Pursuant to the authority vested in the Commissioner of Health by section 4403 of the Public Health Law, Part 98 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended to be effective 90 days after publication of the Notice of Adoption in the State Register, to read as follows:

Subdivision (p) of section 98-1.13 is added to read as follows:

A MCO shall meet standards for network adequacy for mental health and substance use disorder treatment services set forth in Subpart 98-5.

Subpart 98-5 is added to read as follows:

Subpart 98-5 Network Adequacy for Mental Health and Substance Use Disorder Treatment Services

Section 98-5.1 Purpose.

Section 98-5.2 Applicability.

Section 98-5.3 Definitions.

Section 98-5.4 Network provider type standards.

Section 98-5.5 Appointment wait time standards.

Section 98-5.6 Access to participating providers for enrollees.

Section 98-5.7 Provider directory requirements.

Section 98-5.8 Additional MCO responsibilities regarding network adequacy and access.

Section 98-5.9 MCO reporting on network adequacy and access standards.

Section 98-5.1 Purpose

Subpart F of part II of chapter 57 of the Laws of 2023 amended the Public Health Law to improve access to behavioral health services in this State. Public Health Law 4403(5)(b) requires the commissioner, in consultation with the Superintendent of Financial Services, the commissioner of the Office of Mental Health, and the commissioner of the Office of Addiction Services and Supports, to propose regulations setting forth standards for network adequacy for mental health and substance use disorder treatment services, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services, and mobile crisis intervention services, by December 31, 2023. This Subpart implements the requirements of Public Health Law 4403(5)(b), as amended by Subpart F of part II of chapter 57 of the Laws of 2023, by establishing network adequacy and access standards and other protections to improve access to behavioral health services.

Section 98-5.2 Applicability.

(a) Starting January 1, 2025, this Subpart shall apply to all MCOs offering coverage that are subject to the mental health and substance use disorder requirements under Insurance Law § 4303 and Public Health Law § 4406.

Section 98-5.3 Definitions.

As used in this Part:

(a) *Appointment wait time* means the time from the initial request for health care services by an enrollee to the earliest date offered for the appointment for services.

(b) *Behavioral health services* mean mental health services and substance use disorder treatment services.

(c) *Health care professional* means an appropriately licensed, registered, or certified health care professional pursuant to title 8 of the Education Law or a health care professional comparably licensed, registered, or certified by another state.

(d) *Health care provider or provider* means a health care professional, or a facility licensed or certified pursuant to Public Health Law articles 5, 28, 36, 44 or 47, or Mental Hygiene Law articles 19, 31 or 32, or a facility comparably licensed or certified by another state.

(e) *Network* means the health care providers with which a MCO has contracted to provide health care services to enrollees.

(f) *Non-participating* means not having a contract with a MCO to provide health care services to an enrollee.

(g) *Participating* means having a contract with a MCO to provide health care services to an enrollee.

(h) *Telehealth* has the meaning set forth in section 2999-cc of the Public Health Law and includes audio-only visits.

Section 98-5.4 Network provider type standards.

(a) An adequate network of health care providers of behavioral health services shall include residential facilities that provide sub-acute care; assertive community treatment providers; critical time intervention services providers; and mobile crisis intervention services providers.

(b) This section shall take effect on January 1, 2025, and apply to policies and contracts issued or renewed 90 days after the commissioner, in consultation with the Superintendent of Financial Services, the commissioner of the Office of Mental Health, and the commissioner of the Office of Addiction Services and Supports, has determined, for each provider type listed in subdivision (a) of this section, that there is a sufficient number of certified, licensed, or designated health care providers available in this State to meet the network adequacy standards established by Public Health Law 4403(5)(b).

Section 98-5.5 Appointment wait time standards.

(a) A MCO shall ensure that its network has adequate capacity and availability of health care providers of behavioral health services to offer enrollees appointments within:

(1) 10 business days for an initial appointment with an outpatient facility or clinic;

(2) 10 business days for an initial appointment with a health care professional who is not employed by or contracted with an outpatient facility or clinic; and

(3) seven days for an appointment following a discharge from a hospital or an emergency room visit.

(b) A MCO may meet the appointment wait times set forth in subdivision (a) of this section through the use of telehealth unless the enrollee specifically requests an in-person appointment to treat the enrollee’s behavioral health condition.

Section 98-5.6 Access to participating providers for enrollees.

(a) If an enrollee is unable to schedule an appointment with a participating provider of behavioral health services within the appointment wait times set forth in section 98-5.5 of this Part, the enrollee may submit a complaint to the MCO to resolve the access issue.

(b) The MCO shall have three business days from receipt of the complaint to locate a participating provider of behavioral health services that can treat the enrollee's behavioral health condition and is able to meet the appointment wait times set forth in section 98-5.5 of this Part.

(c) If the MCO is unable to locate a participating provider of behavioral health services that can treat the enrollee's behavioral health condition and is able to meet appointment wait times set forth in section 98-5.5 of this Part, respectively, the MCO shall permit the enrollee to receive the behavioral health services from a non-participating provider that can treat the enrollee's behavioral health condition and is able to meet the appointment wait times set forth in section 98-5.5 of this Part regardless of whether the enrollee's coverage includes out-of-network benefits.

(d) The MCO shall not impose cost-sharing on the enrollee, including a copayment, coinsurance, or deductible for the service, that is greater than the cost-sharing that the enrollee would owe if the enrollee had received services from a participating provider. The MCO shall apply the out-of-pocket maximum that would have applied had the services been received from a participating provider.

Section 98-5.7 Provider directory requirements.

(a) In addition to the provider directory requirements set forth in Public Health Law 4403(5), when listing a behavioral health provider, the provider directory shall include:

(1) any affiliation with participating facilities certified or authorized by the Office of Mental Health and the Office of Addiction Services and Supports;

(2) information on restrictions on the availability of services from an individual behavioral health provider. Restrictions on the availability of services means an age limit on the types of patients the health care provider treats or any limits on the types of specific behavioral health conditions that the health care provider treats;

(3) level of care offered by the behavioral health provider; and

(4) the county where the behavioral health provider is located.

(b) With respect to behavioral health providers, the provider directory that is posted on the MCO's website shall be searchable and filterable by behavioral health services provided and conditions treated, level of care, languages spoken, affiliations with participating facilities certified or authorized by the Office of Mental Health or the Office of Addiction Services and Supports, and the county where the provider is located.

(c) In addition to the disclosure requirements set forth in Public Health Law 4408(1)(r), a MCO shall provide the enrollee or the enrollee's designee with a list of behavioral health providers available to treat a specific behavioral health condition upon the request of the enrollee or the enrollee's designee.

(d) A MCO shall verify the accuracy of the information in the provider directory in writing with behavioral health providers annually.

(e) A MCO shall review the claims activity of the first six months of the year by September 1 of that year and, for the second six months of the year by March 1 of the following year. If the MCO did not receive any claims from a participating provider of

behavioral health services within those periods, the MCO shall verify in writing with the participating provider the accuracy of the information in the provider directory.

(f) A MCO shall have a method available on its website for enrollees and health care providers to report errors in the provider directory information. The MCO shall promptly review the errors reported and ensure that the provider directory information is accurate.

Section 98-5.8 Additional MCO responsibilities regarding network adequacy and access.

(a) A MCO shall have designated staff with sufficient knowledge to help enrollee find participating behavioral health providers that treat the enrollee's specific behavioral health condition. The MCO shall post the contact information, including a telephone number, on its website, that allows the enrollee to access this designated staff directly.

(b)(1) A MCO shall have an access plan that establishes a protocol for monitoring and ensuring access to behavioral health services, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:

(i) expected utilization of behavioral health services based on anticipated member enrollment and health care needs of the member population;

(ii) the number and types of health care providers of behavioral health services required to furnish covered behavioral health services, the number and types of

providers actively providing behavioral health services within the health care plan's network, and the number and types of providers accepting new patients;

(iii) the collection and monitoring of data on provider-to-enrollee ratios, travel time and distance to participating providers, percentage of participating providers accepting new patients, and appointment wait times; and

(iv) the role of telehealth in providing access to behavioral health services.

(2) A MCO shall make the access plan available to the commissioner upon the commissioner's request.

Section 98-5.9 MCO reporting on network adequacy.

(a) By December 31, 2025 and annually thereafter, each MCO shall submit to the commissioner a written certification in a form prescribed by the commissioner and signed by an officer of the MCO that confirms the following:

(1) the MCO has an access plan as required by section 5.8 of this Part and that such access plan is available upon the commissioner's request;

(2) the MCO has sufficient participating providers in each network used by the MCO to meet the appointment wait time standards as required by section 98-5.5 of this Part, or in instances where there are not sufficient participating providers to meet the appointment wait time standards as required by section 98- 5.5 of this part, that the MCO allows enrollees to obtain behavioral health services from non-participating providers pursuant to section 98-5.6 of this Part; and

(3) the MCO has performed the provider directory verification required by section 98-5.7 of this Part.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law (PHL) section 4403(2) states the Commissioner may adopt and amend rules and regulations to effectuate the purposes and provisions of Article 44, which governs the certification and operational requirements of managed care organizations (MCOs). Public Health Law 4403(5)(b), as amended by Subpart F of part II of chapter 57 of the Laws of 2023 requires the commissioner, in consultation with the Superintendent of Financial Services, the commissioner of the Office of Mental Health, and the commissioner of the Office of Addiction Services and Supports, to propose regulations setting forth standards for network adequacy for mental health and substance use disorder treatment services, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services, and mobile crisis intervention services, by December 31, 2023.

Legislative Objectives:

To establish network adequacy requirements for mental health and substance use disorder services in order to improve access to behavioral health services.

Needs and Benefits:

The regulation implements the legislative objectives of Chapter 57 by establishing requirements for provider networks used by MCOs that issue comprehensive health insurance policies or contracts in relation to mental health and substance use disorder services. Ensuring meaningful access to mental health and substance use disorder care is

vital to addressing New York's mental health and substance use disorder crisis. A key component of access is the availability of an adequate number of appropriate providers within a MCO's network. The Department of Health, ("Department") consulted with the Department of Financial Services (DFS), the Office of Mental Health (OMH), and the Office of Addiction Services and Supports (OASAS) when drafting the regulation. DFS coordinated meetings with numerous stakeholders representing providers, consumers, and health care plans. The regulation sets forth appointment wait time standards for mental health and substance use disorder services. If an enrollee cannot access mental health or substance use disorder services from an in-network provider within the appointment wait time standards, the regulation requires the MCO to provide assistance to the enrollee in finding an in-network provider. If no in-network provider can provide the appointment wait time standards, the regulation requires the MCO to allow the enrollee to access an out-of-network provider at the in-network cost-sharing, if the out-of-network provider can meet the standards. This is a more streamlined process for MCOs to assist an enrollee in obtaining an appointment with a provider who meets the appointment wait times which does not require appeals. The regulation requires MCOs to verify information in their provider directories and to include information in the directories on any restrictions concerning the conditions or ages treated by network providers. Additionally, the regulation requires MCOs to develop a method for enrollees and providers to report directory errors; develop an access plan to monitor the utilization of mental health and substance use disorder services; and submit an annual certification of compliance to the Commissioner.

Costs:

Costs for the Implementation of, and Continuing Compliance with the Regulation to the Regulated Entity:

A MCO may incur compliance costs to: develop a process to monitor and evaluate access to its network providers; recruit additional mental health and substance use providers for its networks or pay for out of network providers; and submit an annual compliance certification. Some of the compliance costs may impact premium rates charged to enrollees for the commercial line of business. However, certain costs should be minimal because MCOs should already have compliance procedures in place such as the requirement to submit quarterly network reports.

C**osts to State and Local Governments:**

The new regulation does not impose any compliance costs on state or local governments or health care providers.

Costs to the Department of Health:

The new regulation may impose compliance costs on the Department because the Department will need to monitor MCOs compliance with the new regulation, review annual compliance certifications and update contracts with Department for Medicaid lines of business. However, any additional costs incurred by the Department should be minimal because existing personnel are already available to monitor compliance and update contracts necessitated by the new regulation and the Department should be able to absorb the costs in its ordinary budget. In addition, there could be an impact to premiums

because if no in-network provider can provide the services within the appointment wait time standards, the regulation requires the MCO to allow the enrollee to access an out-of-network provider at the in-network cost-sharing, if the out-of-network provider can meet the appointment wait time standards.

Local Government Mandates:

The new regulation does not impose any program, service, duty, or responsibility upon a county, city, town, village, school district, fire district, or other special district.

Paperwork:

MCOs may need to file new policy forms and rates with the Department of Financial Services for commercial lines of business and update contracts with the Department for Medicaid lines of business to comply with the regulation. MCOs will need to develop an access plan that establishes a protocol for monitoring and ensuring access to behavioral health services, outlines how provider capacity is determined, establishes procedures for monthly monitoring of capacity, and establishes procedures for improving and managing access in times of reduced participating provider capacity. MCOs will also need to submit an annual certification of compliance to the Commissioner.

Duplication:

The new regulation does not duplicate, overlap, or conflict with any existing state or federal rules or other legal requirements.

Alternatives:

The Department consulted with the DFS, OMH, and OASAS when drafting the regulation. The Department and DFS considered requiring MCOs to meet appointment wait time standards of 14 to 28 days, instead of ten business days, for initial mental health and substance use disorder treatment appointments. During discussions with various behavioral health provider associations, providers repeatedly stated that there is a state-wide shortage of providers and an increasing demand for mental health and substance use disorder treatment services. Many providers, including providers who do not participate in health care plan provider networks, expressed concern that they would not be able to meet an appointment wait time standard of ten business days, and many providers indicated that appointment wait times can run up to four weeks or longer. However, other states and federally-run exchanges have a ten business-day timeframe for initial appointments, and the ten business-day timeframe is more protective of consumers than a longer timeframe.

The Public Health Law includes a mechanism for an enrollee to go out of network when there is no provider in a MCO's network who can perform the services. That process may require the enrollee to go through multiple levels of appeal. However, the Department chose to require a more streamlined process for MCOs to assist an enrollee in obtaining an appointment with a provider who meets the appointment wait times which does not necessitate appeals.

Federal Standards:

The regulation does not conflict with any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

MCOs will need to comply with the regulation for policies and contracts issued, renewed, modified, or amended on and after January 1, 2025, and will need to submit annual compliance certifications by December 31, 2025.

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STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 44 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2020 (https://www.census.gov/quickfacts/). Approximately 17% of small health care facilities are located in rural areas.

Allegany County	Greene County	Schoharie County
Broome County	Hamilton County	Schuyler County
Cattaraugus County	Herkimer County	Seneca County
Cayuga County	Jefferson County	St. Lawrence County
Chautauqua County	Lewis County	Steuben County
Chemung County	Livingston County	Sullivan County
Chenango County	Madison County	Tioga County
Clinton County	Montgomery County	Tompkins County
Columbia County	Ontario County	Ulster County
Cortland County	Orleans County	Warren County
Delaware County	Oswego County	Washington County
Essex County	Otsego County	Wayne County
Franklin County	Putnam County	Wyoming County
Fulton County	Rensselaer County	Yates County
Genesee County	Schenectady County	

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2020.

Albany County	Niagara County	Orange County
Dutchess County	Oneida County	Saratoga County
Erie County	Onondaga County	Suffolk County
Monroe County		

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:

MCOs, including MCOs in rural areas, may be subject to additional reporting, recordkeeping, or other compliance requirements regarding their network of providers. MCOs will need to develop an access plan that: establishes a protocol for monitoring and ensuring access to behavioral health services, outlines how provider capacity is determined, establishes procedures for monthly monitoring of capacity, and establishes procedures for improving and managing access in times of reduced participating provider capacity. MCOs will also need to submit an annual certification attesting that they are meeting the requirements outlined in 10 NYCRR 98-5.

Costs:

The new regulation may impose compliance costs on MCOs, including those in a rural area, to develop a process to monitor and evaluate access to its network providers; recruit additional mental health and substance use providers for its networks; and submit an annual compliance certification. However, any costs should be minimal because MCOs should already have compliance procedures in place.

Minimizing Adverse Impact:

This rule uniformly affects MCOs that are located in both rural and non-rural areas of New York State. This rule should not have an adverse impact on rural areas.

Rural Area Participation:

The Department of Health participated in virtual meetings with trade associations representing MCOs throughout the state, including those located in rural areas, regarding the proposed regulation. The Department also met with numerous stakeholders

representing providers and consumers. MCOs, including MCOs in rural areas, will have an opportunity to participate in the rule-making process by submitting comments after the proposed rule is published in the State Register and on the Department of Health's website.

STATEMENT IN LIEU OF

JOB IMPACT STATEMENT

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.