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**New York State**  
**Community Oriented Recovery and Empowerment Services**  
**Benefit and Billing Guidance**  
*October 6, 2021*

## Introduction

In 2015, the New York State (NYS) Office of Addiction Services and Supports (OASAS) and Office of Mental Health (OMH), in collaboration with the Department of Health (DOH), transitioned the majority of the Medicaid behavioral health benefit into managed care to create a fully integrated mental health, addiction, and physical health delivery system providing comprehensive, accessible, and recovery-oriented services.

The Centers for Medicare and Medicaid Services (CMS) authorized Adult Behavioral Health Home and Community Based Services (BH HCBS) as a demonstration benefit under NYS' Medicaid Section 1115 Medicaid Redesign Team (MRT) Waiver. BH HCBS are rehabilitative services designed to assist adults (age 21 and over) with serious mental illness and/or addiction disorder to remain and recover in the community, and reduce preventable admissions to hospitals, nursing homes, or other institutions. Medicaid Managed Care Organizations with Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV-SNPs) offer BH HCBS as a covered benefit for enrollees meeting eligibility criteria.

In order to improve access to services, NYS is transitioning four BH HCBS to a new service array called Community Oriented Recovery and Empowerment (CORE) Services. These services include Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training (FST), and Empowerment Services – Peer Support (Peer Support). BH HCBS Short-term and Intensive Crisis Respite services will be transitioned to Crisis Intervention Benefit Crisis Residence services, already available to all adult Medicaid Managed Care enrollees. All other existing BH HCBS will remain available as BH HCBS with previously established requirements, workflows, and processes. HARPs, HIV-SNPs, and Medicaid Advantage Plus (MAP) Plans will offer CORE Services as a covered benefit for eligible enrollees<sup>1</sup>. This guidance refers to Medicaid Managed Care Organizations with HARPs, HIV-SNPs and/or MAPs as MCOs.

BH HCBS access requirements, including the independent eligibility assessment and federal home and community-based settings restrictions, will not apply to CORE Services. CORE Services are available to all HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees based on a recommendation from a Licensed Practitioner of the Healing Arts (LPHA).

This document provides guidance to providers and MCOs about the transition of the four identified BH HCBS into CORE Services, as well as post-implementation management of the CORE benefit for MCOs. MCOs are required to manage CORE Services in accordance with this *CORE Benefit and Billing Guidance* and other applicable State-issued guidance. Until such time as the [Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation](#) and [Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan/ Health and Recovery Plan Model Contract \(Medicaid Managed Care Model Contract\)](#) are updated to reflect requirements applicable to CORE Services, provisions contained therein regarding BH HCBS are applicable to CORE Services, except where this guidance differs, this guidance will control. BH HCBS and CORE providers should refer to applicable Service and Operations Manuals for detailed

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<sup>1</sup> MAP Plans will cover CORE Services when specialty behavioral health benefits carve into the MAP benefit package or when CORE Services are implemented, whichever is later.

information on service definitions, documentation requirements, provider terms and conditions and other information relevant to the provision of BH HCBS or CORE Services.

This document is organized into the following sections:

- I. Transition from Adult BH HCBS to CORE
  1. Overview of CORE Service Implementation
  2. Service Access During BH HCBS Transition to CORE Services
  3. Network Development and Monitoring
  4. Rates and Billing Requirements
- II. CORE Benefit Management
  1. CORE Services Overview and Program Standards
  2. MCO Responsibilities and Provider Oversight
  3. Network Requirements
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- III. Appendices
  - A. LPHA Recommendation Form
  - B. Provider Service Initiation Notification Template
  - C. BH HCBS Transition to CORE: Billing Changes
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## I. Transition from Adult BH HCBS to CORE

CMS approved NYS' 1115 MRT Waiver Amendment Request to transition CPST, PSR, FST and Peer Support from BH HCBS to CORE Services on October 5, 2021. Effective February 1, 2022, CPST, PSR, FST and Peer Support will transition from BH HCBS to the CORE service array within the HARP and HIV-SNP benefit packages. By February 1, 2022, MCOs must have system configurations completed and CORE providers must comply with CORE Service program standards, including service definitions and documentation requirements. Federal HCBS requirements do not apply to CORE Services. Details regarding the four transitioning services can be found below. Providers provisionally designated for CORE during the transition period are required to be fully designated for CORE Services by July 31, 2022. MCOs must meet CORE network adequacy standards by August 31, 2022. CORE Services will become available in the MAP benefit package when specialty behavioral health services are carved into the MAP benefit package or when CORE Services are implemented, whichever is later.

### High-level CORE implementation timeline

Target Date/Period	Implementation event
October 5, 2021	CMS Approval
January 17, 2022	Readiness Attestation Due
February 1, 2022	Go-Live & Continuity of Care period begins
March 1, 2022	Transitioning provider contracts updated
May 2, 2022	Continuity of Care period ends
July 31, 2022	Provisional provider designation complete
August 31, 2022	MCOs must meet Network Adequacy standards

### 1. Overview of CORE Service Implementation

The CORE Service implementation will transition the following services from BH HCBS to the CORE service array:

- These four BH HCBS will transition to CORE Services:
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Support and Treatment (CPST)
  - Empowerment Services – Peer Support (Peer Support)
  - Family Support and Training (FST)
- The definition of PSR will broaden to provide a variety of rehabilitative interventions in pursuit of goals in any life domain, including working and learning.
- BH HCBS Short-term and Intensive Crisis Respite services will be replaced by Crisis Intervention Benefit Crisis Residence services, available to all adult Medicaid Managed Care enrollees.

## **2. Service Access During BH HCBS Transition to CORE Services**

### **A. Access Changes for Services Transitioning from BH HCBS to CORE**

When CPST, PSR, FST and Peer Support transition from BH HCBS to CORE Services on February 1, 2022, Federal HCBS requirements will not apply to these services. As such, the independent BH HCBS Eligibility Assessment, Level of Service Determination (LOSD), and settings restrictions<sup>2</sup> on where individuals can receive services will be eliminated for these services. Enrollees may learn about and be referred to CORE Services through multiple sources, including the MCO, care manager, inpatient and outpatient clinicians, primary care practitioners, family and friends, or provider outreach and education efforts. Health Homes will continue to provide care management and assist individuals to identify needs and access services, however the HCBS plan of care development and conflict-free care management rules for member referral to requested services will not apply to CORE Services.

#### *i. Eligibility Assessment-related H-Codes*

Eligibility Assessment-related H-codes (H2, H3, H5 and H6) will remain a requirement for individuals to access BH HCBS.

Eligibility assessment-related H-codes (H2, H3, H5 and H6) will not be required for enrollees to access or for providers to be reimbursed for CORE Services. As of February 1, 2022, MCOs must have systems configured to remove eligibility assessment-related H-code requirements for the services transitioning from BH HCBS to CORE.

The following H-codes will be used to determine CORE service eligibility:

- H1: HARP enrollees
- H4: HARP-eligible HIV-SNP enrollees
- H9: HARP-eligible MAP enrollees

H9 codes will also continue to be used to identify Medicaid Managed Care enrollees eligible for HARP enrollment. Mainstream Medicaid Managed Care enrollees with an H9 code are not eligible for CORE Services. Please refer to the [Guide to Restriction Exception \(RE\) Codes and Health Home Services](#) for updates.

### **B. Access to CORE Services for BH HCBS Continuity of Care Recipients**

Effective February 1, 2022, MCO systems will extend BH HCBS service authorizations for CPST, PSR, FST and Peer Support which would have expired between February 1, 2022 and May 2, 2022. During this continuity of care period BH HCBS recipients may continue receiving care from providers using existing BH HCBS service definitions and documentation requirements. During this continuity of care period all enrollees should be transitioned to the appropriate CORE Service(s). MCOs should encourage providers to facilitate these transitions as appropriate throughout the continuity of care period, by no later than May 2, 2022. CORE Service definitions and documentation requirements must be in place by May 3, 2022 for all individuals transitioning from BH HCBS to CORE.

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<sup>2</sup> CMS regulations require HCBS, including BH HCBS, to be delivered in settings that meet defined criteria for “home and community-based settings”. These HCBS settings regulations are not applicable to CORE Services. Refer to 42 CFR §§ 441.301(c) and 441.710(a) for the HBCS settings rules.

By May 2, 2022, MCOs must ensure all enrollees currently receiving BH HCBS PSR, CPST, FST, and Peer Support are transitioned to CORE Services as appropriate by the first date of service provided on or after May 3, 2022. Existing recipients of BH HCBS converting to CORE Services must have Individual Service Plans (ISPs) updated to comply with CORE Service definitions and documentation requirements by the first date of service provided on or after May 3, 2022. Providers should send the Provider Service Initiation Notification Form (see Appendix B) to MCOs after the ISP is updated. Please see section I.2.D.ii of this document for more information on the service initiation notification process.

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. For more information on CORE service initiation notification, please refer to section I.2.D.ii of this document.

Below are the most likely continuity of care scenarios describing the MCO and provider processes to ensure enrollees successfully transition from BH HCBS to CORE Services:

1. BH HCBS recipients whose providers are provisionally designated for CORE Services can continue to receive services under existing BH HCBS ISPs with those providers until May 2, 2022. These recipients will be transitioned to the appropriate CORE Service(s) through an updated CORE compliant ISP by no later than the first date of service beginning May 3, 2022, either with the same provider or with another CORE provider of their choice.
2. BH HCBS recipients of CPST, PSR, FST or Peer Support who decline to transition to CORE Services may continue receiving these services as BH HCBS until May 2, 2022. MCOs must work with the enrollee and the enrollee's care manager (if applicable) to identify another appropriate service and in-network provider.
3. BH HCBS providers designated for CPST, PSR, FST, or Peer Support electing not to proceed with designation for CORE Services must notify their respective OASAS or OMH host agency Field Office as well as an enrollee's MCO and care manager (if applicable). These providers must discontinue services on or before May 2, 2022. Provider communication to the MCO should include information about the enrollee, including a summary of their ongoing concerns and/or a discharge summary. MCOs must assist affected enrollees in selecting and transitioning to another CORE provider, as needed.
4. BH HCBS Short-Term Crisis Respite and Intensive Crisis Respite providers may serve enrollees admitted to respite 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. Most BH HCBS Crisis Respite providers applied for Crisis Residence licensure and received designation to

provide and be reimbursed for Crisis Residence services<sup>3</sup> under the NYS 1115 Waiver Crisis Intervention benefit. Beginning February 1, 2022, all enrollees should be referred to Crisis Residence programs for crisis respite services.

### **C. New Referrals:**

Effective February 1, 2022, eligible individuals can be referred to and access CORE Services with an LPHA recommendation. For these new referrals, providers must comply with CORE Service definitions and documentation requirements effective February 1, 2022.

The federal settings rule does not apply to CORE Services. Individuals previously restricted from receiving PSR, CPST, FST and/or Peer Support under BH HCBS because they reside in a non-compliant setting may access CORE Services as of February 1, 2022.

Providers must notify an enrollee's MCO when CORE Services are initiated. See section I.2.D.ii of this document for more information on MCO notification.

Note: If an individual receiving BH HCBS Habilitation, Education Support Services, Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, and/or Ongoing Supported Employment makes an informed choice to receive CORE PSR instead of, or in addition to, continuing with BH HCBS, they will be considered a *new referral* to CORE Services.

### **D. CORE Service Initiation and MCO Notification**

#### *i. CORE Referral Pathway*

An important aspect of the CORE Service demonstration is the “No Wrong Door” referral pathway, which enables enrollees to easily access these services with as few barriers as possible. Enrollees may learn about and be referred to CORE Services through multiple sources, including the MCO, care manager, inpatient and outpatient clinicians, primary care practitioners, family and friends, or provider outreach and education efforts.

#### *ii. CORE Service Initiation Notification*

CORE providers must notify an enrollee's MCO within three business days after the first date of initiating a new CORE Service. CORE service initiation for new referrals will begin with intake and evaluation sessions, which must be completed within 30 days of the initial visit or the first five visits, whichever occurs later. Enrollees transitioning from BH HCBS to an equivalent CORE Service only need their ISP updated for CORE Services, they do not need an intake or evaluation.

NYS developed a Service Initiation Template containing the information providers must submit to MCOs. This template can be found in Appendix B. MCOs may use this template or develop their own but can only include information contained in the template. MCOs are expected to clearly communicate notification expectations to their CORE provider network.

Beginning February 1, 2022, MCOs must have a secure electronic process in place to accept provider CORE Service initiation notifications. The MCO is responsible for confirming enrollees receiving CORE Services are not receiving a duplicative service. CORE Service intake and

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<sup>3</sup> Please refer to the [Crisis Intervention Benefit: Adult Crisis Residence Benefit and Billing Guidance](#).

evaluation sessions are billed using the CORE Service rate codes and are not considered duplicative of any other service (similar to PROS or OMH Clinic pre-admission visits). Please refer to the *CORE Service Initiation Notification* section in II.1.C.i of this document for additional details and the charts in section II.1.C.ii for a list of allowable service combinations with CORE Services.

*iii. LPHA Recommendation*

CORE Services will be available to HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees who receive an LPHA<sup>4</sup> recommendation.

During the CORE transition, individuals determined eligible for and receiving CPST, PSR, FST and/or Peer Support as BH HCBS prior to February 1, 2022, are eligible to continue receiving the same service(s) under CORE. For continuity of care purposes these individuals can transition to CORE Services without an LPHA recommendation.

CORE providers must ensure an LPHA recommendation is obtained for all new referrals received on or after February 1, 2022 within 30 days of the initial visit or the first five visits, whichever occurs later. NYS developed the LPHA recommendation template which can be found in Appendix A of this document. For more information on the LPHA recommendation please refer to section II.1.D of this document.

**E. Utilization Management (UM)**

MCOs may not conduct prior authorization or concurrent review for CORE Services for one year beginning February 1, 2022. NYS will consult with MCOs regarding clinical review criteria and UM guidelines based on data and information gathered during the first year of CORE Service implementation. MCOs may conduct outlier management for purposes of enrollee care management and provider education. MCOs are encouraged to engage in provider education throughout the first year of the CORE Service implementation. For more information see section II.2.C of this document.

**3. Network Development and Monitoring**

**A. Initial Provider Designation**

MCOs must ensure eligible enrollees can access CORE Services. NYS will provisionally designate all existing CPST, PSR, FST, and Peer Support BH HCBS providers for equivalent CORE Service(s).

NYS will work with provisionally designated CORE providers seeking to obtain full designation status. Provisionally designated CORE providers will complete required tasks and submit required paperwork to become a fully designated CORE provider between February 1, 2022 and July 31, 2022. NYS expects full designation to occur no later than July 31, 2022 for providers who complete all designation requirements.

MCOs should continue to reference the Provider Network Data System (PNDS) to identify BH HCBS providers provisionally designated for CORE Services. As permitted, NYS will update the PNDS to reflect provider status changes related to the CORE transition. NYS will notify MCOs if a provider's designation status is terminated, including any providers which do not reach full CORE designation by July 31, 2022. Provider terminations may not be immediately reflected in PNDS.

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<sup>4</sup> Refer to Appendix A for the definition of an LPHA.



## **B. Network Development**

MCOs are encouraged to begin any needed provider contract amendments as soon as possible. If amendments are necessary, contracts should be modified to reflect CORE Services by March 1, 2022. NYS expects MCOs to maintain all existing contracts with BH HCBS providers transitioning to CORE Services unless there are significant quality of care or program integrity concerns. MCOs should notify the provider and the State if the MCO does not intend to maintain any contracts with provisionally designated CORE providers. MCOs will be required to reimburse provisionally designated CORE providers for CORE Services beginning February 1, 2022, notwithstanding the timely execution of contract amendments.

NYS will monitor CORE network development via quarterly PNDS submissions beginning April 2022. MCOs are expected to meet CORE network adequacy requirements by August 31, 2022. For more information on these requirements, please refer to section II.3.B of this document.

### **4. Rates and Billing Requirements**

CORE rates and billing changes are effective February 1, 2022. Only providers provisionally or fully designated for CORE may submit claims and be reimbursed for CORE Services. Per the *Medicaid Managed Care Model Contract* provision 21.22 MCOs are expected to provide education and technical assistance to providers transitioning to CORE Services. MCOs must also initiate claims testing with providers to ensure claims processing and payment procedures are configured by February 1, 2022.

#### **A. Billing Changes and Systems Configuration**

##### *i. MCO Readiness Attestation*

MCOs must demonstrate readiness to implement and manage the CORE benefit. MCOs must submit a completed State-issued *Medicaid Managed Care Organization Community Oriented Recovery and Empowerment (CORE) Benefit Administration Readiness Attestation* by January 17, 2022, confirming preparedness to discontinue the BH HCBS requirements for the services transitioning to CORE, complete system configurations, and ability to pay for CORE Services beginning February 1, 2022. NYS may request supporting documentation from MCOs regarding implementation readiness.

##### *ii. Billing and Reimbursement – MCO Systems Configuration*

MCOs must configure their billing systems to pay provider claims for CORE Services by February 1, 2022, as outlined in *Rates and Billing* section II.4 and Appendices C and D. MCOs must also ensure systems are properly configured to reimburse claims for BH HCBS provided between February 1, 2022 and May 2, 2022, using CORE rate codes and reimbursement rates.

- CORE Service claims may be submitted for new referrals beginning February 1, 2022 for CPST, PSR, FST and Peer Support as outlined in Appendix C.
- CORE providers may begin submitting claims for PSR with an educational or vocational focus (using new billing modifiers) for dates of service beginning on or after February 1, 2022.
- BH HCBS Short-Term and Intensive Crisis Respite providers may submit claims for enrollees admitted to a crisis respite program prior to February 1, 2022, until the enrollee is discharged, no later than May 2, 2022. BH HCBS Short-Term and Intensive Crisis Respite providers may submit

claims after February 1, 2022, within required timely filing timeframes as long as the initial date of service occurs prior to February 1, 2022. MCOs should discontinue reimbursement of BH HCBS Crisis Respite claims for enrollees admitted on or after February 1, 2022.

## **B. Rates**

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. Crisis Respite rate codes will be discontinued for dates of service on or after May 3, 2022<sup>5</sup>. Information regarding CORE rates and billing requirements can be found in section II.4 of this document. Updated rates can be found at: [https://omh.ny.gov/omhweb/medicaid\\_reimbursement/](https://omh.ny.gov/omhweb/medicaid_reimbursement/).

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<sup>5</sup> BH HCBS Short-term and Intensive Crisis Respite services will be replaced by the Crisis Intervention Benefit Crisis Residence services. Most BH HCBS Crisis Respite providers received designation to provide and be reimbursed for Crisis Residence services under the NYS 1115 Waiver Crisis Intervention benefit. Please refer to the [Crisis Intervention Benefit: Adult Crisis Residence Benefit and Billing Guidance](#).

## **II. CORE Benefit Management**

Effective February 1, 2022, MCOs will be required to cover CORE Services for HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees. MCOs must manage the CORE Services benefit in compliance with State and federal mental health and addiction parity laws.

### **1. CORE Services Overview and Program Standards**

CORE Services are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy promoting and facilitating community participation and independence. These services are not case management, personal care services, nor a replacement for custodial care in an institutional setting.

CORE Services must be offered in the setting and modality best suited to support an enrollee's goal acquisition including in the enrollee's home and other community-based locations. The scope and intensity of CORE Services are based on the level of support needed to assist the individual in achieving their recovery goal(s) and sustaining recovery. The State has recommended CORE Service unit ranges, intended to illustrate the scope of services and program design, which may be exceeded when clinically appropriate. These CORE Service unit ranges can be found in the [CORE Services Operations Manual for Designated Providers \(CORE Services Operations Manual\)](#).

Designated CORE providers may be approved by the State to deliver services via telehealth in accordance with applicable regulations and guidance.

For more information on CORE Service definitions, components, limitations and exclusions, staff and supervisory qualifications, and staff training requirements, please refer to the *CORE Services Operations Manual*.

#### **A. Provider Travel Supplement**

The Provider Travel Supplement (Staff Transportation) rate compensates provider agencies for staff travel costs directly related to CORE Service provision. Staff Transportation must only be used when services are delivered off-site and can only be reimbursed in conjunction with a completed CORE Service claim. Staff Transportation cannot be reimbursed for situations when providers travel off-site but a CORE Service was not delivered. Staff Transportation does not need to be included in an enrollee's individual CORE Service plan. Reimbursement for staff transportation can only be paid for one staff per off-site service provided, regardless of the number of staff who travel to the off-site location and shall not be limited except as provided in this guidance. Staff Transportation can be reimbursed per mile or per round trip.

Costs incurred for programs, services, or purposes other than CORE do not qualify for Staff Transportation reimbursement. Additionally, Staff Transportation reimbursement may not be claimed for "staff time" while providers are traveling to deliver CORE Services, as costs associated with staff travel time are already factored into CORE Service reimbursement rates.

Refer to the section II.4 *Rates and Billing Requirements* in this document for more information.

## **B. Provider Designation and Oversight**

CORE providers must be designated by OASAS and OMH in order to provide CORE Services. Designation is granted by service type and providers may apply for designation to provide some or all CORE Services. Designated providers are subject to State oversight and monitoring.

Designated providers must adhere to the “CORE Service Standards and Terms and Conditions for Designated Providers” as outlined in the *CORE Services Operations Manual*. Designated providers may have their designation status suspended or terminated if the State determines a provider is not in compliance with the *CORE Services Operations Manual*. If a provider’s designation is suspended or terminated the State will notify the provider’s contracted MCOs.

## **C. CORE Service Initiation Notification and Allowable Service Combinations**

### *i. CORE Service Initiation Notification*

CORE providers must notify an enrollee’s MCO within three business days after their first date of initiating a new CORE Service, which includes CORE Service intake and evaluation. CORE Service intake and evaluation sessions must be conducted within 30 days of the initial visit or the first five visits, whichever occurs later.

MCOs must implement a secure electronic process for receiving and responding to CORE Services initiation notifications. NYS developed a service initiation template containing the information providers must submit to MCOs. This template can be found in Appendix B. MCOs may use this template or develop their own but can only include information contained in the template. MCOs are expected to clearly communicate and provide any necessary training to their CORE provider network about the MCO’s notification process.

MCOs must notify relevant providers within three business days of notification receipt if the enrollee is receiving a duplicative service, such as the same CORE Service or an equivalent service from another provider. CORE Service intake and evaluation sessions are not considered duplicative of any other service. Please refer to the Allowable Service Combination charts below for a list of duplicative services. Until informing the CORE provider of a service duplication, MCOs are responsible for reimbursing CORE Service claims.

If the enrollee is receiving a duplicative service the MCO should initiate a person-centered discussion between the enrollee, their providers, and their care manager (when applicable) to determine which service or program is the most appropriate for their needs. The MCO is responsible for communicating with the enrollee and providers, in writing, the outcome of the person-centered discussion and the enrollee’s decision regarding which services will continue.

Upon the culmination of services providers are encouraged to share the discharge summary with the recipient’s MCO as notification. This best practice is detailed in the *CORE Services Operations Manual*.

### *ii. CORE Allowable Service Combinations*

Below are two charts for allowable service combinations with CORE Services. The first chart outlines allowable service combinations between CORE Services and BH HCBS. The second chart outlines allowable service combinations between CORE Services and other OASAS/OMH services.

Please refer to the chart below for allowable service combinations for CORE and BH HCBS:

**CORE and BH HCBS Allowable Service Combinations**

<b>BH HCBS</b>	<b>CPST</b>	<b>PSR (rate codes 7784 or 7785)</b>	<b>PSR with Education focus (rate code 7811)</b>	<b>PSR with Employment Focus (rate code 7810)</b>	<b>FST</b>	<b>Peer</b>
<b>BH HCBS Habilitation</b>	Yes	Yes <sup>6</sup>	Yes	Yes	Yes	Yes
<b>BH HCBS Education Support Services</b>	Yes	Yes	No	Yes	Yes	Yes
<b>BH HCBS Pre-Vocational Services</b>	Yes	Yes	Yes	No	Yes	Yes
<b>BH HCBS Transitional Employment</b>	Yes	Yes	Yes	No	Yes	Yes
<b>BH HCBS Intensive Supported Employment</b>	Yes	Yes	Yes	No	Yes	Yes
<b>BH HCBS Ongoing Supported Employment</b>	Yes	Yes	Yes	No	Yes	Yes

<sup>6</sup> Enrollees receiving both CORE PSR and BH HCBS Habilitation must receive services from a single designated provider whenever possible. Exceptions may be made if both services are not available or accessible from a single organization. In such cases the MCO is responsible for ensuring coordination between both providers to prevent a duplication of services. This coordination will include the sharing of ISPs between providers to ensure coordination of interventions.

Please refer to the chart below for allowable service combinations for CORE:

### CORE and Other OASAS/OMH Services Allowable Service Combinations

OMH/OASAS Service	CPST	PSR	FST	Peer
<b>OMH Clinic ((including Licensed Behavioral Health Practitioner (LBHP))</b>	Yes <sup>7</sup>	Yes	Yes	Yes
<b>Certified Community Behavioral Health Clinic (CCBHC)<sup>8</sup>- Sites Receiving NYS CCBHC Demonstration Medicaid Rate</b>	Yes <sup>7</sup>	No	Yes	No
<b>Certified Community Behavioral Health Clinic (CCBHC) Expansion Grant Awardees<sup>9</sup> – Sites Not Eligible for NYS CCBHC Demonstration Medicaid Rate</b>	Yes <sup>7</sup>	Yes	Yes	Yes
<b>OMH Assertive Community Treatment (ACT)</b>	No	No	No	No
<b>OMH Personalized Recovery Oriented Services (PROS)</b>	No	No	No	Yes
<b>OMH Continuing Day Treatment (CDT)</b>	No	Yes	Yes	Yes
<b>OMH Partial Hospitalization</b>	No	Yes	Yes	Yes
<b>OASAS Outpatient / Opioid Treatment Program (OTP)</b>	Yes	Yes	Yes	Yes <sup>10</sup>
<b>OASAS Permanent Supportive Housing (PSH)</b>	Yes	Yes	Yes	Yes
<b>OASAS Residential</b>	Yes	Yes	Yes	Yes
<b>OASAS Outpatient Rehabilitation</b>	Yes	Yes	Yes	Yes <sup>10</sup>
<b>OASAS Inpatient/Outpatient Detox</b>	Yes	Yes	Yes	Yes

#### D. LPHA Recommendation

Eligibility for CORE Services is based on two criteria:

- The enrollment of a HARP-eligible individual in a HARP, HIV-SNP or MAP.
- An LPHA recommendation.

<sup>7</sup> Services comparable to CORE CPST are available through OMH Clinic and CCBHC. Enrollees may access non-duplicative services through CORE CPST and either Article 31 OMH Outpatient Clinic or CCBHC in a single month for the following purposes:

- Access to a psychiatric prescriber (e.g. psychiatric assessment/ evaluation, medication management, health monitoring) if the CPST provider does not have a prescriber. Receiving psychotherapy through CPST and the Article 31 Clinic or CCBHC is duplicative. Medication management and supporting activities through the Article 31 Clinic or CCBHC are duplicative if the CPST provider has a prescriber on staff.
- Transition from CPST to clinic-based services (including at a CCBHC), allowing for a warm-handoff during the clinic pre-admission process (3 sessions).

The CPST provider should maintain communication with the prescriber to ensure integrated treatment/care.

<sup>8</sup> These CORE/CCBHC allowable service combinations apply to sites where CCBHC providers receive the Medicaid Prospective Payment System reimbursement authorized under the NYS CCBHC Demonstration. Please refer to the OMH website for a list of these NYS CCBHC Demonstration providers: <https://omh.ny.gov/omhweb/bho/ccbhc.html>.

<sup>9</sup> These CORE/CCBHC allowable service combinations apply to the OMH/OASAS clinic CCBHC expansion grant awardees funded by Substance Abuse and Mental Health Services Administration (SAMHSA) with sites not eligible for the Medicaid Prospective Payment System reimbursement authorized under the NYS CCBHC Demonstration.

<sup>10</sup> OASAS will allow for patients admitted to an outpatient program certified pursuant to 14 NYCRR Part 822 receiving peer support services to also receive CORE Peer Empowerment Services. The providers should work together to ensure there is no service duplication. The allowable peer services shall complement, not duplicate.

An LPHA is a Licensed Practitioner of the Healing Arts. LPHA qualifications are found in the LPHA Recommendation Form (see Appendix A). An LPHA must complete the LPHA recommendation form to document medical necessity and indicate appropriate CORE Services. The licensed clinical professional completing the LPHA recommendation may be, but is not required to be, employed by the designated CORE provider<sup>11</sup>. It is the CORE provider's responsibility to retain a copy of the LPHA recommendation form in the member's CORE case record. LPHA recommendations last through an enrollee's episode of care. Enrollees previously discharged and re-engaging in a CORE Service will need a new LPHA recommendation. MCOs may not require providers to submit a copy of the LPHA recommendation in order to initiate or be reimbursed for services. MCOs may request a copy of an LPHA recommendation for provider quality management and/or member care management purposes.

## **2. MCO Responsibilities and Provider Oversight**

### **A. Utilization Management**

MCOs may not conduct prior authorization or concurrent review for CORE Services for the first year of CORE implementation. This includes all CORE Services and Staff Transportation. LPHAs will determine whether an individual meets medical necessity to receive CORE Services through the LPHA recommendation process. MCOs may conduct outlier management for purposes of enrollee care management and provider education. For more information see section II.2.C of this document.

NYS will consult with MCOs regarding clinical review criteria and UM guidelines based on data and information gathered during the first year of CORE service implementation. Based on this consultation, NYS will release updated UM guidelines.

Notwithstanding the foregoing MCOs are required to work collaboratively with CORE providers to share relevant information supporting the member's treatment, care management, and discharge planning. The frequency of communication should reasonably reflect the complexity of the member's treatment and care management needs.

### **B. Member Services**

MCOs must ensure Member Services staff, whether employed by the MCO directly or through subcontracts, who are responsible for providing intake, referral, or crisis response referrals to enrollees, have access to updated training materials and receive adequate training related to BH HCBS and CORE Services.

### **C. Quality Management**

As outlined in the *Medicaid Managed Care Model Contract sections 16.1.(c)(iii) and 16.2.(d)*, MCO Behavioral Health UM Committees are charged with implementing a process to collect, monitor, analyze, evaluate, and report utilization data, interpret any variances, review outcomes, and develop

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<sup>11</sup> If the LPHA recommendation is completed by a member of the CORE staff, the time spent by the LPHA with the member for the purposes of making an initial recommendation may be billed at the service-specific rate code, even if the LPHA is not otherwise qualified to deliver the service. For example, if an LPHA meets with a member face-to-face to determine medical necessity for Empowerment Services – Peer Support, that time would be billable in 15-minute increments using rate code 7794, even if the LPHA is not a certified peer.

and/or approve interventions based on the findings in under and overutilization of behavioral health services and cost data. MCOs shall develop and implement protocols for identifying participating providers that do not adhere to practice guidelines and for making reasonable efforts to improve the performance of these providers.

MCOs should implement processes to ensure participating CORE providers are delivering services to enrollees according to State-issued guidelines. For State-issued guidelines for CORE Service providers, including information on service intensity guidelines, please refer to the *CORE Services Operations Manual*. MCOs may conduct outlier management for purposes of enrollee care management and provider education.

MCOs shall have effective mechanisms to obtain information from CORE providers, and report such information and related analytical data in a manner and format to be determined by the State, as required to support the NYS Section 1115 Medicaid Redesign Team (MRT) Waiver and related additional CMS requirements to evaluate the enrollee's level of care, adequacy of service plans, provider qualifications, enrollee health and safety, financial accountability, and compliance with the terms of this guidance and the *Medicaid Managed Care Model Contract*.

### **3. Network Requirements**

#### **A. Credentialing**

MCOs must accept the CORE provider's State designation or provisional designation to fulfill the MCOs' credentialing requirements. MCOs may not individually credential staff employed by CORE provider agencies. MCOs must assure CORE provider agencies are designated by the State and provider staff have not been excluded or de-barred from participation in any other federal or State program.

MCOs maintain responsibility to ensure program integrity pursuant to federal law. The MCO's credentialing committee shall develop and adhere to procedures consistent with 42 CFR 455.436 and Sections 18.9 and 21.4(a)(ii) of the *Medicaid Managed Care Model Contract*. If an MCO determines a practitioner providing a CORE service is excluded any claims submitted for services provided by such practitioner should be denied.

#### **B. Network Adequacy Requirements and Reporting**

MCOs must ensure access to CORE Services for their enrollees as outlined in this guidance. The State will conduct ongoing network adequacy reviews for CORE Services.

MCOs must meet statewide CORE Service network adequacy requirements of a minimum of two providers of each CORE Service per county (as available).

The State will update PNDS with the list of designated CORE providers by services and county. MCOs will continue network reporting through quarterly PNDS submissions. NYS may request additional network information directly from MCOs.

#### **C. Culturally and Linguistically Competent Provider Networks**

Pursuant to Sections 15.10 and 15.11 of the *Medicaid Managed Care Model Contract*, MCOs must maintain a culturally competent provider network capable of delivering services to all enrollees including those with limited English proficiency. MCOs must arrange for language assistance services



and adequately reimburse CORE providers for language assistance services when network providers cannot meet an enrollee’s language needs. MCOs are also responsible for informing CORE providers how to access and be reimbursed for language assistance services for enrollees with limited English proficiency.

#### 4. Rates and Billing Requirements

##### A. Rates

Pursuant to Chapter 57 of the Laws of 2019, Medicaid MCOs must reimburse CORE providers in accordance with the State-mandated rates in the *CORE Services Fee Schedule*<sup>12</sup>.

##### B. Billing

Only CORE providers designated by NYS are permitted to bill MCOs for CORE Services provided to HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees. Claims for CORE Services must be submitted using the appropriate combination of rate codes, procedure codes, and modifiers, as detailed in the tables below. Providers serving an enrollee may submit one claim per day for each rate code/procedure code/modifier combination. In accordance with the *CORE Services Operations Manual*, and if clinically indicated, providers may submit claims for an in-person visit and telehealth visit for the same rate code in the same day.

For additional Medicaid Managed Care claiming and billing resources, please see the [New York State Health and Recovery Plan \(HARP\)/Mainstream Behavioral Health Billing and Coding Manual](#) (Page 5, section *Claims* for details on MCO claiming and encounter reporting processes), and information available on the [Managed Care Technical Assistance Center \(MCTAC\)](#) website and the [MCTAC Interactive Billing Tool](#).

Psychosocial Rehabilitation (PSR)					
Service Name	Individual or Group	Rate Code	HCPCS Code	Modifier	Unit Measure
Psychosocial Rehabilitation (On-site)	Individual	7784	H2017	U1	15 Minutes
Psychosocial Rehabilitation (Off-site)	Individual	7785	H2017	U2	15 Minutes
Psychosocial Rehabilitation- Employment Focus (On-site or Off-site)	Individual	7810	H2017		15 Minutes
Psychosocial Rehabilitation- Education Focus (On-site or Off-site)	Individual	7811	H2017	TF	15 Minutes
Psychosocial Rehabilitation	Group (2-3)	7786	H2017	UN or UP <b>AND</b> • Education Focus - TF <b>OR</b>	15 Minutes

<sup>12</sup> The *CORE Services Fee Schedule* is posted here: [https://omh.ny.gov/omhweb/medicaid\\_reimbursement/](https://omh.ny.gov/omhweb/medicaid_reimbursement/)

				<ul style="list-style-type: none"> <li>• Employment Focus - TG</li> </ul>	
Psychosocial Rehabilitation	Group (4-5)	7787	H2017	UQ or UR <b>AND</b> <ul style="list-style-type: none"> <li>• Education Focus - TF</li> <li><b>OR</b></li> <li>• Employment Focus - TG</li> </ul>	15 Minutes
Psychosocial Rehabilitation	Group (6-10)	7788	H2017	US <b>AND</b> <ul style="list-style-type: none"> <li>• Education Focus - TF</li> <li><b>OR</b></li> <li>• Employment Focus - TG</li> </ul>	15 Minutes

PSR is offered both individually and in groups:

- **Individual (PSR, PSR with an Education Focus, and/or PSR with an Employment Focus)**
  - Billed daily in 15-minute units.
  - Individual service may be billed the same day as a PSR group session.
  - May be provided on or off-site (separate rates may apply).
- **Group**
  - Billed daily in 15-minute units.
  - Group sessions may be billed on the same day as a PSR individual per 15 minutes.
  - Service must be offered in the setting best suited for desired outcomes.
  - Payment for group sessions is broken into various levels using modifier codes to distinguish the number of individuals present in the session (i.e., 2-3, 4-5, 6+). The rate code/procedure code/modifier code combinations are shown on the services coding crosswalk above.
  - Modifiers must be used to indicate if group has an Education focus and/or Employment focus.

#### Community Psychiatric Support and Treatment (CPST)

Service Name	Individual or Group	Rate Code	HCPCS Code	Modifier	Unit Measure
Community Psychiatric Support and Treatment (Physician)	Individual	7790	H0036	AF	15 Minutes
Community Psychiatric Support and Treatment (NP, Psychologist, Physician's Assistant)	Individual	7791	H0036	SA, AH, or U1	15 Minutes
Community Psychiatric Support and Treatment (RN, LMHC/MHC-LP, LMFT/MFT-LP, LCSW, LMSW/MSW-LP, LCAT/CAT-LP, Psychoanalyst, CRC)	Individual	7792	H0036	TD or AJ	15 Minutes
Community Psychiatric Support and Treatment (LPN)	Individual	7793	H0036		15 Minutes

- Billed daily in 15-minute increments.
- Payment for CPST services is broken into various levels using modifier codes indicating the type of staff providing the service (i.e., physician, psychologist, NP, RN, all other professions).
  - For rate code 7791 use the following modifiers:
    - Nurse Practitioner: SA
    - Psychologist: AH
    - Physician’s Assistant: U1
  - For rate code 7792 use the following modifiers:
    - Registered Nurse: TD
    - All other allowable professions: AJ
- There are no group sessions for this service.
- May only be provided off-site unless there is documentation in the member’s CORE case record indicating a strong clinical rationale for onsite service delivery (see *CORE Services Operations Manual*).

<b>Empowerment Services – Peer Support</b>					
<b>Service Name</b>	<b>Individual or Group</b>	<b>Rate Code</b>	<b>HCPCS Code</b>	<b>Modifier</b>	<b>Unit Measure</b>
Peer Support (Credentialed staff)	Individual	7794	H0038	HE or HF	15 Minutes

- Billed daily in 15-minute units.
- May be provided on or off-site.
- Use the HF modifier for an OASAS service or the HE modifier for an OMH service.

<b>Family Support and Training (FST)</b>					
<b>Service Name</b>	<b>Individual or Group</b>	<b>Rate Code</b>	<b>HCPCS Code</b>	<b>Modifier</b>	<b>Unit Measure</b>
Family Support and Training	Individual	7799	H2014	HR or HS	15 Minutes
Family Support and Training	Group (2-3)	7800	H2014	HR or HS, UN or UP	15 Minutes

- **FST session provided to one family**
  - Billed daily in 15-minute increments.
  - FST is detailed by using modifiers indicating whether the service was provided to the family with the recipient present or to the family without the recipient present.
  - If FST is delivered one-on-one with the individual only, no modifier is needed.
  - May be provided on or off-site.
- **Group FST (two to three families)**
  - Billed daily in 15-minute increments.
  - Group sessions may be billed on the same day as an FST one-on-one family session.
  - May be provided on or off-site.
  - Payment for FST group sessions is differentiated using modifier codes to distinguish the number of families present in the session (i.e., two or three).

- Billing is at the recipient family level (e.g., if the group consists of the families of three recipients and, for purposes of this example, eight people are in the group, there would be only three claims submitted).

<b>Provider Travel Supplement (Staff Transportation)</b>						
<b>Service Name</b>	<b>Individual or Group</b>	<b>Rate Code</b>	<b>HCPCS Code</b>	<b>Modifier</b>	<b>Unit Measure</b>	<b>Unit Limit</b>
Provider Travel Supplement (Per mile)	Individual	7808	A0160	U2	Per Mile	60
Provider Travel Supplement (Public Transport)	Individual	7809	A0160	U3	Per round trip	31

CORE providers bill Staff Transportation under an enrollee’s Medicaid ID (CIN) and are only allowed to submit one claim per service regardless of the number of staff persons or practitioners traveling. If two or more unrelated trips are provided to the enrollee on the same day, the MCO should pay each provider separately.

Staff travel time cost is built into the CORE Service rates. There is no reimbursement for “staff time” while in travel status. Travel related to unsuccessful contacts in which the individual isn’t available cannot be reimbursed, as reimbursement is intended to be an add-on to a completed CORE Service. Refer to the *CORE Services Fee Schedule* for reimbursement rates.

There are two types of Staff Transportation:

- **Per mile**
  - Per mile is used when provider is driving.
  - Billed daily in per mile units with a limit of 60 miles for a round trip.
  - Per mile reimbursement rate is dictated by federal guidelines. See the *CORE Services Fee Schedule* for current rate.
- **Public Transport (Per round trip)**
  - Per round trip is used when provider is using public transportation (i.e. bus, subway, etc.).
  - Billed monthly using the first day of the month as date of service.
  - Each round-trip counts as one unit with a limit of 31 units per calendar month.

## Appendix A: LPHA Recommendation Form

### Recommendation for Community Oriented Recovery and Empowerment (CORE) Services

#### Determination of Medical Necessity

<b>Part 1: HARP Eligibility</b>	<i>Instructions:</i> This section may be completed by the care coordinator, Managed Care Organization (MCO), CORE Services Designated Provider, LPHA, or any other entity with appropriate access to the client record.		
	Member Name:	_____	
	Member DOB:	_____	Member Phone #: _____
	HARP Eligibility Status:	<input type="checkbox"/> H1: HARP-Enrolled <input type="checkbox"/> H4: HIV-SNP-Enrolled, meets NYS BH high-needs criteria <input type="checkbox"/> H9: meets NYS BH high-needs criteria <sup>13</sup> <input type="checkbox"/> Other: _____	

<b>Part 2: Recommendation for Services</b>	<i>Instructions:</i> This section must be completed by a Licensed Practitioner of the Health Arts (LPHA), as defined by:		
	<ul style="list-style-type: none"> <li>• Nurse Practitioner</li> <li>• Physician</li> <li>• Physician Assistant</li> <li>• Psychiatric Nurse Practitioner</li> <li>• Psychiatrist</li> <li>• Psychologist</li> </ul>	<ul style="list-style-type: none"> <li>• Registered Professional Nurse</li> <li>• Licensed Mental Health Counselor</li> <li>• Licensed Creative Arts Therapist</li> <li>• Licensed Marriage &amp; Family Therapist</li> <li>• Licensed Psychoanalyst</li> </ul>	<ul style="list-style-type: none"> <li>• Licensed Clinical Social Worker</li> <li>• Licensed Master Social Worker, under the supervision of an LCSW, licensed psychologist, or psychiatrist employed by the agency</li> </ul>
	Note: The CORE Services designated provider will conduct an intake and engage the individual through person-centered planning to determine frequency, scope, and duration of recommended services.		
	<i>Recommended Services</i>		
	Select all that apply:	<input type="checkbox"/> Community Psychiatric Treatment and Support <input type="checkbox"/> Psychosocial Rehabilitation <input type="checkbox"/> Family Support and Training <input type="checkbox"/> Empowerment Services – Peer Support	
	<i>Determination of Medical Necessity</i>		
Based on my knowledge of the individual and clinical expertise, the individual needs and/or would benefit from the above selected CORE Services for the following reasons:			
Select all that apply:	<input type="checkbox"/> To increase capacity to better manage treatments for diagnosed illnesses <input type="checkbox"/> To prevent worsening of symptoms <input type="checkbox"/> To restore/rehabilitate functional level <input type="checkbox"/> To increase compensatory supports <input type="checkbox"/> To facilitate participation in the individual's community, school, work, or home <input type="checkbox"/> To sustain recovery lifestyle <input type="checkbox"/> To strengthen resiliency, self-advocacy, self-efficacy and/or empowerment <input type="checkbox"/> To build and strengthen natural supports, including family of choice <input type="checkbox"/> To improve effective utilization of community resources		
<i>Diagnosis</i>			
DSM-5 or ICD-10 diagnoses, if known: _____			
_____		_____	_____
<i>Signature of LPHA</i>		<i>Date</i>	<i>Printed Name</i>
			<i>NPI #</i>

<sup>13</sup> Individuals falling into this category are eligible to receive CORE Services when enrolled in a HARP or HIV-SNP. Eligible individuals with an H9 wishing to enroll in a HARP or HIV-SNP may contact NY Medicaid Choice at 1-855-789-4277 for enrollment options.

## Appendix B: Provider Service Initiation Notification Template

### CORE Service Initiation Notification Form

The purpose of this notification is to ensure enrollees are not receiving duplicative services. This information must be shared via secure electronic communication.

- CORE providers submit this information to an enrollee's Health and Recovery Plan (HARP) or HIV Special Needs Plan (HIV-SNP) within three business days of the first CORE service visit.
- Submission of this form enables the HARP and/or HIV-SNP to prepare systems to receive claims. Claims submitted prior to this notification submission may lead to payment delay or denial.
- Within three business days of being notified of CORE service initiation, the HARP or HIV-SNP must inform the CORE provider of any issues preventing further service provision and reimbursement.

#### Enrollee information

Enrollee Name \_\_\_\_\_ DOB \_\_\_\_\_

Enrollee CIN \_\_\_\_\_

Managed Care Plan \_\_\_\_\_ Plan ID # \_\_\_\_\_

Enrollee Phone (optional) \_\_\_\_\_ Email (optional) \_\_\_\_\_

Enrollee Address (optional) \_\_\_\_\_

Health Home / Care Manager Contact (if applicable) \_\_\_\_\_

#### CORE Provider Agency Information

CORE Provider Agency \_\_\_\_\_

Agency Address \_\_\_\_\_

Agency NPI # \_\_\_\_\_ Tax ID # \_\_\_\_\_

Agency Contact Person Name \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Alternate Contact \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

#### Secure Electronic Communication Contact Information

Secure Email \_\_\_\_\_ Fax \_\_\_\_\_

Other (if applicable) \_\_\_\_\_

**CORE Service(s)**

Please identify CORE Service(s) being initiated (select all that apply):

- Community Psychiatric Support and Treatment (CPST)
- Family Support and Training (FST)
- Empowerment Services – Peer Supports
- Psychosocial Rehabilitation (PSR)

I attest the enrollee elected to receive all CORE services requested above

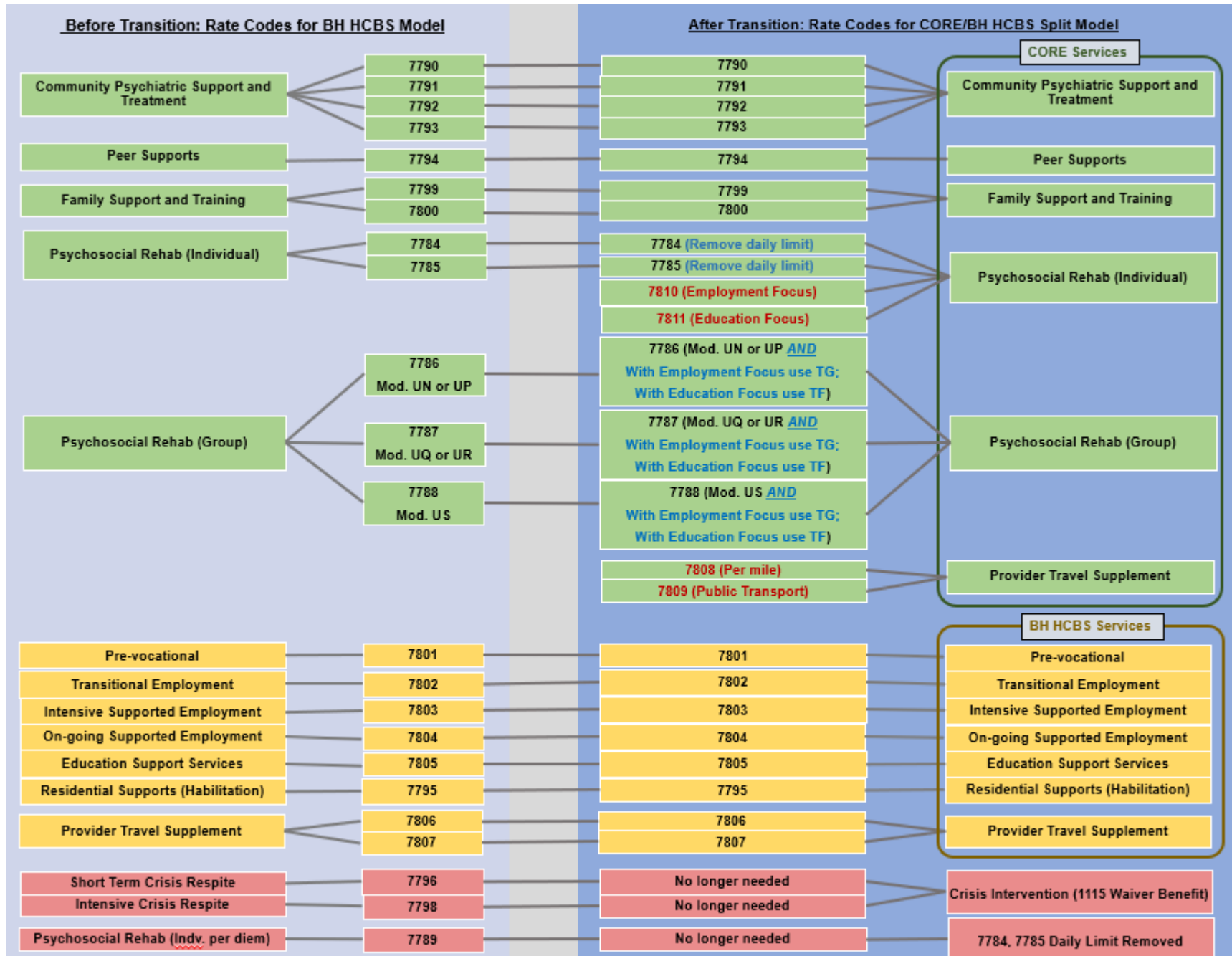
\_\_\_\_\_  
Signature of CORE Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Title

# Appendix C: BH HCBS Transition to CORE: Billing Changes



Note: Non-Medical transportation (no rate code needed) will continue to be available in BH HCBS after the transition.



## Appendix D: MCO Systems Configuration Details

MCOs must complete systems configurations and workflow processes for CORE Services as outlined below:

Date	MCO Requirement	Process / System Impact
<p>February 1, 2022: CORE Services Implemented</p> <p>Provider Operational Standards Effective and MCO Systems Configuration Completed</p>	<ul style="list-style-type: none"> <li>• Discontinue BH HCBS eligibility and access requirements for CORE PSR, CPST, FST and Peer Supports.</li> <li>• Extend existing BH HCBS service authorizations for PSR, CPST, FST and Peer Supports until May 2, 2022.</li> <li>• Ensure ability to accurately pay BH HCBS PSR, CPST, FST, and Peer Supports claims for continuity of care recipients with dates of service up to and including May 2, 2022.</li> <li>• Operationalize processes to securely and electronically receive and respond to provider CORE Service initiation submissions.</li> <li>• Ensure ability to accurately pay for CORE Services.</li> </ul>	<ul style="list-style-type: none"> <li>• Eliminate any requirements for Eligibility Assessment-related H-codes (H2, H3, H5, H6) to reimburse CORE Services.</li> <li>• Eliminate need for BH HCBS Level of Service Determination or Plan of Care for CORE PSR, CPST, FST and Peer Supports.</li> <li>• Eliminate BH HCBS settings rule exclusions for CORE Services.</li> <li>• Ensure systems will authorize payment without prior authorization or concurrent review for CORE Services.</li> <li>• Update billing systems and provider profiles to reflect the CORE Service billing crosswalk, including:               <ul style="list-style-type: none"> <li>○ Add CORE Service and provider travel supplement rate code, procedure code and modifier combinations, as necessary.</li> <li>○ Add CORE Service modifiers, as necessary.</li> <li>○ Update CORE Service names.</li> <li>○ Update daily units to ensure all CORE Services can be billed in 15-minute increments.</li> </ul> </li> </ul>

Date	MCO Requirement	Process / System Impact
		<ul style="list-style-type: none"> <li>○ Remove hard BH HCBS daily unit limits and the Tier 1 and Tier 2 requirements (including any annual caps) for PSR, CPST, FST, and Peer Supports.</li> <li>○ Update allowable service combinations.</li> <li>● Make any necessary updates to designated services for contracted CORE providers. While provider contract changes do not need to be finalized until March 1, 2022, providers must be paid according to the new rules detailed in this guidance for dates of service February 1, 2022 and thereafter.</li> </ul>
May 3, 2022	<ul style="list-style-type: none"> <li>● Discontinue reimbursement for BH HCBS claims provided to continuity of care recipients who elected not to transition to CORE for dates of service on or after May 3, 2022.</li> </ul>	