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

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

Frequently Asked Questions

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. **Which mental health services and facilities does Chapter 57 apply to?**

   Answer: Chapter 57 requires that insurers must, with respect to covered outpatient mental health treatment provided in the following facilities that participate in the insurer's provider network, reimburse the facility at rates that are not less than the Medicaid rate:

   - A facility issued an operating certificate by the Office of Mental Health ("OMH") pursuant to Mental Hygiene Law Article 31.
   - A facility operated by OMH.
   - A crisis stabilization center licensed pursuant to Mental Hygiene Law § 36.01.

2. **What are the facility types for which OMH issues operating certificates pursuant to Mental Hygiene Law Article 31 that Chapter 57 is applicable to?**

   Answer: The facility types include:

   - Mental Health Outpatient Treatment and Rehabilitative Services ("MHOTRS") including School-Based MHOTRS providers. [1]
   - Assertive Community Treatment ("ACT") providers.
   - Continuing Day Treatment ("CDT") providers.
   - Comprehensive Psychiatric Emergency Programs ("CPEP")[2] providers.
   - Day Treatment Services for Children providers.
   - Partial Hospitalization Program providers.
   - Personalized Recovery Oriented Services ("PROS") providers.
   - Certified Community Behavioral Health Clinic ("CCBHC") providers.[3]
   - Children and Family Treatment and Support Services ("CFTSS") providers.[4]

[1] Please note that Federally Qualified Health Centers ("FQHCs") may also be issued operating certificates pursuant to Mental Hygiene Law Article 31, including as Mental Health Outpatient Treatment and Rehabilitative Services ("MHOTRS") providers.
[2] Please note, Extended Observation Bed (a component of CPEP) is not considered outpatient and therefore Chapter 57 does not apply.
[3] Licensed as either OMH Part 599 or OASAS Part 822 Outpatient Addiction Services programs.
[4] CFTSS includes Other Licensed Practitioner ("OLP"), Community Psychiatric Support and Treatment ("CPST"), Psychosocial Rehabilitation ("PSR"), Family Peer Support Services ("FPSS"), and Youth Peer Support and Training ("YPS") services.

3. **Which substance use disorder services and facilities does Chapter 57 apply to?**

   Answer: Chapter 57 requires that insurers must reimburse covered outpatient treatment provided by facilities in this state that are licensed, certified, or otherwise authorized by the Office of Addiction Services and Supports ("OASAS") for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that participate in the insurer's provider network at rates that are not less than the Medicaid rate.

4. **What are the facility types in this state that are licensed, certified, or otherwise authorized by OASAS for the provision of outpatient, intensive outpatient, outpatient rehabilitation, and opioid treatment that Chapter 57 is applicable to?**

   Answer: The facility types include:

   - Outpatient Clinic providers* – both hospital and freestanding, reimbursed under Ambulatory Patient Groups ("APGs").
   - Outpatient Rehabilitation providers* (aka OP Addiction Day Rehab) – both hospital and freestanding, reimbursed under APG.
   - Opioid Treatment Program* ("OTP"), including mobile medication services delivered by a mobile medication unit and Comprehensive Outpatient Program* ("COP") providers– both hospital and freestanding, reimbursed under APGs including the weekly bundled rate.
   - Mobile Crisis Intervention Services providers*.
   - Crisis Stabilization Centers licensed pursuant to Mental Hygiene Law § 36.01.
     * Please note all facility types listed above with (*) may provide services in the community[5] (outside of the facility).

5. **When does Chapter 57 take effect?**

   Answer: Chapter 57 takes effect on January 1, 2025 and applies to health insurance policies and contracts issued, renewed, modified, altered, or amended on and after that date. Health insurance policies and contracts are the documents that set forth the terms and conditions of an insured's coverage with an insurer. Health insurance policies and contracts are separate and distinct from the provider agreements between an insurer and a provider of services. The provider agreements between an insurer and an OMH or OASAS facility are not relevant to when Chapter 57 will begin to apply to a specific insured's health insurance policy or contract.

[5] For additional information on these facilities, please refer to Commercial Billing for Behavioral Health (BH) Services (ny.gov) and Ambulatory Providers Reimbursement webpage.

6. **Do all health insurance policies and contracts renew on the same date?**

   Answer: No. The renewal date of a policy or contract depends on the type of health insurance policy.

   All *individual* comprehensive health insurance policies and contracts renew on January 1st of each year. The requirements of Chapter 57 will apply to individual health insurance policies and contracts beginning on January 1, 2025.

   Group comprehensive health insurance policies and contracts renew on a rolling basis throughout the year. For example, a group policy or contract that renews in December 2024 will not renew again until December 2025. In that case, the requirements of Chapter 57 would not apply to that policy or contract until December 2025.

7. **Does Chapter 57 apply to reimbursements for in-network School-Based Mental Health ("SBMH") clinics?**

   Answer: Yes. Chapter 57 applies to outpatient mental health services provided in SBMH clinics issued an operating certificate by OMH pursuant to Mental Hygiene Law Article 31 that are in an insurer's network.

8. **How does Chapter 57 apply in conjunction with existing Insurance Law requirements for reimbursement of SBMH clinics?**

   Answer: Insurance Law §§ 3216(i)(35)(J), 3221(l)(5)(J), and 4303(g)(11) require insurers to provide reimbursement for covered outpatient mental health services when provided by SBMH clinics regardless of whether the clinic is a participating provider. Reimbursement is at the rate negotiated between the insurer and the SBMH clinic. In the absence of a negotiated rate, the rate must be no less than the Medicaid rate.

   Chapter 57 requires insurers to reimburse covered outpatient mental health services provided in SBMH clinics that are in an insurer's network at a rate that is no less than the Medicaid rate. This requirement supersedes any agreements that an insurer may have with in-network SBMHs containing negotiated rates that are less than the Medicaid rate once the Chapter 57 requirements are effective.

   Chapter 57 does not apply to covered outpatient mental health services provided in SBMH clinics that are not in an insurer's network. For those services, reimbursement is at the rate negotiated between the insurer and the SBMH clinic. In the absence of a negotiated rate, the rate must be no less than the Medicaid rate.

9. **What types of health insurance policies and contracts are impacted by Chapter 57?**

   Answer: Chapter 57 applies to fully insured individual and group comprehensive health insurance policies and contracts issued in New York by insurers authorized to write Accident and Health Insurance in New York, Article 43 Corporations, Health Maintenance

Organizations, Student Health Plans certified pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans, and Prepaid Health Services Plans.

Chapter 57 does not apply to self-funded coverage. Self-funded coverage is when an employer hires a third party (often an insurer) to administer the health plan, but the benefit costs are the responsibility of the employer. Self-funded plans typically involve large employers and are generally regulated by the federal government – mostly the U.S. Department of Labor ("USDOL").

Chapter 57 does not apply to government-sponsored/funded programs such as Child Health Plus ("CHP"), Essential Plan, TRICARE, Medicaid, or Medicare. The requirement to pay Medicaid rates for CHP is pursuant to Part LL of Chapter 57 of the Laws of 2022. TRICARE is a federal government health care program for active-duty service members, their families, or retirees of the military, and it is not regulated by New York State.

10. Are health insurance policies and contracts required to cover outpatient mental health and substance use disorder services for all the facility types listed in questions 2 and 4?

Answer: Health insurance policies and contracts are currently required to cover outpatient mental health services provided in a facility issued an operating certificate by OMH pursuant to Mental Hygiene Law Article 31 and in a crisis stabilization center licensed pursuant to Mental Hygiene Law § 36.01, except for 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.

Health insurance policies and contracts are also required to cover outpatient services for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Coverage is for facilities that are licensed, certified, or otherwise authorized by OASAS to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to Mental Hygiene Law § 36.01, except for outpatient care provided by a mobile crisis intervention services provider licensed, certified, or designated by OMH or OASAS.

If and when the health insurance policy or contract covers outpatient care for ACT services or critical time intervention services provided in facilities issued an operating certificate by OMH pursuant to Mental Hygiene Law Article 31, or outpatient care provided by a mobile crisis intervention services provider licensed, certified, or designated by OMH or OASAS, then the Medicaid rate would apply to outpatient mental health treatment provided in these facilities and outpatient substance use disorder treatment provided by these facilities if the facilities participate in the insurer's network.

11. **Are insurers required to identify on the insured's ID card whether the insured is covered under a fully insured health insurance policy/contract or a self-funded plan?**

    Answer: Yes. 11 NYCRR 52.69 requires that insurance ID cards for comprehensive health insurance coverage include the phrase "fully insured coverage."

    Additionally, when an insurer is acting as an administrator on behalf of a group that provides self-funded health care coverage and the insurer's name appears on the health insurance identification card, the ID card must include the phrase "self-funded coverage".

12. **Do insurance ID cards contain the insurer's contact information for questions about an insured's coverage?**

    Answer: Yes. Insurance ID cards must include the telephone number or numbers that an insured and health care provider may call to obtain member services assistance, confirmation of eligibility or verification of benefits, and prior authorization for health care services.

13. **What if an in-network facility and an insurer have a participating provider agreement with negotiated rates that are less than the Medicaid rate?**

    Answer: Some facilities and insurers may have participating provider agreements containing negotiated rates that are less than the Medicaid rate. In those cases, Chapter 57 supersedes such agreements when the law becomes effective with respect to the insured's health insurance policy or contract (i.e. when the policy or contract is issued, renewed, modified, altered, or amended on and after January 1, 2025). No less than the Medicaid rate may be paid for services rendered on and after the effective date of the law for the insured's health insurance policy or contract.

14. **If an in-network facility and an insurer have a participating provider agreement with negotiated rates that are higher than the Medicaid rate, will the reimbursement go down?**

    Answer: No. Chapter 57 establishes a minimum reimbursement rate requirement for in-network facilities subject to the requirements of the law and not a ceiling.

    If an in-network facility has a participating provider agreement with an insurer at rates greater than the Medicaid rate for the services, then the terms of that agreement would apply.

15. **What can facilities do if an insurer is not providing reimbursement in compliance with Chapter 57?**

    Answer: If an insurer's reimbursement to a facility does not meet the Medicaid rate requirements under Chapter 57, the facility can reach out to the insurer to make sure that there was not a billing mistake and that all the information in their system is correct. If the services have been billed correctly based on the insurer's requirements, and the facility is unable to resolve the issue with the insurer, the facility may file a complaint with the Department of Financial Services through the online portal found here: File a Complaint | Department of Financial Services (ny.gov)

16. Are insurers required to comply with the same billing conventions (e.g., procedure codes, rate codes, modifiers) that are required by NYS Medicaid?

Answer: No. However, insurers must ensure that payment for covered services provided by participating facilities subject to the requirements of Chapter 57 meets the Medicaid rate. 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 all services currently provided by the facilities referenced in this guidance. Where applicable, provider-specific fees have also been made available.

For commercial billing support, please visit the Commercial Billing for Behavioral Health (BH) Services (ny.gov) webpage for OMH services and the Ambulatory Providers Reimbursement webpage for OASAS services.

17. What support is there if an insurer does not respond to a facility's application to become an in-network provider?

Answer: Insurance Law § 4806 and Public Health Law § 4406-h provide that insurers offering a managed care product and health maintenance organizations ("HMOs") have 60 days to respond to a facility's completed application to participate in the network of the insurer or HMO and notify the facility as to whether: (1) the facility is credentialed or (2) additional time is necessary to make a determination because of a failure of a third party to provide necessary information. An insurer or HMO must make every effort to obtain such information as soon as possible and make a final determination within 21 days of receiving the necessary documentation. The law defines "facilities" to mean health care providers licensed or certified under Articles 5, 28, 36, 40, 44, or 47 of the Public Health Law or Articles 16, 19, 31, 32, or 36 of the Mental Hygiene Law.

While the Insurance Law and Public Health Law require insurers offering a managed care product and HMOs to make available and disclose written application procedures and minimum qualification requirements to become an in-network provider and to respond to completed applications, the laws do not require automatic credentialing.

If a facility applying to become an in-network provider with an insurer offering a managed care product does not receive a timely response, the facility can file a complaint (along with documented evidence) with the NYS Department of Financial Services (DFS) here: File a Complaint | Department of Financial Services (ny.gov).

If a facility applying to become an in-network provider with an HMO does not receive a timely response, the facility can file a complaint (along with documented evidence) with the NYS Department of Health at managedcarecomplaint@health.ny.gov.

18. **What technical assistance will be provided to help facilities and insurers implement the requirements of Chapter 57?**

    Answer: OMH and OASAS have taken the following measures to relay information and offer technical assistance to facilities and insurers:

    a) OMH has established a new commercial billing webpage: Commercial Billing for Behavioral Health (BH) Services (ny.gov) where facilities and insurers can find helpful resources and information.

    b) OMH hosts a public-facing Commercial Billing Mailbox to which facilities and insurers can direct questions or concerns regarding billing or reimbursement of insurance claims for behavioral health services: commercial-billing@omh.ny.gov

    c) OASAS will host applicable information for OASAS programs on the designated OASAS webpage.

    d) For addiction/OASAS services, insurers can direct questions or concerns regarding billing or reimbursement to: picm@oasas.ny.gov

    Additionally, in collaboration with the Managed Care Technical Assistance Center ("MCTAC"), OMH and OASAS will develop training and informational materials to assist with understanding Chapter 57 and answer questions about implementing the billing and reimbursement systems necessary for compliance with the requirements, effective on or after January 1, 2025.