Office of Mental Health | Office of Addiction Services and Supports

Community Oriented Recovery and Empowerment (CORE) Services
Provider Frequently Asked Questions

This document is intended to answer frequently asked questions regarding CORE Services from designated providers. The Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) will revise and reissue this document as needed. Additional questions can be sent to your host agency via email at: Adult-BH-HCBS@omh.ny.gov or PICM@oasas.ny.gov.

Acronym Key: The below acronyms are commonly used throughout this document.	
BHCC	Behavioral Health Care Collaborative
BH HCBS	Behavioral Health Home and Community Based Services
BH IPA	Behavioral Health Independent Practice Associations
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
ISP	Individual Service Plan
LPHA	Licensed Practitioner of the Healing Arts
MCO	Managed Care Organization
MCTAC	Managed Care Technical Assistance Center
NIMRS	New York State Incident Management and Reporting System
PSR	Psychosocial Rehabilitation
SUD	Substance Use Disorder

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Section 1: Designation

Issued	#	Question	Answer
11/30/2021	1	Can an agency be designated for both Adult BH HCBS and CORE?	Designation for BH HCBS and CORE is by service type (e.g., PSR, Pre-Vocational Services, etc.). An agency can be designated for individual services under BH HCBS, CORE or both.
12/28/2021	2	Can Behavioral Health Care Collaborative (BHCC) and/or Independent Practice Associations (BH IPA) be direct providers of CORE Services?	No. BHCC/BH IPAs are networks of behavioral health service providers. BHCC/BH IPAs may have CORE Services designated providers within their networks.
2/9/2022	3	Do existing providers have the opportunity to add new services to their designations?	The State anticipates accepting expansion applications from existing CORE providers in the coming months. Interested providers should contact the mailbox to discuss the process.

Section 2: Referral

Issued	#	Question	Answer
11/30/2021 *Updated: 6/23/2022*	1	What needs to be in a CORE referral? Will there be a template?	There is no set template for CORE referrals. The CORE Provider should define their own referral process, including what information or documents are needed with a referral. Providers must establish their referral process in a formal Policy & Procedure. Per the CORE Operations Manual, “a central pillar of the CORE Services demonstration is the ‘No Wrong Door’ referral pathway, which enables HARP members to easily access the services with as few barriers to admission as possible.” Providers are strongly encouraged to accept referrals for eligible HARP/HIV-SNP enrollees even when referral packets are incomplete. Requiring excessive paperwork from referral sources may result in fewer referrals over time.
11/30/2021	2	Who can make a referral?	With the No Wrong Door referral pathway, anyone can make a referral including the prospective client (self-referrals). Referrals are not required to come in with an LPHA Recommendation.

Issued	#	Question	Answer
11/30/2021	3	What will be done to ensure that individuals are offered a choice of providers without conflict free care management?	For referrals made by Health Home Care Managers (CM) the CM will ensure that the member is offered a choice among all in network providers in accordance with the Health Home standards. The State strongly encourages other referral sources to educate members and facilitate an opportunity for an informed choice. As with any other benefit, individuals may choose to access CORE Services from any in network provider.
11/30/2021	4	Will a Plan of Care (POC) be required for CORE Services?	A Health Home Plan of Care will not be required for CORE Services. CORE Services must be documented in an Individual Service Plan (ISP) maintained by the CORE Services provider.
12/28/2021	5	What is the role of Recovery Coordinators with CORE?	Recovery Coordinators do not have any formal role in referrals to CORE Services. CORE Services do not require completion of the NYS Eligibility Assessment or the BH HCBS Plan of Care.
2/9/2022	6	Is there a centralized list of current CORE Services providers?	A list of Designated CORE Service Providers is located on the CORE Website.

Section 3: LPHA Recommendation

Issued	#	Question	Answer
11/30/2021	1	What are the minimum qualifications for a Licensed Practitioner of the Healing Arts (LPHA)?	For the purposes of making a recommendation to CORE Services, the minimum qualifications for an LPHA are: • Doctors (MD/DO) • Physician's Assistant (PA) • Nurse Practitioner (NP) • Registered Nurse (RN) • Licensed Mental Health Counselor (LMHC) • Licensed Marriage and Family Therapist (LMFT) • Licensed Creative Arts Therapist (LCAT) • Licensed Psychologist • Licensed Psychoanalyst • Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW), under the supervision of an LCSW, Psychologist, or Psychiatrist employed by the agency.
11/30/2021	2	Do Credentialed Alcoholism and Substance Abuse Counselors (CASACs) meet the minimum qualifications to complete the LPHA recommendation?	No, CASACs do not meet the minimum requirement to complete the LPHA Recommendation.

Issued	#	Question	Answer
11/30/2021	3	What is the purpose of the LPHA recommendation?	The purpose of the LPHA recommendation is to determine and document medical necessity for CORE Services.
11/30/2021	4	When does the LPHA recommendation need to be done? Before or after referral?	Referrals are not required to come in with an LPHA Recommendation. Providers should be prepared to complete or obtain an LPHA recommendation as a part of intake and evaluation process, prior to developing an ISP.
1/30/2021	5	Can agencies be reimbursed for completing the LPHA Recommendation?	If the LPHA is a member of the CORE Services staff, time spent with the member (in-person or via approved telehealth) for the purposes of completing an LPHA recommendation may be billed under the service specific rate codes. If the LPHA recommendation for Empowerment Services – Peer Support is completed by a member of the CORE staff, the time spent by the LPHA with the individual 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 an individual 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 also a certified peer.
11/30/2021	6	Does the LPHA need to document a qualifying psychiatric and/or SUD diagnosis to make the LPHA recommendation for CORE Services?	No. Under the 1115 Demonstration Waiver, CORE Services are limited to HARP-eligible individuals and as such a diagnosis does not need to be confirmed or documented in the LPHA recommendation or elsewhere in the case record.
11/30/2021	7	Are designated providers required to have an LPHA assigned to CORE?	The State recommends identifying LPHAs within each organization who are able to support this work. Agencies will need to make their own decisions about the sustainability of hiring an LPHA. There are many considerations an agency should take, including whether the LPHA will also be acting as the clinical supervisor for direct service staff. Agencies may also wish to share an LPHA with other programs or services within their agencies (e.g., PROS, Clinic, and/or CFTSS).
11/30/2021	8	Can an LPHA refer someone to HARP?	No. There is currently no community referral for HARP. HARP eligibility is determined by the NYS Behavioral Health High-Needs Criteria (as determined by an algorithm run by the State). Individuals who meet these criteria are identified by an H9 code on their Medicaid file. If the LPHA finds the individual has an H9 on their file, they can connect the individual with NYS Medicaid Choice (1-855-789-4277).

Issued	#	Question	Answer
11/30/2021	9	Do I need to send the LPHA recommendation to the MCO?	Providers are not required to submit LPHA recommendation to MCOs in order to begin providing services. From time to time, MCOs may request a copy of the LPHA recommendation, just as they may request any other documentation from the case record.
12/28/2021	10	Can a staff at an MCO do the LPHA recommendation if they meet the minimum requirements for a LPHA?	At this time, the LPHA recommendation form cannot be completed by staff at the MCO. However, MCOs play an essential role in connecting their members to CORE Services by referring them to in-network providers.
2/9/2022	11	Can a LMSW who does not have a NPI complete the LPHA Recommendation Form?	An LMSW practicing under the supervision of an LCSW, licensed psychologist, or licensed psychiatrist is qualified to complete the LPHA Recommendation Form, even if they do not have an NPI. In this case, the LMSW should enter their license number on the recommendation and indicate on the form that a license number has been used instead. Please note that all Medicaid practitioners including Certified Peers and LMSW can apply to get an individual NPI at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/apply

Section 4: Intake and Evaluation

Issued	#	Question	Answer
11/30/2021	1	How do we determine HARP eligibility or enrollment status?	There are a number of resources a provider can use to determine eligibility/enrollment status including ePACES, PSYCKES, and an individual's Medicaid Managed Care organization (MCO).
11/30/2021	2	Who is eligible to conduct the intake and evaluation?	Any staff who is qualified to provide the specific CORE service can do the intake and evaluation for that service.
11/30/2021	3	Is there an intake/evaluation tool?	There is no state-issued template for the intake and evaluation process, however agencies are encouraged to develop a tool/form that can guide a person-centered discussion of: the individual's recovery goal(s), the individual's strengths and resources, the individual's barriers and needs, the individual's preferences for service delivery (including days, times, staffing, etc.), and how the CORE service will be used to support attainment of their goal. Agencies may also consider the use of standardized screening tools that can inform service plan development. For example, the Daily Living Activities 20 (DLA-20), Columbia-Suicide Severity Rating Scale (C-SSRS), CAGE questionnaire and/or Fagerstrom Tolerance Scale.

Issued	#	Question	Answer
12/28/2021	4	How do CORE providers notify MCOs about an individual initiating CORE Services?	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. MCOs must implement a secure electronic process for receiving and responding to CORE Services initiation notifications. NYS developed a template containing the information providers must submit to MCOs. See the CORE Service Initiation Notification Form for additional information. 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 specific MCO's notification process.
12/28/2021	5	What will happen if the Service Initiation Notification Form is submitted after the 3-business day timeframe?	CORE providers must notify an enrollee's MCO within three (3) business days after the first date of initiating a new CORE Service. This allows for the MCO to identify any concerns regarding duplication of services. If the CORE Service Initiation Notification Form has not been submitted, an MCO may pend (or hold) the claim. The MCO will then reach out to the provider to request submission of the Service Initiation Notification Form. Providers should be aware that if the MCO identifies a duplicative service and the form was not submitted on time, claims may be denied.
2/9/2022	6	Can a CORE Provider meet with an individual who is inpatient in the hospital to begin an intake? Does it make a difference if the hospitalization is for behavioral health or medical reasons?	Yes, it is appropriate to meet with an individual to begin intake if they are hospitalized for BH or medical reasons. This practice will support strong engagement through a warm handoff.
4/4/2022	7	Do separate intake assessments need to be done for PSR and PSR+?	No, Psychosocial Rehabilitation is a single service type with multiple rate codes. You can do a single intake and evaluation that takes into consideration multiple goal areas/ domains of rehab, encompassing both PSR and PSR+.
4/4/2022	8	Would a CORE Provider be able to do one intake and evaluation for multiple service types?	A CORE Provider could do multiple I&E's in a single block of time, but would need to break up the documentation and billing by service type. This would involve paying close attention to the time spent on each service so that you can accurately document service duration for each claim/ progress note.

Service 5: Eligibility & HARP Enrollment

Issued	#	Question	Answer
11/30/2021	2	Who is eligible for CORE services?	Eligibility for CORE Services is based on three criteria: 1. The individual must be HARP Eligible, 2. The individual must be enrolled in a HARP or HIV-Special Needs Plan (SNP); and The services must be recommended by a Licensed Practitioner of the Healing Arts (LPHA).
11/30/2021	3	Does the settings restriction in the HCBS Final Rule apply to CORE Services as it did BH HCBS?	No, the HCBS Settings Final Rule does not apply to CORE Services.
2/9/2022	4	Are OPWDD HCBS waivered enrolled individuals eligible for CORE Services?	OPWDD HCBS waiver enrolled individuals are not able to be enrolled in a HARP/HIVSNP and therefore cannot access CORE Services. OPWDD waiver enrollees have access to similar services. For more information about the OPWDD waiver services please visit https://opwdd.ny.gov/types-services.
2/9/2022	5	If the HARP eligible client is enrolled in FST can their children receive FST services as collaterals?	The only person receiving services is the HARP enrolled/eligible person. The role of the Collateral is to provide support in helping the HARP member achieve their goals. In some circumstances, the HARP member can also ask FST provider to provide psychoeducation. Ultimately the HARP member is the client, and they identify their family of choice (who do not have to be 21+).
4/4/2022	6	Can individuals who reside in OMH community residences receive CORE Services?	Yes, as long as the individuals' outpatient services would not be considered duplicative.

Section 6: Service Delivery

Issued	#	Question	Answer
11/30/2021	1	Can staff provide both BH HCBS and CORE? If so, how do we determine caseloads for staff providing both BH HCBS and CORE?	Staff can provide both BH HCBS and CORE Services. As noted above, there are no caseload restrictions for CORE. For mixed caseloads, BH HCBS caseloads must be representative of the staff time dedicated to BH HCBS. For example, if your agency has a full-time staff who is half-time CORE and half-time BH HCBS, then their BH HCBS caseload should not exceed 10 individuals. This is because the BH HCBS caseload maximum is 20 individuals.

Issued	#	Question	Answer
11/30/2021	2	Can we bill for communication w/ outside providers?	The CORE provider can bill for synchronous (real time, two-way) communication with outside providers as a collateral if it is for the benefit of the individual (i.e., advances their service plan or goal). See the Operations Manual for specific documentation requirements and information on consent. Synchronous communication with collaterals may be provided in person or via telehealth modalities. Emails, text messages, and instant messages with collaterals are not Medicaid reimbursable activities. The minimum service duration (15 min. per unit) applies to collateral contacts.
11/30/2021	3	How often should clinical supervision be available? Does it need to be documented?	In lieu of caseload and staffing ratios, clinical supervision must be available to all staff providing direct services. Although there is no set frequency for supervision, ensuring regular availability and check-in with a clinical supervisor supports quality care, staff morale and retention, and overall professional development. It is recommended that direct service staff receive a minimum of one hour of clinical supervision for every 40 hours of service provision. Supervision does not need to be documented. Clinical supervision may be provided in groups as long as individual consultation is also available to staff as needed.
12/28/2021	4	Will CORE Providers be eligible for permanent approval to deliver services via telehealth?	Yes, designated providers are eligible to apply for permanent approval to deliver services via telehealth. Additional clinical and programmatic guidance regarding CORE and telehealth is forthcoming.
12/28/2021	5	Can you provide a telehealth and in-person CORE Service for the same person on the same day and be able to bill for both services appropriately?	Yes, 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. Please see page 17 from CORE Benefit and Billing Guidance.
12/28/2021	6	If a provider has received permanent approval to deliver BH HCBS via telehealth will that approval transfer over to CORE Services?	Yes, if a provider has been approved to deliver BH HCBS via telehealth that approval will transfer over to CORE Services. Updates may need to be made to the agency's policies and procedures to reflect the change in language.
2/9/2022	7	Can NMT be used to get a participant to a BH HCBS/CORE service at an agency site?	No, BH HCBS/ CORE Services are intended to be primarily home and community based. NMT is only available for transportation to community locations. Refer to NMT Guidance for additional information on how this benefit can be accessed.

Issued	#	Question	Answer
6/23/2022	8	Can an individual receive both BH HCBS Employment/ Education services and PSR with an Employment/ Education Focus (PSR+)?	No, please see the CORE Benefit and Billing Guidance for the allowable service combination charts.
6/23/2022	9	Can people receiving CORE PSR-Employment/Education also receive ACCESS-VR services? If so, how can they be used together?	Yes, ACCES-VR is an important community resource to support individuals with employment goals. However, there is a need for coordination to ensure interventions are not duplicative. When an individual is receiving services through both ACCES-VR and CORE PSR, providers should discuss with the individual whether their Vocational Rehabilitation Counselor at ACCES-VR should be identified as a collateral. The role of the PSR Provider is to focus on addressing behavioral health barriers in the work or school environment, while ACCES-VR will address specific employment and education related concerns like paying for tuition or providing job coaching through a local vendor.

Section 7: Service Planning & Documentation

Issued	#	Question	Answer
11/30/2021	1	How do we determine scope, intensity, duration, and frequency of services?	The CORE provider will conduct an intake and engage the individual through person-centered planning (PCP) to determine frequency, scope, intensity, and duration of recommended services to move the person towards their goal. The clinical supervisor can be a resource to staff in formulating the service plan. See the Operations Manual for additional information about the PCP process.
11/30/2021	2	How long is a unit? What are the recommended unit ranges?	A unit is 15 minutes. Under BH HCBS, services were subject to daily unit limits. These limits have been removed for CORE and replaced with recommended unit ranges, which are intended to illustrate the scope of services. See the Operations Manual for recommended programmatic unit ranges by service type.
11/30/2021	3	What happens if a person wants to do additional CORE Services after their initial referral and intake?	If the LPHA recommendation does not include the additional service(s), an updated LPHA recommendation is necessary. An intake & evaluation for the new service(s) must be done and the service added to their ISP. The MCO must be notified of the additional service(s) as well.
11/30/2021	4	Has “progress made/follow up” been eliminated from the progress notes? If so, how do we document progress made as well as follow-up/next steps?	Yes, this section of the progress note is no longer required. Progress made should be regularly monitored and documented in the ISP review summaries.

Issued	#	Question	Answer
11/30/2021	5	What are non-billable contacts, do I need to document those?	Non-billable contacts, for example outreach to disengaged members, appointment reminders, or contacts that do not reach minimum service duration, are critical to engaging the person in CORE services. These contacts are documented in a contact log, case note, or non-billable progress note. Providers have some discretion in which non-billable contacts are documented. For example, routine appointment reminder calls or texts might not be documented, but a letter attempting to outreach to a disengaged individual should be noted. Documentation on non-billable contacts helps demonstrate the quality of services provided and is particularly helpful during times of staff-turnover.
11/30/2021	6	Do supervisors need to sign off on encounter/progress notes?	The service encounter note needs to have the name, qualifications, dated signature of the staff person delivering the service. Although it is not required for a supervisor to sign off, an agency can choose to do so to ensure notes meet billing requirements.
11/30/2021	7	Do we need to make changes in our Electronic Health Record (EHR) or Electronic Billing Software (EBS) in order to meet the documentation requirements for CORE?	In developing documentation requirements for CORE Services, the State used the 2016 BH HCBS Behavioral Health Information Technology (BHIT) technical specifications as a guide. The intent was to minimize disruption or changes to existing software. The State has issued updated technical specifications that will support agencies in making any needed changes, including new modifiers and rate codes that will need to be added for certain services. For the CORE Case Record, form fields can be named/labeled differently as long as all required elements are included in the content of the documentation to support appropriate billing.
12/28/2021	8	What trainings do supervisors/staff need to take for CORE Services? Do staff need to retake trainings if they have done those trainings in the past for BH HCBS?	All CORE training requirements for staff and supervisors will be indicated in the CORE Staff Training Memo. There are overlapping trainings from BH HCBS that apply to CORE trainings. Staff will not have to repeat previously completed trainings that are required for both BH HCBS and CORE.
12/28/2021	9	What is NIMRS and how do I sign up? What incidents do I have to report?	NIMRS stands for the New York State Incident Management and Reporting System. NIMRS is a secure, web-based, quality management tool used by OMH-hosted providers to report incidents. Incident Reporting and Management Guidance for CORE and BH HCBS was issued via the BH HCBS Listserv on 12/13/21 and was effective immediately. Additional information for OMH-hosted providers can be found on the Division of Quality Management website.
4/4/2022	10	Can CORE & HCBS goals be on the same ISP?	Multiple CORE goals can be on the same ISP, however CORE and BH HCBS goals should not be. CORE and BH HCBS are distinct services and would require their own ISPs.

Issued	#	Question	Answer
6/23/2022	11	Can you clarify what the Agency Contact Form is that's included on the CORE Services Provider Attestation Form?	The Agency Contact Form establishes an organization in the Inter-Agency Master File (IAMF). IAMF is a database OMH shares with other NYS governmental agencies; IAMF establishes the Agency code, which is used for fiscal reporting. Most CORE Providers have already completed an Agency Contact Form, as it is a requirement under the Adult BH HCBS Terms and Conditions. A simple check, if you are unsure you've done this form, is to check your agency's access to MHPD. If anyone in your organization can access MHPD, that means the form has been completed and your organization is established in IAMF. If you need a copy of the form, please contact your host agency.
6/23/2022	12	Can an individual who is currently receiving PSR also receive PSR with an Educational/ Employment (PSR+) focus without any additional paperwork?	PSR, including PSR+, is a single service type. In order to bill at the higher PSR+ rate code an individual must have an employment/ education related goal on their service plan. There is no additional paperwork needed.
6/23/2022	13	Is there a separate designation for PSR+?	No, all designated PSR Providers may provide PSR+ without an additional designation. Individual staff and supervisors must have completed required PSR+ trainings as outlined in the Staff Training Memo.

Section 8: Billing/Claiming

Issued	#	Question	Answer
11/30/2021	1	What are the allowable service combinations for CORE?	CORE Services may be provided in combination with a variety of BH HCBS and State Plan services, like PROS or Outpatient Clinic. For more information on specifical allowable service combinations, please refer to the allowable service combination charts in the Benefit and Billing Guidance (pgs. 13-14).
11/30/2021	2	Does communication with the Managed Care Organization (MCO) "count" as a collateral contact?	No, MCOs are not considered collaterals of the individual and cannot be billed as a collateral contact.
11/30/2021	3	Has there been any change to the mile cap for staff transportation?	There have been no changes made to Staff Transportation. Staff Transportation can be reimbursed per mile or per round trip. Refer to the section II.4 in the Benefit and Billing Guidance for more information.
2/9/2022	4	If an individual's diagnosis is unknown, what diagnostic code should be entered on the claim?	Providers can use ICD-10 code R69 or F99 for claiming when diagnosis code is not available.

Issued	#	Question	Answer
4/4/2022	5	Can individuals in enrolled in CORE Services receive the NMT benefit?	NMT is available to HARP enrollees and HARP-eligible HIV-SNP enrollees who have been found eligible for BH HCBS using the New York State Eligibility Assessment (EA). Any enrollee who is assessed as Tier 1 or Tier 2 eligible may receive NMT. Individuals receiving CORE services would be eligible for NMT upon completion of the EA and assessed as Tier 1 or Tier 2 eligible.
4/4/2022	6	Can a CORE Provider bill for both PSR and PSR+ in the same day?	Yes, however providers would need to ensure both services are documented in separate progress notes.
6/23/2022	7	What kinds of mileage are reimbursable under the Provider Travel Supplement (Staff Transportation)?	Providers may be reimbursed for mileage for travel related to in-person delivery of CORE Services, up to 60 miles per day. This includes travel to and from an off-site setting as well as any travel during the delivery of CORE services. Please see the CORE Operations Manual and the CORE Benefit and Billing Guidance for more information about claiming for staff transportation.

Section 9: Other

Issued	#	Question	Answer
12/28/2021	1	What is NIMRS and how do I sign up? What incidents do I have to report?	NIMRS stands for the New York State Incident Management and Reporting System. NIMRS is a secure, web-based, quality management tool used by OMH-hosted providers to report incidents. Incident Reporting and Management Guidance for CORE and BH HCBS was issued via the BH HCBS Listserv on 12/13/21 and was effective immediately. Additional information for OMH-hosted providers can be found on the Division of Quality Management website.
2/9/2022	2	Do we need to share a copy of our telehealth approval with MCOs?	MCOs may request a copy of your telehealth approval for verification purposes. CORE providers should provide a copy if asked by the MCO. 074