Mental Health and Substance Use Disorder Parity Report Act

Instructions for Reporting

Reporting Periods:

January 1, 2017 through December 31, 2017
January 1, 2018 through December 31, 2018

Introduction

In 2018, the Legislature amended Section 210 of the Insurance Law/added Section 343 to the Insurance Law to establish the mental health and substance use disorder parity report act. This law is intended to ensure compliance with state and federal requirements for mental health and substance use disorder parity laws. It requires entities subject to its provisions to provide a variety of information related to their administration of mental health and substance use disorder benefits in comparison to their administration of medical and surgical benefits.

Applicability

The data reporting applies to individual, group and blanket policies or contracts that provide comprehensive-type coverage and that are issued by insurers authorized to write accident and health insurance in New York State, corporations organized pursuant to Article 43 of the Insurance Law, and managed care organizations certified pursuant to Article 44 of the Public Health Law* ("insurers"). The legislation requires such insurers to provide the requested information for the preceding two calendar years to the Superintendent of the Department of Financial Services ("DFS") beginning July 1, 2019 and every two years thereafter.

*Prepaid Health Services Plans ("PHSPs") are required to report data related to products offered in the commercial individual market for the specified reporting periods.

Report Submission

Due Date for Submission: The due date for submission will be provided in the near future.

The following are the guidelines regarding report submission:

- Submit Report in Microsoft Excel Format using the data template provided.

- Submit reports as instructed by DFS. Specific directions will be provided at a future date.
- Insurers may not consolidate information from multiple NAIC numbers into one report. ***Submit one completed worksheet per NAIC number for each reporting period***.
- Data should not include information related to the following types of coverage:
    - Self-funded;
    - Medicaid:
    - Essential Plan;
    - Managed Long-Term Care,
    - Policies situs outside of New York,
    - Article 47 municipal cooperative health benefit plans,
    - Medicare; and
    - Federal Employee Insurance.

Data Publication

The requested data will allow the DFS to publish the requested information in the biennial Mental Health Parity Report.

Data Template

The data template has the following tabs:

- Utilization Review – Retrospective
- Utilization Review- Prior Authorization
- Utilization Review – Concurrent
- Rate of 1st Level Appeals
- Percentage of Claims Paid
- Number of Behavioral Health Representatives
- Cost Share Comparison – Utilization Review (Schedule 1)
- Cost Share Comparison – Individual Market
- Cost Share Comparison – Small Group Market
- Cost Share Comparison – Large Group Market
- Participating Providers
- External Appeals
- Certification and Contact Information

Utilization Review - Retrospective

Insurers must provide total number of claims or cases, total number of retrospective utilization reviews performed, total number of claims or cases approved through retrospective utilization review and total number of claims or cases denied through utilization review for medical and

surgical claims or as well as mental health and substance use disorder claims or cases. ***In instances where a claim or case involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the claim or case is reported under mental health services or substance use disorder services.***

- Name of Insurer – enter name of reporting insurer. Once entered on the initial tab of the worksheet this information should carry over to the remaining worksheet tabs.
- NAIC # - enter NAIC # associated with reporting insurer. For PHSPs enter the number assigned by DFS. Once entered on the initial tab of the worksheet this information should carry over to the remaining worksheet tabs.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Reporting Basis – Indicate whether utilization review data is reported based on utilization management cases or on a claim basis. The basis selected must be consistent for Medical/Surgical, Mental Health and Substance Use Disorder.
- Total # of Claims or Cases- enter the total number of claims or cases received during the reporting period for each applicable category.
- Total # of Utilization Reviews Performed – enter the total number of retrospective utilization reviews performed during the reporting period for each applicable category.
- Total # of Claims or Cases Approved Through Utilization Review - enter the total number of claims or cases approved through retrospective utilization review performed during the reporting period for each applicable category.
- Total # of Claims or Cases Denied Through Utilization Review - enter the total number of claims or cases denied, in whole or in part, through retrospective utilization review performed during the reporting period for each applicable category.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example, if the reporting NAIC # does not provide out-of-network benefits under any of its plans), please enter N/A in the designated field.

Utilization Review – Prior Authorization

Insurers must provide total number of prior authorization requests, total number of authorization requests approved through utilization review and total number of authorization requests denied through utilization for medical and surgical services as well as mental health services and substance use disorder services. ***In instances where the prior authorization request involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the prior authorization request is reported under mental health services or substance use disorder services.***

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # Prior Authorization Requests- enter the total number of prior authorization requests received during the reporting period for each applicable category.
- Total # of Prior Authorization Requests Approved - enter the total number of prior authorization requests approved through utilization review performed during the reporting period for each applicable category.
- Total # of Prior Authorization Requests Denied - enter the total number of prior authorizations denied, in whole or in part, through utilization review performed during the reporting period for each applicable category.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example, if the reporting NAIC # does not provide out-of-network benefits under any of its plans), please enter N/A in the designated field.

Utilization Review – Concurrent

Insurers must provide total number of concurrent authorization requests, total number of concurrent authorization requests approved through utilization review and total number of concurrent authorization requests denied through utilization review for medical and surgical services as well as mental health and substance use disorder services. ***In instances where the concurrent authorization request involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the concurrent authorization request is reported under mental health services or substance use disorder services.***

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # Concurrent Authorization Requests- enter the total number of concurrent authorization requests received during the reporting period for each applicable category.
- Total # of Concurrent Authorization Requests - enter the total number of concurrent authorization requests approved through utilization review performed during the reporting period for each applicable category.
- Total # Concurrent Authorization Requests Denied - enter the total number of concurrent authorization requests denied, in whole or in part, through utilization review performed during the reporting period for each applicable category.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example, if the reporting NAIC # does not provide out-of-network benefits under any of its plans), please enter N/A in the designated field.

Rate of 1st Level Appeals

Insurers must provide the total number of 1st level appeals filed, total number of denials upheld on 1st level appeal, and total number of denials overturned on 1st level appeals for medical and surgical services as well as mental health and substance use disorder services. ***In instances where a 1st level appeal involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the 1st level appeal is reported under mental health services or substance use disorder services.***

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of 1st Level Appeals Filed – enter the total number of 1st level appeals filed during the reporting period for each applicable category.
- Total # of 1st Level Appeals Closed – enter the total number of 1st level appeals closed during the reporting period for each applicable category. 1st level appeals received prior to January 1, 2018 that were closed during the reporting period of January 1, 2018 through December 31, 2018 should be included.
- Total # of Denials Upheld on 1st Level Appeal – enter the total number of denials upheld based on 1st level appeal determination during the reporting period.
- Total # of Denials Overturned on 1st Level Appeal – enter the total number of denials overturned, in whole or in part, based on 1st level appeal determination during the reporting period.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example if a health plan does not provide out-of-network benefits), please enter N/A in the designated field.

Percentage of Claims Paid

Insurers must provide the following information as applicable for medical and surgical claims as well as mental health claims and substance use disorder claims.

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of Claims Received – enter the total number of claims received during the reporting period for each applicable category.
- Total # of Claims Paid – enter the total number of claims paid during the reporting period for each applicable category.

Notes:

Insurers will enter whole numbers.

Approved in-network exceptions should be included in the "In-Network Exception" category. If an in-network exception request is denied and the plan offers out-of-network coverage, the applicable claim should be included in the "Out-of-Network" category.

If the reporting NAIC # does not offer out-of-network coverage for any of its plans the insurer should enter N/A (Not Applicable) in the "Out-of-Network" category.

Number of Behavioral Health Representatives

Insurers must provide the following information as applicable:

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.

- Total Number of Behavioral Health Advocates Pursuant to Agreement with the Office of the Attorney General – Insurers that entered into an agreement with the Office of the Attorney General enter the total number of Behavioral Health Advocates. Insurers who were not subject to such agreement with the Office of the Attorney General, enter "Not Applicable" in the designated field. *This should be broken out by those employed directly by the insurer and those employed through a third-party vendor.*

- Total Number of Staff Available to Assist Policyholders with Mental Health Benefits and Substance Use Disorder Benefits – enter total number of staff available to assist policyholders with mental health benefits and substance use disorder benefits. If the insurer has no staff available to assist policyholders with mental health benefits and substance use disorder benefits enter the number 0 in the designated field. *This should be broken out by those employed directly by the insurer and those employed through a third-party vendor.*

Cost Share Comparison – Utilization Review (Schedule 1) *

Insurers should provide a comparison of the number of services or prescription drugs that require utilization review for medical and surgical services, and mental health services and substance use disorder services for each treatment category. ***Schedule 1 should only be completed when the insurer's internal guidelines regarding which services or prescription drugs require utilization review is the same across all plans and markets. If the insurer's internal guidelines regarding which services or prescription drugs require utilization review varies by plan and or/market, then the insurer should enter utilization review information in the Utilization Review column on the Cost Share Comparison worksheets by market and plan name.***

Cost Share Comparison – Individual Market

Insurers must provide the following information as applicable for a specific plan offered in the individual market in New York State under the reporting NAIC number. The insurer should submit one cost sharing comparison per plan name until the insurer has provided such cost sharing comparisons for at least 75% of the insurer's total enrollees in the individual market. *Where more than one co-payment or co-insurance exists in a treatment category, please use Schedule 2 to provide* ***service specific detail*** *(for example Outpatient In-Network: Physical Therapy, Chiropractic Services, etc.) and enter "See Schedule 2" in the applicable field on this worksheet.:*

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.

- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Line of Business – Select line of business (ex. HMO, EPO, etc.) from drop down box.
- Product Name (Optional) – enter the product name.
- Plan Name – enter the name of the specific plan.
- # of Enrollees for this plan as of December 31st– enter the number of individuals enrolled in the specified plan as of the last date of the reporting period.
- # of Enrollees for all plans as of December 31st – enter the number of individuals enrolled in all plans offered in the individual market as of the last day of the reporting period.
- Co-Payment – enter the co-payment for the applicable treatment category. If there is no co-payment for the applicable treatment category, enter the number 0 in the designated field.
- Co-Insurance – enter the co-insurance percentage for the applicable treatment category. If no co-insurance is applied to the treatment category, enter the number 0 in the designated field.
- Limitations on Scope – For each treatment category, report any requirements, other than prior authorization, imposed on members or providers before the benefit is covered (ex., referrals, step-therapy, etc.) and the number of services (or number of prescription drugs, where applicable) for which the limitation on scope applies. If there are no limitations on scope for the applicable treatment category, enter the word None in the designated field. If more than one type of limitation on scope applies in a treatment category, add additional lines to the worksheet as needed.
- Limitations on Duration*- For each treatment category, report any limitations in duration (ex. visit limits, quantity limits dollar limits, etc.) and the number of services (or number of prescription drugs, where applicable) for which the limitation in duration applies. If there are no limitations on duration for the applicable treatment category, enter the word None in the designated field. If a visit limit applies, please specify whether visit limit is per condition or per plan year (for example if the treatment category has a duration limit of 60 visits per condition, enter: 60 visits per condition). If more than one type of limitation on duration applies in a treatment category, add additional lines to the worksheet as needed. *If the plan does not have limitations on

duration for mental health and substance use disorder services, the plan is not required to list any duration limits for medical and surgical services.

- Utilization Review – Indicate the number of services or prescription drugs that require utilization review for the applicable treatment category. If the internal guidelines regarding which services or prescription drugs require utilization review is the same for all plans and markets, report once under Schedule 1 and enter "See Schedule 1" on this worksheet for each treatment category.

Notes:

Insurers will enter whole numbers.

In instances where out-of-network coverage is not available under the plan, enter N/A in the designated field.

Insurers should copy the template and add additional pages to the Cost Share Comparison – Individual Market as needed.

Cost Share Comparison – Small Group Market

Insurers must provide the following information as applicable for a specific plan offered in the small group market in New York State under the reporting NAIC number. The insurer should submit one cost sharing comparison per plan name until the insurer has provided such cost sharing comparisons for at least 75% of the insurer's total enrollees in the small group market. *Where more than one co-payment or co-insurance exists in a treatment category, please use Schedule 2 to provide **service specific detail** (for example Outpatient In-Network: Physical Therapy, Chiropractic Services, etc.) and enter "See Schedule 2" in the applicable field on this worksheet.:*

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Line of Business – Select line of business (ex. HMO, EPO, etc.) from drop down box.
- Product Name (Optional)– enter the product name.
- Plan Name – enter the name of the specific plan.

- # of Enrollees for this plan as of December 31st– enter the number of individuals enrolled in the specified plan as of the last date of the reporting period.
- # of Enrollees for all plans as of December 31st—enter the number of individuals enrolled in all plans offered in the small group market as of the last date of the reporting period.
- Co-Payment – enter the co-payment for the applicable treatment category. If there is no co-payment for the applicable treatment category, enter the number 0 in the designated field.
- Co-Insurance – enter the co-insurance percentage for the applicable treatment category. If no co-insurance is applied to the treatment category, enter the number 0 in the designated field.
- Limitations on Scope – For each treatment category, report any requirements, other than prior authorization, imposed on members or providers before the benefit is covered (ex., referrals, step-therapy, etc.) and the number of services (or number of prescription drugs, where applicable) for which the limitation on scope applies. If there are no limitations on scope for the applicable treatment category, enter the word None in the designated field. If more than one type of limitation on scope applies in a treatment category, add additional lines to the worksheet as needed.
- Limitations on Duration*- For each treatment category, report any limitations in duration (ex. visit limits, quantity limits, dollar limits, etc.) and the number of services (or number of prescription drugs, where applicable) for which the limitation in duration applies . If there are no limitations on duration for the applicable treatment category, enter the word None in the designated field. If a visit limit applies, please specify whether visit limit is per condition or per plan year (for example if the treatment category has a duration limit of 60 visits per condition, enter: 60 visits per condition). If more than one type of limitation on duration applies in a treatment category, add additional lines to the worksheet as needed. *If the plan does not have limitations on duration for mental health and substance use disorder services, the plan is not required to list any duration limits for medical and surgical services.
- Utilization Review – Indicate the number of services or prescription drugs that require utilization review for the applicable treatment category. If the internal guidelines regarding which services or prescription drugs require utilization review is the same for all plans and markets, report once under Schedule 1 and enter "See Schedule 1" on this worksheet for each treatment category.

Notes:

Insurers will enter whole numbers.

In instances where out-of-network coverage is not available under the plan, enter N/A in the designated field.

Insurers should copy the template and add additional pages to the Cost Share Comparison – Small Group Market as needed.

Cost Share Comparison – Large Group Market

Insurers must provide the following information as applicable for a specific plan offered in the large group market in New York State under the reporting NAIC number. The insurer should submit one cost sharing comparison per plan name until the insurer has provided such cost sharing comparisons for at least 75% of the insurer's total enrollees in the large group market. *Where more than one co-payment or co-insurance exists in a treatment category, please use Schedule 2 to provide **service specific detail** (for example Outpatient In-Network: Physical Therapy, Chiropractic Services, etc.) and enter "See Schedule 2" in the applicable field on this worksheet.:*

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Line of Business – Select line of business (ex. HMO, EPO, etc.) from drop down box.
- Product Name (Optional) – enter the product name.
- Plan Name – enter the name of the specific plan.
- # of Enrollees for this plan as of December 31st– enter the number of individuals enrolled in the specified plan as of the last date of the reporting period.
- # of Enrollees for all plans as of December 31st—enter the number of individuals enrolled in all plans offered in the large group market as of the last date of the reporting period.
- Co-Payment – enter the co-payment for the applicable treatment category. If there is no co-payment for the applicable treatment category, enter the number 0 in the designated field.
- Co-Insurance – enter the co-insurance percentage for the applicable treatment category. If no co-insurance is applied to the treatment category, enter the number 0 in the designated field.

- Limitations on Scope – For each treatment category, report any requirements, other than prior authorization, imposed on members or providers before the benefit is covered (ex., referrals, step-therapy, etc.). and the number of services (or number of prescription drugs, where applicable) for which the limitation on scope applies. If there are no limitations on scope for the applicable treatment category, enter the word None in the designated field. If more than one type of limitation on scope applies in a treatment category, add additional lines to the worksheet as needed.
- Limitations on Duration*- For each treatment category, report any limitations in duration (ex. visit limits, quantity limits, dollar limits, etc.) and the number of services (or number of prescription drugs, where applicable) for which the limitation on duration applies. If there are no limitations on duration for the applicable treatment category, enter the word None in the designated field. If a visit limit applies, please specify whether visit limit is per condition or per plan year (for example if the treatment category has a duration limit of 60 visits per condition, enter: 60 visits per condition). If more than one type of limitation on duration applies in a treatment category, add additional lines to the worksheet as needed. *If the plan does not have limitations on duration for mental health and substance use disorder services, the plan is not required to list any duration limits for medical and surgical services
- Utilization Review – Indicate the number of services or prescription drugs that require utilization review for the applicable treatment category. If the internal guidelines regarding which services or prescription drugs require utilization review is the same for all plans and markets, report once under Schedule 1 and enter "See Schedule 1" on this worksheet for each treatment category.

Notes:

Insurers will enter whole numbers.

In instances where out-of-network coverage is not available under the plan, enter N/A in the designated field.

Insurers should copy the template and add additional pages to the Cost Share Comparison – Large Group Market as needed.

Participating Providers

Insurers must provide the following information regarding participating providers licensed in New York to diagnose and treat substance use disorder as well as participating providers licensed to diagnose and treat mental health conditions.

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.

- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- # of Participating Providers Licensed to Practice in New York for the Diagnosis and Treatment of Substance Use Disorder as of January 1st of the reporting period – enter the total number of participating providers for the applicable treatment category as of the first day of the reporting period. If applicable, the insurer should add additional types of participating providers licensed to practice in New York for the diagnosis and treatment of substance use disorder where the provider type is not already listed in the template.
- # of Participating Providers Licensed to Practice in New York for the Diagnosis and Treatment of Substance Use Disorder as of December 31st of the reporting period – enter the total number of in-network providers for the applicable treatment category as the last day of the reporting period. If applicable, the insurer should add additional types of in-network providers licensed to practice in New York for the diagnosis and treatment of substance use disorder where the provider type is not already listed in the template.
- # of Participating Providers Licensed to Practice in New York for the Diagnosis and Treatment of Mental Health Conditions as of January 1st of the reporting period – enter the total number of in-network providers for the applicable treatment category as of the first day of the reporting period. If applicable, the insurer should add additional types of in-network providers licensed to practice in New York for the diagnosis and treatment of mental health conditions where the provider type is not already listed in the template.
- # of Participating Providers Licensed to Practice in New York for the Diagnosis and Treatment of Mental Health Conditions as of December 31st of the reporting period – enter the total number of in-network providers for the applicable treatment category as of the last day of the reporting period. If applicable, the insurer should add additional types of in-network providers licensed to practice in New York for the diagnosis and treatment of mental health conditions where the provider type is not already listed in the template.

External Appeals

Insurers must provide the total number of external appeals filed, total number of denials upheld on external appeal, and total number of denials overturned on external appeals for medical and surgical services as well as mental health and substance use disorder services***. In***

instances where an external appeal involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the external appeal is reported under mental health services or substance use disorder services.

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of external appeals Filed – enter the total number of external appeals filed during the reporting period for each applicable category.
- Total # of external appeals Closed – enter the total number of external appeals closed during the reporting period for each applicable category. External appeals received prior to January 1st of the reporting year that were closed during the reporting period should be included.
- Total # of Denials Upheld on external appeal – enter the total number of denials upheld based on external appeal determination during the reporting period.
- Total # of Denials Overturned on external appeal – enter the total number of denials overturned, in whole or in part, based on external appeal determination during the reporting period.

Certification & Contact Information

An officer of the company must certify that the information provided by the insurer is true, accurate and complete to the best of his or her knowledge. The insurer must also provide a point of contact for any questions the Department of Financial Services may have regarding this submission. The following information should be provided:

- Name of Insurer – enter name of reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - enter NAIC # associated with reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Signature of Officer – enter electronic signature of company officer.
- Print Name and Title of Company Officer
- Date Signed
- Contact Name – provide name of individual who can answer questions regarding the submission.
- Contact's title
- Phone Number for contact

Questions

Send questions about the Mental Health and Substance Use Disorder Parity Act data reporting to susan.hesler@dfs.ny.gov