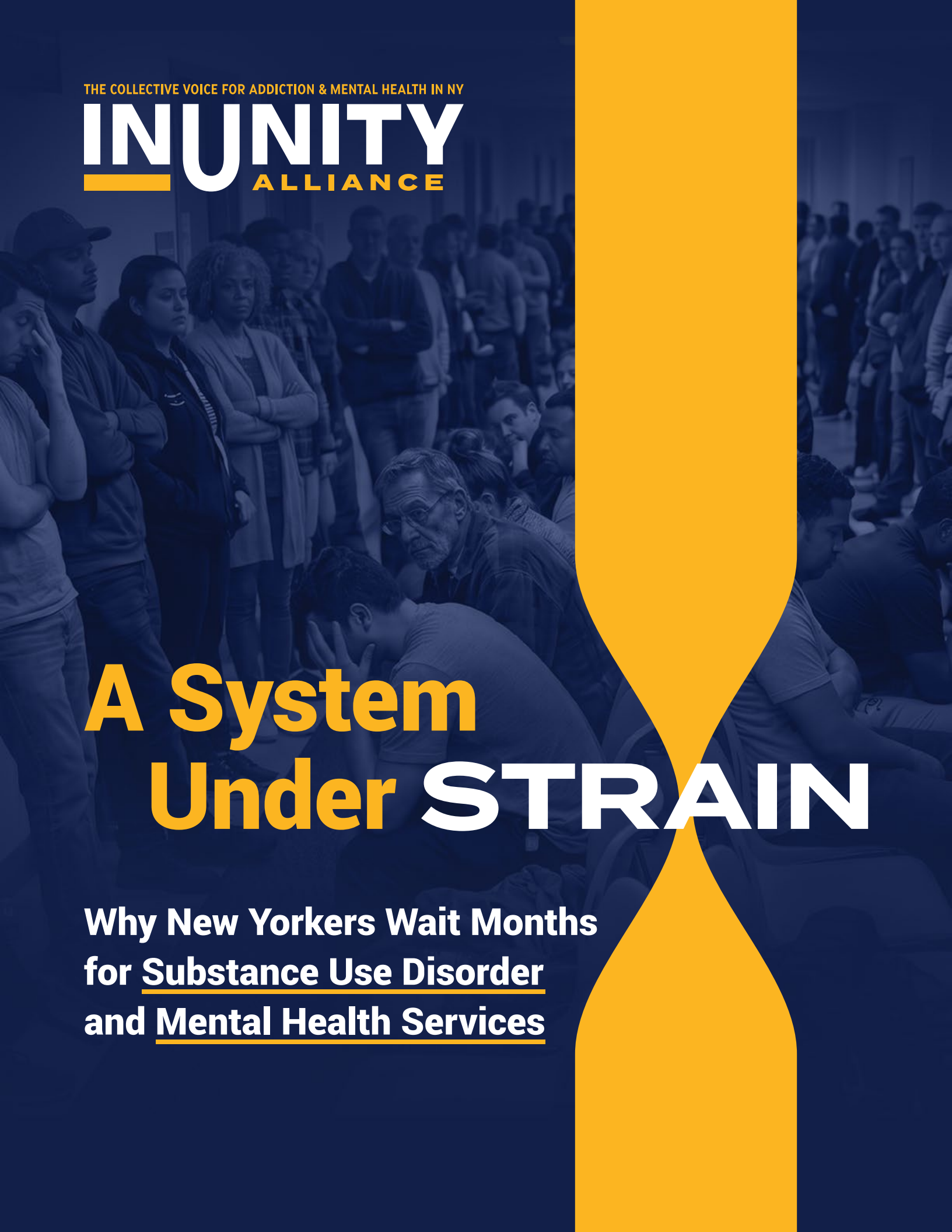
THE COLLECTIVE VOICE FOR ADDICTION & MENTAL HEALTH IN NY

INUNITY ALLIANCE



A System Under STRAIN

Why New Yorkers Wait Months for Substance Use Disorder and Mental Health Services

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INUNITY ALLIANCE

About IUA

InUnity Alliance is a community of more than 150 community-based organizations and professionals that provide essential substance use disorder and mental health services to individuals and families across New York State. We provide strategic advocacy and representation, offer workforce training and credentialing, and convene cross-sector partners to develop solutions that protect and advance access to substance use disorder and mental health services.

Our Mission

Our mission is to promote equitable access to timely, high-quality substance use disorder and mental health services by advancing community-led policies and solutions in prevention, treatment, and recovery.

InUnity Alliance extends its sincere gratitude to the **Altman Foundation** for their generous support, which made the development and publication of this report possible.

Executive Summary

Substance use disorders (SUD) and mental health (MH) conditions are leading contributors to disability and preventable death. They are also closely associated with housing instability, child welfare involvement, and contact with the legal system. Despite recent investments and improved access to limited services, New Yorkers still wait months for needed care, or never receive it, with some communities facing significantly greater barriers.

This report provides a snapshot of factors influencing the capacity of New York State's (NYS) community-based SUD and MH service system and recommendations to support timely access. The analysis draws on Consolidated Fiscal Reports, two focus groups, and a survey of 50 service providers statewide, 26 of whom completed it.

> **In 2024, 80% of U.S. residents with a substance use disorder did not receive care; more than 48% with a mental illness did not receive any mental health services.**

Substance Abuse and Mental Health Services Administration. (2025). Results from the 2024 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf

Key findings (prior 12 months) show that service providers are mission-driven and committed to meeting community needs while navigating financial and operational challenges that limit service capacity:

- Twenty-two organizations had 39 SUD and 81 MH programs operating at a deficit.
- Across payer types, the average time to receive payment was 70 days.
- Seventeen spent ~41,000 hours on insurance prior authorizations and denials.
- Twenty spent ~7,000 hours on follow-up for state and county grant procurement delays.
- Across twenty-three respondents, 3,237 care recipients lost or experienced coverage disruptions due to Medicaid recertification.

The high-level considerations, including four priorities are included in the report:

1) Identify financially unsustainable programs early and implement strategies to preserve access to services.
2) Evaluate the impact of insurance and grant processes and payment delays on timely access to care and service availability, and how different models may influence these outcomes.
3) Reassess workforce requirements to sustain high-quality care and expand timely access, including allowing professionals to practice at the full scope of their credentials.
4) Identify challenges and develop strategies to mitigate Medicaid coverage disruptions for people who need SUD and MH care, including the destabilizing impacts of sudden increases in uncompensated care on service providers.

Addressing these structural challenges requires immediate action. Timely access prevents illness onset, reduces the risk of crises, and helps adults, children, and families maintain long-term recovery, offering the most cost-effective approach to preventing and managing SUD and mental illness.

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Background

Substance use disorders (SUD) and mental health (MH) conditions are chronic, treatable illnesses that impact overall health and life expectancy across New York State (NYS) and intersect with housing instability, child welfare involvement, and legal system contact.[iii] In NYS, community-based services help prevent the onset of SUD and many mental illnesses, reduce hospitalizations, support safe transitions back to the community, and form the foundation for effective, lasting recovery. Maintaining access requires stable infrastructure and workforce capacity; when service providers face financial strain, continuity of care and community health are at risk, particularly for underserved communities.

Current State

Mission-driven SUD and MH community-based service providers are challenged to meet community needs within uniquely complex reimbursement and regulatory structures.[iii] State and national analyses point to long-standing underinvestment and a disconnect between payment and the true cost of delivering high-quality, person-centered SUD and MH care.[ivvvivii] Service providers continue to adapt to complex managed care billing and oversight requirements while maintaining services with chronic resource constraints.[viiiixxxi] As a result, waitlists continue to grow, and entry points to services remain limited, delaying access when early intervention is proven to be most protective and cost-effective.[xiixiiixiv]

These resource constraints also limit the ability to advance evidence-based practices, strengthen quality improvement efforts, and use data to optimize service delivery.

> **Every $1 invested in evidence-based SUD prevention results in a return of up to $63.**

Prevention Technology Transfer Center (PTTC) Network. (2024, September 27). The return on investment of substance use prevention. https://pttcnetwork.org/wp-content/uploads/2024/10/2024.09.27_PTTC_Return-on-Investment_FINAL.pdf

Emerging Policy and Funding Pressures

Medicaid Policy Changes

Federal Medicaid policy changes, including more frequent eligibility redeterminations, reduced retroactive coverage, and work or community engagement requirements, will increase administrative burden and interrupt insurance coverage. Without intervention, these policies will further delay treatment, disrupt therapeutic relationships, and widen gaps in access, putting adults, children, and families at tremendous risk of preventable hospitalizations and long-term harm.

Reprioritization of Grant Funding

Decades of underinvestment have left SUD and MH organizations reliant on state and federal grants to sustain services. Some services, like prevention, are 60-90% reliant on federal funding, according to a separate 2025 InUnity Alliance survey. Shifts in federal priorities are destabilizing this funding, putting service capacity and access at risk, particularly for grants focused on identifying and addressing specific barriers to services faced by underserved communities.

This report examines the financial and policy conditions that influence access, capacity, and sustainability of community-based SUD and MH services.

Methods

This assessment employs qualitative and quantitative mixed-methods, including two focus groups(June 2025), a statewide survey(July 2025), and an analysis of 2024 Consolidated Fiscal Reports (CFRs). Ten senior leaders, representing diverse services statewide, participated in the focus groups. Fifty organizations representing all New York State counties participated in the survey; 26 completed it.

The CFR analysis included 458 organizations: 146 receiving funding from the Office of Addiction Services and Supports (OASAS), 223 from the Office of Mental Health (OMH), and 89 from both agencies. Twenty-eight were proprietary. Organizations not required to submit a full CFR, as well as hospitals, schools, and local government entities, were excluded.

The Bonadio Group A-Score, a financial model for non-profits based on CFR data, was used to measure financial sustainability.

Limitations

Findings draw on a sample of services that may not fully represent all community-based SUD and MH service providers across New York State. Participation was voluntary and may reflect the experiences of organizations facing varying levels of challenges. In addition, data were examined at the organizational level rather than the program level, where structures and services can vary widely. Given the complexity of these issues, the report focuses on high-level analysis and considerations, with more detailed, actionable next steps in development.

Results and Recommendations

These findings point to a set of interconnected factors that drive timely access to high-quality, equitable SUD and MH services.

Payment That Covers the Cost of Care

- Reimbursement reflecting costs
- Grant flexibility to meet changing needs

Oversight Aligned with Access

- Outcome-focused compliance standards aligned across oversight bodies, including for reporting
- Efficient billing and authorization
- Regulatory flexibility supporting person-centered care

A Supported Workforce

- Professionals practicing at the full scope of practice
- Fair, balanced oversight
- Career pathways and workforce participation for underrepresented communities, including peer professionals

Community Partnership

- Strong referral pathways
- Trust & cultural responsiveness
- Cross-sector collaboration

Reliable Payment

- Clear and predictable insurance process
- Timely NYS and county grant contract execution

Technology Infrastructure

- Interoperable Electronic Health Records (EHR) and billing systems
- Accurate claims and automated reporting
- Better engaged service recipients

Leadership & Governance

- Fiscal oversight and controls
- Strategic planning capacity
- Data-informed governance

Outcomes Focused

- Streamlined reporting
- Timely data analysis and feedback to assess outcomes and service delivery needs

OUTCOME

Sustainable, Equitable Access to High-Quality Behavioral Health Services

Financial Indicators Reflect Strained Operating Conditions

Based on CFR data, the Bonadio Group A-Score for 458 organizations receiving funding from OASAS and/or OMH was 62, indicating marginal to poor financial condition, elevated risk of instability, and persistent financial pressure on service delivery.

Table 1 A-Score by Oversight Agency

Agency Funder	Number of Organizations	Mean	Median	Range	Standard Deviation
OASAS	146	60	61	25-91	16
OMH	223	66	66	30-95	14
OASAS & OMH	89	59	61	27-92	17

Financial Strain Limits Access to Services

When providers are under financial pressure, communities feel the impact.

Financial Strain

Providers operate with tight margins and rising costs.

- Below-cost reimbursement
- Delayed payments
- Rising workforce and operating costs

Operational Impact

Financial pressure makes it harder to maintain staffing, capacity, and programs.

- Staffing shortages and burnout
- Reduced program capacity
- Limited ability to invest in services and innovation
- Administrative burden takes time away from services

Access Delays

Fewer resources and less capacity lead to longer wait times and limited opportunities for prevention.

- Months-long wait times
- Fewer admissions available
- Reduced appointment availability
- Uneven access across communities

The Outcome

New Yorkers go without the services they need, leading to avoidable crises at a much higher cost.

Communities feel the impact, and people suffer needlessly.

Recommendations

1) Payment That Covers the Cost of Care

Consistent with federal data, participants reported widespread reliance on cross-subsidization and supplemental fundraising to support underfunded programs.[xvxvi] Survey and focus group responses indicated that reimbursement rates are often insufficient to cover the full cost of high-quality, person-centered care. Smaller, short-term grants were also frequently described as carrying administrative requirements disproportionate to their funding levels.

Participants reported that 81 MH and 39 SUD programs were operating at a deficit. Examples of financially unsustainable programs included Assertive Community Treatment (ACT), Community-Oriented Recovery and Empowerment (CORE), and Personalized Recovery-Oriented Services (PROS).

> **Participants reported that 81 MH and 39 SUD programs were operating at a deficit, with 14 of 26 organizations indicating they had less than 3 months of cash on hand.**

Recommendations

- Identify financially unsustainable programs early with updated volume assumptions to preserve access to services.[xviixviiixixxxxxi]
- Identify mechanisms for service providers to raise concerns about and receive responses to financially unsustainable programs early.[xxiixxiii]

Participants reported widespread reliance on cross-subsidization and supplemental fundraising to support underfunded programs.

2) Reliable Payment

Respondents described delays and unnecessarily burdensome complexity in contract execution and payment for NYS and county grants, Medicaid Managed Care (MMC), and commercial insurance.

Insurance

Across payer types, organizations waited an average of 69.9 days for payment. Seventeen organizations reported dedicating approximately 41,000 hours to prior authorizations and denials, with differences in health plan administrative processes cited as a major obstacle to timely care and payment. These substantial costs are not factored into reimbursement or covered through grant funding. Concerns were also raised about frequent delays in implementing required increases in reimbursement rates in MMC.

One participant noted, "MMC has complicated the claims process and increased overhead costs." Several participants recommended centralized billing training and clear points of contact for unpaid claims.

Twenty-three organizations reported that 3,237 Medicaid recipients experienced coverage disruptions during recertification in the prior year. One respondent described the recertification process as "cumbersome and not user-friendly."

Even a 10% reduction in Medicaid revenue is estimated to reduce A-scores by an average of 3 points; up to 20 points for some.

Twenty-three organizations reported that 3,237 Medicaid recipients experienced coverage disruptions during recertification in the prior year.

Federal policy changes will increase the frequency of Medicaid recertification from annually to every six months and establish work requirements, which will dramatically increase coverage disruptions. Subsequently, service providers face increased unreimbursed costs to support recertification, verify work requirement exemptions, and provide care. Even a 10% reduction in Medicaid revenue is estimated to reduce financial A-Scores by an average of 3 points, with some organizations facing declines of nearly 20 points.

Grants

NYS and county grant funding delays were similarly reported. Twenty organizations allocated approximately 7,000 hours to follow up on contract delays, and several reported county pass-through payment delays that required short-term borrowing, with major impacts on service sustainability and the ability to secure credit lines. In a separate 2025 InUnity Alliance survey, the average unreimbursed interest due to contract delays was $90,000.

Recommendations

- Explore alternate insurance and grant models that result in reliable payment.[xxivxxvxxvixxvii]
- Identify challenges and develop strategies to mitigate Medicaid coverage disruptions for people who need SUD and MH care, including the destabilizing impacts of sudden increases in uncompensated care on service providers.

3) Oversight Aligned with Access

Service providers reported navigating duplicative and misaligned reporting requirements across state agencies, Medicaid Managed Care Organizations, federal and local government, and accrediting bodies. For example, one participant stated, “OASAS and OMH have separate agendas and separate data requirements, which forces programs to duplicate work.”

Respondents noted that regulatory processes do not consistently advance quality improvement as intended. For example, prolonged approval timelines for new services are delaying access to care, while generating enormous unreimbursable costs, such as lease payments for facilities, even for existing service providers in good standing.

Participants reported difficulty responding to changing needs within existing grant and budget structures, particularly because required budget projections make it difficult to account for actual costs.

Recommendations

- Identify factors contributing to and strategies to address protracted regulatory approval timelines for program expansion and access to services.[xxviii]
- Examine timely flexibility within grant contracts and budget structures and its implications for organizations’ ability to adapt to changing needs.[xxix]

4) A Supported Workforce

Recent reports consistently show a turnover rate of 30-45% for SUD and mental health non-profit client-facing or clinical roles[xxx]. Staffing shortages limit service availability and program capacity, especially for underserved communities. Workforce instability also increases recruitment costs and administrative demands associated with hiring and onboarding[xxxi]. Participants overwhelmingly reported that the lack of direct care staff, particularly nurses, prevents them from pursuing grant funding opportunities that would otherwise expand services. Long waits are most often attributed to the limited availability of prescribers, such as psychiatrists.

Recommendations

- Reassess workforce requirements to sustain high-quality care and expand timely access, including allowing professionals to practice at the full scope of their credentials.[xxxii]
- Identify opportunities to strengthen career pathways and workforce participation among underrepresented communities, such as multilingual credentialing examinations and support from people with lived experience, such as peer professionals.[xxxiiixxxiv]

5) Leveraging Technology

Participants reported difficulty integrating billing systems, reporting platforms, and electronic health records, which drives manual work, increases administrative burden, and limits engagement with people served. One respondent recommended "a single access point of coverage data for both service providers and Medicaid Managed Care organizations," noting that outdated data contribute to denials, recoupments, and conflicting coverage information.

Recommendation

- Support the development of interoperable, integrated platforms to improve care coordination, reduce costs, and enhance service quality, including real-time access to Medicaid recertification status.[xxxv]

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6) Strengthening Community Partnerships

Community partnerships strengthen referral pathways, coordination, and continuity of care. However, cross-sector collaboration requires time and infrastructure that remain inconsistently supported. Gaps in shared data systems and communication result in delayed referrals and fragment care, particularly for individuals with complex needs.

Recommendation

- Examine strategies to advance cross-sector agreements, strategic affiliations, and their potential to support referral pathways and shared stewardship.

7) Advancing Financial Stewardship and Governance

Strong financial oversight and governance support organizational stability. Participants emphasized the importance of timely reporting, forecasting, active board engagement, and revenue diversification in managing fiscal risk. Thin operating margins limit the ability to absorb payment delays or cost increases, reinforcing the need to align strategic planning with financial risk management. There was also a strong, equal interest in training on all aspects of financial stewardship and governance.

Recommendations

- Support organizational forecasting and capacity-building practices that allow providers to plan ahead, sustain their workforce, and ensure continuity of care for the people they serve.
- Identify ways to align strategic planning with financial risk assessment to identify vulnerabilities early, protect operational stability, and maintain continuity of care.

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8) Evaluation and Outcomes Analysis

Evaluation and outcomes analysis support informed decision-making and continuous improvement in community-based SUD and MH services. Organizations routinely report program data to multiple oversight entities, including OMH, OASAS, managed care plans, and other grant administrators. While these data could offer valuable insights, fragmented systems, inconsistent metrics across agencies, and limited access to timely, actionable feedback limit the ability to understand people's experiences in care and whether services are helping them achieve meaningful outcomes.

Recommendations

- Advance processes and timely data analysis and feedback to identify trends and develop responses early.
- Align strategic planning with financial and service outcome data.

Conclusion

When New Yorkers face months-long waits for SUD and MH services, multiple system issues, underfunding, workforce shortages, administrative burdens, and insurance disruptions work together to block access. Addressing these structural factors will allow New Yorkers to access services in a timely manner, preventing illness onset, reducing avoidable crises, and keeping adults, children, and families healthy and connected at a lower cost than delayed, crisis-driven care.

To address these challenges, this report identifies four priority recommendations:

1. **Identify financially unsustainable programs early** and implement strategies to preserve access to services.

2. **Evaluate the impact of insurance and grant processes and payment delays** on timely access to care and service availability, and how different models may influence these outcomes.

3. **Reassess workforce requirements to sustain high-quality care and expand timely access,** including allowing professionals to practice at the full scope of their credentials.

4. **Identify challenges and develop strategies to mitigate Medicaid coverage disruptions** for people who need SUD and MH care, including the destabilizing impacts of sudden increases in uncompensated care on service providers.

Endnotes

i Li, W., Seil, K., Paudel, P., Castro, A., Sun, Y., Gurung, S., Robles-Torres, L., & Van Wye, G. (2023). Summary of vital statistics, 2023. New York City Department of Health and Mental Hygiene. https://www.nyc.gov/assets/doh/downloads/pdf/vs/2023sum.pdf

ii New York State Department of Health. (2026). Leading causes of death data application. Retrieved April 17, 2026, from https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/

iii Counts, N. (2023, May 18). Understanding the U.S. behavioral health workforce shortage. The Commonwealth Fund. https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage

iv Dickson-Gómez, J., Weeks, M., Green, D., Boutouis, S., Galletly, C., & Christenson, E. (2022). Insurance barriers to substance use disorder treatment after passage of mental health and addiction parity laws and the Affordable Care Act: A qualitative analysis. Drug and Alcohol Dependence Reports, 3, Article 100051. https://doi.org/10.1016/j.dadr.2022.100051

v Mahomed, F. (2020). Addressing the problem of severe underinvestment in mental health and well-being from a human rights perspective. Health and Human Rights, 22(1), 35–49. https://www.hhrjournal.org/2020/06/18/addressing-the-problem-of-severe-underinvestment-in-mental-health-and-well-being-from-a-human-rights-perspective/

vi Health Resources and Services Administration, Bureau of Health Workforce. (2025). State of the behavioral health workforce, 2025. U.S. Department of Health and Human Services. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf

vii American Society of Addiction Medicine. (2025, April 23). Public policy statement on ensuring the financial sustainability of addiction treatment services in the United States. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2025-final-pps-on-financial-sustainability-of-ats-in-us.pdf

viii Dickson-Gómez, J., Weeks, M., Green, D., Boutouis, S., Galletly, C., & Christenson, E. (2022). Insurance barriers to substance use disorder treatment after passage of mental health and addiction parity laws and the Affordable Care Act: A qualitative analysis. Drug and Alcohol Dependence Reports, 3, Article 100051. https://doi.org/10.1016/j.dadr.2022.100051

ix Mahomed, F. (2020). Addressing the problem of severe underinvestment in mental health and well-being from a human rights perspective. Health and Human Rights, 22(1), 35–49. https://www.hhrjournal.org/2020/06/18/addressing-the-problem-of-severe-underinvestment-in-mental-health-and-well-being-from-a-human-rights-perspective/

x Health Resources and Services Administration, Bureau of Health Workforce. (2025). State of the behavioral health workforce, 2025. U.S. Department of Health and Human Services. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf

xi American Society of Addiction Medicine. (2025, April 23). Public policy statement on ensuring the financial sustainability of addiction treatment services in the United States. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2025-final-pps-on-financial-sustainability-of-ats-in-us.pdf

xii King, C. A., Beetham, T., Smith, N., Englander, H., Button, D., Brown, P. C. M., Hadland, S. E., Bagley, S. M., Wright, O. R., Korthuis, P. T., & Cook, R. (2024). Adolescent Residential Addiction Treatment In The US: Uneven Access, Waitlists, And High Costs. Health affairs (Project Hope), 43(1), 64–71. https://doi.org/10.1377/hlthaff.2023.00777

xiii Brahmbhatt, D., & Schpero, W. L. (2024). Access to psychiatric appointments for Medicaid enrollees in 4 large US cities. JAMA, 332(8), 668–669. https://doi.org/10.1001/jama.2024.13074

xiv Breslau, J., Barnes-Proby, D., Bhandarkar, M., Cantor, J. H., Hanson, R., Kofner, A., Li, R., Malika, N., Mendoza-Graf, A., & Pincus, H. A. (2022). Availability and Accessibility of Mental Health Services in New York City. RAND Health Quarterly, 10(1), 6.

xv American Hospital Association. (2024). 2024 Costs of caring. https://www.aha.org/guidesreports/2025-04-28-2024-costs-caring

xvi Medicaid and CHIP Payment and Access Commission. (2015). Behavioral health in the Medicaid program—People, use, and expenditures. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program—People-Use-and-Expenditures-1.pdf

xvii Zhu, J. M., Zhang, Y., & Polsky, D. (2025). Estimating Medicaid reimbursement for psychological services. Health Affairs, 44(5). https://doi.org/10.1377/hlthaff.2025.00563

xviii Arizona Health Care Cost Containment System. (2023, June 19). Behavioral health rate study report: Adequacy and appropriateness of Title XIX reimbursement rates to providers of behavioral health services. https://www.azahcccs.gov/shared/Downloads/Reporting/2023/2023AHCCCSBHRateStudyReport.pdf

xix Connecticut Office of Health Strategy. (2024). Behavioral health payment parity report. https://portal.ct.gov/ohs/-/media/ohs/reports/ct-ohs-behavioral-health-payment-parity-final-report.pdf

xx Minnesota Department of Human Services. (2024, January 22). Minnesota Health Care Programs fee-for-service outpatient services rate study: Second report. https://mn.gov/dhs/assets/Final%20Rate%20Study%20Report_tcm1053-610638.pdf

xxi Alaska Department of Health. (2025, November 20). Behavioral health rate evaluation overview. https://health.alaska.gov/media/oiwg3z4k/bh-rate-evaluation-overview.pdf

xxii Virginia Department of Behavioral Health and Developmental Services. (2026). Report on Assertive Community Treatment: Program funding, cost effectiveness, and impact (RD199). Virginia General Assembly. https://rga.lis.virginia.gov/Published/2026/RD199/PDF

xxiii Hodgkin, D., Horgan, C. M., Jordan Brown, S., Bart, G., & Stewart, M. T. (2023). Financial sustainability of novel delivery models in behavioral health treatment. Journal of Mental Health Policy and Economics, 26(4), 149–158. https://pmc.ncbi.nlm.nih.gov/articles/PMC10752219/

xxiv Sahni, N. R., Mishra, P., Carrus, B., & Cutler, D. M. (2021, October 20). Administrative simplification: How to save a quarter-trillion dollars in U.S. healthcare. McKinsey & Company. https://www.mckinsey.com/industries/healthcare/our-insights/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare

xxv Chigurupati, A., & Kocher, B. (2021). Challenges and opportunities for administrative simplification in U.S. health care. Health Services Research, 56(4), 578–580. https://doi.org/10.1111/1475-6773.13692

xxvi National Academies of Sciences, Engineering, and Medicine. (2024). Exploring strategies to improve access to behavioral health care services through Medicare and Medicaid: Proceedings of a workshop—in brief. Washington, DC: The National Academies Press. https://doi.org/10.17226/27788

xxvii Carey, C. M., Miller, S., & Wherry, L. R. (2021). Administrative fragmentation in health care (BFI Working Paper No. 2021-80). Becker Friedman Institute for Economics at the University of Chicago. https://bfi.uchicago.edu/wp-content/uploads/2021/07/BFI_WP_2021-80.pdf

xxviii Bailey, J. (2021, May 21). Certificate-of-need laws: How they affect healthcare access, quality, and cost. Mercatus Center at George Mason University. https://www.mercatus.org/economic-insights/features/certificate-need-laws-how-they-affect-healthcare-access-quality-and-cost

xxix Dopp, A. R., Wright, B., Kim, J., Hindmarch, G. M., & Hunter, S. B. (2025). Federal funding recommendations to scale up evidence-based practices in health and social services (Research Brief RB-A3627-1). RAND Corporation. https://doi.org/10.7249/RBA3627-1 https://www.rand.org/pubs/research_briefs/RBA3627-1.html

xxx Mayor's Office of Community Mental Health. (2025). Bridging the gap: Challenges and solutions for a thriving behavioral health workforce. New York City Mayor's Office of Community Mental Health. https://mentalhealth.cityofnewyork.us/wp-content/uploads/2025/01/2024-Bridging-the-Gap-Workforce-Paper.pdf

xxxi Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. (2025). State of the behavioral health workforce, 2025. U.S. Department of Health and Human Services. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf

xxxii Inseparable. (2026). The workforce report: Bridging the mental health care gap. https://www.inseparable.us/wp-content/uploads/dlm_uploads/2026/03/Inseparable-2026WorkforceReport.pdf

xxxiii National Academy for State Health Policy. (n.d.). State strategies to increase diversity in the behavioral health workforce. https://nashp.org/state-strategies-to-increase-diversity-in-the-behavioral-health-workforce/

xxxiv National Conference of State Legislatures. (n.d.). Mental health matters: Policy framework on workforce mental health. https://www.ncsl.org/labor-and-employment/mental-health-matters-policy-framework-on-workforce-mental-health

xxxv U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2024). Health information technology adoption and utilization in behavioral health settings. https://aspe.hhs.gov/sites/default/files/documents/b9f858a38ff71660528cf1e4b8df00fa/HIT-adoption-utilization-bh-settings.pdf

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