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Providing CORE Services: What You Really Need to Know

2021 NYAPRS Annual Rehabilitation and Recovery Academy

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Workshop Overview

- CORE overview
- What are CORE Services?
- How is CORE different from BH HCBS?
- How can CORE help HARP members?
- How can designated providers effectively find and outreach HARP members?

CORE Overview

What is CORE?

Community Oriented

Recovery

& Empowerment

Services

Key Concepts

- Medicaid Managed Care Benefit for HARP Enrollees & HARP-Eligible HIV-SNP Enrollees
- **Community-based** services, largely provided **1:1**, with a focus on **person-centered** goals
- Flexible service design that can be used to meet diverse needs
- May only be provided by agencies designated by OMH and OASAS
    - Current BH HCBS providers will automatically receive **provisional designation** for CORE

Menu of Services

Mobile therapy and treatment services

Community Psychiatric Support and Treatment

Psychosocial Rehabilitation

Skill building to support living, working, learning, and socializing

Education and training for family of choice

Family Support and Training

Empowerment Services – Peer Support

Support from individuals with lived experience

Key Values & Principles

- Person-Centered Care
- Recovery Oriented
- Integrated
- Data-Driven
- Evidence-Based
- Trauma-Informed
- Peer-Supported
- Culturally Competent
- Flexible and Mobile
- Inclusive of Social Network
- Coordination and Collaboration

These values and principles are woven throughout the service design and are assessed through the CORE Service Standards.

Reduced Barriers to Access

- CORE is an 1115 Demonstration of rehabilitation services (“rehab option”), which allowed us to remove federal HCBS requirements
- **Reduced barriers to access**
    - Referrals can come from anywhere
    - Eligibility based on HARP status + LPHA recommendation

No Wrong Door Referral Pathway

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Supervision & Staff Training

- **Supervision** is critical to the success of CORE Services
  - Supports quality of services, workforce competency
  - Supervision by qualified clinicians is required; administrative/task supervision may also be provided by unlicensed staff/peers
  - Allowed us to remove caseload limits; supervisors may set caseloads based on needs of individuals and strengths/abilities of staff
- **Staff Training** requirements focus on essential skills & evidence-based practice
  - Trainings are free and completed via CPI Learning Community
  - Completion of training requirements will be monitored through State oversight and is a requirement for continued designation

Scope of Services

- CORE Services are goal-driven and focused on supporting people with improving their quality of life and satisfaction in life roles
- CORE is not intended to take the place of home health or personal care type services
- Frequency and **intensity of services** is based on **person-centered needs**
- **Programmatic unit ranges are recommended** in the Operations Manual with the intent of illustrating the scope of services
    - The range may be exceeded based on medical necessity; the clinical supervisor should be consulted, and the rationale or justification must be clearly documented in the chart

Collaboration & Collateral Contacts

- All CORE services allow for **billable contacts** with collaterals (face-to-face or telehealth)
- Collateral is an NYS term that is used to identify individuals who are *not* the Medicaid recipient but who may receive services under the beneficiary's Medicaid for the purposes of **direct benefit of the Medicaid beneficiary**
- Collaterals should be identified through a person-centered planning process, and they must be clearly **documented in the chart**
    - Collaterals may include the individual's family of choice and anyone else significant in their recovery (including other providers, if identified by the individual)
- Services should only be delivered to collaterals with the **consent** of the individual
- Billable contacts will support the **integration** of these services in the larger system, supporting collaboration and coordination (key value)

Designation for CORE Services

- **Provisional designation period** for currently designated BH HCBS providers from February 1, 2022 – July 31, 2022
- Providers will have 6 months to achieve requirements for **full designation**
    - Update P&P to align with Operations Manual
    - Aligning with incident reporting/management requirements
    - Meeting staff training requirements through CPI Learning Community
    - Entering into and updated Mental Health Provider Directory (MHPD)
- Providers will document meeting above requirements through an **attestation process**
- The State will perform **due diligence** to check compliance with designation requirements before granting full designation
- Providers that do not meet all requirements before July 31, 2022 will transition clients over to fully designated providers (their designation status will end)

Approaches to Service Delivery

A la carte Service Menu

- CORE Services are designated and provided a la carte, meaning that they can be combined to meet person-centered needs or provided individually
- Individuals may receive just one CORE service if that is what is medically necessary or matches the individual's readiness in participation in CORE.
- For example:
  - Peer only service provided
    - Individual is not ready to engage beyond this service, but is willing to work with someone with lived experience
  - CPST only
    - Individual is having difficulty attending on-site clinic services and is willing to engage with a clinician for psychotherapy only at this time.

CORE Services + Traditional Services

- Designated providers are encouraged to explore how **service bundles** might plug into their OMH/OASAS licensed or funded service models and **meet unmet needs**:
    - Clinic + Peer Support as a CTI intervention post-hospitalization
    - PROS + Peer Support as ACT step-down or step-up
    - Clinic + Peer Support as a PROS step-down

Options for CORE Service Bundles

- Under this approach, CORE services can be provided as a bundle where multiple CORE services are provided at the same time.
- Designated providers are encouraged to explore how **service bundles** might plug into their agencies and **meet unmet needs**:
    - CPST + Peer Support as a CTI intervention post-hospitalization
    - CPST + PSR + Peer Support + FST as ACT step-down
    - PSR + Peer Support as a PROS step-down
    - FST + PSR to support Transition Age Youth (TAY)
- Clinical Supervisors might act as “team leader”; services can be included on a single ISP to **streamline and integrate interventions**

CORE + HH Care Management

- CORE providers can work closely with HH Care Managers to support coordination, education around services, referrals, and continued collaboration for members receiving CORE services (key value/principle for CORE).
- Agencies may choose to create partnerships within their own Care Management program, or with other Care Management Agencies, and CORE staff.
  - For example: A Care Manager and a Peer Specialist might collaborate on a shared member to best meet the goals of the individual.

Finding, Outreaching, & Engaging Eligible Individuals

Who is eligible?

As of today, there are two target populations who can be recommended for CORE Services:

1) Health and Recovery Plan (HARP) Enrollees
2) HARP-Eligible~~,~~ HIV-Special Needs Plan Enrollees

There has been **no change** from the BH HCBS target population.

What are the "NYS BH High-Needs Criteria?"

If you've seen this phrase in our guidance documents, what this refers to is a set of criteria established by New York State (NYS) that is used to determine HARP eligibility status. These criteria are assessed by an algorithm that is run every two months by NYS. Individuals who meet these criteria are identified by an H9 code.

H-Codes: What are they?

- H-Codes are a type of Recipient Restriction Exception (RRE) code applied to an individual's Medicaid file to indicate HARP eligibility/enrollment status.
- H-Codes can be helpful for CORE Services providers trying to determine whether an individual might be eligible for CORE Services.
- Individuals may have multiple H-Codes.

Individuals with an H1-H6 are eligible for CORE Services if they have an LPHA recommendation.

H-Code	Description
H1	HARP Enrolled
H2	HARP Enrolled, HCBS Assessed, Tier 1 Eligible
H3	HARP Enrolled, HCBS Assessed, Tier 2 Eligible
H4	HIV-SNP Enrolled, HARP-Eligible
H5	HIV-SNP Enrolled, HARP-Eligible, HCBS Assessed, Tier 1 Eligible
H6	HIV-SNP Enrolled, HARP-Eligible, HCBS Assessed, Tier 2 Eligible
H9	Meets NYS BH High Needs Criteria ("HARP Eligible")

Individuals who *only* have an H9 may be eligible for CORE Services, but you will need to call NYS Medicaid Choice to find out if they are enrolled in an eligible managed care product. If they are enrolled in an eligible product (HARP, HIV-SNP), then you can proceed with getting an LPHA recommendation.

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Who are HARP members?

- **Medicaid-enrolled individuals aged 21+ with an SMI/SUD diagnosis**
  - Must be enrolled in Mainstream MCO
  - Cannot be participating or enrolled in an OPWDD program

- Must have **HARP "risk factor,"** for example:
  - SSI recipient who received a MH service
  - 3+ months of ACT or PROS in last year
  - Recent history of psychiatric inpatient hospitalizations (last 3 years)
  - Current or expired AOT order
  - Residents of OMH funded housing (last 3 years)
  - Recent history of hospitalization or ER use with SUD diagnosis

Note: The above list is intended for illustration purposes only. The full list of HARP Risk Factors is published on the DOH website and includes more detail. HARP Risk Factors are determined using the BH High Risk algorithm, and individuals meeting these criteria are identified every two months with an H9 Code.

Why would someone be H9 only? How can we help them?

Some individuals will only have an H9 – what does this mean? It could mean a lot of things, so providers need to take a personalized approach to supporting these individuals

Potential Scenarios	How you can help…
Enrolled in an MMC plan that does not offer HARP	Educate the individual on the benefits of HARP and support them in making an informed decision. Note: Changing their MMC plan could impact their access to current service providers. If an individual chooses to proceed with HARP enrollment, they can contact NYS Medicaid Choice to make this change.
Actively chose to disenroll from an eligible plan (HARP, HIV-SNP)	
Enrolled in an HCBS Waiver (OPWDD, TBI, NHTD)	Refer back to their MCO or Care Coordinator for support in accessing services under their current benefit package. These individuals are ineligible for HARP enrollment at this time.
Enrolled in a Medicaid Advantage Plus (MAP) Plan	
Newly enrolled in a HARP or HIV-SNP and H-code hasn't updated on Medicaid file yet	Contact the MCO to confirm enrollment status, then proceed with usual referral/ intake & eval for CORE.

Finding HARP Members*

- Marketing for CORE Services is different from other MH/SUD services that serve a broader population – direct to individual marketing may bring in large numbers of ineligible individuals
- Providers may want to **focus their efforts** on reaching out to referral sources directly
    - HARPs/HIV-SNPs know where their members are / where they are receiving services
- Reminder: Most HARP members are *not* Health Home enrolled (although all are eligible for HH services)

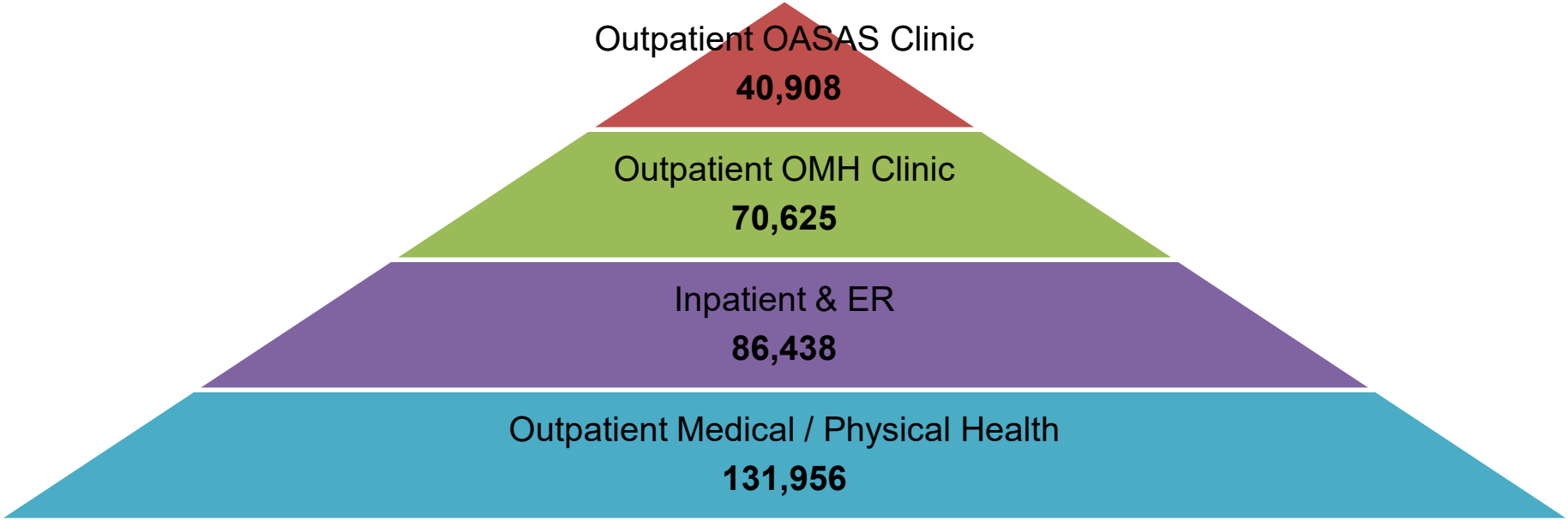
*and HARP-eligible HIV-SNP members

Building Referral Networks

Providers will need a tailored approach by outreaching the places and providers where HARP members traditionally receive services

- Hospitals / Emergency Rooms
  - Make sure hospital social workers and discharge coordinators have your information and can easily connect with you
  - Create value by consistently offering intake appointments within 7 days post-discharge (HEDIS measure)
- Primary Care
  - Find out if your contracted MCOs can give you a list of Primary Care providers with a high volume of HARP members
  - Offer lunch-and-learns for primary care staff
  - Think about whether/how your staff are prepared to address co-morbid physical health conditions (psychoeducation, medication skill-building, whole health/wellness approaches)
- Outpatient Clinics (OMH and OASAS)
  - Make sure clinicians and supervisory staff have your brochures handy
  - Offer an integrated approach to service planning
  - Streamline referral packet/ intake paperwork to make referrals quick and easy

Where have HARP members received services in the last year?

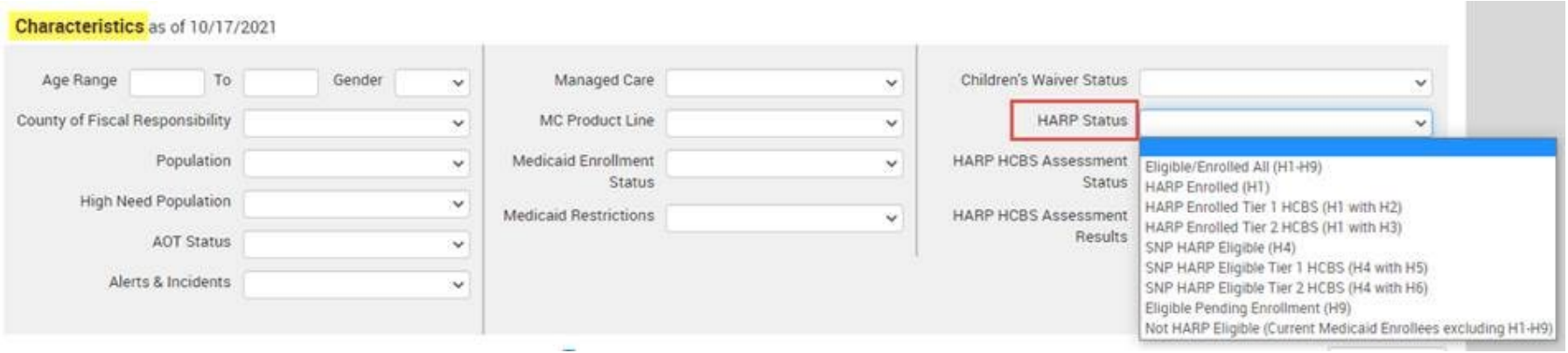


Checking HARP Status

- Unlike BH HCBS, you may receive referrals where an individual's HARP status/eligibility is unknown
- Providers should have **a system for verifying HARP status**:
    - Check ePACES/eMedNY
    - Check PSYCKES (requires consent)
    - Call their MCO
- As with any Medicaid service, your organization should build a system or process for routinely verifying insurance enrollment prior to service delivery – this ensures that if there is a change in the individual's insurance status (e.g., a lapse in coverage) you are aware of it before claims are denied.

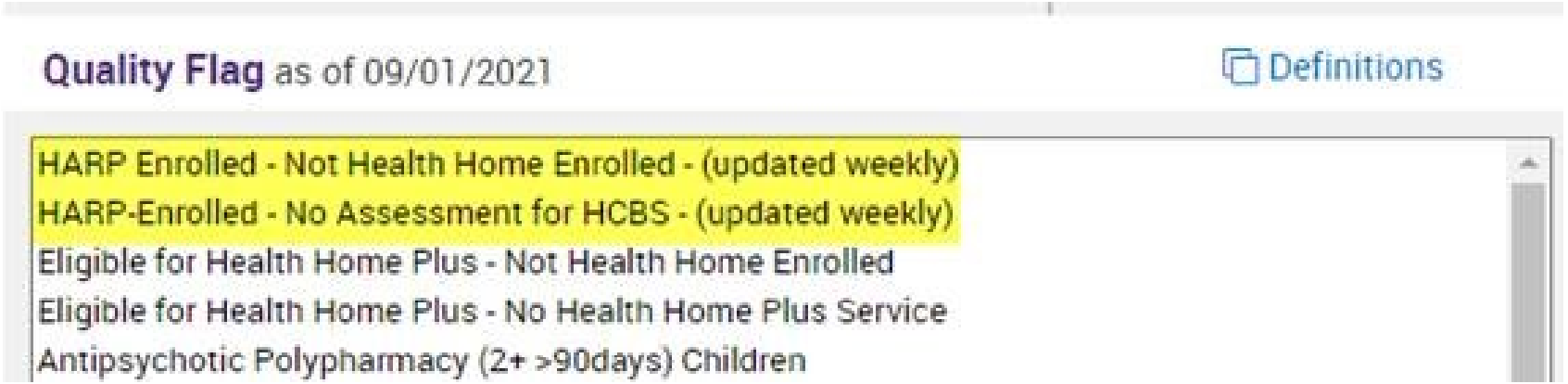
Using PSYCKES to ID HARP Members

To identify HARP members in PSYCKES you can use the “HARP Status” filter located within the Characteristics section on the Recipient Search screen.



PSYCKES Quality Flags & HARP Enrollment

Two Quality Flags related to HARP “HARP Enrolled – Not Health Home Enrolled” and “HARP Enrolled – No Assessment for HCBS”.



The LPHA Recommendation

- After confirming that an individual is HARP-enrolled or HARP-eligible, HIV-SNP enrolled, the next step for determining eligibility is the recommendation of a licensed practitioner of the healing arts (LPHA)
- The State strongly encourages all CORE providers to have an **internal LPHA** available to support this process
- In most cases, the CORE Clinical Supervisor is also a qualified LPHA
- The LPHA Recommendation is completed using **a standardized form** to confirm Medical Necessity
- The LPHA Recommendation only needs to be done once per episode of care

Person-Centered Intake & Eval

- Intake & Evaluation (I&E) completed within **5 sessions or 30 days**, whichever is greater
    - LPHA recommendation must be obtained by end of intake/eval period
    - The I&E sessions are still billable if the LPHA recommendation is not received
- Intake and evaluation gives time for engagement and assessment of strengths, resources, barriers, and needs
- Opportunity for **person-in-environment** evaluation that will contribute to ISP development
- Goals will be identified and refined during the person-centered planning process

How CORE Services Can Help

- Most requested service is **peer support** – HARP members want to receive support from individuals who have walked in their shoes
- Many HARP members struggle with leaving their homes and/or transportation issues, making evident the **need for community-based services**
- HARP members are largely *not* disconnected from the service system (they are identified through claims data), but many are **not well served by traditional behavioral health services**
    - Providers will need to be creative and flexible in designing service bundles meant to address their unique needs

Demonstrating Value

- Emphasis on improved quality of life, higher satisfaction in life roles, and functional status
- Service frequency, intensity, scope, and duration are driven by the person-centered planning process; documentation must demonstrate the "**golden thread**" for medical necessity
- Providers can demonstrate value to MCOs and other referral sources by supporting individuals with:
    - Increasing independence and self-direction
    - Learning and using coping skills and stress reduction techniques
    - Making improvements in their health status
    - Finding and keeping employment or continuing education
    - Navigating their community and connecting to natural supports

Next Steps & Technical Assistance

What should BH HCBS Providers be doing right now to prepare for CORE?

- Read the guidance published so far
- Participate in implementation training through MCTAC
- Identify internal LPHAs able to support recommendation process
- Talk to HARP members currently served so that they understand this change to their benefits/ services
- Work with agency leadership, finance, IT, & QA staff to develop an implementation plan:
    - Review EHR to determine scope of changes needed
    - Review and revise P&P to align with CORE standards
    - Evaluate funding opportunities & engage in strategic planning
    - Staffing & capacity to accept potential influx

Funding to Support CORE Implementation

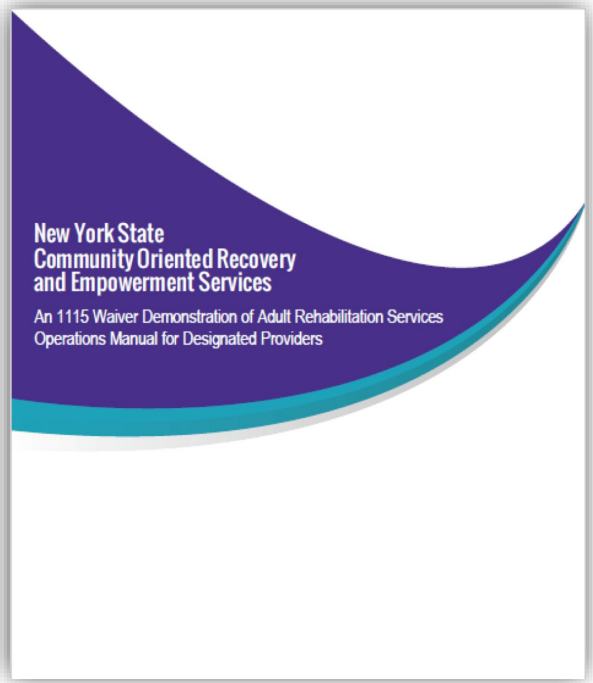
- Infrastructure Program Extension ($31M)
  - Guidance and application template released via listserv on 11/5/21
  - Intended to strengthen BH HCBS and support implementation of CORE Services
  - Funds are contracted through HARPs

- CORE eFMAP to support transition ($12.5M)
  - Details and guidance forthcoming

- Workforce funding (short-term rate increase through 3/31/22)
  - Guidance posted to OMH website 10/29/21

Training and TA

- There will be a series of webinars by State subject matter experts to offer details on operations and implementation.
- For more information, keep an eye out for training announcements through MCTAC and the BH HCBS Listserv.
- For technical assistance related to CORE Services, contact your host agency:
    - OMH: Adult-BH-HCBS@omh.ny.gov
    - OASAS: PICM@oasas.ny.gov
- Email PSYCKES-Help@omh.ny.gov regarding PSYCKES applications or projects.



Our CORE Services Website is now live! Check it out at: https://omh.ny.gov/omhweb/bho/core/

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Q&A

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Thank you for your ongoing commitment to rehabilitation services.