CareSource

REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Behavioral Health Rates-MP-PY-1733	03/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):			
☒ **Georgia**	☐ **Indiana**	☒ **Ohio**	☒ **West Virginia**

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A. Subject
Behavioral Health Rates

B. Background
State exchanges (or marketplaces) were established by the Affordable Care Act (ACA) to provide a platform for individuals and small businesses to compare and purchase health insurance plans, increase access to affordable health insurance, promote competition among insurers and improve the overall quality of care. State marketplaces adhere to consumer protection standards established by the ACA and enforced by the Centers for Medicare & Medicaid Services (CMS). CMS provides guidance and support to state exchanges and issues regulations, guidance documents and technical assistance to help states comply with federal requirements, including operational guidelines that provide instructions on how exchanges should operate (eg, enrollment processes, data reporting, consumer outreach, quality metrics).

Payment practices of state healthcare exchanges are governed by federal regulations established under the ACA, specific guidelines from CMS, state regulations, and consumer protection laws that work together to create a framework promoting access to affordable health insurance. CMS payment guidance helps ensure consistency in the billing and reimbursement of services across states, simplifying processes for providers, assuring compliance with federal regulations, improving quality of care and enhancing financial stability. Utilizing CMS guidance can streamline administrative processes for insurers and providers, leading to reduced administrative costs and improved efficiency in claims processing and reimbursement.

Adhering to CMS guidelines helps ensure that consumers are protected through fair and transparent payment practices. CareSource is establishing a clear framework for reimbursement rates of behavioral health (BH) services. Rates will reflect Medicare reimbursement standards for covered services and utilize the CareSource BH Fee Schedule for services not covered by Medicare.

C. Definitions
N/A

D. Policy
I. CareSource will utilize the following for the establishment of rates for BH services:
   A. If a service is covered by Medicare, rates will reflect Medicare reimbursement standards. A geographic practice cost index (GPCI) is established for every Medicare payment locality for each of the 3 components of a procedure's relative value unit (ie, the RVUs for work, practice expense, malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.
   B. If a service is not covered by Medicare, rates will follow 1) any specified contract rates, and then 2) utilization of the CareSource BH Fee Schedule located in the Provider Portal on www.caresource.com.

II. Rate Development Approach
CareSource will employ the following systematic approach to develop and update rates for the BH Fee Schedule:
A. Internal Median Rate Analysis: Rates will be derived from an analysis of internal median fee schedule rates across various markets.
B. Third-Party Data Validation: Where applicable, third-party data sources will be utilized to validate median rates, providing an additional layer of assurance for the established rates.
C. Single Case Agreement Rates: In cases where both internal and third-party data are unavailable, single case agreement median rates will be utilized as a last resort to ensure the establishment of a rate.

III. Compliance and Review
A. To ensure compliance with industry standards and mitigate potential risks associated with fee schedule determinations, rates will undergo a comprehensive review at least annually to ensure alignment with industry standards and market benchmarks.
B. CareSource will implement a system for ongoing monitoring of rate efficacy and impact on service delivery.

E. State-Specific Information
N/A

F. Conditions of Coverage
NA

G. Related Policies/Rules
NA

H. Review/Revision History

	DATE	ACTION
Date Issued	12/03/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	03/01/2026	
Date Archived		

I. References
1. Health insurance marketplaces. Centers for Medicare and Medicaid Services. Accessed October 14, 2025. www.cms.gov
2. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 45 C.F.R. Parts 155 and 156 (2025).
3. Treatment of Off--Campus Outpatient Departments of a Provider. Public Law 114-74, Section 603 (2015).

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.