New York State Network Adequacy Recommendations

Legal Action Center

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Meaningful access to quality, affordable substance use disorder and mental health care and treatment continues to be out of reach for many New Yorkers. Having health insurance coverage, whether through an employer, a public option like Medicaid, or purchased on the insurance marketplace, should alleviate barriers, but it often does not. One key problem is that insurance networks often do not include a sufficient number of providers to serve their members' needs.

The term "network adequacy" refers to whether a health plan contracts with a sufficient number of qualified providers to ensure members can access quality covered benefits within a reasonable travel distance and/or time. When networks are insufficient or inadequate, consumers are left with few good options for care. They may pay cash if they can afford it, pay higher costs out-of-pocket to go out-of-network and be reimbursed at a lower rate, be forced to travel long distances (if they have access to adequate transportation) or even forgo care altogether. Inadequate networks are a problem in many areas of health care but are especially acute for mental health (MH) and substance use disorder (SUD) care and treatment. Network adequacy may not improve without clear standards for plans to follow and regulators to enforce.

How do we know New York has inadequate networks of MH and SUD providers?

Recent data shows wide disparities in out-of-network utilization of MH and SUD services as compared to medical/surgical services in New York State. In fact, out-of-network service utilization has increased over time, with outpatient out-of-network utilization more than doubling from 2013 to 2017. In 2017, 39% of office-based behavioral health visits were out-of-network, which is eleven times more than for medical visits.[1]

Further, New York's own MH and SUD insurance ombudsman program, known as CHAMP, has indicated that many of their cases are related to network issues, including long appointment wait times, inability to find medication treatment providers in-network, and long distances and limited transportation to available providers.

[1] Melek, S., Davenport, S., & Gray, T.J. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman. Available at https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p

How do we know if a network is adequate?

Regulators need to measure and track that an insurer's network adequately meets plan members' needs and can only do so with strong quantitative metrics. Legal Action Center and the Partnership to End Addiction recently released the *Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services*. The *Spotlight* looks at current laws and regulations related to quantitative network adequacy requirements at the federal and state level and identifies three quantitative metrics: geographic (travel time and distance), appointment wait time, and provider/enrollee ratios. We found that only 29 states have adopted at least one quantitative standard for network adequacy, generally for state-based commercial plans, and only 16 states have adopted at least one metric for MH/SUD providers.

Federal Standards

Federal standards are quite limited and mostly leave it to the States to develop their own network standards for state-regulated insurance. The Centers for Medicare and Medicaid Services (CMS) recently amended the Medicaid Managed Care regulations and removed a requirement that states utilize travel time and distance standards for measuring network adequacy.[2] States are now only required to have one general quantitative standard; however, this is just a floor. States can adopt additional quantitative network standards for Medicaid Managed Care and state regulators are responsible for monitoring and enforcement.

Pursuant to the Affordable Care Act, the Department of Health and Human Services (HHS) adopted regulations requiring qualified health plans (QHPs) to have a "sufficient" number of MH and SUD providers. States are responsible for monitoring and enforcement.

Parity

Network design is subject to the federal Mental Health Equity and Addiction Parity Act (the Parity Act) as a non-quantitative treatment limitation. If the health plan's factors, standards and processes for establishing its MH and SUD networks are not comparable to, or are more stringent than, those used for its medical/surgical networks, it would violate the Parity Act. The recently adopted Parity Compliance Program regulations in New York State require a comparative analysis of out-of-network utilization to ensure networks are adequate, but not of actual network standards.

New York State Requirements

Currently, there are minimal quantitative standards in New York State to measure the adequacy of MH and SUD networks in both commercial and Medicaid Managed Care plans, and

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[2] Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care, Final Rule, 85 FR 72754-72844 (November 13, 2020), https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf.
See Also CMS's Final Medicaid Managed Care Rule: A Summary of Major Changes, Hinton, E., KFF (November 23, 2020) available at https://www.kff.org/medicaid/issue-brief/cmss-2020-final-medicaid-managed-care-rule-a-summary-of-major-changes/

enforcement of these standards is also limited. NYS Law requires the Department of Financial Services (DFS) to review plan networks to ensure they are "adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract."[3] The guidelines require at least two of each specialist provider type (which includes MH and SUD providers) per county, depending on enrollment and geographic accessibility.[4] Additionally, it is preferred but not required that insurers meet a time and distance standard of 30 minutes or 30 miles for non-primary care providers.

The Department of Health has additional network requirements found in the Managed Care Model Contract for managed care plans that commercial plans must also follow.[5] These include specific standards from the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) that require certain numbers of provider types per county or region (commercial plans do not have to comply with the regional standards for rural areas of the state; see graphic below.).

Behavioral Health Services Contracting Standards
Applies to: Medicaid, HIV SNP, HARP, CHP, Commercial**

Category of Service	Urban Counties	Rural Counties**
Office of Mental Health (OMH)		
Outpatient Mental Health Clinic	*The higher of 50% of all licensed clinics or minimum of 2 per county*	*The higher of 50% of all licensed clinics or minimum of 2 per region**
Outpatient Mental Health Clinic – State Operated	*All in county*	*All in region*
Personalized Recovery Oriented Services (PROS); Intensive Psychiatric Rehabilitation Treatment (IPRT); or Continuing Day Treatment	The higher of 50% of the total sites offering those three services, or minimum of 2. Where there are PROS programs within the county or region, the MCO must contract with the PROS programs first to meet its minimum network requirement.	
Assertive Community Treatment (ACT)	*2 per county*	*2 per region*
Partial Hospitalization	*2 per county*	*2 per region*
Inpatient Psychiatric Services	*2 per county*	*2 per region*
Home and Community Based	*2 of each service type per*	*2 of each service type*
Service (HCBS) Services (HARPs and HIV SNPS only	*county (as available)*	*per region (as available)*
Comprehensive Psychiatric Emergency Program (CPEP) and 9.39 ERs	*2 per county*	*2 per region*
Other Licensed Practioner (OLP)	*The higher of 50% of all programs designated or minimum of 2 per county designated where available.*	*The higher of 50% of all programs designated or minimum of 2 per region designated where available*
Psychosocial Rehabilitation Services (PRC)	*The higher of 50% of all programs designated or minimum of 2 per county designated where available.*	*The higher of 50% of all programs designated or minimum of 2 per region designated where available*
Community Psychiatric Supports and Treatment (CPST)	*The higher of 50% of all programs designated or minimum of 2 per county designated where available.*	*The higher of 50% of all programs designated or minimum of 2 per region designated where available*
Office of Alcohol and Substance Abuse Services (OASAS)		
Inpatient Chemical Dependency (ASA Inpatient)	*2 per county*	*2 per region*
Medically Managed Detox Services	*2 per county*	*2 per region*
Medically Supervised Detoxification Services (inpatient and outpatient	*2 per county*	*2 per region*
Outpatient Chemical Dependency (Clinic and Outpatient Rehabilitation)	*50% of all licensed clinics or at least 2 per county, whichever is greater*	*50% of all licensed clinics or at least 2 per county, whichever is greater*
Opioid Treatment Program	*All programs in the county; For NYC – all programs in NYC*	*All programs in region*
Residential Substance Abuse Treatment Services (Stabilization, Rehabilitation)	*2 per county*	*2 per region*
Buprenorphine prescribers	All authorized prescribers in the contractor's service area (Rural/Urban NOT applicable)	

**** Region is defined as the catchment area beyond the border of a county as determined by the State and set forth in the State–issued Behavioral Health Guidance document.***

*****Rural County/Region rules apply ONLY to Medicaid, HIV SNP, and HARP.***

[3] N.Y. Ins. Law § 3241(a)

[4] https://www.dfs.ny.gov/docs/insurance/health/Network_Adeq_standards_guidance_Instructions_9.15_Final.pdf

[5] https://www.health.ny.gov/health_care/managed_care/guidelines_for_mco_service_delivery_networks-V3.0.htm

Recommendations to improve MH and SUD network adequacy in New York State

New York State regulators can take action to reduce barriers to in-network mental health and substance use disorder services by establishing and enforcing more robust quantitative network adequacy standards and monitoring insurance carrier performance. While these recommendations seek to help define and monitor network adequacy, additional policy reforms are needed in the areas of workforce shortages, addressing reimbursement rate disparities, and providing financial protections for plan members who use out-of-network MH and SUD providers to receive contract benefits because of insufficient networks.

New York State should adopt additional quantitative standards for measuring network adequacy. New York's current network standards for MH and SUD services are based entirely on geographic travel distance, requiring a specified number of in-network provider types by county or "region" in rural areas of the state.[6] While the state has recognized the importance of additional quantitative metrics for other types of medical care, it has not included them for MH and SUD care, creating a disparity in networks.

- Geographic standards should include flexibilities based on access to public transportation in urban areas.
- The state should adopt "Patient to Provider Ratio" guidelines for MH and SUD services, as they have for primary care, family medicine, internal medicine, obstetrics and gynecology and pediatrics.[7]
- The state should adopt appointment wait time metrics for MH, SUD and other somatic services that track access to urgent care services as well as non-urgent services.
- Network standards must require the inclusion of Essential Community Providers (ECPs) who traditionally serve the needs of low-income, underserved communities to address health disparities, particularly in communities of color and among individuals with lower incomes.
- The process to develop metric values must be guided by the Parity Act, which means that the travel distance and or/time, appointment wait time, and provider-patient ratios for MH/SUD services must be comparable to, and no more stringent as written than, those for medical/surgical services.

Quantitative metrics should take the availability of telehealth services into account while preserving patient choice. The rapid shift to telehealth for all services, but particularly MH/SUD, brought on by the COVID-19 pandemic has solidified their place in New York's system of care. However, it is important that plans do not significantly rely on telehealth services to meet their network metrics, particularly for geographic standards. Patients need to have the

[6] The different rural standard is only for Medicaid managed care plans and does not apply to commercial carriers. *See* Guidelines for MCO Service Deliver Networks *available at:* https://www.health.ny.gov/health_care/managed_care/guidelines_for_mco_service_delivery_networks-V3.0.htm#att4

option of seeing providers in-person in a reasonable geographic travel time if they so choose or if it is indicated by their provider, and so a network should not be considered to meet the required standards unless they continue to include the necessary in-person services in their networks.

Regulators should perform routine monitoring of each quantitative standards to ensure networks remain adequate over time. Medicaid Managed Care plans and commercial plans are now required to perform compliance reviews in accordance with the recently finalized Parity Compliance Program Regulations. This includes performing analyses of out-of-network utilization, reimbursement rates, and contracting standards in compliance with the Parity Act. This self-monitoring can be a basis for additional regulatory monitoring and enforcement of network adequacy standards.

- Regulators should develop uniform definitions for reporting network metrics to ensure standardization.
- Health plans should be required to submit reports no less than annually.
- Regulators should take enforcement action against plans with inadequate networks by imposing monetary penalties, imposing corrective action plans, and ensure remediation action for consumers who have been harmed by delaying care or facing greater costs for out-of-network care.

Improve consumer education and awareness. Consumers need better information about how to find and access in-network providers and their right to do so.

- Plans, as well as the state, should provide education and transparent information across multiple platforms and in languages other than English about their rights to access care when no in-network provider is available. This will ensure consumers understand their rights and are also able to quickly access necessary care.