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 120 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 and access standards 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 and Access Standards 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 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.

Section 98-6.0 Effective date.

Section 98-5.1 Purpose

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), as added by Subpart F of Part II, 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. Subpart A of Part II establishes the effective date for coverage of sub-acute care in a residential facility, assertive community treatment services, critical time intervention services, and mobile crisis intervention services. 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, and the requirements of Subpart A Part II by establishing network adequacy and access standards and other protections to improve access to behavioral health services.

Section 98-5.2 Applicability.

(a) 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 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, certified, or designated pursuant to Public Health Law articles 28, or Mental Hygiene Law articles 19, 31, 32, or 36, 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) Pursuant to Public Health Law section 4403(5)(b), a MCO shall ensure that its provider network is adequate to meet the behavioral health needs of enrollees and provide an appropriate choice of providers sufficient to render the behavioral health services covered under its health insurance contracts.

(b) 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, 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 this subdivision, 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). Once the commissioner makes this determination, the network adequacy standards shall apply to the provider types listed in this subdivision for contracts issued, renewed, modified, or amended 90 days after the commissioner makes this determination.

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 with providers that can treat enrollees' behavioral health conditions 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 calendar 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 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 because there is not a participating provider of behavioral health services available within the appointment wait times who can treat the enrollee's behavioral health condition, the enrollee, or the enrollee's designee, may submit an access complaint by telephone, and in writing to the MCO to resolve the access issue.

(b) The MCO shall have three business days from receipt of the access 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 and to give the enrollee or the enrollee's designee the name of and contact information for the provider or providers by telephone, if the request was made by telephone, and in writing. If the enrollee specifically requests an in-person appointment, the provider shall be located within a reasonable distance from the enrollee;

however, the distance may be greater for enrollees who reside in rural areas than for enrollees who do not reside in rural areas.

(c) If the MCO is unable to locate a participating provider of behavioral health services that can treat the enrollee's behavioral health condition, is able to meet appointment wait times set forth in section 98-5.5 of this Part, and is located within a reasonable distance from the enrollee if the enrollee specifically requests an in-person appointment, the MCO shall;

(1) notify the enrollee by telephone, if the request was made by telephone, and in writing, at the expiration of the time period in subdivision (b) of this section that the enrollee may obtain a referral to a non-participating provider at the in-network cost-sharing and include contact information for the New York State Behavioral Health Ombudsman Program; and

(2) approve a referral to a non-participating provider, regardless of whether the enrollee's coverage includes out-of-network benefits, if the non-participating provider:

(i) can treat the enrollee's behavioral health condition;

(ii) is able to meet the appointment wait times set forth in section 98-5.5 of this Part, as measured from the enrollee's receipt of the notification in paragraph (1) of this subdivision;

(iii) is located within a reasonable distance from the enrollee if the enrollee specifically requests an in-person appointment; and

(iv) charges rates that are not excessive or unreasonable.

(d) The approved referral shall remain in effect until the earlier of the following:

(1) the behavioral health services are no longer medically necessary; or

(2) the MCO locates a participating provider of behavioral health services that can treat the enrollee's behavioral health condition, is able to meet the appointment wait times set forth in section 98-5.5 of this Part and is located within a reasonable distance from the enrollee if the enrollee specifically requests an in-person appointment, and the enrollee's treatment can be transitioned to the participating provider, unless the MCO determines, in consultation with the enrollee's treating provider, as appropriate, that such a transition would be harmful to the enrollee. If the enrollee or the enrollee's designee disagrees with the MCO's transition of care determination, the enrollee or the enrollee's designee may request an expedited determination or appeal pursuant to Public Health Law section 4408-a or 4904, as applicable.

(e) The MCO shall not impose cost-sharing on the enrollee, including a copayment, coinsurance, or deductible, for the service rendered by a non-participating provider pursuant to an approved referral, 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 and 4408, 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 a behavioral health provider. Restrictions on the availability of services means an age limit on the types of patients the behavioral health provider treats or any limits on the types of specific behavioral health conditions that the behavioral health provider treats;

(3) if the behavioral health provider is a facility, the level of care offered by the facility, including inpatient, outpatient, partial hospitalization, and intensive outpatient programs;

(4) the city/town and zip code where the behavioral health provider is located;

(5) whether the behavioral health provider offers services via telehealth; and

(6) if the behavioral health provider is a health care professional, the languages spoken by the health care professional.

(b) With respect to behavioral health providers, the provider directory that is posted on a publicly accessible area of the MCO's website shall be searchable and filterable by behavioral health services provided and conditions treated, level of care offered by a facility, 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 city/town or zip code 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 within three business days of the request of the enrollee or the enrollee's designee.

(d) A MCO shall verify the accuracy of the information in the provider directory with behavioral health providers at least 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 confirm whether the provider is accepting new patients and the provider's participation status with the MCO.

(f) A MCO shall have a method available on a publicly accessible area of its website for enrollees, health care providers, and other persons to report errors in the provider directory information. Within 15 calendar days of receipt of reported errors, the MCO shall review the errors reported and ensure that the online 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 for the department or unit, including a telephone number, on a publicly accessible area of its website, that allows the enrollee to access this designated staff directly.

(b) A MCO shall post information on a publicly accessible area of its website describing the appointment wait time standards for behavioral health services and the process to submit an access complaint.

(c)(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 quarterly 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 enrollment and health care needs of the enrollee 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 MCO'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, and appointment wait times;

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

(v) the ability of the MCO's network of behavioral health providers to meet the cultural and linguistic needs of the MCO's enrollee population.

(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 and access.

(a) By December 31, 2026 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 98-5.8 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;

(3) the number of access complaints received and a description of how the access complaints were resolved, including the behavioral health services requested, the geographic area of the State where the services were requested, the number of approved referrals to non-participating providers made during the prior 12 months pursuant to section 98-5.6 of this Part; and the number of referrals that the MCO did not approve and the reasons why the MCO did not approve the referrals; and

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

Section 98-6.0 Effective date.

This Part shall take effect 120 days after publication of the Notice of Adoption in the State Register and shall apply to all policies issued, renewed, modified, or amended on or after such date.

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 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 who can treat the enrollee's behavioral health condition and is available within the appointment wait time standards, the regulation gives the MCO three (3) business days from receipt of an access complaint to provide the enrollee or the enrollee's designee with contact information for an in-network provider who can treat the enrollee's behavioral health condition and is available with the appointment wait time standards. If the enrollee requests an in-person visit rather than a telehealth visit, the in-network provider must also be located within a reasonable distance. If no such in-network provider is available within the appointment wait time standards, the regulation requires the MCO to provide the enrollee with a referral to an out-of-network provider at the in-network cost-sharing, if the out-of-network provider can treat the enrollee's behavioral health condition, is able to meet the appointment wait time standards, is located within a reasonable distance from the enrollee, and charges are not excessive or unreasonable. The regulation requires the referral to remain in effect until the behavioral health services are no longer medically necessary or the MCO locates an in-network provider that can treat the enrollee's

behavioral health condition, is able to meet the appointment wait time standards and is located within a reasonable distance, and the enrollee's treatment can be transitioned to the in-network provider and such transition would not be harmful to the enrollee. 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, language spoken by a health care professional, whether the provider offers services via telehealth and, if the provider is a facility, the level of care offered by the facility. The regulation requires MCOs to review claims activity twice each year to identify behavioral health providers who have not submitted claims and to verify their participation status and confirm whether they are accepting new patients. Additionally, the regulation requires MCOs to post certain information on a publicly accessible area of the websites, including a method for enrollees, providers, and other persons to report provider directory errors, a description of the appointment wait time standards, and the process for submitting an access complaint. The regulation requires MCOs to 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 that includes the number of access complaints received by the MCO and a description of how the access complaints were resolved.

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 disorder providers for its networks or pay for out of network providers; modify on-line provider directories to ensure that they are searchable and filterable; provide training to staff on the requirements for responding to access complaints; update its website with required information; 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 the 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 DFS 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 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 MCO 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.

The Department considered several different timeframes for MCOs to monitor network capacity and provider access including monthly, quarterly, and annually. The Department added a quarterly timeframe to align with the network adequacy quarterly network submission process.

The Department considered requiring a pre-determined length of time for a referral to an out-of-network provider to be covered, such as sixty (60) or ninety (90) days. However, the interruption of certain behavioral health treatments may cause harm to the enrollee in some circumstances, while in other situations may be more appropriately transitioned to an in-network provider sooner. The Department also considered requiring out-of-network referrals pursuant to the regulation to be effective until the completeness of enrollee's treatment. However, some behavioral health treatments can be very lengthy, lasting years, which would be costly for MCOs and increase premiums. In addition, MCOs currently can transition enrollees to in-network providers in order circumstances where out-of-network referrals are made.

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 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, such as monitoring utilization of those services, numbers and types of providers who are actively providing services, collecting data on provider-to-enrollee ratios and appointment wait times, and assessing the cultural and linguistic needs of the enrollee populations. MCOs should also outline how provider capacity is determined, establish procedures for quarterly monitoring of capacity, and establish 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 and to report on the number of access complaints received with a description of how the access complaints were resolved, including the number of approved referrals.

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 disorder 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 MCOs, 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.

SUMMARY OF THE ASSESSMENT OF PUBLIC COMMENT

The New York State Department of Health (Department) received comments on the proposed amendment to Sections 98-1.13 and addition of Subpart 98-5 of Title 10 of the New York Codes, Rules and Regulations, as published in the State Register on January 10, 2024, from many interested parties, including associations that represent managed care organizations (MCOs), associations that represent healthcare providers, and advocacy organizations that provide or promote mental health and substance use disorder health care services.

Interested parties submitted a number of comments, including comments that: requested a change in the effective date to provide MCOs with more time to meet the new requirements; suggested amending the regulation to use the terms mental health and substance abuse disorder instead of behavioral health; asked to clarify that the enrollees can request the provider directory either be provided by email, mail, or telephone and that the MCO must provide the requested format to the enrollee; suggested that MCOs should be required to correct provider directory errors reported to them within fifteen days of receiving the notification; suggesting that the enrollee should not be held responsible for any cost beyond their in-network cost-sharing when receiving out-of-network services due to error in the plan's directory; suggested that when an error is corrected in the provider directory, the MCO should be required to notify all enrollees with claims from a provider inaccurately listed in the network within the current and previous years so that enrollees can avoid future surprise bills; suggested that the information in the provider directory should be available in a searchable and filterable directory on the MCO's website; suggested the MCO's verification of the accuracy of the provider directory data

should be multi-method (e.g., including email and other forms of electronic verification as well as telephonic verification); suggested if the "level of care offered by the behavioral health provider" is required in the provider directories, a reference to where these levels are defined should be included; suggested that the information in the MCO's provider directory should include the age a practitioner treats and if they offer family treatment options; recommended that the Department define a set of health conditions and require providers to report the health conditions that they can treat in the MCO's provider directory; suggested that standardized categories of behavioral health providers should be created for the MCO's provider directory; requested clarification on how, and by when, the commissioner will determine if there are enough providers available to meet the network adequacy; recommended that each provider category should be specified and tracked separately to ensure adequate access to enrollee treatment; suggested that the MCO submit an annual Applied Behavioral Analysis (ABA) network adequacy report to the Department; recommended that the MCO must verify the accuracy of the information in the provider directory in writing with behavioral health providers every six months; recommended that the MCO access plan be available to the commissioner by request and publicly available and updated on the homepage of the MCO's website; asking MCO's to accept reports of provider directory error via website, phone, or in writing; from any interested party, not including only enrollees but also providers, family members, and advocates, without requiring reports be attached to the name of the enrollee and accompanied by the enrollee's authorization; requested that the provider directory describe whether a provider will see patients via telehealth, in-person, or both and if they are accepting new patients and if they are not accepting new patients, to remove them

from the directory; requested removing the requirement from the MCO's provider directory to include the provider's county, but also received several comments requesting that the MCO provider directory list all the counties served by the behavioral health provider; requested DOH to propose a series of escalating fines for each incident when a plan fails to comply with the requirements of these regulations; suggested that the MCO have a designated staff that is reported on the MCO's website to assist the enrollee in finding an in-network provider or an out-of-network referral within a twenty-four-hour request; recommended that MCOs should have to report on the following: the percentage of participating behavioral health providers accepting new patients, broken down by provider type/level of care; the percentage of participating behavioral health providers who submitted claims during the year being reported on, and number of claims submitted; the number of access complaints filed, and the outcome of those access complaints; and the number of access complaints filed with the MCO about the adequacy or quality of the MCO's network and the accuracy of its network directory; suggested that the MCO complaint department telephone number be added to the back of the enrollee insurance card; recommended in cases where an MCO approves a referral to a non-participating provider, that a provision should be added that allows the MCO flexibility to transition the member to a participating provider for subsequent treatment; suggested that DOH should include a default rate that the non-participating provider be required to accept as a payment in full; requested that the term "complaint" should be changed to "request" as a request for an MCO to help find a provider should not be treated as a complaint; suggested that the MCOs should designate behavioral health access system separate from an existing system for general complaints including process

for MCOs to send by mail to all enrollees the following records within thirty days of the initial complaint: date and time of the complaint, method used, date and time MCO responded, the type of behavioral health service enrollee is seeking, and the behavioral health providers the MCO located.

The Department considered all the comments received and made changes to the regulation in response thereto.

ASSESSMENT OF PUBLIC COMMENT

The New York State Department of Health (Department) received comments regarding the amendment to Sections 98-1.13 and addition of Subpart 98-5 of Title 10 of the New York Codes, Rules and Regulations, as published in the State Register on January 10, 2024. The Department received comments from associations that represent managed care organizations (MCOs), associations that represent healthcare providers, and advocacy organizations that provide or promote mental health and substance use disorder health care services. These comments and the Department's responses are summarized below.

Comment: The Department received multiple comments suggesting that the regulation should expand the list of provider types to capture multiple providers in addition to those identified in the amendment.

Response: The Department added language to the proposed amendment ensuring that the MCO's provider network would be adequate in meeting the behavioral health needs of the enrollees under its health insurance contracts.

Comment: The Department received multiple comments suggesting amending the regulation to use the terms mental health and substance abuse disorder instead of behavioral health.

Response: Current language in section 98-5.3(b) defines behavioral health services as "mental health services and substance use disorder treatment services." This definition makes clear that "behavioral health" as used in the proposed regulation is a comprehensive term that means either or both mental health and/or substance use

disorder. The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received multiple comments asking to clarify that the enrollees can request the provider directory either be provided by email, mail, or telephone and that the MCO must provide the requested format to the enrollee.

Response: The Department changed the regulation to clarify that the MCO shall post their provider directory in a publicly accessible place on an area of the MCO's webpage. Section 98-5.7(4)(c) refers to disclosure requirements set forth in Public Health Law 4408(1)(r) and added language to the regulations that a MCO shall provide the enrollee or enrollee's designee with a list of behavioral health providers available to treat a specific behavioral health condition within three business days of the request of the enrollee or the enrollee's designee.

Comment: The Department received multiple comments suggesting that MCOs should be required to correct provider directory errors reported to them within fifteen days of receiving the notification.

Response: The Department made changes to the regulation to specify that within 15 calendar days of receipt of the reported errors, the MCO shall review the errors and ensure that the provider directory information is accurate.

Comment: The Department received multiple comments suggesting that the enrollee should not be held responsible for any cost beyond their in-network cost-sharing when receiving out-of-network services due to error in the plan's directory.

Response: The Department did not make changes to the regulation in response to this comment because these protections already exist in law.

Comment: The Department received multiple comments suggesting that when an error is corrected in the provider directory, the MCO should be required to notify all enrollees with claims from a provider inaccurately listed in the network within the current and previous years so that enrollees can avoid future surprise bills.

Response: The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received multiple comments suggesting that the information in the provider directory should be available in a searchable and filterable directory on the MCO's website.

Response: The Department has added clarifying language stating that the provider directory will be posted in a publicly accessible area of the MCO's website and revised the searchable/filterable list to include the city/town or zip code where the provider is located.

Comment: The Department received comments suggesting the MCO's verification of the accuracy of the provider directory data should be multi-method (e.g., including email and other forms of electronic verification as well as telephonic verification).

Response: The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received comments suggesting if the "level of care offered by the behavioral health provider" is required in the provider directories, a reference to where these levels are defined should be included.

Response: The Department has incorporated language to clarify that the level of care, if the behavioral health care provider is a facility, must be included in the provider directories (e.g., inpatient, outpatient, partial hospitalization, and/or intensive outpatient programs).

Comment: The Department received multiple comments suggesting that the information in the MCO's provider directory should include the age a practitioner treats and if they offer family treatment options. One comments also recommended that the Department define a set of health conditions and require providers to report the health conditions that they can treat in the MCO's provider directory.

Response: Section 98-5.7 (2) requires the provider directory include restrictions on the availability of services, which includes an age limit on the types of patients or limits on types of specific behavioral health conditions that the behavioral health provider treats.

Comment: The Department received comments suggesting that standardized categories of behavioral health providers should be created for the MCO's provider directory.

Response: The Department did not make changes to the regulation in response to these comments. However, consideration will be given as to whether guidance should be issued in consultation with OMH and OASAS.

Comment: The Department received comments requesting clarification on how, and by when, the commissioner will determine if there are enough providers available to meet the network adequacy.

Response: The Department added language to specify that the requirement becomes effective 90 days after the determination that there are sufficient providers in those classifications listed, which is the timeframe set forth in Chapter 57 of the laws of 2023. The determination is made by the commissioner in consultation with DFS, OMH and OASAS.

Comment: The Department received comments stating that each provider category should be specified and tracked separately to ensure adequate access to enrollee treatment.

Response: The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received a comment suggesting that the MCO submit an annual Applied Behavioral Analysis (ABA) network adequacy report to the Department.

Response: The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received a comment suggesting that the MCO must verify the accuracy of the information in the provider directory in writing with behavioral health providers every six months.

Response: The Department added ‘at least’ to the current language: The regulation requires that a MCO shall verify the accuracy of provider directory information with behavioral health providers at least annually. MCOs have discretion to verify their provider directories using methods that they choose.

Comment: The Department received a comment suggesting that the MCO access plan be available to the commissioner by request and publicly available and updated on the homepage of the MCO’s website.

Response: The regulation states the MCO shall make the access plan available to the commissioner upon the commissioner’s request. Regarding making access plans publicly available, the Department did not revise the regulation in response to this comment. Access plans are internal quality control documents developed by each MCO. However, nothing prohibits a MCO from publicly posting its access plan if it chooses to do so.

Comment: The Department received several comments asking MCO’s to accept reports of provider directory error via website, phone, or in writing; from any interested party, not including only enrollees but also providers, family members, and advocates, without requiring reports be attached to the name of the enrollee and accompanied by the enrollee’s authorization.

Response: The Department added language to require MCOs to have a method available on a publicly accessible area of their website for not only enrollees and health care providers, but any other persons, to report errors in the provider directory.

Comment: The Department received several comments requesting that the provider directory describe whether a provider will see patients via telehealth, in-person, or both

and if they are accepting new patients and if they are not accepting new patients, to remove them from the directory.

Response: The Department has incorporated clarifying language stating that the MCO's provider directory shall include whether the behavioral health provider offers services via telehealth. The Department also added language to the MCO claims review requirement that if the MCO did not receive any claims from a participating provider of a behavioral health service within the review period, the MCO shall confirm whether the provider is accepting new patients and the provider's participation status with the MCO.

Comment: The Department received several comments requesting to remove the requirement from the MCO's provider directory to include the provider's county. The Department also received several comments requesting that the MCO provider directory list all the counties served by the behavioral health provider.

Response: The Department has incorporated clarifying language stating that the MCO's provider directory shall include the city/town and zip code where the behavioral health provider is located. The provider directory posted in a publicly accessible area of the MCO's website shall be searchable and filterable by the city/town or zip code where the provider is located.

Comment: The Department received several comments requesting that providers should be held responsible for informing the MCOs of any changes (e.g. address, participation status, etc.) proactively to ensure the accuracy of the provider directories.

Response: The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received comments requesting DOH to propose a series of escalating fines for each incident when a plan fails to comply with the requirements of these regulations.

Response: The Department acknowledges and appreciates the comment but did not implement the change. The Department already has authority and mechanisms in place for intermediate sanctions or enforcement penalties when MCOs are not in compliance with the Public Health Law, regulations, or Medicaid contract.

Comment: The Department received comments suggesting that the MCO have a designated staff that is reported on the MCO's website to assist the enrollee in finding an in-network provider or an out-of-network referral within a twenty-four-hour request.

Response: The Department has incorporated clarifying language stating that an MCO shall post the contact information for the department or unit, including a telephone number, on a publicly accessible area of its website, that allows the enrollee to access this designated staff directly.

Comment: The Department received comments suggesting that MCOs should have to report on the following: the percentage of participating behavioral health providers accepting new patients, broken down by provider type/level of care; the percentage of participating behavioral health providers who submitted claims during the year being reported on, and number of claims submitted; the number of access complaints filed, and the outcome of those access complaints; and the number of access complaints filed with the MCO about the adequacy or quality of the MCO's network and the accuracy of its network directory.

Response: In addition to the access plan requirements already included in the regulation, the Department added the ability of the MCO's network of providers to meet the cultural and linguistic needs of the MCO's enrollee population. The Department also made changes to the regulation to include a requirement that the MCO will report on the number of access complaints received and a description of how the access complaints were resolved, including the number of referrals to non-participating providers made during the prior twelve-months pursuant to section 98-5.6.

Comment: The Department received comments suggesting that the MCO complaint department telephone number be added to the back of the enrollee insurance card.

Response: The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received comments regarding cases where an MCO approves a referral to a non-participating provider, a provision should be added that allows the MCO flexibility to transition the member to a participating provider for subsequent treatment.

Response: The Department has incorporated clarifying language stating the approved referral shall remain in effect until the behavioral health services are longer medically necessary or the MCO locates a participating provider of behavioral health services that can treat the enrollee's behavioral health condition, is able to meet the appointment wait times set forth in section 98-5.5 of this Part and is located within a reasonable distance from the enrollee if the enrollee specifically requests an in-person appointment, and the

enrollee's treatment can be transitioned to the participating provider, unless such a transition would be harmful to the enrollee.

Comment: The Department received comments suggesting that DOH should include a default rate that the non-participating provider be required to accept as a payment in full.

Response: The Department acknowledges and appreciates the comment but did not implement the change in these regulations. However, the Department did add language that a referral shall be approved if the non-participating provider charges rates that are not excessive or unreasonable.

Comment: The Department received comments suggesting that the MCO should not be permitted to implement an approved referral process as this can further delay access to care.

Response: The Department acknowledges and appreciates the comment but did not implement changes to the regulation.

Comment: The Department received comments suggesting that the MCO be responsible for reimbursing non-participating providers due to the lack of an available or qualified participating provider.

Response: The Department acknowledges and appreciates the comment but did not change current language in the regulation.

Comment: The Department received comments requesting that the MCO should be required to educate enrollees on their right to seek out-of-network care when there is not an available or appropriate in-network provider.

Response: The Department acknowledges and appreciates the comment but did not implement the change because this requirement already exists in law.

Comment: The Department received comments regarding the incorporation of time and distance standards and enrollee to provider ratio standards into the regulation.

Response: The Department is assessing standards for all health care services and will address separately from this regulation.

Comment: The Department received comments requesting that the term "complaint" should be changed to "request" as a request for an MCO to help find a provider should not be treated as a complaint. The Department also received comments suggesting that the MCOs should designate behavioral health access system separate from an existing system for general complaints. MCO's should be required to send by mail to all enrollees the following records within thirty days of the initial complaint: date and time of the complaint, method used, date and time MCO responded, the type of behavioral health service enrollee is seeking, and the behavioral health providers the MCO located.

Response: The Department revised the regulation to use the term "access complaint" to distinguish from other types of complaints. Language was also added to clarify the process and specify that an access complaint could be submitted by telephone or in writing (which includes electronic means, such as email).

Comment: The Department received comments requesting that the MCO should be given five business days to locate a participating provider from the date of the complaint.

Response: The Department acknowledges and appreciates the comment but did not change the three business day requirement.

Comment: The Department received comments suggesting that instead of requiring the MCOs to submit their certification for the requirements of this regulation annually, MCOs should be required to demonstrate compliance, and DOH should monitor compliance via surveillance, such as "secret shoppers," as well as by closely reviewing the data submitted pursuant to Section 98-5.9. Results of secret shopper surveys and enforcement activity should be publicly reported on DOH's website to build consumer confidence in the plans and the regulatory function.

Response: The Department acknowledges and appreciates the comment but did not implement the change because DOH surveillance activities are addressed in separate regulations.

Comment: The Department received comments suggesting that the wait time standard for appointments following discharge from a hospital or emergency room visit, should be reduced from the proposed seven days. Comments recommended that the MCO network have adequate capacity to ensure an offer for a behavioral health appointment will be made a maximum of three days following a discharge from a hospital or an ER visit.

Response: The Department acknowledges and appreciates the comment but did not implement the change. The word "calendar" was added for clarity.

Comment: The Department received comments requesting to decrease the wait time standards as they are too long for those that need immediate behavioral health services.

Response: The Department acknowledges and appreciates the comment but did not implement the change. When developing this regulation, the Department in coordination with DFS, met with numerous provider representatives who acknowledged that their initial appointment wait times are often 30 days or longer due to a high demand for services and a shortage of providers, regardless of whether they participate in a MCO's network.

Comment: The Department received comments recommending that DOH include standardization of MCO administrative functions in efforts to improve MCO network adequacy and access to care.

Response: The Department acknowledges and appreciates the comment but did not implement the change.

Comment: The Department received comments recommending that DOH should institute more stringent quantitative standards for behavioral health services and specific behavioral health provider types.

Response: The Department acknowledges and appreciates the comment but did not implement the change.