Systems Requirements for Transitioning DOH CAH I & II and OPWDD CAH Waiver Providers to Health Homes Serving Children

July 19, 2017

Agenda

- Introductions

- Brief overview of the transition of 1915(c) DOH and OPWDD Care at Home Waivers to the Children's MRT Behavioral Health and Health 1115 Waiver

    - Welcome OPWDD CAH Providers!

- Today is the first of many webinars and discussions to guide you and families through implementation of Children's 1115 Waiver

- Focus of Today's Webinar – Systems and Readiness Work CAH providers need to begin now to be ready to transition to Health Home

    - Health Commerce System Access and Purpose

    - Medicaid Analytics Performance Portal (MAPP) Overview

    - Health Home Tracking System (HHTS)

    - Access to the Uniform Assessment System (UAS)

- Questions and Answers

New York State and Care at Home Partnership in Implementing Medicaid Redesign Team (MRT) Initiatives for Transforming Delivery of Health Care for Children

- The State's Key Partnership Goals:
  - ✓ Work with CAH I & II and OPWDD CAH providers (collectively CAH providers) to incorporate the expertise of CAH providers in caring for medically complex/fragile children that are eligible for Health Home and Home and Community Based Services under the Children's 1115 Waiver (includes members that will transition to Managed Care **and** those that are excluded/exempt from Managed Care)

  - ✓ Enhance the service array provided to medically complex/fragile children that are now eligible for CAH I & II and OPWDD CAH Program to improve care

  - ✓ Ensure that CAH Providers and the children and families they now serve smoothly (and as seamlessly as possible) transition to Health Home care management, maintain the services they receive today and benefit from the expanded services available under the 1115 Waiver

  - ✓ Provide CAH providers and the children and families they serve, with as much technical assistance and information, including personal State engagement and interaction with providers and stakeholders, to ensure successful and smooth transition to the new design (webinars, face-to-face meetings, questions/answers, implementation challenges, solutions etc.)

> *We look forward to our partnership and improving delivery of care management and services to medically fragile and complex population!*

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Key Components of 1115 Children's Behavioral Health and Health Waiver

- ✓ Transition of six 1915(c) waivers to 1115 Waiver authority – includes DOH and OPWDD CAH

- ✓ Alignment of 1915(c) HCBS under one array of Home and Community Based Services (HCBS) authorized under 1115 Waiver

- ✓ Six New State Plan Services

- ✓ Health Home Care Management

- ✓ Transition of Behavioral Health Benefits to Managed Care

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Key Components of 1115 Children's Behavioral Health and Health Waiver

✓ *All services available to eligible members through in fee-for-service that are exempt or excluded from Managed Care, including:*

- Members with Comprehensive TPHI

- Dual eligible members (Medicare/Medicaid)

- Children in Foster Care (Voluntary Foster Care Agencies) – on January 1, 2019 are no longer excluded and will transition to Managed Care

✓ *Following the receipt of stakeholder comments from draft 1115 Waiver Children's waiver amendment State added the OPWDD CAH Waiver to the 1115 Children's Waiver submitted to CMS on May 9, 2017*

- ✓ Avoids bifurcating the transition of medically fragile children to 1115 waiver
- ✓ Provides expanded opportunities and services for children
- ✓ Consistent approach statewide to access for children/families
- ✓ Streamlining eligibility and enrollment

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Schedule of Key Implementation Dates

New York State Proposed 1115 Waiver Amendment (Effective Date of Waiver Amendment January 1, 2018)	Effective Date
Children's 1115 Waiver	
• CAH Providers Conduct Health Home System Readiness Activities and Develop Health Home Relationships (Business Associate Agreements with Health Homes, Connectivity to Health Home Systems)	Beginning Now 8/1/17 to 11/1/17 Focus of Today's Webinar
• **Six 1915(c) Waivers Authority Transitions to 1115 Waiver Authority** • **Care at Home I/II and OPWDD Care at Home** and other 1915(c) Children's Waivers (OMH HCBS Waiver, Bridges to Health (DD, MFC, SED)	1/1/18
• **Preparatory activities** for aligned service delivery and transition of care coordination for children/families from 1915(c) Children's Waivers to Health Home for **DOH Care at Home I/II and OPWDD Care at Home and other 1915(c) waivers** (OMH HCBS Waiver, Bridges to Health (DD, MFC, SED))	1/1/18 to 7/1/18
• Complete alignment of Children's HCBS 1915(c) under 1115 (Level of Care)	7/1/18 to 12/31/18
• Children's Behavioral Health Benefits Transition to Managed Care and Exemption from Enrollment in Managed Care will be Removed for Children in the Six 1915(c) Waivers	7/1/18
• Foster Care Population to Managed Care, Expansion of HCBS and Family of One to Level of Need Population	1/1/19

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Alignment of HCBS Services

- Adaptive and Assistive Equipment
- Accessibility Modifications
- Palliative Care **(End of Life Requirements Eliminated)**
- Respite (Planned and Crisis)
- Habilitative Skill Building
- Caregiver/Family Supports and Services
- Prevocational Services
- Supported Employment
- Community Self-Advocacy Training and Support
- Habilitation

Determining HCBS eligibility

- ✓ Level of Care – Population, Risk and Functional criteria that indicate a child is eligible for or at risk of institutional placement

- ✓ Level of Need – new concept to prevent escalation to LOC and a step down in services - Population, Risk and Functional criteria for child that does not meet institutional placement criteria but does have extended impairment in functioning (applicable to SED and Abuse, Neglect Maltreatment Complex Trauma Population)

- ✓ Draft HCBS manual and service descriptions available at:

http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/hcbs.htm

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Children's 1115 HCBS Eligibility Criteria

State is working to streamline process and avoid current and past challenges

LOC Criteria Medically Fragile Population

- Target criteria – details and process for documenting physical disabilities now under development – as soon as possible (August), proposed approach will be shared with stakeholders for comments

- Risk Factor – Licensed Professional of the Healing Arts (LPHA) – written determination child in absence of HCBS, child is at risk for institutionalization

- Functional criteria – Determined by CANS-NY algorithm

LOC Criteria Developmentally Disabled Population

- Target criteria, Risk Factor and Functional Criteria – OPWDD Front Door process for I/DD determination and Child Medically frail as determined by LPHA – written determination child in absence of HCBS, child is at risk for institutionalization and Family of One eligible

For Members Not currently Eligible for Medicaid

- State will use Independent Entity to develop streamlined, consistent statewide process – details under development and will be shard with stakeholders

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Six New State Plan Services

- Other Licensed Practitioner

- Crisis Intervention

- Community Psychiatric Supports and Treatment (CPST)

- Psychosocial Rehabilitation Services

- Family Peer Support Services

- Youth Peer Advocacy and Training

✓ Proposed in Separate State Plan Amendments submitted to CMS in December 2016

✓ New State Plan services available to all children that meet medical necessity criteria

✓ Effective date of July 1, 2018 – aligned with the transition of benefits to Managed care

✓ Draft SPA manual and service descriptions available at: http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm

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Key Documents and Information

- ***Children's 1115 Waiver Amendment – Submitted to CMS on May 9, 2017***

  http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm

- ***Draft Medicaid MCO Children's System Transition Requirements and Standards***

  http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/mco_qual_process.htm

  - ✓ Draft being revised to reflect stakeholder comments
  - ✓ Anticipated release date of Medicaid Managed Care Organization Children's System Transition Requirements and Standards on track for July 31, 2017
  - ✓ MCOs will have 90 days to submit responses

  State is working to set up a meeting with the Plans and MFC / CAH to help Plans understand the needs of Medically Fragile Population, discuss provisions in Plan requirements and standards for medically fragile children and begin a dialogue to facilitate transition to Managed care for members not excluded or exempt - target date likely late August

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Designation of Children's SPA and HCBS Providers

- Applications will be accepted on ongoing basis

- For initial start up, Applications are due July 31, 2017 and the State will prioritize the designation of current system providers

- Designations likely to occur in October – corresponding with anticipated date SPAs and regulations will be approved

- Initial list of designated providers sent to Managed Care Organizations in November – to allow for contracting, credentialing, and claims testing

- Information on how to Apply:
http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Planning for the Transition from 1915(c) to 1115 MRT Waiver

- Objective is to ensure the transition of children and families to the 1115 is smooth, well informed and there is no disruption in services

- *State partners are preparing a draft Transition Plan for review and comment by stakeholders and CMS – target date is August*

- Transition Plan subject to CMS review and approval

- The Transition Plan provides a road map for all activities under the Children's system transformation, including:
  - The timing and process for transitioning from 1915(c) care management to Health Home care management – including ample time to complete required CANS-NY assessment and initial care plans
  - The timing and process for transitioning from 1915(c) HCBS to the fully aligned 1115 HCBS
  - Clearly defined billing rules and procedures during and after the Transition Period
  - More formal communication and education activities will begin in September 2017 when the Transition Plan is finalized
  - It is anticipated first transition activities for children/families will be scheduled to begin in March/April 2018

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Health Home Care Management for Children

- Health Home Program expanded to serve children - launched in December 2016

- There are 15 Health Homes designated to serve children (individuals under 21) – Listed by Name and County service area http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm

- Children that meet current Health Home eligibility criteria can be enrolled in Children's Health Home today (if they are not enrolled in 1915(c) waiver)

- Health Home criteria is now being expanded to include I/DD chronic conditions (requires CMS approval)

- All Children that are currently enrolled in six 1915(c) waivers that will transition to 1115 waiver or that will be eligible for HCBS under Children's 1115 Waiver will receive Health Home Care management from designated children's Health Homes
  - This includes children with I/DD that will transition from CAH 1915(c) waivers, meet the Children's 1115 Waiver LOC criteria for HCBS (Target, Risk and Functional criteria) will be enrolled in Children's Designated Health Homes
    - All other I/DD children will transition to or be enrolled in CCO/HH for I/DD population that are currently under development (RFA for CCO/HH designation released on June 30, 2017)

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Next Steps…. Including:

- Answering all questions posed by Medically Fragile Coalition – Processes that are now under development will be shared with stakeholders for review and comment, State is willing to meet with Stakeholders

- State is working to streamline medically fragile LOC eligibility process, including the use of Independent Entity for Family of One Medicaid Eligibility determinations. Webinars will be held in the near future to discuss proposed approach for stakeholder comment and feedback

- Meeting with the Plans

- Developing HCBS workflow process, including roles of Plan, for stakeholder feedback, CMS requirements for care plans

- Stakeholder Comments and Webinars will be held on 1915(c) to 1115 Transition Plan

- State will collaborate with CAH providers to help with transition of children and families to the 1115 Waiver – State is willing to conduct in person meetings

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Next Steps…. Including:

- At least monthly Webinars (likely more frequently) will be held between now and throughout next year as the transition schedule unfolds

- MCTAC Trainings – working and contracting with Plans, HCBS and State Plan services, HCBS workflows, scheduling under development

- CANS-NY Trainings – in-person and on-line

- How can we Help ?
  - Do CAH providers want another series of 101 Webinar on Health Homes – OPWDD CAH providers recently added to the transition - How Can We Help?
    - All Webinars posted to DOH Website
    - Previous Webinars for CAH providers held in 2015 and 2016

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1115 Children's System Transformation
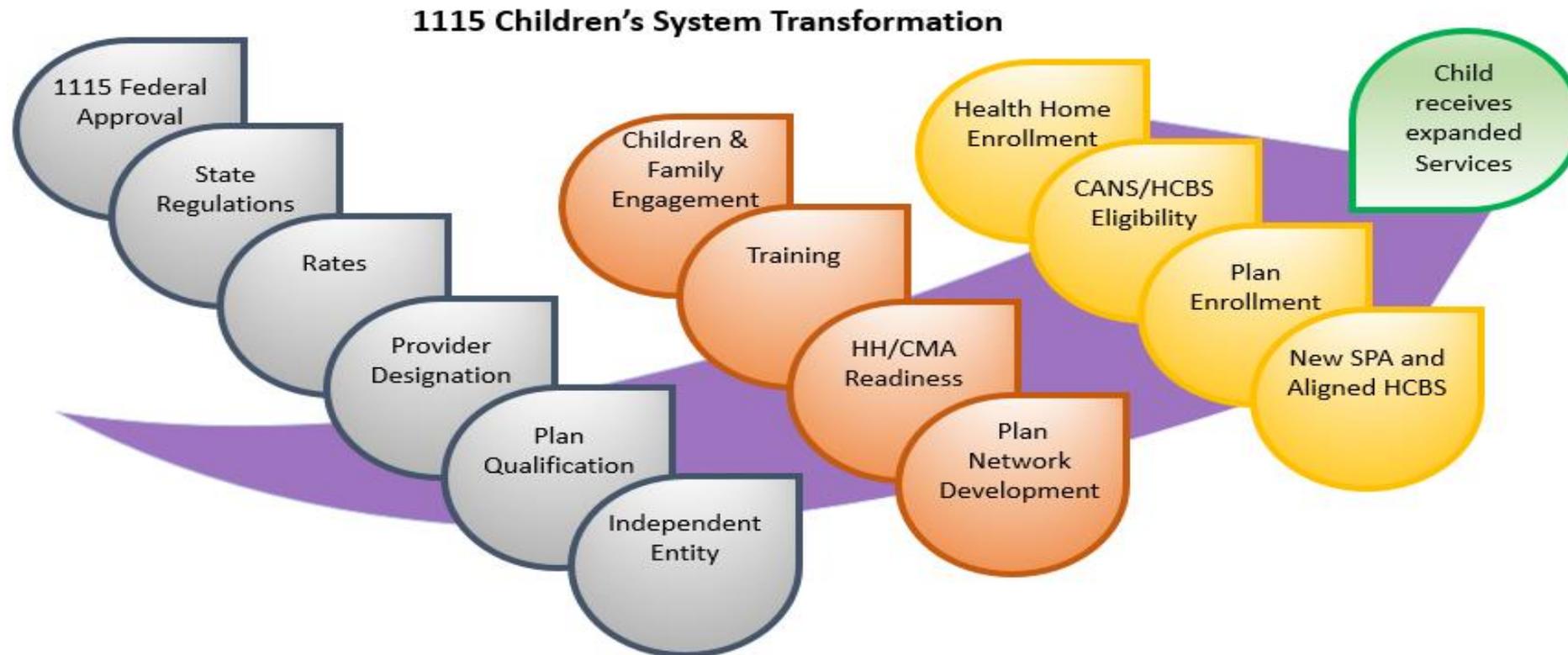
Health Home Care Management for Children

- Many of you have already established relationships with Health Homes - today's Webinar will focus on the administrative and systems process you need to have in place to be ready to transition to be a Health Home Care Manager/Agency

- DOH Website for Children's Health Homes – Resource of all past Webinars and Standards and Requirement for Children's Health Home care management

  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm

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Readiness Activities for CAH Providers to Become Health Home Care Managers:

Readiness work should be completed no later than November 1, 2017

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Health Home and Linkages to CAH Providers

- To ensure Health Homes leverages and imbeds the expertise of CAH I & II and OPWDD CAH providers, DOH is requiring each Health Home Serving Children to have linkages to current CAH providers that want to become Health Home care managers

- If you have not already contacted a Health Homes that serves the service area you now or are willing serve, please use contact list below to reach out to lead Health Homes to begin discussions

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_children_designations.pdf

- The State will also be providing Health Homes with a list of Case Management and Waiver, including CAH providers, so they may begin to reach out as well
    - Provide the Health Home with information about your organization, the work you do and your performance/ successes, your relationships with families
    - Have the Health Home explain their processes for ensuring Health Homes care managers meet the standards and requirements of the Health Home program – including software expectations
        - Not all Health Homes use the same care planning electronic records – (examples include: GSI Health and Netsmart)

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Readiness Activities Needed to be a CMA Contracts and BAAs

After you identify the Health Homes you want to work with, you will need to formalize your care manager Health Home relationship with Health Home

- You must enter into a Business Associate Agreements (BAAs) – BAAs are between Health Homes and care management agencies
- Your Health Home may engage you in other business documents to establish Health Home care management relationship

- Be aware that Health Homes have Administrative Service Agreements with Medicaid Managed Care Plans that will be serving your members. This information can be found on the link below:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_asa_mco_tracker.pdf

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Readiness Activities Needed to be a CMA
DEAAs and BAAs - Sharing Protected Health Information

- Health Homes are required, by State and Federal Laws, to have Data Exchange Application Agreements with NYSDOH in order to share minimum necessary data *prior to obtaining signed informed consent*
- To facilitate outreach efforts (i.e., locating adult Medicaid members that have been identified as potentially Health Home eligible and placed on an assignment list – re: process in adult HH) the MAPP provides "minimum PHI for Medicaid members (i.e., CIN#, name, address, PHI from the last five claims and encounters)
- Although children will be enrolled in Health Homes through a referral process the minimum PHI information described above for Medicaid members that are children will be available in MAPP and may be used by Health Homes, care managers, and Plans to assist in the referral process and care planning

- To allow the limited PHI information for both children and adults to be shared prior to consent the following agreements must in place:
  - ✓ Data Exchange Application Agreements (DEAAs) between the New York State Department of Health and the lead Health Homes
  - ✓ **Business Associate Agreements (BAAs) between Health Homes and care management agencies (e.g. CAH providers)**
    - Existing Health Homes will need to enter into BAAs with any new care management agencies they contract with
    - Example BAA:
      http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_deaa_5_25_2015.docx
    - Additional Details: See May 27, 2015 Webinar on DEAAs and BAAs
      http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/5_27_2015_children_webinar.pdf

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Preparing for transition to Health Home Systems

- DOH Health Home Serving Children's Team will be sending information out to Case Management providers regarding the various steps that are necessary to be system ready and prepared to transition to HH CM

- DOH will be monitoring where providers are with the transition to Health Home's system access and provide technical assistance when needed

- **Single Point of Contact (SPOC):**
  It is important that providers identify a person within their agency for DOH to send communication to and able to share and disseminate the information within their organization so that steps can be met, the agency and staff can be connected to systems and the staff can get trained
  - Facilitate communication between SDOH and CAH provider concerning the implementation of Health Home Serving Children including access to the HCS, the MAPP Health Home Tracking System, the Uniform Assessment System for New York (UAS-NY), etc.
  - Receive direct communication from SDOH and is expected to disseminate the information to the appropriate staff within his/her organization
  - compile any required responses and submit the information to SDOH.

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Medicaid Analytics Performance Portal
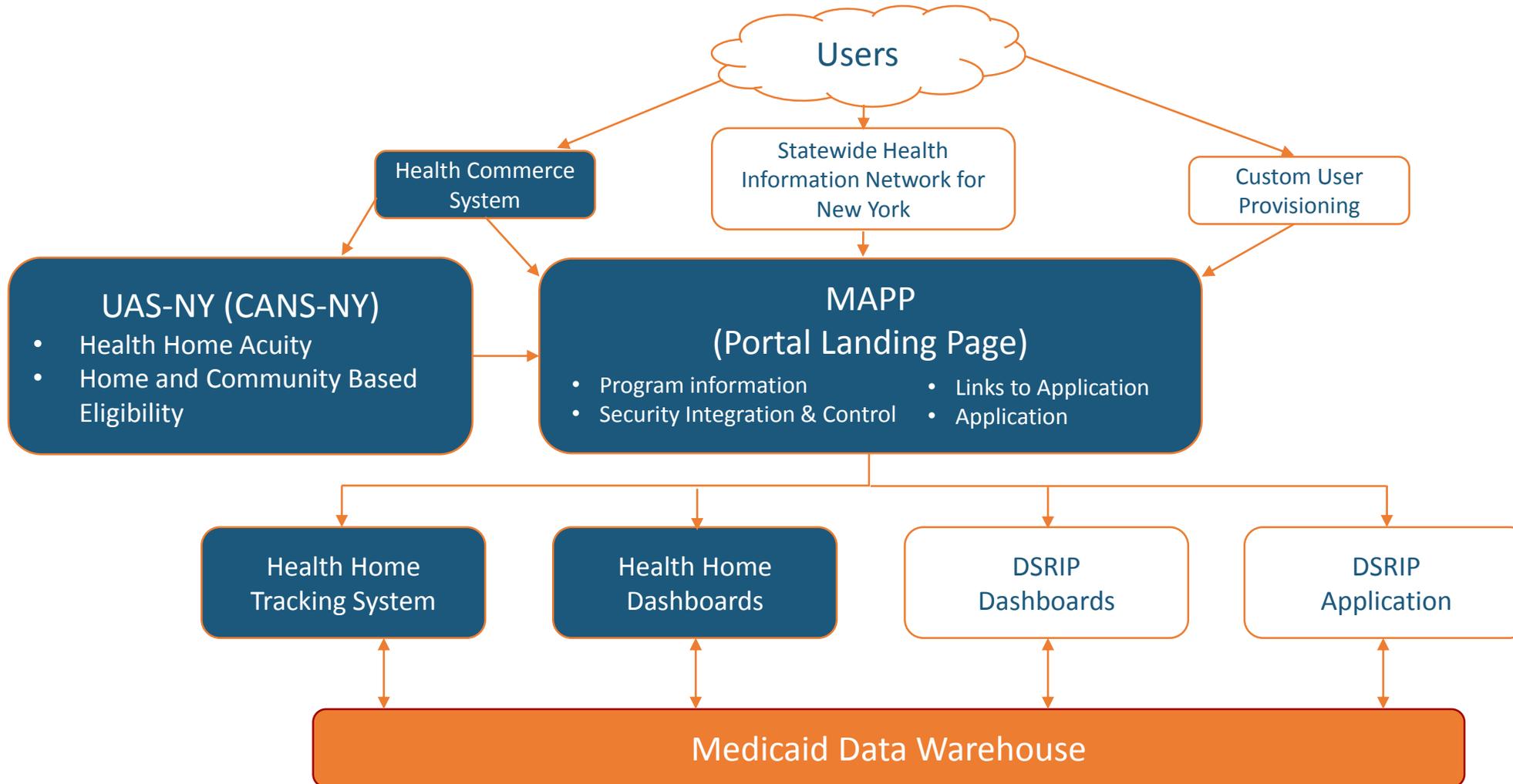
Health Commerce System (HCS)

- Secure portal managed by SDOH

- Used by a range of organizations

- Home to 100's of different applications

- Manages user authentication

HCS access is required to access the Medicaid Analytics Performance Portal (MAPP) and the CANS-NY which will reside in the Uniform Assessment System (UAS-NY)

Care at Home Providers and HCS

HCS Director - can bind the organization with NYSDOH (preferably a CEO, CFO or COO). This person by default is also a Coordinator, Security Coordinator and User. Each organization can only have one HCS Director.

HCS Coordinator - has the responsibility and authority to request and manage Commerce accounts and manage roles in the Communications Directory. This person by default is also a User. Each organization is encouraged to have two HCS Coordinators.

• Each organization must ensure compliance with HCS security requirements

REMINDERS:
• Even if your organization has a current HCS account, your organization needs to obtain Health Home Care Management HCS **organization type** to get access to Health Home systems

❖ Organization can have multiple HCS accounts under different organization types of business

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HCS User Account Creation

- HCS Coordinator ensures staff have an active HCS User Account.
- All MAPP Users must have their own active HCS User Account
- Staff without an active account must work with their HCS Coordinator

1. Staff person completes Part A
2. HCS Coordinator completes Part B
3. Staff person completes Part C

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HCS User Account Creation

- Can I use the HCS Paperless process for a staff member who is an out-of-state resident?

  No. The paperless process may only be used for staff with a New York State Driver's License or a New York State Non-Driver's Photo Id. The HCS Coordinator must use the **Coordinator Account Tool** to complete an **Account Request**.

- The user created an HCS user account. Why is it showing up as not active?

  The most likely reason for an account being listed as not active is that that HCS Coordinator did not complete **Step B** in the HCS Paperless Process.

- Is it necessary for staff to have an HCS User Account for training and to access the MAPP?

  Yes. This is one of the basic requirements for a user.

Select "Documents by Group" to access HCS Coordinator resources

HCS Coordinator Resources

-> My Content -> Documents by Group -> Coordinator ->HCS Coordinator

- ✓ This section provides the instructions for completing the HCS Coordinator responsibilities.
- ✓ This section includes the steps to create a HCS Coordinator account.
- ✓ Coordinators are encouraged to contact CAMU at 518-473-1809 for training (~ 1 hour).

HCS Coordinator

- Delegated authority to grant access to HCS for staff from your organization.

- Primary responsibility is to create new users and edit existing users the HCS for their organization.

- Ensure that only authorized and appropriate staff have access

- HCS Coordinator will be directed to training to connect MAPP Gatekeeper

MAPP Gatekeeper

- Delegated authority to grant access to MAPP for staff from your organization.

- Primary responsibility is to create new users and edit existing users *within MAPP* for their organization

- Responsible for updating organizational information.

- Must be adequately informed of MAPP to ensure that only authorized and appropriate staff have access to MAPP.

Next Steps After Identifying a MAPP Gate Keeper

- Once your agency has identified a Gate Keeper – the identified person will receive an email to complete gate keeper training

- The Gate Keeper will then identify who within your agency will need access to MAPP HHTS and connect the staff to MAPP (Staff MUST have an active HCS account with proper Health Home type connection)

- As staff are connected to MAPP HHTS they will receive email information to obtain training to be able to access MAPP HHTS

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Understanding the Process to Access MAPP

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Access

1. Log in to HCS

HCS Login

User ID

User ID

Password

Password

The sharing of user accounts is strictly forbidden. Repeat offenses may result in the permanent removal of your account.

Sign In

Forgot your password? ?   Forgot your user ID?

Or sign up for an account:
     Lic. Med. Prof.   All Others

2. Launch "MAPP"

My Applications

Acronyms & Abbreviations	
Application Access	ⓘ
CART	
ComDir Role Lookup Tool	ⓘ
Coord Account Tools - HCS	ⓘ
Coord Account Tools - LHD	ⓘ
Coord Account Tools - PCC	ⓘ
Coordinator's Update Tool	ⓘ
Emergency Contacts	
Health Facilites Info Sys HFIS	ⓘ
HINAPCF	ⓘ
IHANS (Notification System)	ⓘ
MAPP	ⓘ
Move development to test	ⓘ
Move test to production	ⓘ

3. Complete MFA Process

Instructions
- Please enter the code received from your SMS message on your registered phone number.
- You will be logged out of HCS after 3 unsuccessful attempts.

Authentication

Verification Code: * [ ] Authenticate

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Access

4. Select MAPP Application
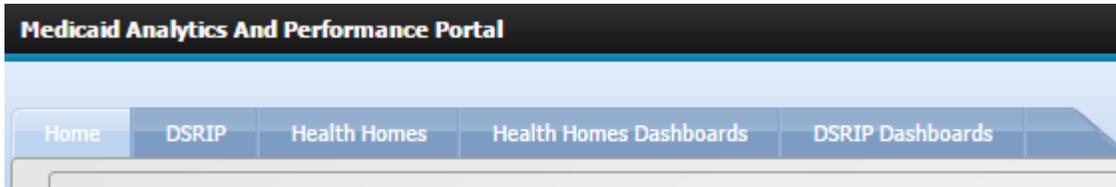
5. Work within the Health Home Tracking System

Health Home Tracking System

Provides online interface to the Manage Care Plans (MCP), Health Homes (HH), and Care Management agencies (CMA) to collaborate in real-time and track a member's status.

Users are able to:

- Refer members to Health Homes.

- Upload/download member information & transactions.

- Coordinate across MCPs, HHs, and CMAs using workflows & notifications.

- View member's Medicaid information.

End-User Next Steps

- Complete Multi-Factor Authentication process.

- Complete required training

  ✓ End-users will receive email from MAPP Customer Care Center, which will include instructions for accessing training environment.

End-User Next Steps - MFA

Multi-factor Authentication
Quick Reference Guide

The Multi-factor Authentication (MFA) is a method of access which a user can pass by successfully presenting several separate authentication stages. It will provide another security level to an HCS application that contains protected health information (PHI) or personal identifying information (PII). Users of the MFA protected applications will be able to choose how they will authenticate MFA, by SMS (text message) or voice call. However, to use the MFA feature, the user will need to enroll their MFA information using their valid NYS driver license or non-driver photo ID. If they do not have one, they must see their HCS Coordinator in person who can enroll them with a valid photo ID.

- ➤ End-user completes the process if he/she has New York State Driver's License or New York State Non-Drivers Photo Identification.

- ➤ HCS Coordinator completes for all others.

CANS-NY and Health Home
(CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

- CANS-NY tool is housed in UAS and will interface with Medicaid Analytics Performance Portal (MAPP) to provide billing information

- The CANS-NY assessment (as modified for New York) will be conducted by the Health Home care manager and will be used:
  - ✓ To assist in the development of the person centered care plan
  - ✓ Determine a care management acuity, using an algorithm run against the results of a completed CANS-NY, for purpose of determining Health Home per member per month rate tier (i.e., High, Medium, Low)
  - ✓ CANS-NY by itself will not determine Health Home eligibility

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UAS- NY Access to the CANS-NY

- Once organizations and their staff have access to the Health Commerce System (HCS); then access to MAPP and UAS-NY can occur

- The UAS-NY requires the HCS Coordinator to attend a training of the various roles and responsibilities within the UAS-NY and that is CANS-NY specific

- Then the HCS Coordinator should work within their agency to determine the staff and the role assignment

- After staff are assigned a role within the UAS-NY system, on-line training will be required prior to accessing the UAS-NY

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UAS-NY

- Secure system accessed through HCS web portal

- Role-based system

- Training Environment

- LearnerNation

CANS-NY Roles

Role	Role Designed For
CANS-NY15	**Administrative Support Staff** - supports the provider level assessors and supervisors. Limited access. Cannot add assessment data to record.
CANS-NY40	**CANS-NY Assessor** - must have CANY-NY Certification to conduct assessments
CANS-NY50	**CANS-NY Assessor Supervisor** – individuals that have the supervisory or managerial purview over the assessor teams
CANS-NY60	**CANS-NY Assessor READ (ONLY)** - assessors who have lapsed CANS-NY Certification

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Assigning CANS-NY Roles

Coordinator's Update Tool

| Main Page | Location | Manage People | Organizational Offices | Manage Role Assignments | Reports | Add a New Person |
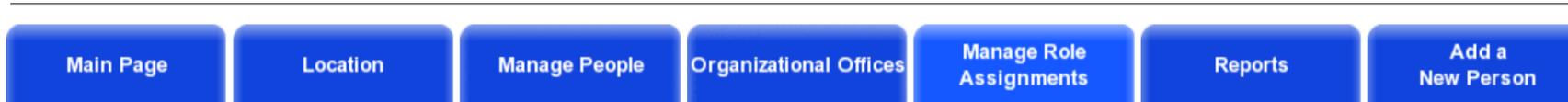
Form Name:
Role Assignments

Select a Role to Assign/Modify
for *Z Test Health Home Care Management Agencies (CMA)*

Role Description	Person in Role?	Modify Role Assignments	Role Description	Person in Role?	Modify Role Assignments
CANS-NY-15	No	Modify	CANS-NY-40	No	Modify
CANS-NY-50	No	Modify	CANS-NY-60	No	Modify
HPN Coordinator	DOH Assigned	Modify	LOCADTR	No	Modify
MAPP Gatekeeper	No	Modify	MAPP SPOC	No	Modify
MAPP User	No	Modify	OMHCMH-01 Assessor	No	Modify

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Training to Work in UAS Environment

Uniform Assessment System for New York

Welcome to the Uniform Assessment System for New York (UAS-NY) Training Environment. The purpose of this online training environment is to provide long term care provider staff with the information required to learn about and use the UAS-NY. This site is developed and maintained by the New York State Department of Health, Office of Health Insurance Programs, Divison of Long Term Care.

UAS-NY Support Desk

For questions on the UAS-NY Training Environment or any of the content presented in this site, please email the **UAS-NY Support Desk** at uasny@health.state.ny.us or contact us at 518-408-1021 between the hours of 8:30 ~12 and 1 ~ 4.

Course categories

UAS-NY Fundamental Courses (34)

UAS-NY Intermediate Courses (8)

UAS-NY Advanced Courses (3)

UAS-NY References and Resources (13)

- Online, Self-Paced Topic-Specific Courses

- Required and Recommended Courses

- Reference Manuals and User Guides

- Accessed Directly from the UAS-NY

- Available 24 x 7

- Use of VPN connection is not supported

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Accessing the UAS Applications (Training)

Behavioral Health Managed Care Transition Guide Page 21.

LearnerNation – CANS-NY Training

- Users provisioned a CANS-NY assessor role must successfully complete a course sequence in LearnerNation in order to be considered CANS-NY Certified for a period of one year.

- All CANS-NY assessors must add their HCS User ID into their LearnerNation account in order for the UAS-NY Training Environment to recognize their CANS-NY Certification.

LearnerNation – CANS-NY Training

- Before you can conduct a CANS-NY assessment in the UAS-NY, you must enter your HCS ID to the <u>External GUID</u> in your Learner Nation User Prolife https://tcomtraining.com/

CANS-NY and Health Home – Training Schedule
(CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

- Training and certification in the CANS-NY is required to access and complete CANS-NY in the UAS

- Currently scheduled in person one–day trainings – additional trainings will be schedule later this Fall and Winter

Date	Location	Capacity
July 21	The NY Foundling, 33-00 Northern Blvd, 5th Floor Long Island City, Queens NY 11101	30 People
July 31	Parsons Campus, SATRI Building, 60 Academy Road, Albany, New York	50 People
August 9	1 Mustard Street, Rochester New York 14609	30 People
August 11	1 Mustard Street, Rochester New York 14609	30 People

- Prior recorded trainings and other information available at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm

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Next Steps

- Secure a BAA with Health Homes

- Identify a Single Point of Contact (SPOC)

- DOH will be sending out communication to instruct providers based upon the steps outline in this presentation and based upon your level of readiness

Questions and Discussion

Additional Information and Support

UAS-NY Support Desk
uasny@health.ny.gov
or
518-408-1021, option 1
Monday – Friday
8:30 AM – 12:00 PM
1:00 PM – 4:00 PM

CANS-NY Training
LearnerNation
support@CANSTraining.com
Or
www.canstraining.com and click on contact us

CANS-NY Policy
hhsc@health.ny.gov

Commerce Accounts Management Unit (CAMU)
1-866-529-1890

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Subscribe to the HH Listserv

- Stay up-to-date by signing up to receive Health Home e-mail updates

- Subscribe
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

- Health Home Bureau Mail Log (BML)
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action

Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569

- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

Health Homes Serving Children
List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application

- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit

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Health Homes Serving Children
List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services

- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS-NY: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency

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