MHANYS
Mental Health Association
in New York State

Karl Shallowhorn, MS, CASAC
Board Chair

Glenn Liebman, MA
CEO

Katherine Ceroala
DOH Bureau of Program Counsel
Reg. Affairs Unit
Room 2438
ESP Tower Building
Albany, NY 12237
Email: regsqna@health.ny.gov

Dear Ms. Ceroala:

My name is Glenn Liebman, Chief Executive Officer at the Mental Health Association in New York State. Thank you for the opportunity to provide comments on the proposed regulations published by DOH in the January 10, 2024 State Register (I.D. # HTL-02-24-0008P), regarding network adequacy and access standards for behavioral health services.

Immediately below are general observations and comments, followed by specific comments on these proposed regulations.

I . General Observations and Comments:

Initially it is important to note that network adequacy and access standards for behavioral health services have been required by state and federal parity laws and regulations for many years.

AG's Report on Mental Health Network Directories:

This need was alarmingly exposed on December 7, 2023, when State Attorney General Leticia James issued a report entitled: "Inaccurate and inadequate: Health plans' mental health provider network directories."

The report found massive deficits regarding health plans' network directories for behavioral health services, and found that these so-called "ghost networks" serve to undermine network adequacy requirements and contribute to the mental health crisis in the state.

Federal Behavioral Health Parity Law:

In 2008, the federal parity law was enacted, entitled The Mental Health Parity and Addiction Equity Act (MHPAEA) (42 U.S.C. § 300gg-26). This Act generally prohibits group health insurance plans from imposing financial requirements or treatment limitations for behavioral health benefits that are more restrictive than the financial requirements or treatment limitations that apply to medical/surgical benefits.

Federal parity regulations implementing the MHPAEA as they apply to managed care organizations (MCOs) became effective in 2016 (42 C.F.R. Part 438). Specifically, the federal Department of Health and Human Services (HHS) published a final rule, effective May 31, 2016, clarifying requirements under the federal parity law for behavioral health coverage, offered by MCOs. Those final rules included network adequacy parity requirements for MCOs as they applied to behavioral health services (81 FR 18390). These rules require that MCOs shall not impose such "non-quantitative treatment limitations" (NQTL) for mental health or substance use disorder benefits in any classification, unless they are "are comparable to, and applied no more stringently than" limitations for medical/surgical benefits.

HHS provided guidance and explanation for these parity requirements in the Supplemental Information section accompanying these final rules, explaining the behavioral network adequacy (and wait time) requirements of these regulations (81 FR 18400) as follows:

"In a Medicaid managed care environment, if a provider network is unable to provide necessary services covered under the contract to a particular enrollee, the MCO, PIHP or PAHP must adequately (and on a timely basis) cover these services out-of-network for the enrollee for as long as the MCO, PIHP or PAHP is unable to provide them in-network (see 42 CFR § 438.206(b)(4)). The proposed rule specified that the standard for providing access to out-of-network services (when they cannot be provided in-network) is considered to be a non-quantitative treatment limitation (NQTL) for the purposes of this rule." (Paragraph F. Non-quantitative Treatment Limitations (NQTLs) (§ 438.910(d), § 440.395(b)(4), and § 457.496(d)(4) and (d)(5)),

Therefore, it is clear that under federal law, MCOs have been required to cover all necessary behavioral health services, under the contract with the state, on a timely basis, and offer out-of-network behavioral health services if the network of participating providers is not adequate to meet the needs of enrollees.

Similarly, under New York State law (Public Health law, section 4403 (5) (b)) requires network adequacy to provide appropriate and timely care, and requires compliance with the ADA and the MHPAEA.

NY State obligations to enforce behavioral health parity:
It is also clear that the state has compliance and enforcement responsibilities regarding the federal parity regulations. States that contract with MCO's to deliver Medicaid services are required to develop and enforce network adequacy standards (42 CFR § 438.68 (a) and (b)(1)(iii)).

The OMH RFP on Behavioral Health Parity Analysis, re-issued by OMH on Nov 3, 2023, summarized these requirements as follows:

"The Centers for Medicare & Medicaid Services (CMS) final regulations (42 CFR Parts 438, 440 and 457) address the application of the Mental Health Parity and Equity Addiction Act

(MHPAEA). The Division of Managed Care and their State partners are required to assess states and ensure MHPAEA parity compliance of MCOs."

The parity standards for NQTLs do not apply a simple arithmetic test to compare the treatment of mental health or substance use disorder benefits to the treatment of medical/surgical benefits. The formula for determining whether an NQTL is, or is not, comparable to a medical/surgical benefit can be complicated, and is not something the average consumer can readily determine.

Furthermore, New York State PHL section 4403 (5) (b) requires that plans, comply with network adequacy standards, and for compliance with the ADA and the MHPAEA. This section of law provides as follows:
"… the availability of appropriate and timely care that is provided in compliance with the standards of the Federal Americans with Disabilities Act to assure access to health care for the enrollee population; (ii) the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population; (iii) the availability of appropriate and timely care that is in compliance with the standards of the Mental Health Parity and Addiction Equity Act of 2008…"

That is why we believe it is essential that the DOH must ramp up efforts to determine when treatment limitations (and particularly NQTLs) imposed by MCOs may violate parity laws. The Department should ensure that these proposed regulations fully cover all circumstances under which MCO's must comply with state and federal network adequacy requirements, including wait time standards, to ensure that these (and all other non-quantifiable treatment limitations) are effectively enforced.

Unfortunately, we believe that state and federal parity requirements, including but not limited to network adequacy problems, have not been vigorously enforced by state oversight agencies, which has contributed to the mental health and substance disorder crisis for persons with behavioral health challenges in the state.

II. Specific Comments on the Proposed Regulations:

1. Our major concerns revolve around section 98–5.4, Network Provider Type Standards.

Subdivision (a) states that an adequate network of behavioral health services "shall include residential facilities that provide sub-acute care; assertive community treatment providers; critical time intervention services, providers; and mobile crisis intervention services providers." Subdivision (a) lists some but not all of the types of behavioral health services that must be included in networks offered by MCOs. For example, outpatient facilities or clinics are not referenced in (a), but we know the regulations also apply to them, as they are referenced in section 98–5.5.

Comment: Therefore, we suggest that in subdivision (a) the phrase "but not be limited to" be included immediately after the words "shall include."

2. Subdivision (b) states that the effective date of these regulations is January 1, 2025, however, this effective date could be delayed and in fact will only apply to policies and contracts issued or renewed 90 days after the Commissioner has determined "for each provider type listed in subdivision (a) of this section that there is a sufficient number of … providers available in this state to meet the network adequacy standards" of section 4403 (5) (b) of the Public Health Law. Specifically, as noted above, the network adequacy standards under PHL section 4403 (5) (b) require the Commissioner of Health to consider several criteria, and federal parity law, when determining network adequacy for behavioral health services,

A. Clarification is requested regarding the circumstances under which the effective date of the regulations could be delayed.

(a) We request clarification that the intent is that the Commissioner could delay the effective date of these regulations regarding determinations of insufficiency of **only the four specific types of services listed** in 98–5.4 (a) to meet network adequacy standards. (We assume that is the case.)

(b) Further, it is not clear whether a determination that **any one** of these four listed services is insufficient in number could result in delay of the entire regulation?
Therefore, clarification is requested, regarding whether the Commissioner could delay the implementation of the regulations, if any <u>one</u> of the four types of services listed in 98–5.4 is not sufficient in number to meet network adequacy standards, and if so:

a) would that delay only apply to that particular type of service,
b) would that delay apply to all four listed types of services, or
c) would that delay apply to all behavioral health services?

B. ***Clarification is requested regarding whether the Commissioner could delay implementation of these regulations if it is determined that there is an insufficient number of a particular type of behavioral health service providers in one area of the state?*** In other words, will behavioral health services have to be available in sufficient number statewide, before this provision will become effective in other parts of the State?
For example, if there were an inadequate number of a particular type of behavioral health service in the North Country, will that fact delay implementation of all of these network adequacy standards statewide? Regionally? In that county? etc?

3. Section 98–5.5 establishes appointment wait time standards. An MCO shall be required to ensure the network has sufficient capacity and availability to offer enrollees behavioral health appointments within 10 days for an initial appointment with an outpatient facility or clinic, or a healthcare professional. Following discharge from a hospital or emergency room, sufficient capacity should be available to ensure such an appointment is offered within a seven-day period. Telehealth services and out-of-network providers could be used to meet these timeframes.

Comment: While we support having a defined time to offer appointments to measure sufficient capacity for outpatient behavioral health services, we are concerned that the 10 or seven-day time frame may be too long for people who need more immediate services. Particularly for people who are discharged from an inpatient hospital setting or an emergency room, the initial days after discharge are critical to ensuring a successful discharge.
Therefore, we recommend that the MCO network have adequate capacity to ensure an offer for a behavioral health appointment will be made a maximum of three days following a discharge from a hospital or an ER visit.

[NOTE: Furthermore, while outside the scope of these proposed regulations, we recommend conforming amendments be made by DOH to regulations that govern discharges from hospital inpatient and emergency departments to ensure that there is a mechanism in place to schedule timely outpatient behavioral health appointments after discharge, and additional protections be in place whenever there are urgent behavioral health needs.]

4. In section 98–5.7 Provider Directory Requirements, paragraph (a) (4), the provider directory shall include "*the county where the behavioral health provider is located*." We are concerned that MCOs could narrowly interpret this paragraph and only include counties where the provider is located. For example, an ACT Team may be **located in** one county, but serve adjacent counties.
Therefore, we request clarification (and amendment if necessary) that this paragraph should require the directory to list <u>all</u> counties served by the behavioral health provider.

Similarly, a conforming amendment should also be made to paragraph (b) that requires provider directories to be searchable and filterable by a number of factors, including "the county where the provider is located."

Regarding each of the comments and issues raised above, given the State's inconsistent history of enforcement of network adequacy and parity requirements, and the unprecedented behavioral health crisis that the citizens of this state face, we urge the Commissioner to promulgate and enforce final regulations in a manner that provides fully effective behavioral health network adequacy and access standards.

To family members such as my own and individuals in need of services, the importance of behavioral health parity cannot be understated. We are very supportive of Governor Hochul's commitment to changing the parity regulations to reflect the needs of those in greatest need. Separately from the regulations, we urge the impacted State agencies to meet with the managed care plans and peer and family organizations to dramatically improve practice around parity engagement and enforcement.

Glenn Liebman, CEO

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