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

May 2, 2025

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. **If a facility is in-network with an insurer, but their provider contract does not include a specific service or Current Procedural Terminology ("CPT") code that Medicaid reimburses, would the insurer be required to pay for the non-contracted code at the Medicaid rate?**

   Answer: If the provider contract does not include reimbursement for a particular CPT code or service, providers should contact the insurer to confirm the list of covered procedure codes. Insurers are not required to pay the Medicaid rate for services or CPT codes not covered. Chapter 57 does not specify which services an insurer must cover. If a provider wishes to add services or CPT codes to their provider contract, the provider should contact the insurer.

2. **When must an insurer comply with Chapter 57? If an insurer does not comply with Chapter 57 on time, must the insurer reprocess all claims back to the health insurance policy renewal date on or after January 1, 2025?**

   Answer: An insurer is required to comply with Chapter 57 when a health insurance policy or contract is issued, renewed, modified, altered, or amended on and after January 1, 2025. Note, all individual health insurance policies renew on January 1, but group health insurance policies renew throughout the year.

   Any delay in implementing Chapter 57 must be rectified in accordance with Insurance Law section 3224-a. Insurers must reprocess any claims that the facility coded in accordance with the insurer's billing guidance for the service rendered and that the insurer incorrectly reimbursed without requiring facilities to resubmit claims. Insurers also must pay interest as required by Insurance Law section 3224-a. Insurers may require a facility to resubmit any claim that was not coded in accordance with the insurer's billing guidance for the service rendered.

3. **May insurers delay implementation of Chapter 57 by, for example, requiring that updates be made to participating provider agreements first?**

Answer: No. There is nothing in Chapter 57 that allows insurers to delay the implementation of Chapter 57, which applies to health insurance policies and contracts issued, renewed, modified, altered, or amended on and after January 1, 2025. While some facilities and insurers may have participating provider agreements containing negotiated rates that are less than the Medicaid rate, Chapter 57 requires reimbursement at not less than the Medicaid rate. See questions 13 and 14 of the January 1, 2025 FAQ for how Chapter 57 applies in those cases.

4. **How should insurers comply with retroactive rate updates established by the Office of Mental Health ("OMH"), Office of Addiction Services and Support ("OASAS"), and the Department of Health ("DOH")?**
   Answer: There will be no retroactive rate updates for commercial health insurance coverage. OMH, OASAS, and DOH establish annual reference rate sheets effective January 1 of each year. Annual reference rates are published prior to October 1 of the preceding calendar year. These rates remain unchanged until the next calendar year in alignment with Chapter 57.
   For 2025, OMH and OASAS have provided detailed fee schedules. Facilities and insurers can consult OMH's Commercial Billing for Behavioral Health (BH) Services and OASAS's reimbursement webpage for this information.

5. **Must an insurer reimburse covered outpatient mental health and substance use disorder services subject to Chapter 57 at not less than the Medicaid rate at the individual claim level or in the aggregate at the facility level?**
   Answer: Insurers must reimburse covered outpatient mental health and substance use disorder services that are subject to Chapter 57 at not less than the Medicaid rate at the individual claim level and **NOT** in the aggregate.
   Reimbursement at the individual claim level means that an insurer would pay not less than the Medicaid rate for a submitted claim for covered services. Reimbursement at the individual claim level includes instances when an insurer and a facility have a participating provider agreement whereby the facility bills and the insurer pays a per diem rate or monthly rate that is not less than the Medicaid rate.
   Reimbursement in the aggregate means that insurer would calculate its average payment for multiple claims and multiple insureds to determine if the claims, on average, were paid at not less than the Medicaid rate.

6. **If an in-network OMH or OASAS facility submits a bill for less than the applicable Medicaid rate, must an insurer reimburse the facility at not less than the Medicaid rate?**
   Answer: Yes. Insurers must reimburse covered outpatient mental health and substance use disorder services that are subject to Chapter 57 at not less than the Medicaid rate. This

requirement applies regardless of whether the facility submits a bill for less than the Medicaid rate and regardless of whether the provider contract has "lesser-of" contract language (i.e., clauses allowing insurers to pay facilities the lesser-of the billed charges or the negotiated rate). To ensure that claims are properly processed, facilities should bill insurers at not less than the Medicaid rate.

7. **May an insurer comply with Chapter 57 only upon request by facilities?**

   Answer: No, it is not permissible for an insurer to comply with Chapter 57 only upon request by the facility.

8. **Does Chapter 57 require insurers to reimburse Ambulatory Patient Groups ("APG") for multiple outpatient mental health or substance use disorder services provided to an insured on the same date of service?**

   Answer: Yes, if the services are covered under the health insurance policy or contract. The NYS Medicaid Enhanced Ambulatory Patient Grouping ("EAPG") methodology includes reimbursement calculations for combinations of certain services, up to three per day. Therefore, applicable secondary and tertiary services provided to an insured on the same date of service are subject to the minimum reimbursement standards set forth in Chapter 57. For additional guidance, refer to the EAPG reimbursement methodology for multiple services at Calculating Ambulatory Patient Group (APG) Rates for OMH-Licensed and OASAS-Certified Facilities.

9. **Must insurers pay "add-on" rates (e.g., after hours, Psychiatrist /Physician /Non-Physician Practitioner ("NPP"), Language Other than English, or other add-ons) in alignment with APG reimbursement methodology?**

   Answer: Yes. The "add-ons" are rate enhancements associated with specific service delivery components that Medicaid reimburses and, therefore, must be factored into an insurer's calculation of the Medicaid rate, per Chapter 57. Consistent with Q16 of January 1, 2025 Commercial Rate Mandate FAQs, insurers are not required to adopt the Medicaid billing conventions, which use procedure codes, modifiers, and rate codes to signify "add-on" components on a claim form. However, insurers are responsible for reimbursing facilities at rates not less than what Medicaid would pay for the same services, including any applicable "add-on" rate enhancements.

   To assist insurers in complying with this requirement, OMH and OASAS have provided a comprehensive breakdown of fee schedules and rate calculation tools that NYS Medicaid uses to calculate reimbursement for services, including applicable "add-ons" on OMH's Commercial Billing for Behavioral Health (BH) Services and OASAS's reimbursement webpage.

10. **What rates must insurers pay to federally qualified health centers ("FQHC") and certified community behavioral health clinic ("CCBHC") facilities pursuant to Chapter 57?**
    Answer: The minimum reimbursement rate is the prospective payment system ("PPS") rate, which is the all-inclusive, cost-based, threshold visit rate set by NYS Medicaid for these facilities*. Accordingly, if an FQHC or CCBHC facility is in-network with an insurer and provides covered outpatient mental health or substance use disorder services to an insured whose policy or contract renews on or after January 1, 2025, the insurer must reimburse the facility at no less than the published PPS rate under the FQHC or CCBHC program. This requirement applies regardless of the number of procedures performed during a threshold visit. To support compliance with Chapter 57, OMH has published facility-specific PPS rates for facilities subject to Chapter 57 in Exhibit C: Non-APG OMH Outpatient Services Fee Schedule. Similarly, for OASAS services, additional information on FQHC can be found on the Ambulatory Providers webpage, under the "APG Outpatient Rate list" under the "FQHC-PPS" tab.

    **Note: There are some FQHC facilities with MHOTRS Article 31 licenses that have opted to be reimbursed according to EAPG methodology. A list of those facilities can be found here: FQHC Rates.*

11. **May facilities subject to Chapter 57 continue to bill insurers using the institutional claim form (837i / UB-04)?**
    Answer: Chapter 57 does not specify which claim form a facility should use to comply with the rate mandate effective on and after January 1, 2025, and the facility should contact the insurer. 11 NYCRR 17 establishes standard claim forms which include both the institutional claim form (837i / UB-04) and the provider claim form (837p / HCFA 1500).
    The NYS Medicaid program recognizes outpatient facilities licensed, certified, or authorized by OMH and OASAS as institutional providers. Medicaid adjudicates reimbursement for these facilities at the Medicaid rate using an institutional claim form (837i / UB-04). Since Medicaid rates are the foundation of the reimbursement requirements imposed on insurers pursuant to Chapter 57, using an institutional claim form (837i / UB-04) is a best practice for insurers that aligns with NYS Medicaid reimbursement.
    Regardless of an insurer's claim submission process, insurers are required to reimburse outpatient mental health and substance use disorder services provided at OMH and OASAS facilities at not less than the Medicaid rate, provided the services are covered and the facility is in the insurer's network.

12. **When using the institutional claim form (837i / UB-04) to bill an insurer, in which field is the rate code reported?**

Answer: Rate codes are entered in Field 39 on the institutional claim form (837i / UB-04), by entering "24" and then the four-digit rate code. For additional information, please refer to the Managed Care Technical Assistance UB-04 Billing Tool at https://billing.ctacny.org/ (CTAC-MCTAC login required).

13. **How does Chapter 57 impact the coordination of benefits when an insured has both commercial insurance and Medicaid or Medicare?**

    Answer: Chapter 57 does not modify current requirements regarding the coordination of benefits between commercial insurance and Medicaid or Medicare. Medicaid remains the payer of last resort.