April 22, 2024

Adrienne A. Harris, Superintendent
New York State Department of Financial Services
1 Commerce Plaza
Albany, New York 12257
HealthRegComments@dfs.ny.gov

RE: Proposed Draft Insurance Regulations 230, new subpart 11 NYCRR 38 Network Adequacy Access Standards

Dear Superintendent Harris:

The NYS Council for Community Behavioral Healthcare (NYS Council) appreciates the opportunity to comment on the establishment of new network adequacy standards for certain New York State Health Insurance Plans that will apply to mental health and substance use disorder treatment services.

The NYS Council represents 150 community-based agencies that operate a broad range of programs and services that are regulated, certified, or otherwise registered with the NYS Office of Mental Health (OMH) and/or the Office of Addiction Services and Supports (OASAS).

For over 20 years, the NYS Council has focused our advocacy efforts on ensuring all New Yorkers have access to on demand addiction and mental health services available in local communities around the state. We have relentlessly advocated for the Department to address inadequate commercial reimbursement rates that create limited access to these services for New Yorkers with commercial insurance and so we are deeply grateful for the historic passage of Part AA in the Article VII Health/Mental Hygiene budget bill that was passed by the Legislature and signed into law on April 20, 2024. Thank you.

Having said this, we remain deeply concerned with Network Adequacy standards that have not been updated for some time.

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 New York State insureds to exercise their rights to care. While until now, regulatory standards have not existed in New York on this issue, some network standards that apply to commercial plans can be found in the Medicaid Managed Care Model Contract ("Model Contract"), others are included in guidance available on the DFS website. We urge DFS to adopt strong standards to ensure adequate access to care, and to align standards

across insurance and managed care products which will ease confusion as people cycle between plan types and not discriminate against anyone simply based on the type of insurance they have.

We commend DFS for including several key standards in the proposed regulations, however, we are concerned that there are no standards proposed for travel distance and time or provider-to-enrollee ratios. Both are critical to ensuring access to MH and SUD services in a network and we urge DFS to adopt strong standards for both.

Additionally, throughout the proposed regulations, the term "behavioral health" is used rather than specifying mental health or substance use disorder. These are separate diagnoses with separate provider types who are separately licensed and in New York, are regulated under different agencies. 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 "[i]t 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.

We also strongly urge DFS to engage in robust monitoring activities and to strongly enforce these standards once implemented. Without strong enforcement, insurers 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 38.3 Network provider type standards.

The list of service types in 38.3 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.

We recommend amending 38.3(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 *in-person* providers available in *all regions/counties of* the State to meet network adequacy standards.

Section 38.4 Appointment wait time standards.

The ability to access a provider appointment within a short timeframe after requesting one is not just a key measure of network adequacy but is critical to providing quality care. Establishing a strong standard will incentivize insurance plans to right size their networks and provide consumers with a mechanism to access out-of-network providers when appointments are not available. Importantly, these wait time standards, as well as the definition of appointment wait time in Section 38.2(a) should stress that appointments for services must meet the enrollee's specific clinical treatment needs and be culturally and linguistically effective for that enrollee.

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 Medicaid Model Contract are in some cases better than the proposal, indicating that New York State has already determined that shorter wait times are preferable. 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 request (Model Contract 15.2(a)(iv)). Additionally, the proposed regulations do not have a standard for urgent appointments at all. We urge DFS to include standards for urgent and emergent care in the regulations.

Specifically, we recommend DFS (1) clarify that the standards it has proposed in Section 38.4(a)(1) and (2) re: for "non-urgent" outpatient visits, (2) reduce the timeframe for each of these to 7 calendar days for non-urgent outpatient visits, and (3) add a new subsection 38.4(a)(4) to adopt a discrete standard requiring “urgent” MH and SUD care to be available within 24 hours, consistent with the Medicaid model contract language. In the midst of our country’s ongoing opioid epidemic and mental health crisis, now is not the time to make treatment less accessible, and we urge the Department to maintain these critical access standards and incorporate them into the final regulations.

Further, we urge DFS 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 health plans 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. See CA Senate Bill 221 Health care coverage: timely access to care. As such, we recommend DFS amend Section 38.4(a)(1) and (2) to read “for an initial appointment and for any ongoing appointments...”

Section 38.5 Access to participating providers for enrollees.

We commend DFS for including this simplified process for ensuring access to an out-of-network provider when an in-network provider is not available. We urge DFS to ensure that health plan 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 38.4, however, the Department of Health has issued “Guidelines for MCO Service Delivery Networks” that provide network contracting requirements for various service types and indicate that they apply to commercial networks. (i.e. the health plan 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 DFS in section 38.5 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 DFS 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 DFS further specify in 38.5 that the health insurance plan will pay the remainder of the billed charge. In doing so, DFS can help incentivize insurers to build adequate networks of MH and SUD providers by reimbursing them at sufficient rates.

Section 38.6 Provider directory requirements.

In addition to the details listed in section 38.6 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 insurers, as required by 38.6(b).

Secondly, we were pleased to see requirements for insurers to check the accuracy of directories, but we encourage DFS to strengthen these requirements. For example, insurers should be checking the accuracy of directories at least quarterly, rather than annually. Providers can enter and leave a network regularly throughout the year and contact information can change often. Additionally, insurers are already required to submit network information to the PNDS quarterly[1], and that information should have been verified before submission. Further, we urge you to add a provision to require insurers to update information in the directory immediately upon notification by a provider that their contact information or network status has changed.

We suggest adding that in addition to verifying accuracy of the provider's information and network status as required in 38.6(d) the insurer must also verify whether the provider is actively accepting new patients and remove them from the directory if not. Additionally, we are pleased to see the provision in 38.6(e) to review claims activity by providers and verify accuracy of any providers who haven't submitted claims.

We also strongly support section 38.6(f) that requires insurers to have a method available on their website for enrollees to flag errors, and would urge you to ensure insurers accept reports through multiple channels including the website, by phone, or in writing and that the process be prominently displayed on the website and on each provider listing given to enrollees.

[1] See PNDS data dictionary available at https://www.health.ny.gov/health_care/managed_care/docs/dictionary.pdf

<u>Section 38.7 Additional responsibilities regarding network adequacy and access.</u>

The NYS Council appreciates DFS's addition of certain responsibilities for health plans 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 DFS clarify in Section 38.7(a) that the health plan 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.

We also support the requirement to create an access plan establishing protocols for monitoring access. In addition to the list of details for the access plan identified in the proposal, we urge DFS to monitor the availability of in-person services by adding a metric to look at the number of providers necessary to provide in-person services and the number of providers in the network providing in-person and telehealth services to account for a potential shortfall in in-person service providers. We also urge DFS to require health plans to post their access plan publicly in a structure that is understandable to health plan enrollees.

Appointment wait time standards measure whether care is reasonably available, but geographic criteria (travel time/distance standards) and minimum number of providers or provider-to-enrollee ratios are metrics for determining whether providers are reasonably accessible. Both are necessary, and we are concerned that DFS 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 ensuring all New Yorkers can receive and remain in treatment.

It's clear that NYS and DFS understand the importance of travel time and distance standards as they are included in DFS guidance for Primary Care Providers (PCPs).[2] Additional guidance includes a travel time and distance standard of 30 minutes or 30 miles from an enrollees residence to a participating provider without specifying the provider type.[3] The guidelines also inlclude requirements for commercial providers (as included in the Model Contract and Network Guidelines on the DOH website) to contract with a certain quantity of provider types in each county and rural region, for example, 2 Medically Managed Detox providers per county (or per region in rural areas) or all opioid treatment providers in a county.[4] 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 an be found within those time and distance standards to meet their clinial needs.

[2] See Network Adequacy Requirements, Standards, and Submission Instructions, last accessed April 5, 2024, available at: https://www.dfs.ny.gov/apps_and_licensing/health_insurers/network_adequacy_reqs_standards_submission_instructions

[3] See Guidelines for MCO Service Delivery- Version 3.0, available at: https://www.health.ny.gov/health_care/managed_care/guidelines_for_mco_service_delivery_networks-v3.0.htm#att4

[4] Id at Appendix 4.

Maryland has recently adopted strong network adequacy standards for commercial insurance, at COMAR 31.10.44 which we recommend DFS replicate for New York regulated health insurance plans. Maryland's 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 DFS to consider adopting comparable geographic network access standards and miminum provider-to-enrollee ratios for New York health plan enrollees for both MH and SUD providers and facilities.

Thank you for the opportunity to provide comments on behalf of the NYS Council. Please feel free to contact me at 518-461-8200 or lauri@nyscouncil.org with any questions.

Sincerely,

Lauri Cole
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NYS Council for Community Behavioral Healthcare