Best Practices for Community Oriented Recovery and Empowerment (CORE) Services and Adult Behavioral Health Home and Community Based Services (BH HCBS): What's Working?

The following practices have been shared by Medicaid Managed Care Plans (MMCPs) throughout the course of the Adult BH HCBS Infrastructure Program and ***do not necessarily reflect current NYS policies or requirements.*** *This information is intended to demonstrate innovative practices that MMCPs and providers have reported they are implementing that have been successful in supporting engagement in and access to CORE Services and Adult BH HCBS.*

Best Practices for CORE Services	
Topic	**Practices**
Provider Network Engagement	MMCP Practices: 1. Educate Health Homes (HHs) and Care Management Agencies (CMAs) on CORE Services, including up-to-date Allowable Service Combinations for accurate and efficient referrals. 2. Ensure MMCP Care Managers (CMs) are educated on Allowable Service Combinations. 3. Engage in ongoing collaboration and communication with CORE providers for referrals, relationship building, and care management. 4. CMA collaboration: When MMCP CMs and HH care managers (HHCMs) are both contacting members, it often creates confusion. The MMCP CM and HHCM should communicate regularly, for example, every 90 days, or if member has received emergency room services. 5. Notify CORE providers when a member begins receiving inpatient services. 6. MMCP introduce providers to hospital systems, larger primary care physician offices, and county clinics. a. Embed HARP CM staff in hospitals and inpatient psychiatry units in effort to identify eligible members, and link members to CORE services prior to discharge. Provider Practices: 1. Use internal housing programs and network with other housing providers to solicit referrals. 2. Develop referral networking pipelines with residential facilities, Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS, formally known as clinics), PROS programs, ACT, Addiction Treatment programs facilities, inpatient psychiatry units, Crisis Stabilization Centers, Specialty Mental Health CMAs, and Certified Community Behavioral Health Centers (CCBHCs). to share information about the CORE services, to communicate availability or waitlists, and to develop referral networks. These partnerships can help to identify individuals who may benefit from rehabilitative services and to coordinate service plans and plans of care. 3. Conduct targeted trainings to educate community providers on the psych rehab services available through CORE, including skill building opportunities, Peer Support, readiness development, and steps toward life goals such as vocation or education 4. Establish meet and greets with local hospitals to educate utilization management (UM) staff and to facilitate referral pathways.

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Member Outreach and Engagement	MMCP Practices: 1. Educate members on CORE Services available to them and how CORE can support their recovery goals. 2. Ensure member contact information is up to date, especially for accurate and helpful referrals. a. CMs verify the member's current contact and demographic information before referring to CORE. b. Develop flags within the system to identify potential discrepancies with claims demographic information vs. care management system demographic information. 3. Connect members to in-network providers by referring them to services the member is interested in. a. Educate the member on what a CORE provider can do to help connect to priority services. When discussing benefits of CORE, members may want to address other physical health and health-related social needs before considering CORE. 4. Increase community engagement efforts to share various population-specific strategies to educate members on how they may benefit from CORE Services. For example: a. Educate Mental Health Courts and Drug Courts in an effort to engage with individuals who are mandated by the court systems to participate in recovery programs. b. Focus on employment services where there is a need for members to get mental health services. c. Engage individuals experiencing homelessness. d. Engage individuals experiencing service access barriers. 5. Use CORE as a step-down service(s) a. Ensure immediate support, rapport building, and awareness of treatment options for members receiving services in acute levels of care by deploying staff to meet with them while the initial outreach call is still in progress and continuing to follow-up at time of discharge. Provider Practices: 1. Use systems such as PSYCKES and closed-loop referral platforms to identify eligible members receiving services across various programs. 2. Create a survey to gather information about why members decline services.
Choice of Providers & Referral	MMCP Practices: 1. Communicate with CORE providers on network capacity to ensure members are offered a meaningful choice of providers able to complete intakes quickly. 2. Maintain a real-time CORE provider directory accessible online to reflect accurate provider capacity and to ensure providers with service capacity receive referrals. 3. Notify the Care Manager about existing CORE provider waitlists so referrals can be appropriately directed, and members have relevant information while making their choice. Provider Practices: 1. Consistently outreach recurring and potential referral sources with continuing education about CORE Services offered and how to make a referral to your organization.

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	2. In addition to outreaching external referral sources, providers are encouraged to develop structures and processes to identify, engage, and refer individuals who are enrolled within a provider's clinical or residential programs. 3. Promptly respond to referrals from inpatient facilities, MMCPs, etc. When a referral source receives quick responses, they are more likely to send future referrals.
Marketing and Training Strategies	Provider Practices: 1. Create reusable marketing resources to increase visibility of programs and services within the community. 2. Update website to include CORE services offered, including a mechanism for individuals to self-refer, such as having an assistance request link. 3. Develop targeted training refreshers for all staff. Collaborate with NYS and training consultants to revise training and materials. 4. Educate staff on CORE referrals, outreach, and networking. 5. Develop strategies specific to potential peer staff a. Peers receiving services can provide testimonials from a member perspective. b. When hiring Peer staff, work with the individual to obtain necessary certification as part of the hiring process.
CORE Services Utilization	**CORE Service Initiation Notification Form (MMCP best practices)** MMCP Practices: 1. It is strongly encouraged to confirm receipt of the CORE Service Initiation Notification from a provider a. If provider is unable to contact the member within 2-3 weeks, MMCP follows up with provider and attempts to connect with member to connect to services or help troubleshoot any barriers. 2. After referring to a CORE provider, develop a process to follow up with the provider if a CORE service notification is not received within 30 days. **Licensed Practitioner of the Healing Arts (LPHA) Recommendation** Provider Practices: 1. Employ an LPHA on staff. 2. If unable to identify an LPHA source, outreach contracted MMCPs, who can connect to providers with an LPHA on staff to meet this function.
Plan/Provider Collaboration	MMCP Practices: 1. Send providers warm handoffs and direct referrals with up-to-date member contact information and where members are currently receiving services. 2. Develop dashboard reports to frequently and routinely send to providers, with trending CORE service utilization, information on where HARP members are commonly receiving services, provider names, addresses, phone numbers, and counties of service to inform targeted marketing. MMCP and Provider Practices:

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	1. Initiate and maintain mutual communication and ongoing opportunities for respective staff to interact. a. For example: CORE providers, MMCP case management staff, MMCP behavioral health provider relations staff, and respective billing staff b. Discuss referral processes, opportunities for increased quality and quantity of referrals, issues, concerns, questions, and ways the members can be supported.

Best Practices for Adult BH HCBS	
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Provider Network Engagement	MMCP Practices: 1. Facilitate regular meetings with Recovery Coordination Agencies (RCA) network to direct activities, discover effective practices, and manage processes (RCAs are directed by the MMCP, not the Health Home). 2. Foster collaboration and partnership between providers by making introductions. This is particularly helpful in situations where the providers are not competitors (e.g. one is an RCA, but not an Adult BH HCBS provider and vice-versa). 3. Attend in-person provider forums (e.g. MCTAC events) so that providers can build/strengthen their relationships with payers. 4. Build on relationships developed with providers around other State initiatives, for example the Intensive Care Transitions and Clozapine components of the Performance Opportunity Program (POP).
Member Outreach/Engagement and Connection to CMA or RCA	MMCP Practices: 1. Referral is more effective when the member has already spoken with someone at the MMCP about what Care Management/Recovery Coordination is and how they might benefit from Adult BH HCBS. 2. Provide resources and support (e.g., mailing lists) to providers who are engaging in outreach activities. 3. When sharing member contact information with the CMA/RCA, use the most current information available. For example, one MMCP reported sharing member phone numbers successfully used by pharmacies within the last three weeks with CMA/RCAs. a. MMCPs can assist providers with verifying member contact information before making any referrals to ensure current demographic information. Provider Practices: 1. Bring Adult BH HCBS eligibility and access into the conversation whenever discussing high risk members with HH CMAs (e.g. during clinical case conference calls). 2. Fund outreach to members across systems, including Local Departments of Social Services (LDSS), homeless shelters/rescue missions, drop-in centers, and court systems. 3. Make active, targeted referrals for HH and Recovery Coordination for individual members.

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	4. Use claims data to direct member outreach by RCAs. For example, connect RCAs with the top physical and behavioral health providers where non-HH-enrolled members are currently served (e.g. primary care, MH/SUD outpatient clinics). 5. Train contracted RCAs on billing/claiming processes. 6. Support HHCMs/RCs in tailoring their "pitch" for diverse Adult BH HCBS populations to ensure all members are made aware of how Adult BH HCBS can help with their life goals. For example, older adults may be less interested in vocational or educational goals/services, but more interested in independent living and community life.
NYS Eligibility Assessment & Level of Service Determination	MMCP Practices: 1. Establish internal infrastructure to decrease the time between receipt of the level of service request and the level of service determination (LOSD). Some strategies may include, but are not limited to: a. Coordinate with CMAs/RCAs to ensure that when a member is found eligible and is interested in services, the LOSD process is initiated within that same meeting; b. Allow LOSD requests and approvals to be completed via telephone, using confirmation numbers to verify that appropriate process has taken place, and allow follow-up with appropriate paperwork sent via email or web portal; c. When an LOSD is issued over the phone, ensure this approval is also communicated to the Adult BH HCBS provider who will receive the referral; d. Provide electronic copies of LOSDs to the RCA/CMA as soon as possible, even when a paper copy is being mailed to the member directly; e. Designate a point person to track LOSD requests, approvals, and timeframes to ensure that reviews and communications are timely; and, f. Ensure an appropriate number of staff have been trained to provide LOSD approvals, including coverage for staff absences. 2. Develop internal data reports to track member and care manager contacts, LOSD requests/approvals, authorization requests/approvals, and claims submissions/approvals to ensure MMCP processes are meeting and exceeding State timeframes in the workflow.
Choice of Providers & Referral	MMCP Practices: 1. Monitor Adult BH HCBS provider network capacity to ensure members are offered a meaningful choice of providers able to complete intakes quickly. 2. Notify the CM or RC about existing Adult BH HCBS provider waitlists so referrals can be appropriately directed, and members have relevant information while making their choice. MMCP and Provider Practices: 1. Keep in contact with the State regarding access and capacity concerns so provider designation and technical assistance efforts can be targeted to address these issues (email us at Adult-BH-HCBS@omh.ny.gov).
BH HCBS Authorization	MMCP Practices:

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	1. Provide continued technical assistance and training for Adult BH HCBS providers around issues with prior authorization, claiming, and billing issues.
Plan of Care Completion/ Submission	MMCP Practices: 1. Facilitate trainings for CMAs and RCAs to support Plan of Care completion, submission, and approval. One MMCP provides in-person training on SMART goals and objectives so less back-and-forth is needed in approving the POC.
Annual Re-Assessment	MMCP Practices: 1. Systematically identify members needing reassessment at least two-three months prior to the reassessment due date. 2. Regularly remind the member, their CM/RC, and the Adult BH HCBS provider that an annual reassessment is required.