Network Adequacy and Access Standards for Behavioral Health Services

(10 NYCRR 98-5)

Frequently Asked Questions

The Department of Financial Services ("DFS") has also issued FAQs on its corresponding regulation, 11 NYCRR 38.

Q-1 When do the requirements of the 10 NYCRR 98-5 take effect?

10 NYCRR 98-5 takes effect on July 1, 2025. However, for Health Maintenance Organization (HMO) commercial coverage, the regulation applies when the policy is issued or renewed on and after such date.

Q-2. What types of Managed Care Organizations (MCOs) must comply with the requirements of 10 NYCRR 98-5?

MCOs offering coverage that is subject to the mental health and substance use disorder requirements under Insurance Law § 4303 and Public Health Law § 4406 must comply with these regulations. This coverage includes:

- Medicaid Managed Care Plans (Mainstream)
- HIV Special Needs Plans (HIV SNP)
- Health and Recovery Plans (HARP)
- Medicaid Advantage Plus (MAP)
- Program for the All–Inclusive Care for the Elderly (PACE)
- Child Health Plus (CHP)
- Essential Plan (EP)
- HMO commercial coverage

DFS promulgated a corresponding regulation, 11 NYCRR 38, that applies to insurers.

Q-3 Does the new DOH regulation supersede current appointment availability standards outlined in the Medicaid Model Contract?

10 NYCRR 98-5.5 (a)(1)&(2) is specific to initial appointments. MCOs must comply with Appointment Availability Standards in Medicaid Managed Care Model Contract Section 15.2. When wait time standards differ from existing Medicaid policy, the more stringent requirement will apply.

Q-4 If an enrollee or the enrollee's designee requests a list of in-network providers available to treat a specific behavioral health condition (not in connection with an access complaint), must the MCO verify appointment availability before providing the list of in-network providers to the enrollee or enrollee's designee?

No. With respect to a request that is not in connection with an access complaint, the MCO must provide the enrollee or the enrollee's designee with a list of behavioral health providers available to treat a specific behavioral health condition within three (3) business days, but the MCO is not required to verify appointment availability.

Network Adequacy and Access Standards for Behavioral Health Services

(10 NYCRR 98-5)

Frequently Asked Questions

Q-5 The regulation requires MCOs to have designated staff with sufficient knowledge to help enrollees find in-network behavioral health providers to treat their behavioral health condition, as well as a designated phone number for this purpose. May MCOs use existing staff members who assist enrollees with locating providers and other general member services?

A MCO may use existing staff if the staff are trained to assist enrollees to locate in-network providers that can treat their behavioral health condition and, if necessary, assist the enrollee with an access complaint. The MCO must also post the contact information for the department or unit, including a telephone number, on a publicly accessible area of its website that allows an enrollee to access this designated staff directly.

Q-6 If a MCO locates an in-network provider that is able to meet the appointment wait time, treat the enrollee's behavioral health condition, and is located a reasonable distance from the enrollee (if the enrollee requested an in-person appointment) but the enrollee chooses not to take the available appointment, does this resolve the access complaint?

Yes, this would resolve the access complaint. The MCO should include a note in the access complaint record that an appointment was offered and declined.

Q-7 What method must a MCO use to verify the accuracy of provider directory information? Is it sufficient to use provider portals where providers can update their information.

A MCO must proactively contact in-network behavioral health providers in order to verify the accuracy of the information in the provider directory at least annually. Relying on providers to keep their information up to date in a portal is not sufficient.

Additionally, a MCO must have a method available on a publicly accessible area of its website for enrollees, providers, and other persons to report errors in the provider directory information. Within 15 calendar days of receipt of reported errors, the MCO must review the errors reported and ensure that the online provider directory information is accurate.

Q-8 If the provider is no longer accepting new patients, would the MCO suppress that provider in the directory or remove them from the network?

MCOs are required to include whether the provider will accept new enrollees. Providers that are not accepting new enrollees should not be suppressed or removed from the provider directory.

Q-9 What specific behavioral health services and conditions should be included in the searchable and filterable feature of an MCO's provider directory?

Provider directories must be searchable and filterable by the specific behavioral health services and conditions treated by the provider that the provider reports to the MCO.

Network Adequacy and Access Standards for Behavioral Health Services

(10 NYCRR 98-5)

Frequently Asked Questions

Q-10 Do OMH and OASAS maintain updated lists of providers with affiliations with facilities certified or authorized by OMH and OASAS that MCOs can reference to meet the provider directory requirements imposed by the regulation?

OMH and OASAS do not maintain centralized or updated lists of individual behavioral health provider affiliations with OMH-certified or OASAS-certified facilities. MCOs should work directly with their contracted behavioral health facilities and providers to maintain accurate and current information for their provider directories.

Q-11 Following a review of claims activity, if a MCO determines that an in-network behavioral health provider has not submitted a claim in the previous 6 months, what action must the MCO take?

MCOs are required to review claims activity every six (6) months. If the MCO did not receive any claims from an in-network behavioral health provider within the six-month period, the MCO must contact the provider to confirm the provider's participation status with the MCO and whether the provider is accepting new patients.

If a provider indicates that they are not accepting new patients, the MCO must update the provider directory to reflect that the provider is not accepting new patients. In addition, the MCO should not provide an enrollee with that provider's information when assisting an enrollee in finding a participating provider in response to an access complaint.

If a provider indicates that they are no longer participating in the MCO's network, then the MCO must remove the provider from the provider directory and take any other steps necessary to remove the provider from its network.

Q-12 What is an access plan?

An access plan is an internal control document developed by a MCO that establishes a protocol for monitoring and ensuring access to behavioral health services. The access plan requirements are set forth in 10 NYCRR 98-5.8.

Q-13 How should MCOs monitor and ensure access to behavioral health services, including compliance with appointment wait time standards?

10 NYCRR 98-5.8 states that MCOs must 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. Each MCO may choose its own methods to monitor appointment wait times that best address the specific needs of their covered population and service area as part of its access plan.

MCOs are encouraged to work with their providers to meet the behavioral health needs of their enrollees, as well as to engage in recruiting efforts for additional providers. MCOs must ensure that their networks have adequate capacity and availability of health care providers of behavioral health services to offer enrollees appointments with providers that can treat

enrollees' behavioral health conditions and that are located a reasonable distance from the enrollee (if the enrollee wants an in-person appointment).

Q-14 Does displaying information such as race, ethnicity, gender, and languages spoken in the provider directory satisfy the requirement for MCOs to have an access plan and monitoring protocol that addresses the ability of in-network behavioral health providers to meet the cultural and linguistic needs of enrollees?
No. A MCO's access plan must include a process to consider the cultural and linguistic needs of enrollees and to evaluate whether the cultural and linguistic capabilities of network providers is sufficient, or whether the network should be improved to better meet the needs of its enrollees.

Q-15 The regulation requires enrollees to annually report information on access complaints, including the geographic area where services were requested. What unit of geographic area must be reported?
Information on access complaints should be maintained and reported at the county level.

Q-16 Will the State be sharing a template for the report or a list of all the reporting requirements for the access complaint report?

The reporting requirements for the annual MCO reporting on network adequacy and access are outlined in Section 98-5.9(3). This will be due by December 31, 2026 and annually thereafter.

Q-17. If an enrollee is discharged from an in-network hospital and is need of an outpatient follow-up appointment, is the seven calendar day appointment wait time only satisfied if that same hospital offers the enrollee an outpatient follow-up appointment within seven calendar days?

No. The regulation does not require that the follow-up appointment be with the same in-network hospital in order to satisfy the appointment wait time for a follow-up appointment.

Date Issued: July 7, 2025