Office of Mental Health
Office of Addiction Services and Support
Department of Financial Services

Commercial Insurance Reimbursement Mandate for OMH & OASAS Behavioral Health Outpatient Services Beginning on and after January 1, 2025

Frequently Asked Questions

November 27, 2024

Part AA of Chapter 57 of the Laws of 2024 ("Chapter 57") amended Insurance Law sections 3216(i)(31)(J), 3216(i)(35)(K), 3221(l)(5)(K), 3221(l)(7)(J), 4303(g)(12), and 4303(l)(10) to require insurers to reimburse certain in-network facilities that provide covered outpatient mental health and substance use disorder treatment at negotiated rates that are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under Social Services Law Article 5, Title 11 ("Medicaid rate").

1. **Can the State develop equivalent rates for commercial insurers as a proxy for Ambulatory Patient Groups ("APGs")?**

   Answer: Part AA of Chapter 57 of the Laws of 2024 ("Chapter 57") amended Insurance Law sections 3216(i)(31)(J), 3216(i)(35)(K), 3221(l)(5)(K), 3221(l)(7)(J), 4303(g)(12), and 4303(l)(10) to require insurers to reimburse certain in-network facilities that provide covered outpatient mental health and substance use disorder treatment at negotiated rates that are not less than the Medicaid rate in effect on April 1 of the preceding year that is established prior to October 1 of the preceding calendar year. For facility types for which the Office of Mental Health ("OMH") issues operating certificates and the facility types that are licensed, certified, or otherwise authorized by the Office of Addiction Services and Supports ("OASAS") and for which Medicaid rates are determined pursuant to the APG methodology, this methodology must be used to determine the minimum reimbursement required by law. It's important to note as of January 1, 2024, commercial insurers have been required to reimburse out of network School-Based Mental Health Clinics, which utilize the APG payment methodology, at a rate negotiated between the insurers and school-based mental health clinic or, in the absence of a negotiated rate, an amount no less than the Medicaid rate.

   To help insurers with the implementation of Chapter 57, APG fee schedules, tools to support commercial plan configurations, and other resources are available through the OMH Commercial Billing webpage. OASAS will host applicable information for OASAS programs at this link: Ambulatory Providers | Office of Addiction Services and Supports (ny.gov).

   In addition, insurers always have the discretion and flexibility to develop reimbursement strategies that ensure reimbursement is not less than the Medicaid rate.

2. **Can the State identify specific revenue codes for School-Based Mental Health ("SBMH") Clinics and specific revenue codes for those additional services that must be reimbursed at the Medicaid rate under Chapter 57?**

Answer: A list of suggested revenue codes for OMH facilities, which includes SBMH Clinics, can be found here: Revenue-Codes-OMH-Programs MCTAC-Billing-Tool (ctacny.org). The SBMH revenue codes would be the same as those listed for Mental Health Outpatient Treatment and Rehabilitative Services ("MHOTRS").

3. **Which mental health and substance use disorder services and facilities are subject to Chapter 57?**

Answer: For the mental health and substance use disorder services and facilities that are subject to Chapter 57, please refer to the January 1, 2025 Commercial Rate Mandate FAQs (ny.gov).

Outpatient Mental Health Services:

Please note, the services that each OMH licensed facility type is authorized to provide under its operating certificate are outlined in applicable OMH regulations. There is not much variation in the services offered by OMH-licensed programs. Optional services that MHOTRS programs, including SBMH Clinics, may provide are listed in OMH regulations codified at 14 NYCRR § 599.8; however, optional services that do not require OMH's prior approval are not listed on the provider's operating certificate. Insurers may obtain information about services provided by MHOTRS programs through the network contracting process. Note also, that insurers are not currently required to cover outpatient care for assertive community treatment ("ACT") services and critical time intervention services provided by facilities issued an operating certificate by OMH pursuant to Mental Hygiene Law Article 31, and outpatient care provided by a mobile crisis intervention services provider licensed, certified, or designated by OMH or OASAS. However, if and when a health insurance policy or contract covers services mentioned above, the Medicaid rate would apply.

Additionally, OMH has developed the following resources that provide the list of facilities for each applicable OMH service described above:

a. OMH APG Provider-Specific Fee Schedule
b. OMH Non-APG Provider-Specific Fee Schedule
c. Non-APG OMH-licensed Outpatient Services Fee Schedule (not provider-specific)

The materials listed above outline the specific services and their Fee Schedules effective for commercial insurers on or after January 1, 2025. For MHOTRS services paid APG rates, OMH is developing additional instructions to correctly reimburse at the procedure level.

Outpatient Substance Use Disorder Services:

The services provided by the facilities that are licensed, certified, or otherwise authorized by OASAS are outlined in applicable OASAS regulations.

Additionally, OASAS has developed the following resources that provide the list of facilities/programs for each applicable OASAS service described above:

a. OASAS APG Outpatient Rate file
b. List of provider-specific OASAS outpatient rates

The materials listed above outline the specific programs and their rates effective for commercial insurers on or after January 1, 2025.

Furthermore, insurers can find the reimbursement rates for OASAS programs here: Ambulatory Providers | Office of Addiction Services and Supports (ny.gov)

4. **If the State APG calculator utilized to identify the Medicaid rate doesn't return a rate, how should the service be priced?**

Answer: There are OMH and OASAS services for which the Medicaid rates are established through APGs (e.g. MHOTRS), while there are other services that are not priced through APGs (e.g. bundled payments, monthly rates, etc.).

Outpatient Mental Health Services:

For all OMH outpatient services that are not priced through APG for which Chapter 57 is applicable, the State has developed a Fee Schedule that provides insurers with the minimum reimbursement rate (available on Commercial Billing for Behavioral Health (BH) Services (ny.gov)).

For OMH Part 599 MHOTRS services, every reimbursable procedure has an APG rate. If the provider bills a MHOTRS procedure that does not return an APG rate, then that procedure is not reimbursed by the NYS Medicaid Program and therefore is not required to be reimbursed at the Medicaid rate pursuant to Chapter 57. The service would be reimbursed based on a rate negotiated between the provider and the insurer.

Outpatient Addiction Services:

All OASAS outpatient services for which Chapter 57 is applicable are priced through APG except Opioid Treatment Program ("OTP") bundles. The OTP bundle rates can be found in Ambulatory Providers | Office of Addiction Services and Supports (ny.gov).

5. **Do facilities need to be approved Medicaid providers in order for Chapter 57 to apply?**

Answer: No, Chapter 57 applies to facilities that are contracted with the insurer regardless of Medicaid enrollment status.

6. **Do the minimum facility reimbursement rates (not less than the Medicaid rate) as required by Chapter 57 only apply to participating providers?**

   Answer: Yes. Chapter 57 requires insurers to reimburse in-network facilities that provide covered outpatient mental health and substance use disorder treatment at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the Medicaid rate.

   However, the Insurance Law requires insurers to provide reimbursement for covered outpatient mental health services when provided by SBMH clinics regardless of whether the clinic is a participating provider. For covered outpatient mental health services provided in SBMH clinics that are not in an insurer's network, reimbursement is at the rate negotiated between the insurer and the SBMH clinic. In the absence of a negotiated rate, the reimbursement rate must be no less than the Medicaid rate. For more details, please see Q7 and 8 in the January 1, 2025 Commercial Rate Mandate FAQs (ny.gov).

7. **Will OMH and OASAS identify preferred billing codes for facility services?**

   Answer: Yes. To support insurers and providers, OMH and OASAS have provided instructions and fee schedules of the respective Medicaid rates for all services provided by facilities to which Chapter 57 applies. Where applicable, provider-specific fees have also been made available (see responses above to questions #3 and 4). In addition, although not required, insurers should consider adopting all applicable and published Medicaid guidelines regarding reimbursement, including applicable rate codes, procedure codes, modifiers, and units of services. All resources will be made publicly available through either the OMH Commercial website or the OASAS Ambulatory Providers Website.

8. **Critical Time Intervention ("CTI") services after discharge must be covered "until the insured is stabilized." How is stabilized defined? Also, what is the rate for these services?**

   Answer: The mandate for coverage of CTI services provided by OMH licensed providers under commercial health insurance policies and contracts does not apply yet. It applies, after DFS and DOH promulgate regulations, to policies and contracts issued, renewed, amended, modified, or altered 90 days after DFS and DOH determine, in consultation with OMH and OASAS, that for a particular provider type, there are a sufficient number of certified, licensed, or designated providers in the State to meet such network adequacy requirements. See § 15 of Subpart A of Part II of Chapter 57 of the laws of 2023. OMH will provide additional guidance regarding appropriate clinical review criteria to determine

when individuals may be considered stabilized in the community and no longer in need of CTI services after discharge from a hospital.

Please note the Medicaid rates for CTI services have not been established before October 1, 2024, therefore the requirement of Chapter 57 will not apply as of January 1, 2025 for CTI services. Insurers may reimburse for such services at negotiated rates. At such time as the mandate becomes effective and insurers contract with OMH-licensed CTI providers to provide these services, OMH will provide additional guidance regarding the applicable Medicaid Rate.

9. **Does Chapter 57 apply to both crisis residential facilities for any diagnosis and community residences for an eating disorder diagnosis?**

   Answer: Chapter 57 only applies to covered outpatient services for the treatment of mental health conditions provided in OMH-licensed or operated facilities. Crisis residential facilities and Community Residences for Eating Disorder Integrated Treatment ("CREDIT") are OMH-licensed facilities for the provision of sub-acute residential services, not outpatient services. Chapter 57 does not apply to these services as they are bedded programs.

10. **Are OMH/OASAS certified, licensed, authorized, or operated facility programs licensed or certified for both Medicaid and commercial insurance members?**

    Answer: OMH and OASAS license, certify, authorize, and operate facilities for the provision of services for all people, without regard to insurance coverage status.

11. **What is the applicable sub-acute clinical criteria for services intended to be delivered in a crisis residential facility or a community residence?**

    Answer: OMH has developed clinical criteria for sub-acute services provided in crisis residential facilities licensed pursuant to OMH regulations codified at 14 NYCRR Part 589, as these services are currently covered by NYS Medicaid Managed Care plans.

    The clinical criteria for sub-acute services provided in CREDIT facilities licensed pursuant to OMH regulations codified at 14 NYCRR Parts 594 and 595 are being developed by OMH, consistent with the recent Medicaid State Plan approval from CMS.

    Pursuant to Subpart A of Part II of Chapter 57 of the laws of 2023, "residential facility" means crisis residence facilities and community residences for eating disorder integrated treatment programs licensed pursuant to article thirty-one of the mental hygiene law.

    Note, the mandate for coverage of sub-acute care in residential facilities under commercial health insurance policies and contracts does not apply yet. (It applies, after DFS and DOH

promulgate regulations, to policies and contracts issued, renewed, amended, modified, or altered 90 days after DFS and DOH determine, in consultation with OMH and OASAS, that for a particular provider type, there are a sufficient number of certified, licensed, or designated providers in the State to meet such network adequacy requirements. See § 15 of Subpart A of Part II of Chapter 57 of the laws of 2023.)

When these services are required to be covered (note the effective date provisions in § 15 of Subpart A of Part II of Chapter 57 of the laws of 2023 for commercial coverage), insurers may develop clinical criteria for these services. Such criteria shall be subject to the review and approval of the Office of Mental Health pursuant to Section 4902 of the Insurance and Public Health Laws.

12. Are insurers required to utilize the same billing codes for sub-acute care provided in a residential facility that are available on OMH's website?

Answer: Chapter 57 does not apply to sub-acute care provided in a residential facility licensed or operated by the OMH.

13. Are insurers required to utilize the mobile crisis intervention codes currently used in the Medicaid space?

Answer: Chapter 57 requires insurers to pay not less than the Medicaid rate for mobile crisis intervention services, but it does not require the use of specific procedure codes. To assist insurers in complying with this requirement, OMH and OASAS have provided instructions, including all the applicable rate codes, procedure codes, modifiers and units of services, and fee schedules of the respective Medicaid rates for mobile crisis intervention services currently provided by the facilities referenced in this guidance. Where applicable, provider-specific fees have also been made available.

Note, the mandate for coverage of mobile crisis intervention services under commercial health insurance policies and contracts does not apply yet. (It applies, after DFS and DOH promulgate regulations, to policies and contracts issued, renewed, amended, modified, or altered 90 days after DFS and DOH determine, in consultation with OMH and OASAS, that for a particular provider type, there are a sufficient number of certified, licensed, or designated providers in the State to meet such network adequacy requirements. See § 15 of Subpart A of Part II of Chapter 57 of the laws of 2023.) However, if and when a health insurance policy or contract covers mobile crisis intervention services, the Medicaid rate would apply.

14. What are the Medicaid rates for Assertive Community Treatment ("ACT")?

Answer: OMH has developed a Commercial Fee Schedule that identifies all applicable billing codes and rates for ACT as well as other services pursuant to Chapter 57, which can be found on the OMH Commercial Billing webpage.

Note, the mandate for coverage of ACT services under commercial health insurance policies and contracts does not apply yet. (It applies, after DFS and DOH promulgate regulations, to policies and contracts issued, renewed, amended, modified, or altered 90 days after DFS and DOH determine, in consultation with OMH and OASAS, that for a particular provider type, there are a sufficient number of certified, licensed, or designated providers in the State to meet such network adequacy requirements. See § 15 of Subpart A of Part II of Chapter 57 of the laws of 2023). However, if and when a health insurance policy or contract covers ACT services, the Medicaid rate would apply.