one of the best models of integrated care is through the Certified Community Behavioral Health Clinics (CCBHCs), which are paid outside managed care through Medicaid fee-for-service. And it is the providers, not managed care plans, who help clients navigate the system of care, coordinate care, make referrals, and adhere to treatment plans and medications.

It is laughable that health plans tout an integrated approach when most Medicaid managed care plans subcontract with other plans for behavioral health services, further fragmenting and bifurcating the management of physical health and behavioral health services for enrollees.

MYTH: Health Plans Claim Managed Care Carve Out would be a Step Backwards

FACT: New York is currently paying over a dozen health plans under Medicaid managed care to serve as middlemen between the state and providers/clients. These plans are permitted to keep a minimum of 11% for administration and profit. This amounts to over $400 million per year paid to health plans that provide no added value. These plans serve as barriers to clients' access to critical care, which can save their lives and help them live healthy, productive lives in the community, reducing the need for far more costly inpatient care.

Managed care plan denials and coverage delays place the onus on the client and their provider to fight for coverage, often resulting in clients falling through the cracks. However, those who are able to get through the complicated web of appeals processes, paperwork, and red tape have demonstrated the fallacy of these plan denials.

A recent report by the People's Action Institute analyzing Medicaid Managed Care and Private Insurance claims denials in New York found that between 2019-2023, patients with diagnoses relating to substance use disorders in Medicaid managed care had their wrongful denials overturned 64% of the time through external appeals and for individuals with mental health disorders, external appeals overturned denials 52% of the time.

In 2023, New York successfully carved out the pharmacy benefit from Medicaid managed care. It was returned to fee-for-service, where drug costs and other pharmacy services are directly paid for and managed by the state. This shift has saved hundreds of millions of dollars through direct administration, transparency, and utilization management. It has created a far more efficient program, and the state coordinates with managed care plans that oversee other physical health services for Medicaid enrollees. New Yorkers with Medicaid are no longer limited by health plan provider networks and varying health plan rules and processes to access their needed medications and pharmacy care.

The outpatient behavioral health carve out would work similarly, with the benefit of additional oversight and management by OMH and the Office of Addiction Services and Supports (OASAS).

New York State Must Carve Outpatient, Residential & Rehabilitation Behavioral Health Services Out of Medicaid Managed Care

State leaders have taken a number of actions in recent years that make it clear that ensuring access to mental health and addiction care for New Yorkers who need it is a priority. In order to truly accomplish this goal, New York must carve out outpatient, residential, and rehabilitation behavioral health services from Medicaid managed care in the SFY 2027 Budget. By doing so, the State can save hundreds of

millions of dollars in scarce resources and reinvest them in much-needed mental health and addiction care and a well-trained workforce to provide these lifesaving services.

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