TEAM UP | SCALING & SUSTAINABILITY CENTER™

Exploring Opportunities to Expand Behavioral Health Services in New York City

NYC Systems-Level Landscape Analysis

BOSTON MEDICAL CENTER

August 2024 – August 2025

Funding for the NYC TEAM UP Roadmap has been provided by The Carmel Hill Fund.

manatt

To:	TEAM UP Scaling and Sustainability Center
From:	Manatt Health
Date:	July 15, 2025
Subject:	New York City Systems-Level Landscape Analysis: Strategic Implications for TEAM UP

Introduction

This memo outlines strategic considerations for advancing and sustaining the TEAM UP model in New York City, including market-entry decisions, partnership development, and policy engagement strategies. Drawing on Manatt's existing knowledge and expertise in New York, as well as new research conducted for TEAM UP, it describes key features of New York's healthcare landscape, including the structure for administering the State's healthcare programs, coverage and delivery of primary care and behavioral health care for children, and relevant policy initiatives and financing strategies. We conclude the memo with discussions of the implications and recommendations for TEAM UP as it weighs an expansion into New York City.

Table of Contents

Administrative Structure of New York's Healthcare System

New York's healthcare system is governed by a complex and fragmented administrative structure. Four State agencies — the Department of Health (DOH), the Office of Mental Health (OMH), the Office of Addiction Services and Supports (OASAS), and the Department of Financial Services (DFS) — share responsibility for overseeing components of health care delivery across the State. While each agency operates with distinct agendas, staff resources and expertise, and stakeholder communities, they are tasked with co-regulating key healthcare programs. This can result in misaligned priorities, inefficient processes, and even competition for limited State resources. The agencies are funded through the State budget process, with the State fiscal year running from April 1 to March 31.

At the city level, the New York City Department of Health and Mental Hygiene (DOHMH) serves as the primary health authority, with both primary care and behavioral health-focused programs. DOHMH is one of the largest public health agencies in the world, responsible for implementing public health programs tailored to New York City's unique demographics and challenges. DOHMM is funded through the City budget process; the city's fiscal year for the city runs from June 1 to May 31.

Broadly speaking, the State agencies are responsible for developing and managing statewide programs and initiatives, regulating payers and providers, licensing and certifying healthcare professionals, overseeing statewide health data collection and surveillance, and providing oversight and support to local health departments; New York City DOHM runs citywide public health programs and campaigns, can adopt more stringent health regulations than the State's, provides free or low-cost clinical services for city residents (e.g., STI testing, immunizations), and manages local health inspections.

Despite overlapping areas of focus between State and city agencies, there is often limited alignment in policy execution, data sharing, and programmatic integration. This siloed approach has led to redundant reporting requirements and administrative burdens for providers who must work with both the State and the city. For TEAM UP to enter the New York City market, it will need to navigate both city and State-level regulations, initiatives and policy goals.

Coverage of Children's Primary Care and Behavioral Health Care

New York City currently boasts near-universal health coverage for children, with only 2.6% of children remaining uninsured. The primary sources of coverage are Medicaid and Child Health Plus ("CHP," the State's Children's Health Insurance Program), which together serve approximately 56% of the city's pediatric population.

- Medicaid Managed Care (MMC): Most Medicaid-eligible children are enrolled in one of nine MMC plans operating in New York City. These plans cover children up to age 20, with eligibility extending to families earning up to 154% of the federal poverty level (FPL). There are no premiums or copayments for this population.
- Child Health Plus (CHP): CHP covers children up to age 19 in families earning between 154% and 600% of the FPL. Premiums are income-based and, currently, children can enroll regardless of immigration status.

Three plans—Healthfirst, Fidelis Care, and MetroPlus—account for approximately 75% of Medicaid and CHP enrollment in New York City. Two of these three plans are provider-sponsored non-profit plans: MetroPlus is owned by New York City Health + Hospitals (NYC H+H) and Healthfirst is owned by 18 downstate hospitals, including several H+H hospitals.

Both Medicaid and CHP cover a robust suite of behavioral health services, such as Children's Home and Community-Based Services (HCBS), Children and Family Treatment and Support Services (CFTSS), Health Home Care Coordination, High-Fidelity Wraparound, and Youth Assertive Community Treatment (ACT).

The high rate of coverage and relatively broad scope of covered benefits in New York State, including in New York City, likely will be disrupted by policies advanced in the 2025 One Big Beautiful Bill Act (OBBBA), including its new restrictions on eligibility for immigrants and work requirements for certain adults. OBBBA slashes federal funding for public coverage programs and makes it more difficult for individuals to access coverage, including substantial changes in how Medicaid and New York's Essential Plan (EP) are funded and operated, which will place enormous strain on New York's healthcare system. New York has estimated that OBBBA will cost the State $13.5 billion annually as a result of lost federal funding and new State costs. Given the magnitude of the cuts to federal funding, New York has noted that it will be impossible for the State to absorb the impacts and that significant changes to eligibility, financing and benefits will be required.

Delivery System Serving Children

Settings and Practices Delivering Primary Care and Behavioral Health Care

Hospital-based practices provide a significant portion of pediatric primary care to Medicaid and CHP-enrolled kids in New York City. FQHCs, school-based health centers, and private practices also play a key role.

- **Hospital-Based Clinics:** The primary providers of pediatric care for Medicaid and CHP enrollees, these clinics are often located within or affiliated with major hospital systems.
- **Federally Qualified Health Centers (FQHCs):** While there are many in the city (496 total), not all FQHCs offer robust pediatric services.
- **School-Based Health Centers (SBHCs):** Totaling 146 across the city, SBHCs typically operate in partnership with hospitals. The carve-in of SBHC services into MMC continues to be delayed at the State level (currently slated to occur no sooner than April 1, 2026); these services continue to be reimbursed through the Medicaid fee-for-service system.
- **Private Practices:** These serve a smaller share of the Medicaid and CHP pediatric population and are more prevalent in areas with limited hospital or FQHC capacity.

Key Players in New York City Delivery System Serving Children

Hospital-Based Clinics		FQHCs	
Providers	**Location**	**Providers**	**Location**
NYC H + H	All boroughs	**SOMOS Community Care**	Bronx
BronxCare	Bronx	**Institute for Family Health**	Bronx, Manhattan, Brooklyn
Maimonides	Brooklyn	**Sunset Park Health Council**	Manhattan, Brooklyn
Montefiore	Bronx	**Bronx Community Health Network**	Bronx, Queens
Mount Sinai	Manhattan		
Northwell	Brooklyn, Manhattan, Queens	**Urban Health Plan**	Bronx, Queens
NYU Langone	Manhattan, Brooklyn		

Spotlight: New York City Health + Hospital

NYC H+H, the city's municipal hospital system, plays a core role in the delivery of care to children across New York City and we recommend TEAM UP consider it as a central component of its approach to piloting and deploying its model in New York City. See below for more on NYC H+H.

NYC Health + Hospital is the largest municipal health care delivery system in the U.S., serving more than 1 million patients annually across all 5 boroughs of the City.

Acute Care Hospitals

10 locations across the Bronx, Brooklyn, Manhattan and Queens

All locations have pediatric emergency departments and 6 have psychiatric emergency departments

Gotham Health Centers

6 large centers and many smaller practices, located in high-need areas

Primary care services offered at each location based on assessed neighborhood need

Primary Care

For adult and pediatric patients, offered at hospital and community-based locations across all boroughs

Behavioral Health Care

Providing inpatient and outpatient services, e.g., Comprehensive Psychiatric Emergency Program (CPEP), Outpatient Clinics, Intensive Outpatient Programs, Services for Youth, ACT, and Partial Hospitalization

Known Access and Quality Issues

Despite New York's robust coverage of behavioral health care through Medicaid and CHP, access to care remains a significant challenge. Like many parts of the country, the capacity of New York

City's child and adolescent behavioral health delivery system is limited. Over half (56%) of New York City children report difficulty accessing mental health care when they need it. Leading causes of these access challenges include:

- **Workforce shortages**, particularly among providers of color, non-English-speaking clinicians, and those trained in evidence-based practices;
- **Providers not accepting public coverage**, such as Medicaid and CHP, or other forms of insurance; and
- **Misaligned service availability with areas of greatest need**, particularly in low-income neighborhoods, exacerbating disparities in patient experience and outcomes.

Integration of Physical and Behavioral Health

In part driven by the reasons highlighted above, New York City's behavioral health care delivery system includes significant siloes: it is common for families to need to visit entirely separate providers to address their children's physical and mental health needs. Coordination between parts of the healthcare system (as well as related social service providers) can be limited, leading to a fragmented care experience.

In 2014, New York State began implementation of its Delivery System Redesign Incentive Payment (DSRIP) Program, an initiative established under a now-expired Medicaid 1115 waiver that drove billions of dollars to largely hospital-based "Performing Provider Systems" (PPS) to implement specific projects in support of the overarching goal of reducing hospital readmissions. One such project was primary care/behavioral health "co-location." All 25 PPS opted into the co-location project, which focused on the adult population and involved spatially-adjacent clinical care delivery, warm handoffs, and care teams to advance physical and behavioral health integration. However, the lack of sustainable funding following the DSRIP demonstration period has resulted in very few entities being able to maintain these efforts, much less expand them to younger patient populations.

Beyond the DSRIP co-location project, New York State has not endorsed a specific integrated behavioral health model. HealthySteps has made inroads with New York State policymakers, though, successfully advocating for increased funding and reimbursement for integrated care for young children. For example, the State's Fiscal Year 2024 budget included a $12 million in additional funding for the HealthySteps program, with the aim of adding up to 50 HealthySteps clinics Statewide. Similar State-level investments have not been made in integrated care for school-aged and older children who are not served by the HealthySteps model.

New York State has implemented regulatory reforms that seek to increase coverage of integrated care, though. For example, the State instituted Medicaid billing for preventive behavioral health services (effective April 2023), reimbursement for additional provider types (e.g., community health workers) effective January 2024, and increased provider licensure thresholds to facilitate integrated care delivery (effective October 2024). Both the financing strategy section of this memo and the Working Session 1 deck include additional information on these initiatives and how they may relate to TEAM UP's model.

Technical Assistance Resources for Providers Offering Integrated Care

Despite the lack of sustained investment in integrated care, there are some resources available in New York City and across the State to support practices and providers taking steps toward

more integrated primary and behavioral health care. Some of the most relevant potential resources include:

- **Project TEACH NY:** An OMH-funded program that provides child health providers with consultations and referrals to tele-psychiatry services and offers resources such as guidelines for incorporating screening and treatment of behavioral health into pediatric primary care settings.
- **Training and Technical Assistance Center (TTAC):** Through a partnership between New York University's McSilver Institute and the New York Center for Child Development, TTAC offers in-person and web-based trainings and a range of resource materials for professionals who work with children age zero through five. The resources are designed for mental health professionals serving children and their families in the New York City DOHMH-funded Early Childhood Therapeutic Centers, as well as professionals working in New York City outpatient mental health clinics; Early Intervention, Universal Pre-K and Early Learning sites; and other child-serving systems.
- **Technical Assistance Center for Children's Behavioral Health Providers:** OMH is actively seeking a contractor to develop a dedicated training and technical assistance center focused on assisting New York's behavioral health providers with enhancing care quality for children. The award for this RFP was expected in July 2024, but it has not yet been issued and no recent updates have been provided.

Relevant City and State Policy Priorities and Initiatives

Following the COVID-19 pandemic, increasing access to behavioral health care and improving behavioral health outcomes were key priorities at both the city and State levels. However, sustained funding and attention to these priorities is challenged by competing priorities, such as the State's new 1115 waiver program (called "NYHER" and discussed below) that largely focuses on health-related social needs, and longstanding issues with safety net hospital financing and managed long term care enrollment and costs. All of this is exacerbated by the drastic cuts to federal funding for New York's healthcare programs, as noted above. This loss of funding, paired with other changes in the federal OBBBA legislation, will result not only in significant coverage losses but also State and local policymakers needing to focus their more limited resources on minimizing those coverage losses and implementing new program requirements (e.g., increased redeterminations, work requirements in Medicaid, potential changes to the Essential Plan). Still, the State has made several recent investments in behavioral health worth noting:

State-Level Initiatives

- **$1 Billion Mental Health Investment:** Initially allocated in the Fiscal Year 2024 State budget, this initiative aims to combat past underinvestment in behavioral health and seeks to expand access, reduce wait times, and ensure appropriate levels of care. Funds are being distributed through OMH-administered RFPs.
- **New York Health Equity Reform (NYHER) 1115 Waiver Amendment:** The waiver amendment was originally approved in January 2024, with many of the waiver initiatives beginning implementation in early 2025. While the waiver did not include any behavioral health integration-specific initiatives, it includes $694 million for workforce

investment and retention for primary care and behavioral health providers, administered through two programs:

  - Career Pathways Program (CPT) a new program designed to build the healthcare workforce—including Licensed Mental Health Counselors, Masters of Social Work, Community Health Workers, and Patient Care Managers—by funding training and education for both career advancement and new careers.
  - Loan repayment for providers who meet certain metrics regarding serving Medicaid and uninsured members.

Of note, the future of New York's 1115 waiver, which is due for renewal in April 2027, is also at risk of being terminated or not renewed by the federal government. The Trump Administration has already taken steps to scale back CMS' Making Care Primary model that New York sought to leverage as a complement to its 1115 waiver, as well as steps to curtail certain waiver funding mechanisms used by New York (e.g., elimination of the use of Designated State Health Program (DSHP) to help finance the non-federal share of the cost of the 1115 Waiver). We understand that DOH is in the process of drafting the next iteration of its 1115 waiver amendment and plans to release it for public comment in late fall 2025. While the scope of innovative initiatives will likely be scaled back in the State's next waiver application, it is possible that the 1115 waiver renewal process will offer an opportunity to raise the importance of integrated primary and behavioral health care for Medicaid enrollees, including children, youth and their families.

- **Patient Centered Medical Home (PCMH):** PCMH is New York's main primary care innovation model and has been the primary vehicle for distributing supplemental payments to primary care providers over time. Under the NYHER waiver amendment, PCMH practices can receive enhanced payments for demonstrating improvement on a suite of quality measures, including some related to behavioral health integration.

City-Level Initiatives

- **Care, Community, Action: Mental Health Plan for New York City:** New York City's strategic plan prioritizes children, youth, and families, emphasizing prevention, early intervention, and coordinated care. However, implementation timelines and measurable outcomes remain unclear.

TEAM UP's model is well aligned with these policy priorities, offering a concrete way to make integrated care a reality for many of New York City's children and their families, as well as potentially assisting with the workforce challenges and other issues that have slowed progress on integrated care in the past.

Financing Strategies for Integrated Behavioral Health Efforts

To ensure the TEAM UP model is both scalable and sustainable in New York City, Manatt encourages TEAM UP to consider pursuing a dual-track financing strategy that addresses immediate implementation needs while laying the groundwork for long-term structural support.

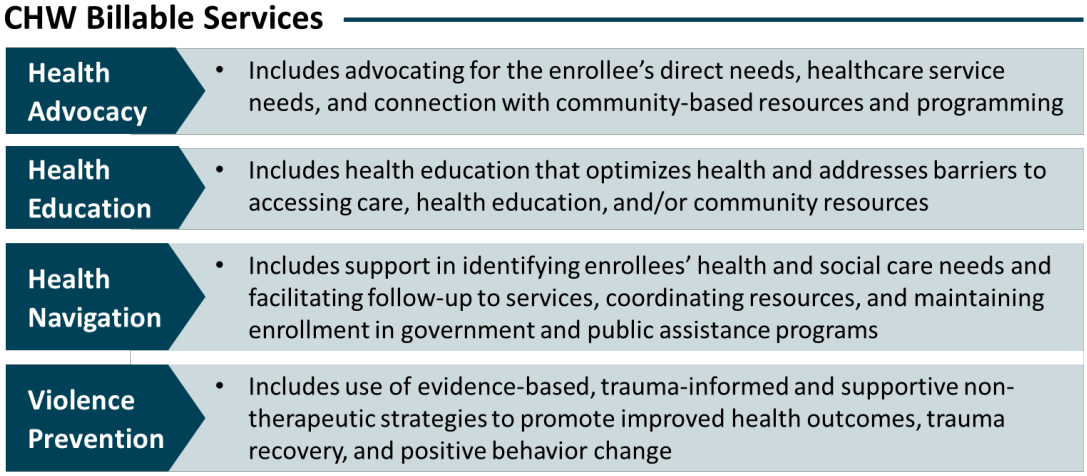
Near-Term Strategies

In the near term, TEAM UP could look to existing Medicaid reimbursement pathways and regulatory flexibilities to support core components of the model. These mechanisms offer

immediate opportunities to fund workforce capacity, service delivery infrastructure, and care coordination functions.

Community Health Worker and Behavioral Health Clinician Services

Community Health Worker (CHW) Services. Since January 2024, New York Medicaid has reimbursed CHW services for a range of non-clinical activities including health advocacy, education, navigation, and violence prevention. These services, described in more detail in the figure below, are available to children under 21 and other high-need populations. A licensed clinician must supervise the service in order for it to be billed. CHW services can be delivered under the supervision of providers within Article 28 clinics and FQHCs, though there are specific considerations for how CHW services should be billed (i.e., they are carved out of PPS rates when delivered as a standalone service, but when delivered as part of a "comprehensive encounter," where other services are also provided, the FQHC should bill the PPS rate). See the Working Session 2 slide deck for additional resources on specific billing codes and rates for CHW services. While the population eligible for CHW services and the number of participating providers have expanded since January 2024, MMC plans report limited uptake of CHW services to date.



Services Provided by Behavioral Health Clinicians. Behavioral health clinicians — including Licensed Clinical Social (LCSW) Workers, Licensed Masters Social Workers (LMSW) acting under supervision, and Licensed Mental Health Counselors (LMHC) — can be reimbursed under New York's Medicaid program for a broad array of services, such as psychotherapy, crisis intervention, and psychosocial rehabilitation services (see figure below). Reimbursement rates vary by provider type and service duration, and billing requirements differ by setting. See the Working Session 2 slide deck for additional information and resources on specific billing codes and rates.

We recommend TEAM UP prioritize partnerships with providers that are already positioned to bill for CHW and behavioral health clinician services and could enhance these partnerships by offering technical assistance aimed at optimizing billing practices and maximizing revenue capture.

New York State-Funded Collaborative Care Medicaid Program (CCMP)

The CCMP offers monthly case payments to physical health providers, serving enrollees age 12 and older, that implement the Collaborative Care Model (CoCM) for depression and anxiety treatment. Eligible practices must meet staffing and infrastructure requirements (see below).

CCMP Practice Eligibility

Reimbursement open to **physical health providers**, **serving enrollees 12 years and older** (i.e., Pediatrics, Family Medicine, Internal Medicine, Women's Health). Does not include Article 31 clinics.

To qualify, practices must have appropriate team members and resources in place, including:

- Behavioral Health Care Manager (recommended to be a licensed clinician)
- Designated Program Lead
- Data Manager
- Billing Lead
- Psychiatric Consultant and a minimum of 1 hr/week designated for consultation
- Registry to manage your Collaborative Care Caseload
- Standardized screening process using the PHQ-9
- Warm connection to the Behavioral Health Care Manager

Practices must apply to OMH and be accepted for program participation in order to bill Medicaid for CCMP reimbursement. TEAM UP could consider assessing the feasibility of adapting its model to meet CCMP eligibility criteria and support partner practices in applying for and operationalizing CCMP using the TEAM UP model.

Regulatory Authorities Supporting Integrated Care

New York has taken regulatory actions that provides new opportunities to pay for integrated care in Medicaid. As of April 2023, Medicaid reimburses for preventive mental health services — including individual, group, and family psychotherapy services — for children without a formal behavioral health diagnosis and their caregivers. Z-code Z65.9 is used to indicate medical necessity for the specified services for Medicaid enrollees under 21 who do not have a behavioral health diagnosis.

In October 2024, New York implemented regulation to allow primary care providers to deliver up to 30% of their visits as behavioral health services without having to acquire additional licensure from OMH or OASAS, reducing administrative barriers to integration.

We recommend that TEAM UP consider how to leverage these regulatory flexibilities in the implementation of its model and identify ways to support practices in using these options to promote access to and reimbursement of integrated care.

Long-Term Strategies

To ensure the TEAM UP model is financially sustainable beyond initial implementation, it is critical to pursue more durable funding mechanisms that use a combination of State-level investment, payer partnerships, and alignment with broader system transformation initiatives. As a result of the OBBBA, and the substantial cuts to Medicaid and public coverage funding, New York will be operating in a constrained fiscal environment for the coming years and policymakers will likely be focused on implementing cost-saving provisions and identifying efficiencies in the Medicaid program. Given these priorities, we recommend TEAM UP highlight the cost effectiveness of its model as it lays the foundation for long-term funding for integrated care.

State-Driven Financing

TEAM UP may wish to pursue targeted State appropriations to support model adoption and scale. This approach has precedent: HealthySteps and Project TEACH have secured long-term funding through targeted State appropriations. While promising, this strategy is subject to the uncertainties of the annual State budget process and federal funding dynamics and, importantly, requires significant investments in sustained advocacy over years — to build legislative champions and effectively "make the case" to the Executive that the model is cost-effective, scalable and needed to achieve desired outcomes.

TEAM UP could consider whether to adopt a multi-year advocacy strategy focused on securing State appropriations in the future. Advocacy efforts could also include identifying opportunities to build coalitions with interested stakeholders and aligning TEAM UP's approach with existing State initiatives. An advocacy strategy would also be bolstered by data from pilot projects that demonstrate the positive impacts of TEAM UP.

Payer-Led Initiatives

We recommend TEAM UP also explore opportunities to integrate into existing or new payer-provider arrangements, including:

- Value-Based Payment (VBP) arrangements — While no longer mandated by State policy, VBP arrangements remain active in several systems (e.g., NYC H+H) and could support integrated care delivery. Some provider partners may have relevant experience using VBP to drive integrated care, as behavioral health integration for the adult population was part of several previous DSRIP VBP projects.
- In Lieu of Services (ILS) authority — ILS allows Medicaid plans to propose cost-effective alternatives to traditional, State Plan-covered benefits. Using ILS to support integrated care would be a new use of the authority in New York (which has approved 3 ILS programs since 2019), but TEAM UP could look into how such a program could be structured for approval in the future and engage in conversations with targeted

stakeholders (plans, provider partners, DOH or OMH) to understand the level of openness to develop such a program. This, too, would take some time and effort to determine and potentially advance.

We recommend TEAM UP engage key MMC plans to identify potential opportunities to help plans advance their priorities *through* TEAM UP interventions, as plans may have other programs available that could fund TEAM UP activities.

Multi-Stakeholder Initiatives

TEAM UP may also align with the New York City Behavioral Health Centers of Excellence (COE) program, which incentivizes Medicaid plans and providers to expand behavioral health capacity and improve quality. The model is primarily focused on individuals with higher level of need but there are components of the programs focused on enhancing outpatient care and behavioral health provider capacity that align with TEAM UP's priorities. This initiative offers a potential platform for TEAM UP to demonstrate impact and secure performance-based funding.

TEAM UP could consider initiating conversations with NYC H+H, and other COE participants, to explore pathways for integrating the model into COE quality improvement activities and funding streams.

Implications for TEAM UP

We recommend that TEAM UP aim to advance its model in New York through strategic partnerships that will demonstrate the model's *value* to providers, payers and the State, aligned with the key interests of each group. When looking toward piloting and scaling the program, we recommend TEAM UP consider the following recommendations.

Strategic Partnership

TEAM UP could consider positioning its model as the platform for system integration for school-aged children. The model's alignment with Medicaid billing, regulatory reforms, and collaborative care infrastructure positions it as a scalable platform for integrated behavioral health delivery in pediatric primary care.

TEAM UP could also consider leveraging strategic partnerships to accelerate adoption and generate early data demonstrating the model's impact. We recommend TEAM UP work with NYC H+H to deploy TEAM UP for school-aged children who are not currently served by existing programs; leveraging H+H's familiarity with integrated care to facilitate initial implementation and to serve as a pilot for demonstrating the model's efficacy in New York City. TEAM UP could also consider partnering with one FQHC provider where the TEAM UP model can support the center's adoption of integrated care for children.

Diversified Funding Streams

We recommend TEAM UP aim for an approach that relies on multiple fundings streams and supports progress toward long-term, sustainable funding. In the near term, TEAM UP could consider working with identified partner practices to maximize funding for the model by leveraging — and, where possible, expanding on — existing payment arrangements or reimbursement pathways.

Over time, we recommend TEAM UP pursue an advocacy strategy aimed at securing targeted State funding through budget appropriations to support adoption of the model and

complementary billable services. Additionally, TEAM UP could consider engaging DOH, OMH and Medicaid plans on new opportunities to fund opportunities to advance integrated care, including through the Behavioral Health COE program and/or plan financing opportunities.

*****

Please do not hesitate to contact the Manatt Team with any questions: Jocelyn Guyer (JGuyer@manatt.com), Hailey Davis (HDavis@manatt.com), and Alex Singh (ARSingh@manatt.com)