Commission is now requiring the Responsible Party to retain an executed training completion form, as prescribed by the Commission.

4. Costs:

a. Costs to regulated parties for implementation and compliance: Minimal.

b. Costs to the agency, State and local governments for the implementation and continuation of the rule: No costs to such entities.

c. Cost information is based on the fact that there will be minimal costs to regulated parties and state and local government for training staff on changes to the requirements.

5. Local Government Mandates: The Proposed Rulemaking does not impose new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

6. Paperwork: This regulation eliminates the requirement for the regulated community to complete and executed affidavit; instead; requires the completion of a training completion form, as prescribed by the Commission.

7. Duplication: This regulation does not duplicate any existing federal, state or local regulations.

8. Alternatives: Currently, the Commission requires each Individual Lobbyist submit a completed and executed affidavit of training completion. The only other alternative would be to keep the burden on Individual Lobbyists to complete an executed affidavit.

9. Federal Standards: This regulation does not exceed any minimum standards of the federal government with regard to a similar subject area.

10. Compliance Schedule: Compliance with the Emergency Rulemaking will take effect on January 1, 2025.

Regulatory Flexibility Analysis

A Regulatory Flexibility Analysis for Small Businesses and Local Governments is not submitted with this Notice of Emergency Adoption and Proposed Rulemaking because the rulemaking will not impose any adverse economic impact on small businesses or local governments, nor will it require or impose any reporting, recordkeeping, or other affirmative acts on the part of these entities for compliance purposes. The Commission on Ethics and Lobbying in Government makes this finding based on the fact that the rule implements current law and, therefore, imposes no new requirements on such entities.

Rural Area Flexibility Analysis

A Rural Area Flexibility Analysis is not submitted with this Notice of Emergency Adoption and Proposed Rulemaking because the rulemaking will not impose any adverse economic impact on rural areas, nor will it require or impose any reporting, recordkeeping, or other affirmative acts on the part of rural areas. The Commission on Ethics and Lobbying in Government makes this finding based on the fact that the rule implements current law and, therefore, imposes no new requirements on such entities. Rural areas are not affected.

Job Impact Statement

A Job Impact Statement is not submitted with this Notice of Emergency Adoption and Proposed Rulemaking because the proposed rulemaking will have limited, if any, impact on jobs or employment opportunities. This regulation implements current law and, therefore, imposes no new requirements. This regulation does not relate to job or employment opportunities.

Department of Financial Services

REVISED RULE MAKING NO HEARING(S) SCHEDULED

Network Adequacy and Access Standards for Mental Health and Substance Use Disorder Treatment Services

I.D. No. DFS-08-24-00001-RP

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following revised rule:

Proposed Action: Addition of Part 38 (Regulation 230) to Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301, 302; Insurance Law, sections 301, 3217-a, 3241, 4324; L. 2023, ch. 57, part II

Subject: Network Adequacy and Access Standards for Mental Health and Substance Use Disorder Treatment Services.

Purpose: To establish network adequacy and access standards and other protections to improve access to behavioral health services.

Substance of revised rule (Full text is posted at the following State website: https://www.dfs.ny.gov/industry_guidance/regulatory_activity/insurance): New Part 38 sets forth standards for network adequacy for mental health and substance use disorder treatment services to improve insureds' access to behavioral health services.

Section 38.0 is the preamble for Part 38.

Section 38.1 makes Part 38 applicable, effective [January 1, 2025] *120 days after publication of the Notice of Adoption in the State Register*, to any health care plan that delivers, or issues for delivery, in New York a comprehensive health insurance policy or contract that uses a network of health care providers to deliver behavioral health services.

Section 38.2 defines terms used in Part 38.

Section 38.3 sets forth standards regarding network provider types.

Section 38.4 sets forth appointment wait time standards and permits the use of telehealth appointments *to meet the appointment wait time standards* unless the insured specifically requests an in-person appointment.

Section 38.5 permits an insured to file a*n access* complaint with the health care plan when access to behavioral health services from an in-network provider who can treat the insured's behavioral health condition, and is available within the appointment wait time standards, is unavailable. The health care plan has three days to locate such a provider, and if it cannot do so, the health care plan must permit the insured to receive the behavioral health services from a non-participating provider *who can treat the insured's condition,, can and meet the appointment wait time standards, and is located within a reasonable distance if the insured requests an in-person appointment,* regardless of whether the insured's coverage includes out-of-network benefits. *In addition, the health care plan cannot impose a greater cost-sharing requirement on the insured than the cost-sharing for services from a participating provider and must apply the same out-of-pocket maximum.*

Section 38.6 sets forth provider directory requirements for the listing of behavioral health providers *and requires thea health care plan to verify the accuracy of such information at least annually*, [requires a health care plan to] *provide the insured or insured's designee with a list of behavioral health providers available to treat a specific behavioral health condition within three business days of the request,* [requires a health care plan to] *review claims activity every six months and confirm certain information with those behavioral health providers that did not submit claims during such period, and* [requires a health care plan to have] *post a method on a publicly accessible area of its website for a person to report errors in the provider directory information and to correct such errors within specified timeframes*.

Section 38.7 sets forth additional healthcare plan responsibilities regarding network adequacy and access, such as the provision of and access to staff designated to help insureds find appropriate participating behavioral health providers and the making of an access plan to establish protocol for monitoring and ensuring access to behavioral health services.

Section 38.8 sets forth reporting requirements regarding a health care plan's access plan made in accordance with section 38.7, sufficiency of in-network providers and permission for insureds to use non-participating providers in accordance with section 38.5, *information on access complaints received and their resolution in accordance with section 38.5,* and provider directory verification made in accordance with section 38.6.

Revised rule compared with proposed rule: Substantial revisions were made in Part 38.

Text of revised proposed rule and any required statements and analyses may be obtained from Stephani Schendlinger, New York State Department of Financial Services, One Commerce Plaza, Albany, NY 12257, (518) 473-0273, email: HealthRegComments@dfs.ny.gov

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Revised Regulatory Impact Statement

1. Statutory authority: Financial Services Law ("FSL") sections 202, 301, and 302, Insurance Law ("IL") sections 301, 3217-a, 3241, and 4324, and Part II of Chapter 57 of the Laws of 2023 ("Chapter 57").

FSL section 202 establishes the office of the Superintendent of Financial Services ("Superintendent").

FSL sections 301 and 302 and IL section 301, in pertinent part, authorize the Superintendent to prescribe regulations interpreting the IL and to effectuate any power granted to the Superintendent in the IL, FSL, or any other law.

IL section 3217-a sets forth disclosure requirements for all comprehensive, expense-reimbursed health insurance contracts, managed care health insurance contracts, and any other health insurance contract for which the Superintendent deems such disclosure appropriate.

IL section 3241 requires an insurer, a corporation organized pursuant to

IL Article 43, a municipal cooperative health benefit plan certified pursuant to IL Article 47, and a student health plan established or maintained pursuant to IL section 1124 (collectively, "health care plans"), that issues a health insurance policy or contract with a network of health care providers to ensure that the network is adequate to meet the health care needs of insureds and provide for an appropriate choice of providers sufficient to render the services covered under the policy or contract.

IL section 4324 sets forth disclosure requirements for all comprehensive, expense-reimbursed health insurance contracts, managed care health products, and any other contract or product for which the Superintendent deems such disclosure appropriate.

Chapter 57 amended the Insurance Law to require the Superintendent, in consultation with the Commissioners of Health, the Office of Mental Health ("OMH"), and the Office of Addiction Services and Supports ("OASAS"), to propose regulations setting forth standards for network adequacy for behavioral health treatment services.

2. Legislative objectives: To effectuate the statutory intent of Chapter 57 to increase access to behavioral health services in this State by establishing provider network standards. The regulation strengthens network adequacy requirements for behavioral health services, requires health plans to establish internal protocols for monitoring access and utilization of these services, assists insureds in finding timely access to providers, and takes certain actions to ensure the accuracy of provider directories. Together, these requirements will make it easier and faster for consumers to access behavioral health services.

3. Needs and benefits: The regulation implements Chapter 57, which requires the Department of Financial Services ("Department") to establish by regulation requirements for provider networks used by health care plans that issue comprehensive health insurance policies or contracts in relation to behavioral health services. Ensuring meaningful access to behavioral health care is vital to addressing New York's behavioral health crisis.

A key component of access is the availability of an adequate number of appropriate providers within a health care plan's network. The regulation sets forth appointment wait time standards for behavioral health services. If an insured cannot access behavioral health services from an in-network provider who can treat the insured's behavioral health condition and is available within the appointment wait time standards, the regulation gives the health care plan three business days from receipt of an access complaint to provide the insured or the insured's designee with the contact information for an in-network provider who can treat the insured's behavioral health condition and is available within the appointment wait time standards. If the insured requests an in-person visit rather than a telehealth visit, the in-network provider also must be located within a reasonable distance.

If no such in-network provider is available within the appointment wait time standards, the regulation requires the health care plan to provide the insured with a referral to an out-of-network provider at the in-network cost-sharing, if the out-of-network provider can treat the insured's behavioral health condition, is able to meet the appointment wait time standards, is located within a reasonable distance from the insured, and charges rates that 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 health care plan locates an in-network provider that can treat the insured's behavioral health condition, is able to meet the appointment wait time standards, is located within a reasonable distance if an in-person appointment is requested, and the insured's treatment can be transitioned to the in-network provider, unless the health care plan determines, in consultation with the insured's treating provider, as appropriate, that such transition would be harmful to the insured.

The regulation requires health care plans 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, languages 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 health care plans 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 health care plans to post certain information on a publicly accessible area of their websites, including a method for insureds, 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 a health care plan to have an access plan that establishes a protocol for monitoring and ensuring access to behavioral health services, including assessing the ability of the health care plan's network of behavioral health providers to meet the cultural and linguistic needs of the health care plan's insured population. The regulation also requires health care plans to submit to the Superintendent an annual certification of compliance that includes the number of access complaints received by the health care plan and a description of how the access complaints were resolved.

4. Costs: A health care plan may incur compliance costs to: file new insurance policy and contract forms and premium rates with the Department; develop a process to monitor and evaluate access to its network providers; recruit additional behavioral health 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 insureds; however, certain costs should be minimal because health care plans submit insurance policy or contract form and premium rate filings as a part of the normal course of business and should already have compliance procedures in place.

The regulation may impose compliance costs on the Department because the Department will need to review amended insurance policy and contract forms and premium rates and review annual compliance certifications. However, any additional costs incurred by the Department should be minimal because existing personnel are already available to review any filings necessitated by the regulation and the Department should be able to absorb the costs in its ordinary budget.

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

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

6. Paperwork: Health care plans may need to file new insurance policy forms and premium rates with the Department to comply with the regulation. These include the health insurance contracts and certificates that describe the covered benefits that are reviewed and approved by the Department and then issued to covered individuals. Health care plans also will need to submit an annual certification of compliance to the Superintendent. Health care plans must annually certify that they have an access plan that includes protocols 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-insured ratios and appointment wait times, and assessing the ability of their networks' behavioral health providers to meet the cultural and linguistic needs of their insured populations. The access plan must be available to the Department upon request. Health care plans also must certify that they have sufficient providers to meet the appointment wait time standards or otherwise permit insureds to go out-of-network at no additional cost to the insureds and performed the provider directory verification as required by the regulation.

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

8. Alternatives: The Department consulted with the Department of Health, OMH, and OASAS when drafting the regulation. The Department also met with numerous stakeholders representing providers, consumers, and health care plans. 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 behavioral health 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. The Department considered requiring health care plans to meet longer appointment wait time standards of 14 to 28 days, instead of ten business days, for initial behavioral health treatment appointments. 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 IL includes a mechanism for an insured to go out of network when there is no provider in a health care plan's network who can perform the services. That process requires the insured to file an internal appeal with a health care plan and an external appeal with independent medical experts. The Department considered the use of that process to assist insureds in finding timely and proximate access to behavioral health services. However, the Department chose to require a more streamlined process for health care plans to assist an insured in obtaining an appointment with a provider who meets the appointment wait times, which does not necessitate an appeal with independent medical experts.

The Department considered several different timeframes for health care plans 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 60 or 90

days. However, the interruption of certain behavioral health treatments may cause harm to an insured in some circumstances, while in other situations an insured may be more appropriately transitioned to an in-network provider sooner.

The Department also considered requiring out-of-network referrals to be effective until the completion of an insured's treatment. However, some behavioral health treatments can be very lengthy, lasting years, which would be costly for insurers and increase premiums. In addition, insurers currently can transition insureds to in-network providers in other circumstances where out-of-network referrals are made.

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

10. Compliance schedule: Health care plans will need to comply with the regulation 120 days after publication of the Notice of Adoption in the State Register for policies and contracts issued, renewed, modified, or amended on or after such date, and will need to submit their first annual compliance certifications by December 31, 2026.

Revised Regulatory Flexibility Analysis

1. Effect of rule: The regulation applies to insurers licensed to write accident and health insurance pursuant to Insurance Law Article 42; corporations organized pursuant to Insurance Law Article 43; municipal cooperative health benefit plans certified pursuant to Insurance Law Article 47; and student health plans established or maintained pursuant to Insurance Law section 1124 (collectively, "health care plans"). Although most health care plans do not come within the definition of "small business" as defined in State Administrative Procedure Act ("SAPA") section 102(8) because they generally are not both independently owned and have fewer than 100 employees, industry has previously asserted that certain health care plans, in particular mutual insurers, subject to the regulation are small businesses but has not provided the Department of Financial Services ("Department") with either the names of specific health care plans or the number of such entities. The regulation does not apply to local governments.

2. Compliance requirements: Any health care plan that is a small business affected by the regulation may need to file new policy and contract forms and rates with the Department to comply with the regulation. In addition, any health care plan that may be a small business must annually certify that it has an access plan that includes protocols 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-insured ratios and appointment wait times, and assessing the cultural and linguistic needs of their insured populations. The access plan must be available to the Department upon request. A health care plan that may be a small business also must annually provide a certification confirming that it has sufficient providers to meet the appointment wait time standards or otherwise permits insureds to go out-of-network at no additional cost to the insureds and that it has performed the provider directory verification as required by the regulation, and provide the number of access complaints received with a description of how the access complaints were resolved, including the number of approved referrals.

No local government will have to undertake any reporting, recordkeeping, or other affirmative acts to comply with the regulation.

3. Professional services: A health care plan that is a small business affected by the regulation will not need to retain professional services, such as lawyers or auditors, to comply with the regulation. No local government will have to undertake any reporting, recordkeeping, or other affirmative acts to comply with the regulation because it does not apply to any local government.

4. Compliance costs: No local government will incur any costs to comply with the regulation because the regulation does not apply to any local government.

A health care plan that is a small business may incur compliance costs to file new insurance policy and contract forms and premium rates with the Department; develop a process to monitor and evaluate access to its network providers; recruit additional behavioral health 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. However, any costs should be limited because health care plans submit policy or contract form and rate filings as a part of the normal course of business and should have compliance procedures already in place.

5. Economic and technological feasibility: A health care plan that is a small business affected by the regulation may experience an economic or technological impact as a result of the regulation's requirement for the on-line provider directory to 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. No local government will experience any economic or technological impact because of the regulation because it does not apply to any local government.

6. Minimizing adverse impact: There will not be an adverse impact on any local government because the regulation does not apply to any local government. The regulation should not have an adverse impact on a health care plan that is a small business because the regulation uniformly affects all health care plans. A health care plan that is a small business should not face additional challenges when compared to larger entities when complying with the proposed regulatory requirements.

7. Small business and local government participation: The Department complied with SAPA Section 202-b(6) by notifying trade associations that represent health care plans across the entire state, including plans that may be small businesses, that the Department intends to promulgate the regulation. The Department posted the regulation on its website on January 9, 2024 for comment by interested parties, such as health care plans that are small businesses, if any. Health care plans that are small businesses will have yet another opportunity to participate in the rulemaking process when the revised regulation is published in the State Register and posted on the Department's website.

Revised Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: Health care plans affected by the regulation operate in every county in New York State, including rural areas as defined by State Administrative Procedure Act section 102(10).

2. Reporting, recordkeeping, and other compliance requirements; and professional services: Health care plans, including those located in a rural area, may need to file new insurance policy and contract forms and premium rates with the Department of Financial Services ("Department") in order to comply with the regulation. In addition, health care plans, including those located in a rural area, must annually certify that they have an access plan that includes protocols 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-insured ratios and appointment wait times, and assessing the cultural and linguistic needs of their insured populations. The access plan must be available to the Department upon request. Health care plans also must annually provide a certification confirming that they have sufficient providers to meet the appointment wait time standards or otherwise permit insureds to go out-of-network at no additional cost to the insureds and performed the provider directory verification as required by the regulation; and provide the number of access complaints received with a description of how the access complaints were resolved, including the number of approved referrals.

Health care plans, including those in a rural area, should not need to retain professional services, such as lawyers or auditors, to comply with this regulation.

3. Costs: The regulation may impose compliance costs on health care plans, including those in a rural area, to make new policy and contract form and rate filings to comply with the regulation; develop a process to monitor and evaluate access to their network providers; recruit additional behavioral health providers for their networks; and submit an annual compliance certification. However, any costs should be minimal because health care plans submit policy or contract form and rate filings as a part of the normal course of business on a regular basis and should have compliance procedures already in place.

4. Minimizing adverse impact: The regulation uniformly affects health care plans located both in rural and in non-rural areas of New York State. The regulation should not have an adverse impact on rural areas.

5. Rural area participation: The Department notified trade associations representing health care plans across the entire state, including those located in rural areas, that it intended to promulgate the regulation. The Department also met with stakeholders representing health care plans, including those located in rural areas. The Department posted the regulation on its website on January 9, 2024 for comment by interested parties, such as health care plans that are located in rural areas, and the public. Health care plans, including those located in rural areas, will have yet another opportunity to participate in the rulemaking process when the revised regulation is published in the State Register and posted on the Department's website.

Revised Job Impact Statement

Revised 11 NYCRR 38 (Insurance Regulation 230) is not expected to adversely impact jobs or employment opportunities in this State. The revised regulation establishes provider network adequacy and access standards and other protections for behavioral health services to improve access to behavioral services, as required by Part II of Chapter 57 of the Laws of 2023.

Assessment of Public Comment

The New York State Department of Financial Services ("Department") received comments from many interested parties, including insurers and associations representing insurers and health maintenance organizations (collectively, "health care plans"); provider associations representing hospitals, community-based providers, psychologists, and psychiatrists; an association that advances telehealth; and advocates for consumers and children's behavioral healthcare.

Interested parties submitted a number of comments, including comments that: requested a change in the effective date to provide health care plans with more time to meet the new requirements; requested clarification of how the number of days in the definition of "appointment wait time" are counted and how an initial request for services is defined; suggested appointment wait time standards be included for sub-acute residential facilities, assertive community treatment, critical time intervention services, and mobile crisis intervention services; indicated confusion regarding requirements for provider types not mentioned in section 38.3 of the regulation; requested a definition of "residential facilities that provide sub-acute care;" recommended including a list of Office of Mental Health and Office of Alcohol and Substance Abuse Services-licensed residential facilities; requested section 38.3 be amended to allow additional time before it becomes effective following the determination that there are enough providers in each classification; suggested that language in section 38.3 could delay or prevent the regulation from taking effect for all provider types while waiting for just those four categories to be determined sufficient; sought an explanation of when the determination of provider sufficiency in section 38.3 of the regulation would be made and how deficiencies would be handled; requested clarification that the providers must be in-person providers when requested; stated the appointment wait times were too short, impossible to meet due to a statewide provider shortage, and will create unreasonable expectations; stated the standards for appointment wait times are too long, or that there should be a single appointment wait time for all services; recommended removing the appointment wait times altogether or having them apply only to urgently needed services; recommended adding additional standards such as time and distance, provider-to-insured ratios, and a minimum percentage of providers that must accept new patients; encouraged the Department to align with recently issued federal time and distance standards, rather than implement appointment wait time standards; suggested the regulation replicate the minimum provider-to-insured ratio standards of another state; requested adding appointment wait time standards for services such as urgent care, emergency care, inpatient and crisis services, as well as follow-up appointments; sought clarification on how the appointment wait time standards in the proposed regulation will interact with standards for Medicaid managed care plans and programs; requested inclusion of an exception process to allow approval of a network and certification of a qualified health plan where the provider network does not meet standards; requested clarity as to whether the seven-day appointment wait time following discharge from a hospital or emergency room is business days or calendar days; advised that health care plans will face challenges meeting the seven-day appointment wait time because it is not normal practice for an emergency room to assist an individual in finding a provider; noted that health care plans often do not get information about emergency room visits until a claim is submitted; stated that there are not enough behavioral health providers to meet the needs of New Yorkers, and that the proposed appointment wait time standards will not create provider capacity and will be difficult to enforce due to a provider shortage and the demand for behavioral health services; recommended possible solutions to the provider shortage; requested the annual certification language be changed; supported the use of telehealth to meet appointment wait time standards; requested clarification of how adequate capacity and availability will be determined; requested clarity for how health care plans should calculate adherence section 38.4 of the regulation; noted that appointment wait times may be difficult to monitor as they fluctuate widely by provider; suggested that the Department provide standardized guidance to ensure consistency; suggested that a third-party vendor could be commissioned by the State or by health care plans to test access and availability of providers; suggested the regulation should establish a threshold below 100% for compliance; stated that insureds should not have to contact the health care plan for assistance finding an out-of-network provider in urgent situations; requested that "complaint" be changed to "request" because helping an insured find a participating provider should not be treated as a complaint; suggested health care plans create an access complaint tracking system; suggested that health care plans should report detailed data, including information on percentage of providers accepting new patients, claims, and complaints; requested clarification of how the insured would submit or initiate an access complaint; expressed the need for a simplified complaint process and to permit complaints to be made via phone, email, or text message; opposed requiring the submission of a specific form to initiate an access complaint; requested health care plans be required to educate insureds on access complaints and transmit the instructions by email and text message; recommended requiring health care plans to provide instructions on their websites, in provider directories, on explanations of benefit and adverse determinations, by telephone, and in response to complaints about networks; recommended requiring health care plans provide a written response to access complaints; made suggestions on the contents of the written response; requested a revision to language in section 38.5(c) of the regulation; requested the amount of time health care plans have to locate a participating provider be increased; requested the amount of time to locate a provider be decreased; requested clarification whether out-of-network care is automatic; requested that an appeal to the Department be created if the health care plan does not respond within three business days; urged the Department to amend the regulation so that an insured could also seek out-of-network services whenever access standards for managed care organization networks are not met; suggested standards be aligned across insurance and managed care products; recommended defining "unable to schedule" and suggested that it not include instances when the provider was not answering the phone; stressed the need to clarify that available providers must be appropriate for the insured's condition and needs; suggested that, if there is no participating provider or non-participating provider available in the appointment wait time standards, then the health care plan would not be required to approve a referral; stated that the health care plan should be required to assist insureds in finding out-of-network providers that can meet the appointment wait times to the same degree as finding in-network providers; expressed concern that the regulation is silent on the length of time for out-of-network services and the process for transitioning an individual to a participating provider; urged permitting health care plans to transition the insured to a participating provider; urged covering the full episode of care out-of-network; noted that the regulation did not address reimbursement rates for non-participating providers; stated that providers will be incentivized to not join networks, or even leave networks, so they can be paid a higher reimbursement rate, which will increase premiums; suggested that reimbursement for non-participating providers be capped at the in-network rate, Medicaid rate, or a median rate published by a third party; stated that requiring out-of-network services creates extra-contractual benefits and violates benefit plans that were previously approved; recommended treating the out-of-network provider as an in-network provider; urged that insureds be held harmless for costs of out-of-network services; suggested requiring health care plans to provide insureds with a document that promises payment to the provider; recommended that the Department specify that health care plans will pay the remainder of the out-of-network providers' billed charges; stated health care plans should be required to confirm that their claims processing platforms have been updated; expressed concern about ensuring the accuracy of provider directories because the regulation does not require providers to give updated information to health care plans; suggested that providers, not health care plans, be responsible for directory information; expressed concerned that the regulation doesn't reflect the shared responsibility between providers and health care plans, and strongly recommended requiring provider engagement and accountability; recommended that the Department create a monitoring system; offered suggestions on information that should be included in provider directories; suggested the Department develop a list of specific conditions treated and services offered that providers must report; requested clarifying "level of care" offered by the behavioral health provider; opposed including county location in directories; recommended specific fields to be included or excluded as searchable and filterable in directories; suggested requiring health care plans to furnish the list of available providers within 24 hours; suggested clarifying that a list of providers can be given to insureds' representatives upon request; offered suggestions for verifying the accuracy of directory information; supported the annual verification requirement, while others suggested it be semiannual, quarterly, monthly, or only apply to providers who have not been credentialed or re-credentialed in the past 12 months; suggested which information should be verified; stated that providers should be removed from the directory if they are not accepting new patients; suggested verification methods; stated that attempted verification should be deemed compliant whether or not the provider responds; recommended eliminating the semi-annual requirement to review claims activity, or requiring verification every 2 years or only if not already verified in the previous 180 days; recommended different dates for claims review; recommended adding an obligation on the health care plans to immediately update their electronic provider directory upon notification of a change; requested that health care plans be required to review and respond to error reports within 15 days or no less than 30 days; suggested health care plans be required to accept reports of directory errors from any interested party; suggested health care plans should acknowledge complaints regarding directory misinformation; recommended insureds be held harmless for any costs beyond in-network cost sharing when services are received from an out-of-network provider due to errors in the directory; requested that the designated staff's contact information be shared,

including on a publicly available section of the health care plan's website and on identification cards; requested confirmation that contact information for a department, rather than an individual, satisfies the requirement for staff contact information; offered suggestions regarding what types of staff members should be designated to help insureds find participating behavioral health providers; requested that the Department issue guidance on staffing requirements; offered suggestions on staffing requirements; suggested that the designated staff be satisfied by using existing member services staff; recommended that designated staff be available on the same day, with a wait time of 15 minutes or less; supported the requirement that an access plan establish a protocol for monitoring and ensuring access; stated that the access plan requirements place a significant burden on health care plans and providers; recommended that the Department standardize access plans; requested that the regulation be modified to emphasize providers' obligations, such as providing health care plans with updates about the provider's capacity; noted that most providers participate with more than one network and that provider counts may incorrectly indicate more behavioral health providers are available than exist; requested changing the frequency of monitoring of capacity and access from monthly to quarterly or eliminating it altogether; suggested the access plan include the number of providers necessary to provide in-person services, and the number providing in-person and telehealth services; suggested adding the number of essential behavioral health community-based providers; supported the access plans and annual certification requirements; urged making the access plans and annual certifications publicly available and requiring health care plans to demonstrate compliance by reporting detailed data; recommended adding methods of monitoring, enforcement and penalties; and expressed dissatisfaction with the term "behavioral health" instead of specifying mental health or substance use disorder separately, and requiring each to be tracked separately.

The Department considered all the comments received and made changes to the regulation in response thereto. The Department has posted on its website the full assessment of public comments received.

Justice Center for the Protection of People with Special Needs

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Modernizing SDMC Hearings

I.D. No. JCP-47-24-00002-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: Amendment of sections 705.5, 705.6, 710.3, 710.4, 710.5 and 710.7 of Title 14 NYCRR.

Statutory authority: General Construction Law, section 22; Executive Law, section 553(15); Mental Hygiene Law, section 80.07(d); Surrogate's Court Procedure Act, section 1750-b(1)(a)

Subject: Modernizing SDMC Hearings.

Purpose: To clarify and modernize the venue of Surrogate Decision Making Committee hearings to use current technologies.

Text of proposed rule: Subdivision (c) of section 705.5 is amended to read as follows:

(c) Inquiry of personal representative. The service provider shall ask the personal representative if [he or she has] *they have* additional information not known to the service provider concerning the most effective ways to communicate with the service recipient [in order] to support the interview process.

Paragraph (3) of subdivision (a), paragraph (1) of subdivision (b), and subdivision (e) of section 705.6 are amended to read as follows:

(3) If conducting an interview of the service recipient would be clinically contraindicated, despite the provision of appropriate accommodations, the interview shall not take place, except where circumstances exist which support a determination that there exists an overriding health and safety need to proceed with the interview. Such circumstances may include but not be limited to: an investigator reasonably believes that a service recipient has information relevant to maintaining or securing the safety of service recipients and is capable of reliably communicating that information; an investigator reasonably believes that failure to interview a service recipient may allow for the destruction of evidence or for a subject to evade law enforcement; or a delay in interviewing a service recipient may allow a subject to evade law enforcement. Prior to proceeding with the interview, the investigator shall consult with and obtain approval of [his or her] *their* supervisor. Further, such investigator shall document in the investigative record the reason why it was appropriate to proceed with the interview and include the steps taken to protect the service recipient's health, safety, and wellbeing during the interview.

(1) An investigator must notify a service provider if [he or she] *they* will need specific information from a service provider to determine whether to proceed with an interview, including the identity of any additional service recipient witnesses for whom the service provider did not make the required notification as set forth in section 705.5(b)(1) of this Part.

(e) Information for service recipients. Prior to beginning an interview with a service recipient, the investigator shall advise service recipients and/or their personal representatives about what to expect in an interview. The investigator shall explain that participation in an interview is voluntary. In addition, and as applicable, the investigator shall advise the service recipient and/or [his or her] *their* personal representative about searches of the service recipient's personal property and searches of the service recipient's person for the purposes of non-criminal investigations.

Subdivisions (c), (e), and (l) of section 710.3 are amended to read as follows:

(c) Conflict of interest means an association, including a financial or personal association, which precludes the participation of a panel member in the proceedings with regard to a patient. In general, any member who has any interest, financial or otherwise, direct or indirect, or engages in any business or transaction or professional activity or incurs any obligation or receives any benefit of any nature which is in conflict with the impartial discharge of [his or her] *their* duties as a panel member shall neither be assigned to the panel considering the case nor vote upon its disposition. A panel member will be precluded whenever the panel member:

(1) is a relative of the patient;

(2) has served as a board member, officer, employee, or otherwise has been affiliated with the facility where the patient resides or receives services; provided, however, that a member of a board of visitors may serve on a panel for a patient served by the psychiatric center or developmental disabilities services office to which the board of visitors member is assigned, absent any close affiliation or affinity;

(3) has provided health services or has been an officer, board member or employee of any provider of health services to the patient; provided, however, that health care professionals are not precluded from serving on a panel wherein the patient is known to be served by another provider within the same health care network or parent corporation or entity, absent any close affiliation or affinity;

(4) has engaged in any business or has been an officer, board member or employee of any corporation, association, partnership or joint venture which has transacted business with the facility where the patient resides; or has recently received a gift of significant value from the facility where the patient resides; or

(5) is a relative of another panel member.

In general, any member who has any interest, financial or otherwise, direct or indirect, or engages in any business or transaction or professional activity or incurs any obligation or receives any benefit of any nature which is in conflict with the impartial discharge of [his or her] *their* duties as a panel member shall neither be assigned to the panel considering the case nor vote upon its disposition.

(e) Declarant means a person who submits a declaration seeking a major medical treatment decision on behalf of a patient, or seeking a decision to withhold or withdraw life-sustaining treatment on behalf of a patient. Such persons may include the director of the patient's residential facility or [his or her] *their* designee or staff member, the patient's service coordinator, physicians, dentists, staff of hospitals as defined in article 28 of the Public Health Law (PHL), or a relative or correspondent of the patient.

(l) Minor means a person who has not attained the age of 18 years, unless each of the minor's parents satisfy one of the following conditions: the parent's parental rights have been legally terminated; the parent is deceased; the parent has indicated [his or her] *their* willingness to allow the panel to proceed.

Clause (C) of subparagraph (ii) of paragraph (1) of subdivision (c) of section 710.4 is amended to read as follows:

(C) a statement whether the patient has any medical, podiatric, or dental condition which would prevent [his or her travel to or] *their* presence at the panel hearing and a description of such condition; and

Paragraphs (1), (2), and (3) of subdivision (a) of section 710.5 are amended to read as follows:

(1) The program staff or its designee shall send a copy of the declaration to the following interested parties as set forth in the declaration: the