March 11, 2024

Commissioner Dr. James V. McDonald
New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237

RE: Proposed new subpart 98-5 Network Adequacy for Mental Health and Substance Use Disorder Treatment Services

Dear Commissioner McDonald:

The New York State Council for Community Behavioral Healthcare (The NYS Council) represents 150 mental health and/or addiction prevention, treatment, recovery, and harm reduction community-based organizations operating in local communities across New York. Our members offer these services in a variety of settings including freestanding nonprofit agencies, mental hygiene departments that operate direct services, and general hospitals. Our core mission is now and has always been to ensure the availability of mental health and addiction care to New Yorkers who need these services. Access to care is our true north. As such, we appreciate the opportunity to comment on the establishment of new network adequacy standards that will apply to mental health and substance use disorder treatment services here in New York.

The development of these regulations presents an opportunity to greatly increase access to affordable, geographically accessible MH and SUD care and to streamline the ability for Medicaid Managed Care members to exercise their rights to care. While until now, regulatory standards have not existed in New York on this issue, several network standards can be found in the Medicaid Managed Care Model Contract ("Model Contract") as well as certain federal standards that apply across Managed Care products. However, the proposed regulations do not align with the standards in the Model Contract and in some cases are quite different. It is unclear at this time how the proposed regulations will interact with the existing standards in the Model Contract and so we urge DOH to align the standards where it makes sense to do so. In addition, we think it is important for the Department to issue guidance so that MCOs, providers and managed care members understand the applicable standards. If changes are to be made to the Model Contract, we ask that you please comply with a new law that was enacted last June that requires the Department to post anticipated changes to the Model Contract on its Website.

We commend the Department for including several key standards in the proposed regulations, however, we are concerned that there are no standards proposed for **travel distance**. This is a critical indicator that tells the story of how easy it is for an insured to access MH and SUD services in a network and as you know, transportation in some areas of the state is a huge problem. As such we urge the Department to

adopt strong standards associated with (at a minimum) the distance an insured must travel to obtain timely care.

Additionally, throughout the proposed regulations, the term "behavioral health" is used rather than specifying mental health or substance use disorder. The Centers for Medicare & Medicaid Services (CMS) recently proposed amending the Medicaid managed care regulations to use the terms mental health and substance use disorder, instead of behavioral health, recognizing that behavioral health "is an imprecise term that does not capture the full array of conditions that are intended to be included" and that it is important to use clear, unambiguous terms in regulatory text. (*See* 88 Fed. Reg. 28092, 28110.) Therefore, whenever applicable, each provider category should be specified and tracked separately to ensure adequate access to both mental health and substance use disorder treatment for enrollees.

Over the years, the NYS Council has focused our efforts on advocacy designed to ensure adequate surveillance, monitoring and enforcement of all state and federal laws, regulations and contract provisions associated with the carve-in of our services to the state's Medicaid managed care program. As you know, since 2019 over 200 citations have been issued against numerous health plans for a variety of problems including failure to adequately oversee the MCO vendor that some health plans use to manage these benefits. While citations have been issued, we see little in the way of meaningful enforcement in instances where the health plan has failed to correct its actions in a timely manner. **We strongly urge the Department of Health to engage in robust monitoring activities and to strongly enforce these and all requirements on health plans and their MCOs once implemented. Without strong enforcement, MCOs have no real incentive to come into compliance.**

The NYS Council offers the following comments on the proposed standards as well as suggested additions:

Section 98-5.4 Network provider type standards.

The list of service types in 98-5.4(a) are all important, but it should also identify other practitioners and community-based providers that are essential for the continuum of MH and SUD care or at least specify that this is a non-exhaustive list. The Model Contract includes several other contracting requirements for MH and SUD services that could also be reflected here.

We further recommend amending 98-5.4(b) to make clear that the commissioners of health, mental health and addiction services and supports has determined that there is a sufficient number of providers available in *all regions/counties of* the State to meet network adequacy standards.

Section 98-5.5 Appointment wait time standards.

The ability to access a provider appointment within a short timeframe after requesting one is critical to providing on demand care to a group of New Yorkers who are struggling to stay alive amidst a raging overdose epidemic and rising numbers of suicide attempts and suicide completions. Establishing a strong standard for wait times will incentivize plans to right size their networks and provide consumers with a mechanism to access out-of-network providers when appointments are not available. New York must re-double its efforts to ensure providers are reimbursed on time and in full, and in compliance with all applicable state laws, so they can quickly meet fluctuations in demand for care. This begins with the state taking strong and decisive action that makes clear to all MCOs that they must follow the laws and contract provisions they are bound to.

The standards in the proposed regulation, 10 business days for initial appointment with an outpatient facility or clinic, 10 business days for an appointment with a health care professional that is not part of an outpatient clinic and seven days for an appointment following hospital or emergency room discharge are a good start, but they do not go far enough. The wait time standards found in section 15.2 of the Model

Contract are in some cases better than the proposal. For example, the Model Contract requires an appointment available within one week of a request for non-urgent MH and SUD care at an outpatient clinic (Model Contract 15.2(a)(xiv)) and requires an appointment for certain urgently needed SUD services within 24 hours of the request (Model Contract 15.2(a)(iv)). Additionally, the proposed regulations do not have a standard for urgent appointments at all. In these and other cases, it is unclear which standard will apply, but we urge the Department to include standards for urgent and emergent care in the regulations.

Specifically, we recommend the Department: (1) clarify that the standards it has proposed in Section 98-5.5(a)(1) and (2) are for "non-urgent" outpatient visits; (2) reduce the timeframe Section 98-5.5(a)(1) and (2) to 7 calendar days for non-urgent outpatient visits, and (3) add a new subsection to adopt a discrete standard requiring "urgent" MH and SUD care to be available within 24 hours, consistent with the existing model contract language, and 4) ensure that 'same day access' appointments are counted in this exercise.

Further, we urge the Department to adopt a standard to require availability of ongoing appointments. As written, the proposed standards only apply to an "initial visit." MH and SUD treatment almost always requires regular, ongoing care which the regulations should reflect. Based on the experience in other states, we are concerned that MCOs will meet the standard by making an initial appointment available, but someone will still need to wait several weeks to receive continuing treatment necessary for their condition.

California recently adopted network adequacy standards for MH and SUD care and found that health plans were in fact only making initial appointments available, with widespread lengthy delays for follow up appointments continuing. The state had to enact legislation in 2021 to close this "loophole" and ensure that their appointment wait time standards applied to *follow up* appointments as well as initial appointments.

Section 98-5.6 Access to participating providers for enrollees.

We commend the Department of Health for including this simplified process for ensuring access to an out-of-network provider when an in-network provider is not available. We urge the Department to ensure that MCO enrollees are fully aware of the process for submitting a complaint and that it is easy and accessible.

The proposal provides these protections when a participating provider is not available within the wait times set forth in section 98.5.5, but as described above, there are additional wait time standards in the Model Contract as well as time and distance standards that are not included in this proposal. Additionally, the Department has issued "Guidelines for MCO Service Delivery Networks" that provide network contracting requirements for various service types (i.e. the MCO must contract with all opioid treatment programs in a county). It is unclear why the protections provided in this section would not apply to all the network standards set forth by the Department and we would urge you to amend this section to ensure that enrollees can complain and seek out-of-network care without additional cost sharing whenever a provider is unavailable based on all the standards indicated.

Additionally, the protections in this section must be available when a provider with the skills and expertise to meet an individual's particular needs is not available. If there are in-network providers available in the specified wait time, but they are inappropriate for that individual patient's needs, that patient should be permitted to seek out-of-network care with no additional cost sharing, and we urge the Department to make this clarification in the final regulations.

To ensure that these out-of-network providers are still appropriately compensated, particularly when their networks for MH and SUD providers are inadequate to meet their enrollees' needs, we recommend the Department further specify in Section 98-5.6(d) that the Medicaid MCO will pay the remainder of the

billed charge. In doing so, the Department can help incentivize Medicaid MCOs to build adequate networks of MH and SUD providers by reimbursing them at sufficient rates.

Section 98-5.7 Provider directory requirements.

In addition to the details listed in section 98-5-7 for inclusion in the provider directory, the provider directory shall also describe whether a provider will see patients via telehealth, in-person, or both. This information should specifically be available in the searchable and filterable directory on the MCO's website, as required by 98-4.7(b).

We are also pleased to see requirements for MCOs to check the accuracy of directories, but we encourage the Department to strengthen these requirements and to do so in a manner that does not burden the provider. Again, this is an insurer's responsibility.

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

The NYS Council appreciates the Department's addition of certain responsibilities for MCOs in this section, especially the requirement to have designated staff focused on finding in-network providers based on the enrollee's specific treatment needs. We recommend the Department clarify in Section 98-5.8(a) that the MCO should have designated staff with sufficient knowledge *in both MH and SUD*, to assist these enrollees, recognizing that staff with expertise in the delivery of one of these conditions may not have the knowledge of the other delivery system.

Appointment wait time standards measure whether care is reasonably available, but geographic criteria (travel time/distance standards) and minimum number of providers are metrics for determining whether providers are reasonably accessible. Both are necessary, and we are concerned that the Department has failed to include metrics that ensure MH and SUD care are reasonably accessible. As previously noted, many individuals with MH and SUD needs require care on a regular basis. Thus, having discrete standards that measure access are necessary to ensure Medicaid managed care enrollees can receive and remain in treatment.

It is clear that the Department understands the importance of travel time and distance standards as they are included in the Model Contract for Primary Care Providers (PCPs) and HIV specialty providers for enrollees in HIV SNPs (Model Contract 15.5(b). Additional guidance includes a travel time and distance standard of **30 minutes or 30 miles** from an enrolled residence to a participating provider without specifying the provider type. The guidelines also include requirements for MCOs to contract with a certain quantity of provider types in each county and rural region, for example, two (2) Medically Managed Detox providers per county (or per region in rural areas) or all opioid treatment providers in a county. However, by not incorporating these standards into the regulations, enrollees will not as easily be afforded the right to obtain out-of-network care when no provider can be found within those time and distance standards to meet their clinical needs.

Maryland has recently adopted strong network adequacy standards for commercial insurance, at COMAR 31.10.44 which we recommend the Department replicate for New York Medicaid managed care enrollees. These standards identify the maximum travel distance from the enrollee's location to specific MH and SUD (as well as medical) provider and facility type, based on whether the enrollee is in an urban, suburban, or rural area. *See* COMAR 31.10.44.05(5). These regulations also include minimum provider-to-enrollee ratio standards, specifying that each health plan must have at least one full-time provider of MH services per 2000 enrollees, and at least one full-time provider of SUD services per 2000 enrollees. *See* COMAR 31.10.44.07. We urge the Department to consider adopting comparable geographic network access standards and minimum provider-to-enrollee ratios for New York Medicaid managed care enrollees for both MH and SUD providers and facilities.

Thank you for the opportunity to provide comments. Please feel free to reach out with any questions. I remain available to you at 518 461-8200 at your convenience.

Sincerely,

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