NYS Council for Community Behavioral Healthcare

January 6, 2025

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

RE: Revised Proposed Draft Insurance Regulations 230, New Subpart 11 NYCRR 38 Network Adequacy Access Standards

Dear Superintendent Harris:

On behalf of the NYS Council for Community Behavioral Healthcare (NYS Council), we appreciate the opportunity to comment on the revised proposed network adequacy standards for certain New York State Health Insurance Plans that will apply to mental health (MH) and substance use disorder (SUD) treatment services.

The NYS Council is a statewide membership organization composed of 160 community-based organizations that provide recovery-focused mental health and/or substance use disorder/chemical dependence and addiction treatment programs and services for New Yorkers in need. NYS Council members offer a broad array of behavioral health services designed to meet the unique needs of children and adolescents, individuals and families seeking our assistance. Our services are available in a variety of community settings including freestanding agencies, behavioral health divisions of general hospitals, and county mental hygiene programs. The NYS Council is also part of CHAMP, New York's MH and SUD health insurance ombudsman program. As one of three specialist organizations for the program, we provide training, technical assistance, outreach and engagement services, and we assist CHAMP Helpline staff with specific issues callers are experiencing. Through this work as well as our considerable achievements in the areas of policy and rate reform, and our representation of community-based agencies where the primary focus is to provide on demand, high quality access to care in local communities across the state, the NYS Council has gained significant expertise and perspective about the need to enhance network adequacy standards to increase access to care.

As a specialist agency in CHAMP, we are aware of many examples of consumers struggling with network adequacy issues. In fact, network inadequacy and transportation barriers are some of the most common barriers to care for CHAMP callers. Clients have experienced barriers such as an inability to find in-network psychiatrists at all in their region, mental health providers with extremely long wait times for an appointment, and difficulty finding providers who accept new patients. We see provider directories that are out-of-date or inaccurate which impacts clients who assume they have several local options for mental health and/or substance use disorder care in-network, but upon further research, are unable to make an appointment with a provider and are left without critical care.

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. We applaud DFS for recognizing that specific network adequacy standards for MH and SUD care are necessary to increase access to care. Although strong regulatory standards have not existed in New York for these services, some network standards that apply to commercial plans can be found in the Medicaid Managed Care Model Contract ("Model Contract") and 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. In addition, and because we know that regulations are just that, we urge the Department in the strongest possible terms to enhance its monitoring, surveillance and enforcement of all relevant regulations, guidance and contract requirements that relate to Network Adequacy. Without strong and persistent enforcement, health plans will continue to find ways around meeting the letter of the law as it relates to this critical metric.** We also **urge DFS to adopt some metrics for travel distance and time standards**. While we appreciate that using an appointment wait time standard is a key metric for evaluating access to services, it is still necessary to ensure appointments can be accessed within a reasonable distance from an insured's home. Both are critical to ensuring access to MH and SUD services in a network and we urge DFS to adopt strong standards for both.

The NYS Council offers the following comments on the revised proposed standards, as well as suggested additions.

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 lifesaving 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.**

It is a common occurrence that individuals and families are told there is no appointment availability for timeframes that range from several weeks to several months, and there are workforce shortages for many provider types in many parts of the state. However, we also know that it is often easier to find an out-of-network provider and so it seems providers exist and have availability, they just aren't part of some or all insurance networks. Stronger wait-time standards will require plans to include more providers in their networks to meet a shorter timeframe, and to do so they will have to make it easier and more appealing to join their networks.

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 DFS proposal, indicating that New York State regulators have already determined that shorter wait times are preferable. For example, the Model Contract requires an available appointment 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.** We appreciate that there is no need to make an appointment for an urgent care facility or emergency department, but a walk-in urgent care situation is not the same thing as an urgently needed appointment for MH or SUD care from a community-based provider. Even so, many areas of New York do not have an urgent care facility equipped to provide mental health assessments nearby, and even if they do, they are not necessarily in-network, and the current proposed standards will not incentivize plans to include them. **Several states have adopted appointment wait time standards for urgent appointments for MH or SUD services. Colorado and Maryland, for example, require the availability of urgent care for behavioral health or SUD within 24 hours, while New Hampshire requires availability within 48 hours. Even Texas requires an urgent behavioral health appointment within 24 hours.**[1]

Specifically, we recommend DFS (1) clarify that the standards it has proposed in Section 38.4(a)(1) and (2) are 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. 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 continue to urge DFS to adopt a **standard for availability of ongoing appointments**, not just initial visits. MH and SUD treatment almost always requires regular, ongoing care which the regulations should reflect. While the frequency of ongoing care should be left to the provider and the care recipient, it is important for the State to understand the availability for ongoing appointments when evaluating a plan's network adequacy. By not including this metric, it incentivizes plans simply to ensure a provider can have single appointments available to meet network adequacy standards, without ensuring a robust network that is available to meet the needs of its insureds on an ongoing basis. 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..."**

Additionally, while we readily acknowledge workforce shortages, it is important to note that New Yorkers are often able to find out-of-network providers, which clearly indicates that providers are available, they are just not joining networks. And the ongoing and serious problems associated with enforcement (and lack thereof) of timely and full reimbursement for services as required under the law, leaves providers without the resources they need to recruit and retain the staff they need to manage fluctuations in demand for care.

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

[1] See list of States as of 2020 in the "Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services."

when an in-network provider is not available. We appreciate the addition to section 38.7 to require plans to include information about wait time standards and right of access on each plan's website. This provision provides access protections when a participating provider is not available within the wait times set forth in section 38.4, however, we continue to be disappointed that these same access standards in the regulation do not explicitly apply to other network contracting requirements. The Department of Health has issued "Guidelines for MCO Service Delivery Networks" that provide network contracting requirements for various service types and the plain language of these guidelines indicate that they apply to commercial networks. (i.e. the health plan must contract with all opioid treatment programs in a county). When a plan has not contracted with all required providers, the access standards set forth in section 38.5 should still be available. Alternatively, *if it is not true that the "Guidelines" apply to commercial plan networks*, we urge DFS to work with DOH to update the guidelines to appropriately reflect that. 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 participating provider is unavailable based on all the standards indicated.

Section 38.6 Provider directory requirements.

We appreciate the update to this provision that now includes information about whether the provider is available via telehealth and that ensures all information is available in the searchable and filterable directory on the insurer's website, 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, the Federal No Surprises Act requires health plans to review and update provider directories every 90 days.[2] New York's standards should align with this requirement. Additionally, insurers in New York are already required to submit accurate network information to the PNDS quarterly[3], and that information should have been verified before submission. Despite these requirements, **inaccurate provider directories are a pervasive issue.** The recent secret-shopper survey conducted by the NY Attorney General's office found that 86% of mental health care providers listed on insurance directories were "ghosts," meaning that the providers listed were not actually accessible - some were no longer accepting new patients, some stopped participating with certain health plans, while others had retired or moved away. To date, we have seen few if any citations or other types of enforcement to address the myriad issues uncovered by the Attorney General's report. And to further ensure accurate networks, **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, rather than wait for the health plan's periodic review.**

We appreciate the updated provision requiring insurers to verify whether a provider is accepting new patients in 38.6(d). 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 available to the insured.

Section 38.7 Additional responsibilities regarding network adequacy and access.

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

[2] 42 U.S.C § 300gg-115(a)

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

the enrollee's specific treatment needs. 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 of in-person service providers. Further, health plans should regularly report the rates of out-of-network utilization for MH and SUD care for their plan members and aggregate these rates by region. Not only will a high rate of out-of-network utilization indicate problems with their network's adequacy, but it will also help to identify available providers that *should* be in-network. **We also urge DFS to require health plans to post their access plan publicly in a structure that is understandable to health plan enrollees.**

In the past when DFS expectations of health plans have been strengthened or increased, there have been several instances in which the health plans were able to pass the responsibility for operationalizing the change required onto the provider. This is an ongoing concern of providers. Health plans should not be permitted to make the provider responsible for any new activities, tasks, etc. in order to meet the plans obligation to comply with these standards. Network Adequacy is a shared responsibility; however, if the plans are going to be required to step up their own internal data collection and monitoring, they should also be required to minimize any additional work requirements for the provider.

<u>Suggestions for Inclusion</u>

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 ensure 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).[4] 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.[5] The guidelines also include 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, two Medically Managed Detox providers per county (or per region in rural areas) or all opioid treatment providers in a county.[6] 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.

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[4] 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

[5] 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

[6] 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 minimum provider-to-enrollee ratios for New York health plan enrollees for both MH and SUD providers and facilities.

The NYS Council appreciates the opportunity to provide these comments. Please contact Lauri Cole, Executive Director, at 518-461-8200, or at lauri@nyscouncil.org with any questions. Thank you for your time and consideration.

Sincerely,

Lauri Cole
Executive Director
NYS Council for Community Behavioral Healthcare