NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
11 NYCRR 38
(INSURANCE REGULATION 230)

NETWORK ADEQUACY AND ACCESS STANDARDS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES

I, Adrienne A. Harris, Superintendent of Financial Services, pursuant to the authority granted by sections 202, 301, and 302 of the Financial Services Law, sections 301, 3217-a, 3241, and 4324 of the Insurance Law, and part II of chapter 57 of the Laws of 2023, do hereby promulgate a new Part 38 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York to take effect July 1, 2025, to read as follows:

(ALL MATERIAL IS NEW)

A new Part 38 is added to Subchapter A, Life, Accident and Health Insurance, of Chapter III, Policy and Certificate Provisions, to read as follows:

Section 38.0 Preamble.

Part II of chapter 57 of the Laws of 2023 amended the Insurance Law, including Insurance Law section 3241, to improve access to behavioral health services in this State. Insurance Law section 3241(a)(2), as added by Subpart F of Part II, requires the superintendent, in consultation with the commissioner of the Department of Health, the commissioner of the Office of Mental Health, and the commissioner of the Office of Addiction Services and Supports, to propose regulations setting forth standards for network adequacy for mental health and substance use disorder treatment services, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services, and mobile crisis intervention services. Subpart A of Part II establishes the effective date for coverage of sub-acute care in a residential facility, assertive community treatment services, critical time intervention services, and mobile crisis intervention services. This Part implements the requirements of Insurance Law section 3241, as amended by Subpart F of Part II of chapter 57 of the Laws of 2023, and the requirements of Subpart A of Part II by establishing network adequacy and access standards and other protections to improve access to behavioral health services.

Section 38.1 Applicability.

This Part shall apply to a health care plan that delivers or issues for delivery in this State a comprehensive health insurance policy or contract that uses a network of health care providers to deliver behavioral health services.

Section 38.2 Definitions.

As used in this Part:

(a) *Appointment wait time* means the time from the initial request for health care services to the earliest date offered for the appointment for services.

(b) *Behavioral health services* mean mental health services and substance use disorder treatment services.

(c) *Health care plan* means an insurer licensed to write accident and health insurance pursuant to Insurance Law article 42; a corporation organized pursuant to Insurance Law article 43; a municipal cooperative health benefit plan certified pursuant to Insurance Law article 47; or a student health plan established or maintained pursuant to Insurance Law section 1124.

(d) *Health care professional* means an appropriately licensed, registered, or certified health care professional pursuant to Education Law Title 8 or a health care professional comparably licensed, registered, or certified by another state.

(e) *Health care provider or provider* means a health care professional or a facility licensed, certified, or designated pursuant to Public Health Law article 28, or Mental Hygiene Law article 19, 31, 32, or 36, or a facility comparably licensed or certified by another state.

(f) *Network* means the health care providers with which a health care plan has contracted to provide health care services to insureds.

(g) *Non-participating* means not having a contract with a health care plan to provide health care services to an insured.

(h) *Participating* means having a contract with a health care plan to provide health care services to an insured.

(i) *Telehealth* has the meaning set forth in Insurance Law sections 3217-h and 4306-g and includes audio-only visits.

Section 38.3 Network provider type standards.

(a) Pursuant to Insurance Law section 3241(a)(1), a health care plan shall ensure that its provider network is adequate to meet the behavioral health needs of insureds and provide an appropriate choice of providers sufficient to render the behavioral health services covered under its health insurance policies and contracts.

(b) An adequate network of health care providers 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, after the superintendent, in consultation with the commissioner of the Department of Health, the commissioner of the Office of Mental Health, and the commissioner of the Office of Addiction Services and Supports, has determined, for each provider type listed in this subdivision, that there is a sufficient number of certified, licensed, or designated health care providers available in this State to meet the network adequacy standards established by Insurance Law section 3241(a). Once the superintendent makes this determination, the network adequacy standards shall apply to the provider types listed in this subdivision for policies and contracts issued, renewed, modified, or amended 90 days after the superintendent makes this determination.

Section 38.4 Appointment wait time standards.

(a) A health care plan shall ensure that its network has adequate capacity and availability of health care providers of behavioral health services to offer insureds appointments with providers that can treat insureds' behavioral health conditions within:

(1) ten business days for an initial appointment with an outpatient facility or clinic;

(2) ten business days for an initial appointment with a health care professional who is not employed by or contracted with an outpatient facility or clinic; and

(3) seven calendar days for an appointment following a discharge from a hospital or an emergency room visit.

(b) A health care plan may meet the appointment wait times set forth in subdivision (a) of this section through the use of telehealth unless the insured specifically requests an in-person appointment to treat the insured's behavioral health condition.

Section 38.5 Access to providers for insureds.

(a) If an insured is unable to schedule an appointment with a participating provider of behavioral health services within the appointment wait times set forth in section 38.4 of this Part because there is not a participating provider of behavioral health services available within the appointment wait times who can treat the insured's behavioral health condition, the insured, or the insured's designee, may submit an access complaint by telephone or in writing to the health care plan to resolve the access issue.

(b) The health care plan shall have three business days from receipt of the access complaint to locate a participating provider of behavioral health services that can treat the insured's behavioral health condition and is able to meet the appointment wait times set forth in section 38.4 of this Part and to give the insured or the insured's designee the name of and contact information for the provider or providers by telephone, if the request was made by telephone, and in writing. If the insured specifically requests an in-person appointment, the provider shall be located within a reasonable distance from the insured; however, the distance may be greater for insureds who reside in rural areas than for insureds who do not reside in rural areas.

(c) If the health care plan is unable to locate a participating provider of behavioral health services that can treat the insured's behavioral health condition, is able to meet the appointment wait times set forth in section 38.4 of this Part, and is located within a reasonable distance from the insured if the insured specifically requests an in-person appointment, the health care plan shall:

(1) notify the insured by telephone, if the request was made by telephone, and in writing, at the expiration of the time period in subdivision (b) of this section that the insured may obtain a referral to a non-participating provider at the in-network cost-sharing and include contact information for the New York State Behavioral Health Ombudsman Program; and

(2) approve a referral to a non-participating provider, regardless of whether the insured's coverage includes out-of-network benefits, if the non-participating provider:

(i) can treat the insured's behavioral health condition;

(ii) is able to meet the appointment wait times set forth in section 38.4 of this Part, as measured from the insured's receipt of the notification in paragraph (1) of this subdivision;

(iii) is located within a reasonable distance from the insured if the insured specifically requests an in-person appointment; and

(iv) charges rates that are not excessive or unreasonable.

(d) The approved referral shall remain in effect until the earlier of the following:

(1) the behavioral health services are no longer medically necessary; or

(2) the health care plan locates a participating provider of behavioral health services that can treat the insured's behavioral health condition, is able to meet the appointment wait times set forth in section 38.4 of this Part and is located within a reasonable distance from the insured if the insured specifically requests an in-person appointment, and the insured's treatment can be transitioned to the participating 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. If the insured or the insured's designee disagrees with the health care plan's transition of care determination, the insured or the insured's designee may request an expedited determination or appeal pursuant to Insurance Law section 4802 or 4904, as applicable.

(e) The health care plan shall not impose cost-sharing on the insured, including a copayment, coinsurance, or deductible, for the service rendered by a non-participating provider pursuant to an approved referral, that is greater than the cost-sharing that the insured would owe if the insured had received services from a participating provider. The health care plan shall apply the out-of-pocket maximum that would have applied had the services been received from a participating provider.

Section 38.6 Provider directory requirements.

(a) In addition to the provider directory requirements set forth in Insurance Law sections 3217-a and 4324, when listing a behavioral health provider, the provider directory shall include:

(1) any affiliation with participating facilities certified or authorized by the office of mental health and the office of addiction services and supports;

(2) information on restrictions on the availability of services from a behavioral health provider. Restrictions on the availability of services means an age limit on the types of patients the behavioral health provider treats or any limits on the types of specific behavioral health conditions that the behavioral health provider treats;

(3) if the behavioral health provider is a facility, the level of care offered by the facility, including inpatient, outpatient, partial hospitalization, and intensive outpatient programs;

(4) the city/town and zip code where the behavioral health provider is located;

(5) whether the behavioral health provider offers services via telehealth; and

(6) if the behavioral health provider is a health care professional, the languages spoken by the health care professional.

(b) With respect to behavioral health providers, the provider directory that is posted on a publicly accessible area of the health care plan's website shall 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.

(c) In addition to the disclosure requirements set forth in Insurance Law sections 3217-a and 4324, a health care plan shall provide the insured or the 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 of the insured or the insured's designee.

(d) A health care plan shall verify the accuracy of the information in the provider directory with behavioral health providers at least annually.

(e) A health care plan shall review the claims activity of the first six months of the year by September 1 of that year and, for the second six months of the year by March 1 of the following year. If the health care plan did not receive any claims from a participating provider of behavioral health services within those periods, the health care plan shall confirm whether the provider is accepting new patients and the provider's participation status with the health care plan.

(f) A health care plan shall have a method available on a publicly accessible area of its website for insureds, health care providers, and other persons to report errors in the provider directory information. Within 15 calendar days of receipt of reported errors, the health care plan shall review the errors reported and ensure that the online provider directory information is accurate.

Section 38.7 Additional health care plan responsibilities regarding network adequacy and access.

(a) A health care plan shall have designated staff with sufficient knowledge to help insureds find participating behavioral health providers that treat the insured's specific behavioral health condition. The health care plan shall post the contact information for the department or unit, including a telephone number, on a publicly accessible area of its website, that allows the insured to access this designated staff directly.

(b) A health care plan shall post information on a publicly accessible area of its website describing the appointment wait time standards for behavioral health services and the process to submit an access complaint.

(c)(1) A health care plan shall have an access plan that establishes a protocol for monitoring and ensuring access to behavioral health services, outlines how provider capacity is determined, and establishes procedures for quarterly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:

(i) expected utilization of behavioral health services based on anticipated enrollment and health care needs of the insured population;

(ii) the number and types of health care providers of behavioral health services required to furnish covered behavioral health services, the number and types of providers actively providing behavioral health services within the health care plan's network, and the number and types of providers accepting new patients;

(iii) the collection and monitoring of data on provider-to-insured ratios, travel time and distance to participating providers, and appointment wait times;

(iv) the role of telehealth in providing access to behavioral health services; and

(v) 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.

(2) A health care plan shall make the access plan available to the superintendent upon the superintendent's request.

Section 38.8 Health care plan reporting on network adequacy and access.

(a) By December 31, 2026 and annually thereafter, each health care plan shall submit to the superintendent a written certification in a form prescribed by the superintendent and signed by an officer of the health care plan that confirms the following:

(1) the health care plan has an access plan as required by section 38.7 of this Part and that such access plan is available upon the superintendent's request;

(2) the health care plan has sufficient participating providers in each network used by the health care plan to meet the appointment wait time standards as required by section 38.4 of this Part, or in instances where there are not sufficient participating providers to meet the appointment wait time standards as required by section 38.4,

the health care plan allows insureds to obtain behavioral health services from non-participating providers pursuant to section 38.5 of this Part;

(3) the number of access complaints received and a description of how the access complaints were resolved, including the behavioral health services requested, the geographic area of the state where the services were requested, the number of approved referrals to non-participating providers made during the prior twelve months pursuant to section 38.5 of this Part, and the number of referrals that the health care plan did not approve and the reasons why the health care plan did not approve the referrals; and

(4) the health care plan has performed the provider directory verification required by section 38.6 of this Part.

Section 38.9 Effective date.

This Part shall take effect July 1, 2025 and shall apply to all policies issued, renewed, modified, or amended on or after such date.

KATHY HOCHUL
Governor

ADRIENNE A. HARRIS
Superintendent

CERTIFICATION

I, Adrienne A. Harris, Superintendent of Financial Services, do hereby certify that the foregoing is new Part 38 of Title 11 of the Official Compilation of Codes, Rules, and Regulations of the State of New York (Insurance Regulation 230), signed by me on January 27, 2025 pursuant to the authority granted by Financial Services Law sections 202, 301, and 302, Insurance Law sections 301, 3217-a, 3241, and 4324, and part II of chapter 57 of the Laws of 2023, to take effect upon the publication of the Notice of Adoption in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed rule was published in the New York State Register on February 21, 2024, and a revised proposed rule was published in the New York State Register on November 20, 2024. No other publication or prior notice is required by statute.

Signed copy filed with Department of State
Adrienne A. Harris
Superintendent of Financial Services

Date: January 27, 2025