Department of Health | Office of Mental Health | Office of Addiction Services and Supports

Community Oriented Recovery and Empowerment Services: Technical Assistance for Managed Care Organizations November 19, 2021 Webinar: Questions and Answers

Acronym Key: The below acronyms are commonly used throughout this document.	
BH HCBS	Behavioral Health Home and Community Based Services
CORE	Community Oriented Recovery and Empowerment
CPST	Community Psychiatric Support and Treatment
FST	Family Support and Training
HARP	Health and Recovery Plan
HIV-SNP	HIV-Special Needs Plan
LPHA	Licensed Practitioner of the Healing Arts
MCO	Managed Care Organization
NYS	New York State
PSR	Psychosocial Rehabilitation

Q#	Topic	Question	Answer
1.	Billing	Has rate code 7789 (PSR – individual – Per Diem) been terminated?	Some PSR rate code combinations, rates, and other billing-related information will change as a result of the transition to CORE, including the discontinuation of the PSR per diem rate code. As CORE PSR rate codes do not have unit limits, there is no longer a need to bill PSR per diem. Individuals can continue to receive BH HCBS PSR per diem through the end of the CORE continuity of care period. MCOs must continue to accept and reimburse claims for PSR per diem with dates of service until May 2, 2022. For more information see the *CORE Benefit and Billing Guidance*.
2.	Billing	Will rate codes stay the same or change for services transitioning from BH HCBS to CORE?	Rates and rate code combinations will remain the same for CPST, FST, and Peer Support. Some PSR rate code combinations, rates, and other billing-related information will change as a result of the transition to CORE, including the addition of two new PSR rate codes and the discontinuation of the PSR per diem rate code. There will be two new provider travel supplement rate codes for CORE. Information regarding CORE rates and billing requirements can be found in section II.4 and a visual crosswalk of billing rate code changes can be found in Appendix C of the *CORE Benefit and Billing Guidance*, as well as the MCTAC CORE Services Implementation Provider Billing Overview webinar.

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3.	Billing	Can claims be denied if the allowable service combinations are not adhered to?	CORE providers must notify an enrollee's MCO within three business days after the first date of initiating a new CORE Service. The following outlines possible CORE service duplication scenarios: **1. The CORE provider submits the service initiation template.** MCOs should respond to the provider within three business days if an enrollee is receiving a duplicative service. If the enrollee is receiving a duplicative service, the MCO should initiate a person-centered discussion with the enrollee, their providers, and their care manager (when applicable) to determine which service or program is the most appropriate for their needs. MCOs are responsible for reimbursing CORE Service claims until informing a CORE provider of service duplication. **2. The CORE provider does not submit the service initiation template and the individual is not receiving a duplicative service.** MCOs must reach out to the provider to request submission of the Provider Service Initiation Notification. MCOs may pend claims while awaiting provider submission. MCOs may not deny a CORE Service claim solely because they did not receive a service initiation notification. **3. The CORE provider does not submit the service initiation template and the individual is receiving a duplicative service.** The MCO may deny the claim. In this situation, the MCO must immediately begin the person-centered discussion with the enrollee, their providers, and their care manager (when applicable) to determine which service or program is the most appropriate for their needs. Additional information regarding the service initiation notification and the allowable service combinations with CORE Services can be found in section II.1.C of the *Benefit and Billing Guidance*.

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4.	Billing	For CORE PSR, are the TG and TF modifiers REQUIRED to be submitted with PSR codes H2017 UN, UP, UQ, UR, and US? For example, can a provider bill just H2017 UN for rate code 7786 and only add on the TF or TG if employment or education applies?	PSR group sessions with rate codes 7786, 7787, and 7788 need to be billed with modifiers indicating the number of individuals present in the session. These are: • UN: Two patients served • UP: Three patients served • UQ: Four patients served • UR: Five patients served • US: Six or more patients served PSR group session claims should indicate whether there was an education or employment focus. Modifiers should be used as outlined below. PSR group sessions: • Without an education or employment focus DO NOT need an additional modifier. • With an education focus should include modifier TF. • With an employment focus should include modifier TG. For additional information about billing for CORE Services, please refer to the MCTAC CORE Services Implementation Provider Billing Overview webinar.
5.	Crisis Services	Can NYS clarify timeline information around the Crisis Residence implementation and sunsetting of other crisis benefits?	The only Medicaid crisis services impacted by the CORE Services implementation are the BH HCBS short-term crisis respite and BH HCBS intensive crisis respite services. BH HCBS short-term and intensive crisis respite services will be replaced by Crisis Residence services. Crisis Residence services were implemented in Medicaid Managed Care in December 2020 and are currently available to all Medicaid Managed Care enrollees. BH HCBS Short-Term Crisis Respite and Intensive Crisis Respite providers may serve enrollees admitted to these programs on or before January 31, 2022, until the enrollee is discharged, no later than May 2, 2022. Beginning February 1, 2022, no new BH HCBS Short-Term or Intensive Crisis Respite program admissions may occur. Beginning February 1, 2022, all enrollees should be referred to Crisis Residence programs for crisis respite services. Most BH HCBS Crisis Respite providers applied for Crisis Residence licensure and received designation to provide and be reimbursed for Crisis Residence services under the NYS 1115 Waiver Crisis Intervention benefit. Additional information can be found on pages 6-7 and 9-10 in the *Adult Crisis Residence Benefit and Billing Guidance*.

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6.	Claims	Is there an MMIS requirement for CORE providers?	At this time, providers solely providing CORE Services cannot register for an MMIS number. CORE providers who have an MMIS number with another line of business can use that number. New York State (NYS) is planning to create a category of service for CORE in the coming months.
7.	Eligibility	In addition to having an H1 code, can enrollees who have codes H2, H3, H5, and H6 also access CORE Services?	To be eligible for CORE Services, individuals must be enrolled in HARP, or be HARP-eligible and enrolled in an HIV-SNP. • H1- indicates an individual is enrolled in a HARP • H4- indicates an individual is HARP-eligible and enrolled in an HIV-SNP H2, H3, H5, H6 are related to the NYS Eligibility Assessment, which is only required for BH HCBS. The presence of these codes do not prevent access to CORE Services.
8.	Eligibility	Can you clarify that HARP members with codes H2 and H3 can also access CORE?	H2 and H3 are related to completion of the NYS Eligibility Assessment, which is only required for BH HCBS. H2 and H3 codes do not prevent access to CORE Services, but do not indicate an individual is eligible for CORE Services. To be eligible for CORE Services, individuals must be enrolled in HARP, or be HARP-eligible and enrolled in an HIV-SNP. Individuals enrolled in HARP or are HARP-eligible and HIV-SNP enrolled are eligible for CORE Services with an LPHA recommendation regardless of H-code status.
9.	MCO Role/ Expectations	Are MCOs expected to monitor members who transition successfully to CORE with the same or different provider?	Yes. MCOs must work collaboratively with enrollees and their providers and care managers (if applicable) to transition from BH HCBS to CORE Services. MCOs must communicate with providers to ensure continuity of care for enrollees and must identify and resolve barriers that prevent enrollees from transitioning to CORE Services. The continuity of care period will occur between February 1, 2022 and May 2, 2022. During the continuity of care period MCOs are required to track the successful transition of enrollees receiving PSR, CPST, FST, and/or Peer Support under BH HCBS to the equivalent CORE Service as part of enrollee care management. MCOs may use claims, CORE service initiation notifications from providers, or other means identified by MCOs to accomplish this. Detailed information is on pages 5-7 of the *CORE Benefit and Billing Guidance.*
10.	Network Requirements	CORE Services network requirements will be 2 per county. For the services remaining in BH HCBS, will the network requirements remain 2 per urban county and 2 per rural region?	The BH HCBS network standards will remain the same.

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11.	Provider Designation	How will the state be managing the CORE Designation? Will they be managing a spreadsheet on the website like they did for HCBS, but CORE Specific? Or will they be including them on the existing HCBS Spreadsheet?	Initially, NYS will share a CORE provider designation list with MCOs via the BHO mailbox, which will be updated monthly. NYS is developing an automatically updated CORE designation list which will be posted on the OMH website, but this is not anticipated to be ready by February 1, 2022. CORE providers will also have provisional designation letters they can share with MCOs during the contract amendment process. NYS anticipates provisional designation letters will be sent by early January 2022.
12.	Referrals	Can MCOs directly refer individuals to CORE Services?	Yes, MCOs can refer individuals to CORE Services.
13.	Referrals	What is the role of recovery coordinators with CORE and Adult BH HCBS?	Recovery Coordinators assist individuals to access Adult BH HCBS by conducting the NYS Eligibility Assessment and completing the BH HCBS Plan of Care. CORE Services do not require completion of the NYS Eligibility Assessment or the BH HCBS Plan of Care.
14.	Reports	Will reports be amended for CORE?	Yes. See question 15 below for details.
15.	Reports	Does the State anticipate updates to the Claim Stat Report and Outpatient UR Report templates to include CORE Services and if so, when can MCOs expect to receive the new report templates?	NYS issued the updated Adult Claims Stats Report template to MCOs on December 15, 2021. The first due date for MCOs to use the updated template is March 14, 2022. NYS will issue updated Outpatient Utilization Review (UR) Report Templates before January 14, 2022. The first due date for MCOs to use the updated templates is April 15, 2022.

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16.	Services Provided via Telehealth	How will MCOs know if a designated CORE provider is able to deliver CORE Services via Telehealth?	During the COVID-19 disaster emergency, OMH-hosted BH HCBS and CORE providers are granted telehealth approval once the *Self-Attestation of Compliance to Offer Telemental Health Services* is submitted to OMH. MCOs may request a copy for verification purposes. Similarly, OASAS-hosted BH HCBS and CORE providers are granted telehealth approval once the *OASAS COVID-19 Telehealth Application* is submitted to OASAS. MCOs may request a copy for verification purposes. OMH has also developed a streamlined telehealth approval process, which would allow BH HCBS and CORE providers to receive permanent telehealth approval. This permanent telehealth approval will remain effective after the COVID-19 disaster emergency ends. This process is outlined in the *Streamlined Process to Permanently Add Telemental Health as an Optional/Additional Service*. OMH-hosted BH HCBS and CORE providers will receive a permanent telehealth approval email from their local Field Office. MCOs may request a copy for verification purposes. OASAS-hosted BH HCBS and CORE providers should refer to the *Telehealth Standards for OASAS Providers* (available on the OASAS website in the near future) for information on the permanent approval process.