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PARITY for ALL

New Yorkers: Can't find mental health or substance use disorder providers that take your insurance? A new proposed rule could help!

New York State proposed new regulations for network adequacy of mental health (MH) and substance use disorder (SUD) care that require health plans to make sure providers are available in network.

What is "Network Adequacy"?

Health plans need to make sure that their plan members can use their services when they need health care. "Network adequacy" refers to a plan's ability to have enough providers in their plan members' area who accept their health insurance.

Some examples of network adequacy red flags are:

- If a plan member has long wait times to see providers in their network;
- If providers on the plan's directory aren't taking new patients,
- If there are no providers available that treat a particular condition; or
- If the only providers in network are far away requiring long travel distances.

Make your voice heard: submit a public comment!

What is a public comment?

During the rulemaking process, agencies will post "proposed" versions of rules. During a fixed time period, the public can submit comments to clearly communicate their position on the proposed regulations and make recommendations for changes.

The rule for Medicaid Managed Care plans' comment period closes on March 11th.

The rule for private insurance plans' public comment period closes on April 22nd.

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Summary of Proposed Rules:

Wait Times

- Appointments to be available within 10 business days or 7 days after hospital discharge.
- Appointments can be virtual unless in-person appointment is requested.
- If the plan member is unable to get an appointment within 10 business days or 7-days post hospital visit, they can submit a complaint to the health plan/managed care organization who must find a provider within 3 business days that can provide treatment. If there are no in-network providers available, the plan member should be able to get the services out-of-network without extra cost-sharing.

Provider Directories

- Provider directors list all of the providers that are in a plan's network. The proposed regulations would:
  - Lay out the requirements for health plans to make sure their directories are accurate. This will include reviewing them every year and monitoring providers who don't have any in-network claims and then checking their information every 6 months to prevent "ghost providers."
  - Require health plans to have a method to report errors they find in their directories.

Other Health Plan Responsibilities

- Staff to help people find in-network providers to treat their particular condition
- Development of an access plan with protocols for monitoring and ensuring access
- Submission of access plans and assurances of an adequate network to the state

What's Missing?

The proposal is missing some key standards to ensure networks are adequate, including:

- Requirements for travel times or geographic distances to make sure providers are available nearby where plan members live;
- Wait time requirements for urgent and emergency care as well as access to ongoing treatment; and
- Standardized provider to enrollee ratios.

Questions about this fact sheet or any of the issues covered? Reach out to Christine Khaikin at ckhaikin@lac.org.

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