NYS Council for Community Behavioral Healthcare

2027-2028 NYS Council Budget/Legislative Priorities

Targeted Inflationary Increase and other Workforce Priorities

REQUEST: Targeted Inflationary Increase + CareForce Wage Enhancement

1. Year 1: 3.4% Targeted Inflationary Increase (TII) (July '26 CPI-U)
2. Year 2 & 3: TII of at least CPI-U
3. CareForce Wage Enhancement Package: Year 1 - $2,500; Year 2 – $2,000; Year 3 - $1,500

FACTS/DATA

- A 2025 MH and SUD provider survey revealed a 34% annual staff turnover rate and a job vacancy rate that hovers between 20-30% depending on program type.
- The average annual premium for workers with insurance covered by their employer in 2024 was $8,951 for single coverage and $25,572 for family coverage. These averages were, respectively, 6 percent and 7 percent higher than in 2023. Coverage costs have continued to skyrocket since 2024.
- As of 2025, 1 in 9 New Yorkers (12% of all NYers) work in a Human Service-related job. Since 2000, Human Service wages have grown 3% while all other private employee wages have grown 12%, according to a recent survey by Forvis.
- Poverty wages drive down nonprofit recruitment and retention, which in turn reduces, even eliminates, services and access to care. Vulnerable communities, families, and individuals are at risk.

REQUEST: OASAS must develop and implement a **Community Workforce Loan Repayment Program for Addiction Professionals** (including but not limited to CASACs) modeled after the Program available to practitioners in the OMH system of care. To date, the only loan repayment available through OASAS is for OASAS state staff.

Carve Out Most BH Services From Medicaid managed care

REQUEST: Carve out most OMH mental health and OASAS substance use disorder services from the state's Medicaid managed care program and reinvest savings in OASAS and OMH systems of care

DATA:

Recent (August) OIG report that found that NYS:

- failed to ensure MMC plan compliance with MH/SUD parity requirements related to the misuse/overuse of prior authorizations
- denial rates were not comparable to those for medical care
- denial rates exceeded NYS established thresholds
- plans continued to remain non-compliant 6 years after the 2017 compliance date

The OIG report recommended improved policies/procedures and use of correction action measures like sanctions to address these problems, but NYS stipulated that even with its monitoring, required plan compliance programs, MMC plans are still committing parity violations.

The real issue is flagrant disregard for parity and other laws related to access to care and enforcement actions/citations are just the cost of doing business, in order to continue to profit and focus on their bottom line.

In general, NYS has:

- high denial rates/ inappropriate denials and when an individual has the wherewithal to actually take denials to external appeals, they prevail 60+% of the time. But this just delays/impedes essential care for those with serious MH/SUDs.
- There have been 320 citations in recent years but there are not changes to plan behavior.
- MMC plans consistently do not meet required spending requirements on actual care, they are motivated to pocket and sit on the money and have succeeded until we forced the state to act and begin recoupments which remain inadequate
- Ghost networks are also highly prevalent; AG report found 86% of plans hae them
- All while needs and wait lists grow
- This is urgent and NYS must carve out BH services from MMC

Bloomberg News reporters analyzed 2025 prior-authorization data that insurers have been required to disclose under new federal rules. The analysis found that five major publicly traded insurers (Aetna, Centene, Elevance, Humana, and UnitedHealth) denied more than 10% of standard prior authorization requests in most of their Medicare, Medicaid, and ACA plans in 2025. When patients appealed, they won roughly half the time. *In some plans, the reversal rate hit nine out of ten.*

In NYS, a Physicians for a National Health Program 2025 Report found that 64% of SUD insurance denials pursued to final appeal are overturned by third party experts; in Mental Health the overturn rate is 54%

MCOs consistently demonstrate an unwillingness to process payments in a timely manner, or at the correct rate (both Medicaid APG and commercial rates for fully funded policies are state mandated).

Regulators do not robustly oversee the BH Medicaid managed care program, nor do they enforce all laws, regulations, guidance and contract provisions pertaining to the carve in of these services, on a consistent or timely basis.

Over 300 citations against MCOs have been issued by OHIP since 2019, however only 147 are publicly available for review. Very few citations have resulted in meaningful enforcement actions. Plans see this as the cost of doing business. There are no real protections for providers in terms of timely payment for services rendered, and often MCOs are months, if not years, behind in making payments.

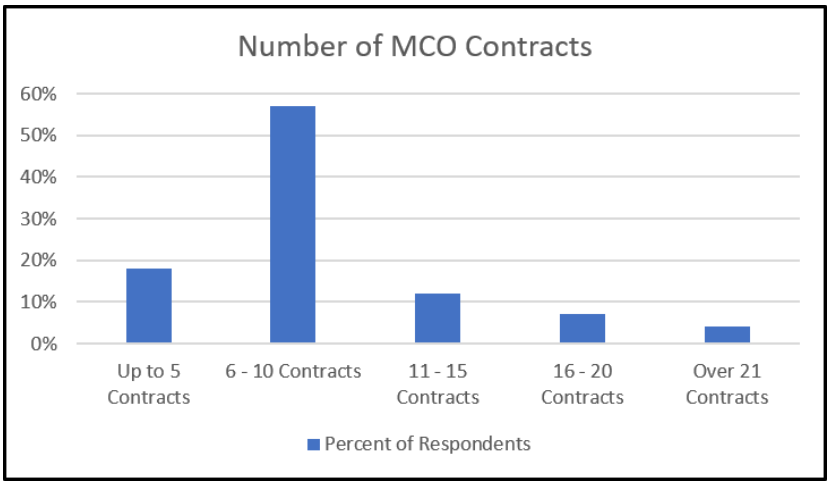
MCO use of delay and deny tactics are overwhelmingly responsible for current claims denial rates approaching 60% annually for mental health services.

MCOs clear approximately 11% of the annual total spend of Medicaid funds (conservative estimate $3-4B) for services provided to Medicaid beneficiaries with these conditions despite the plans (arguably) being the single greatest barrier to access to care. The State pays the MCOs $400M/year to 'manage' services. **A carve out would yield a minimum of over $400M in savings for reinvestment in OMH and OASAS systems of care to address workforce crisis and rate inadequacy.**

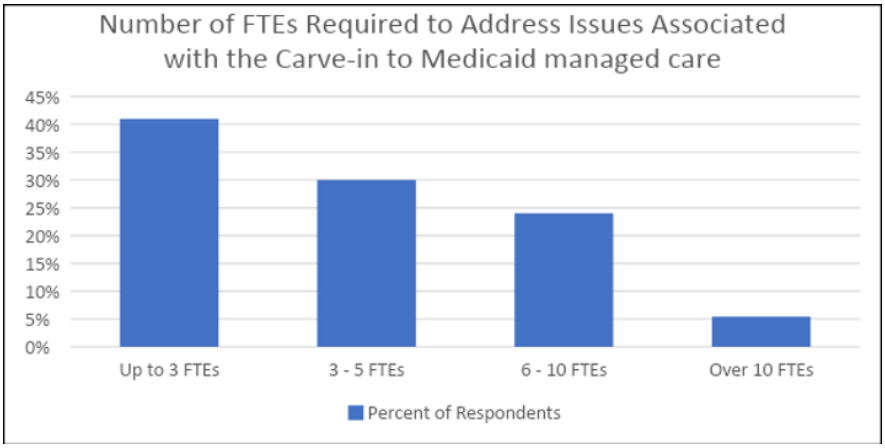
In 2022, NYS Council advocacy resulted in the OHIP (finally) enforcing a contract requirement (between the state and the MCOs) that is designed to hold MCOs to a 96% expenditure target where 96% of the funds they receive from the state must be spent on actual services for Medicaid beneficiaries. MCOs failed to meet these requirements, and for years the state failed to recoup the funds. The state is now enforcing the contract provision and to date, over $600M has been recouped from MCOs that failed to meet expenditure targets. Although recently the state implemented an appeals process for insurers so they can protest the methodology used to calculate the recoupment. This was implemented without any public notice.

According to a recent NYS Council Member Survey:

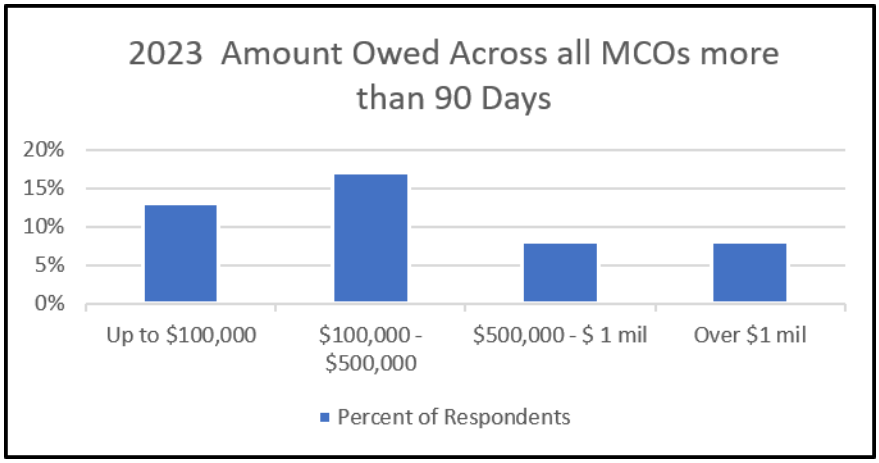
- 57% of respondents have between 6-10 Medicaid managed care contracts. All MCOs have their own paperwork requirements, and most have a poor track record of providing any type of assistance/responding to provider questions/concerns in a timely manner.



- 84% of respondents said they employed numerous staff (measured in FTEs) for the sole purpose of addressing issues associated with the carve-in of mental health and substance use disorder services to Medicaid managed care.



- The total outstanding payments due to providers from MCOs for more than 90 days was over $10 million. The minimum amount owed was $80,000 and the maximum amount owed was $3 million. In 2024, the amounts owed to providers was considerably higher as the result of the CHANGE Healthcare cyber-attack and New York's failure to require MCOs to pay claims caught up in the cyber-attack where the claim was denied for timely filing despite the fact the provider did not receive electronic remittances, or where the claim was denied for another reason using a denial code that is inaccurate. Use of inaccurate denial codes is commonplace.



Uncompensated Care, Medicaid Work Requirements and Access to Care / Continuity of Care

REQUESTS

New York State **must** double the existing funding currently available through the MHOTRS and CCBHC Demo uncompensated care and indigent Care / Safety Net pools, and *expeditiously implement a pool for OASAS providers.* Reimbursement to eligible providers must occur quarterly.

Note: *NYS Council has provided draft budget language to Executive Chamber representatives that would require the state to enact the changes (described below) to the existing Uncompensated Care and Safety Net Pools, implement a similar Pool for OASAS providers, and amend current reimbursement practices such that eligible would be paid on a \quarterly rather than yearly basis.*

DISCUSSION:

Hospitals and other institutional settings are preparing for an increase in the number of uninsured New Yorkers seeking their care once Medicaid Work Requirements are implemented, and the state has responded accordingly with almost $3.7B over two budget years to ensure viability for hospitals, nursing homes, and assisted living centers as they experience increased uncompensated care.

Given the implementation of Medicaid Work Requirements on January 1, 2027, New York State **must** have a plan to address increased numbers of uninsured New Yorkers with mental health and or substance use disorder needs seeking services from community-based mental health and substance use disorder providers that serve as the safety net for communities across New York. These essential providers will undoubtedly encounter increased numbers of uninsured New Yorkers seeking care, as well as New Yorkers who fall off Medicaid (if even for a short period of time) but who still need timely care, as the result of the January 1, 2027

implementation of Medicaid Work Requirements. Continued access to and continuity of care are particularly important when it comes to behavioral health conditions and any lapse in an episode of treatment can result in negative consequences that are costly from a human as well as a financial standpoint for the state. The way to mitigate this risk is to invest now with new (additional resources) to ensure the availability of at least partial payment in instances where a New Yorker loses his Medicaid benefits either as the result of a mistake, an oversight or because the individual has dropped out of the Program.

Currently, OMH oversees two state/federal pools of resources available to eligible providers that serve a significant number of New Yorkers with no insurance. The Article 31 (MHOTRS) Uncompensated Care Pool (federal/state), and the more recent Indigent Care Pool for CCBHC Demo providers (state only funds at present time with application for federal matching funds pending) are critical resources that must be adequately funded to preserve continui**ty of care.** **There is currently no Uncompensated Care Pool for OASAS providers.**

Not all mental health providers eligible for assistance will receive it:

- *In 2024, Article 31 MHOTRS Uncompensated Care Pool subsidized **72 providers**; all avail funds were depleted. **$17.3***
- *In 2025, MHOTRS Uncompensated Care Pool subsidized **69** providers with **$17.3M**. All available funds were depleted.*
- *In 2026, **73** providers have applied for subsidies through the Pool currently funded at the same amount as two years ago (**$17.3) despite anticipated incoming increases in uncompensated care with the implementation of Medicaid Work Requirements.***

Notes: Year over year provider need for assistance has exceeded available funds.
Not all eligible MH providers that seek assistance will receive it as resources are insufficient and reimbursement is prioritized for those with greatest need. When OMH awards UCP funds, it is never a full dollar for dollar reimbursement, the provider is always taking on a portion of the cost and reimbursement in not timely.

CCBHC Indigent Care Pool (pending federal participation)

- *In 2024 10 providers (out of 13) received assistance from Indigent Care Pool for CCBHC Demo agencies. State paid out $11.25M*
- *2025 - 10 providers (out of 26) - $20.6*
- *2026 - 11 providers (out of 39) - $22.5M*

→ There is currently nothing akin to the OMH MHOTRS or OMH/OASAS CCBHC Indigent Care pools (described above) to assist eligible OASAS providers. This needs immediate attention←

- OASAS should immediately work with the Executive and DoB to apply for a new Uncompensated Care Pool for OASAS Article 32-822 and Part 820 providers. Federal approval will take time, so OASAS should set aside state only funds for the express purpose of assisting providers seeing significant increases in uncompensated care, while the SPA for federal matching funds is being negotiated in Washington.
- OMH and the Executive should increase currently available funds in both OMH pools, by 100%.
- In both cases, **provider reimbursement cycle must be quarterly rather than annually.**
- OASAS providers that receive state aid should be permitted to apply excess funds to other OASAS programs that show financial need.
- Reimburse practitioners that provide crisis-related advocacy and referral / linkages to assist care recipients that have lost their Medicaid benefits (add a code/s for reimbursement purposes)
- Certify (and reimburse) providers for the time re-directed to train and 'certify' staff to be able to intervene with care recipients as needed.

Insurance Reform

REQUESTS

1. Prompt Payment Statute Reform
    - Implement mandatory sanctions on state and MCOs for missing timely payment and related laws/regulations.
    - Implementation of commercial rate mandate must include robust state surveillance, monitoring and enforcement.
    - Mandatory financial sanctions on MCOs and commercial insurance plans that fail to pay on time and in full.
        - Prohibit pre-payment reviews by plans.
        - Prohibit retroactive payment reviews and takebacks after 1 year has elapsed.
2. Strengthen and accelerate steps leading to financial enforcements against MCOs in the crosshairs as result of MCO non-compliance with relevant laws, regulations, guidance, and contract terms.
3. Address commercial insurance non-compliance in which certain insurers are still not reimbursing CCBHC Demo providers at the correct (PPS) rate, where eligible for this rate.

EXPAND New York's CCBHC Program

REQUESTS

- Rebase language in current 600.1 draft regs must be omitted.
- Expedite process by which MHOTRS providers can qualify to offer CCBHC services paid at PPS rate.

- Double the funds currently available in the CCBHC Demo Pool to ensure viability given anticipated increase in numbers of New Yorkers seeking care that have no insurance.

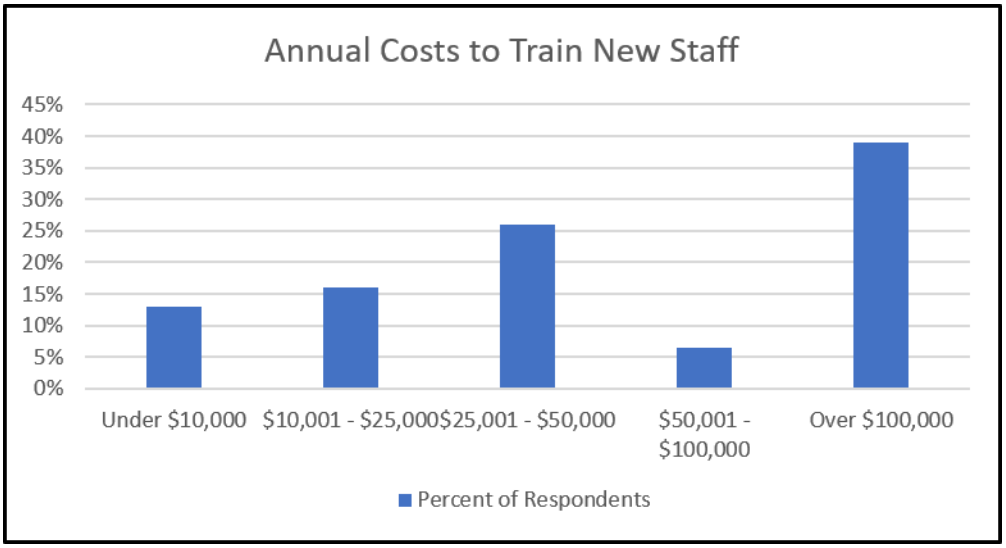
Scope of Practice Reform

REQUESTS

- Immediately improve turnaround times at SED/OP for processing of applications for licenses, permits to include Diagnostic Privilege credential.
- Contract with several regional colleges that can offer the course work some LMHCs must now complete to practice at the top of their scope, AND allocate funding that can subsidize the expense associated with some MHCs going back to school to complete required course work in order to earn Diagnostic Privilege.
- Designate certain existing CEU courses as acceptable for purposes of LMHC obtaining the additional credit hours, they need to practice at top of their scope and satisfy the educational requirements for 'old' LMHCs.

According to a NYS Council's September 2024 Member Survey:

- 39% of respondents reported it costs over $100,000 annually to train new staff, and when you add in all costs (not just training) associated with constant turnover, the average is $400k/year.



Administrative/Regulatory Flexibility

REQUESTS

- OASAS and OMH intake standards should conform with federal standards which are far less aggressive than NYS requirements.

- Accelerate implementation timeline for implementing new joint licensing program enacted via legislation in June 2026.
- Justice Center Regulatory Reform project
- Medicaid provider validation/revalidation process is currently taking more than two months to complete due to system delays on state side – this must be immediately addressed, and certainly prior to Jan. 1, 2027.
- OMH Part 551 draft regs – there should be no requirements for providers in good standing to be required to notify state re: census changes and seek approval prior to expanding access to care.
- Background Checks Flexibility and Streamlining package of reforms
- Community Workforce Loan Repayment Program for Addiction Professionals (through OASAS) modeled after the Program available to practitioners in the OMH system of care.
- CCBHC re-base rules must be clear, concrete and fixed

Children and Youth Services

REQUESTS

- Class Action: Increase transparency of and stakeholder participation in the work of the state advisory group assembled to identify class action implementation plans.
- Outpatient Rate Reform Enhancement proposal: Calls for $214M to be appropriated to rates/contracts of BH providers serving children and youth.

Critical Data Points:

- In NYS in 2023, 11.7% of youth with private insurance had insurance that did not cover mental or emotional problems, ranking it 41st among other states (*https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf*)
- In NYS in 2023, 53% of youth with major depression did not receive mental health services in the past year (*https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf*)
- In NYS in 2023, 11% of youth are experiencing severe major depression and 16% of youth had at least one major depressive episode in the last year (*https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf*)
- 3,065 children and young people age 0-24 for hospitalized for self-harm in 2019, and 6,545 were admitted to an Emergency Department for self-harm (*https://nyshc.health.ny.gov/web/nyapd/suicides-in-new-york*)

For more information contact Lauri Cole, Executive Director, NYS Council for Community Behavioral Healthcare at (518) 461-8200 or lauri@nyscouncil.org Our website address: www.nyscouncil.org *Note*: The NYS Council is represented by Marcy Savage from Reid, McNally and Savage Government Relations. You can contact Marcy at (518) 505-2325.