Children's Health Home of Upstate New York

Policy/Procedure: CANS-NY Policy and Procedures
Reviewed and Accepted by: CHHUNY Clinical Quality Committee
Approved by: CHHUNY Board of Directors
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Policy:

The Child and Adolescent Needs and Strengths- New York (CANS-NY) is the assessment tool that was implemented to determine member acuity levels within the Health Home Serving Children program. As specified by the New York State Department of Health (DOH), every child/youth enrolled into the Health Home program must have a CANS-NY completed within 30 days of enrollment into the program and reevaluated, at a minimum, every 6 months or earlier if a significant life event occurs as outlined below. If a member is enrolled in the program and then transferred to another CMA within the same Health Home, the CANS-NY must be completed based on the date of the last completed CANS-NY for that member with the previous CMA (no Initial CANS-NY upon Enrollment shall be completed again for a transferred member).

CANS-NY has two versions available based on the enrolled member's age. CANS-NY 0-5 should be completed for any members aged 0 through 5 and the CANS-NY 6-21 should be completed for any members aged 6 to 21. The CANS-NY output should be utilized to drive the Comprehensive Assessment (and vice versa) and the member's Plan of Care.

CHHUNY requires that all Care Management Agencies (CMAs) comply with the assessment timeframes for enrolled members as well as the training and certification process for CANS-NY assessors. The CANS-NY must be completed within the Uniform Assessment System- New York (UAS-NY) and requires that the Care Manager obtain the signed Functional Assessment Consent, DOH 5230, from the member or parent, guardian, or legally authorized representative prior to entering any data into UAS-NY.

CMAs shall be paid a one-time assessment payment for the completion of the Initial CANS-NY Upon Enrollment per episode of care with that health home.

CMAs are responsible for following the training requirements and procedural guidance provided below to ensure compliance with this policy.

Training Requirements:

All care managers and Supervisors must complete the required CANS-NY training(s) as outlined in the CHHUNY Care Manager Training and Educational Requirements Policy.

Trainings can vary depending on the type of CANS-NY role you have in UAS-NY. CMA Support Staff are able to have access for reporting purposes. If a Care Manager does not recertify annually, their role is changed to a CANS-NY Assessor READ ONLY until the certification is obtained by completion of the online exam.

Role	**Role Designed For**
CANS-NY15	Administrative Support Staff - supports the provider level assessors and supervisors
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

Procedures:

1. The CANS-NY is required to be completed within 30-days of enrollment (unless the member transferred from another CMA within the same Health Home) and assist in the completion of a family driven, youth guided Plan of Care.
    - A one-time assessment payment ($185) per enrollment segment within a Health Home is paid for the initial "CANS-NY Assessment Upon Enrollment" only, that is completed when the member is first enrolled in the Health Home program.
    - How to determine if an Initial CANS-NY upon Enrollment type should be selected:
        i. If a child has been previously enrolled in the same Health Home but is enrolling under a new CMA, an Initial Cans-NY Upon Enrollment is allowed as long as the most recent CANS-NY is over 6 months old and no longer active.
        ii. If a child is enrolled in the same Health Home under a new CMA, but it has been less than 6 months since a previous enrollment with another CMA in the same HH, then the new CMA must review the current CANS-NY on file upon enrollment as the acuity level is still active in MAPP. If the new CMA feels as though the CANS-NY should be completed with updated information upon enrollment, then the new CMA can select the Initial CANS-NY selection when completing it.
        iii. If a child is reenrolled with the same CMA under the same HH, the CMA needs to select a Reassessment type if it has been less than six months since the previous enrollment segment for that child in their CMA.
        iv. For transfer cases within a HH, if there is no break in enrollment at the HH level from one CMA to another, the CANS-NY currently on file should be utilized by the new CMA unless they feel as though the information is not accurate, then a reassessment prior to 6 months can be completed.
        v. If a child changes HHs, then an Initial CANS-NY can be completed again

2. HHCM must obtain the Functional Assessment Consent and add a member to their UAS case list upon enrollment and review CANS-NY history linked with the current Health Home.

3. It is expected that at least one face to face visit occurs when introducing and completing the CANS-NY with the child/youth and family.
    - It is expected that the HHCM is documenting notes in Netsmart CareManager reflecting the completion of the CANS-NY and child/family participation.

4. The CMA can bill for the member for up to 2 months (month of enrollment and the following month) at the LOW rate only if a CANS-NY is not yet completed. If the initial CANS-NY is not completed and finalized in UAS –NY by the end of the third month post-enrollment, you will not be able to bill for the third month or any subsequent months until the CANS-NY is finalized.

5. The CANS-NY must be completed every 6 months, from the first day of the month in which the most recent CANS-NY was completed (considered month 1), unless one of the following significant life events occurs that requires the CANS-NY to be completed prior to 6 months:

    - Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
    - Service plan or treatment goals were achieved
    - Child admitted, discharged or transferred from hospital/detox, residential placement, or foster care
    - Child has been seriously injured or in a serious accident
    - Child's (primary or identified) caregiver is different than on the previous CANS-NY
    - Significant change in caregiver's capacity/situation
    - Court request

    CMAs will be expected to meet best practice standards by completing the "CANS-NY Reassessment prior to 6 months," 30 days from the date of the documented significant event. An early reassessment is not to be done for any other reason than those state identified significant life events above. If a member turns the age of 6 during enrollment, the next CANS-NY Reassessment at 6 months will use the new version CANS-NY 6-21.

    There is no payment for reassessments. If a CANS-NY reassessment is not completed within the 6th month, from the 1st of the month in which the most recent CANS-NY was completed, then the CMA can still bill at the current rate for the 6th month. If the CANS-NY is not completed by the end of the 7th month, from the 1st of the month in which the most recent CANS-NY was completed, then billing cannot occur for that month or any subsequent months until the CANS-NY reassessment is finalized.

6. Care Managers are expected to print the following documents from UAS when any CANS-NY is completed for an enrolled member and upload the documents to the attachments areas in the member's Netsmart chart:
    - CANS-NY Assessment Results
    - CANS-NY Strengths and Needs

7. Upon completion of the CANS-NY, an algorithm will be run for the purpose of determining the Health Home Per Member Per Month (PMPM) fee, also referred to as the member's acuity level

of High, Medium, or Low. The acuity outcome of the CANS-NY will then be transmitted from UAS-NY to the Medicaid Analytics Performance Portal (MAPP), so the Health Home is able to bill for the member.

- If the member's acuity level is High or Medium, the Care Manager must complete two core services within the service month, one of which must be a face to face contact with the child/youth and the services must be completed on different days within the month.
- If you are unable to meet the High or Medium standards within the service month, **no partial payment can be received** for that month and billing cannot occur.

8. Care Managers must ensure the member's chart includes the appropriate supporting documentation to align with the CANS-NY answers per the "Health Homes Serving Children: CANS-NY Algorithms for Determining Health Home Per Member Per Month Fees And Documentation Guidance" attached to this policy as Appendix A.
    - Where providers may not be able provide documentation of a situation, then well documented case notes from discussions the care manager has with relevant involved professionals, providers and family members may be acceptable.

9. If the CANS-NY expires while a child/youth is in DSE, the HHCM is able to complete the CANS-NY with the information known at the time in order to continue DSE and be paid. The HHCM must update the CANS-NY upon locating the child/youth to ensure accurate information at that time.

Type of CANS-NY

1. CANS-NY Assessment upon Enrollment: used for any child newly enrolled in a Health Home – for both the initial time the child receives services in their lifetime and also when the child transfers from one HH into a new HH. This assessment type triggers the one-time only assessment payment in the MAPP system.
2. CANS-NY Re-assessment at 6 months: used for the standard reassessment period for any child enrolled in a HH and receiving continuous services
3. CANS-NY Re-Assessment Prior to 6 months: used when a child has a change of circumstances within 6 months of the last CANS-NY conducted that warrants an early new assessment.
4. Existing CANS upon Enrollment: used for NYC VFCAs IV-E program that utilizes the same CANS-NY as Health Home, for children that have had a CANS-NY assessment conducted as a part of the foster care placement process (not to be used for transfers)

Member CMA Change or HH Re-enrollment & CANS-NY

If a member is transferred from a CMA within the same Health Home, the CMAs are responsible for following the CHHUNY Member Transfer Policy. The new CMA must determine the next CANS-NY reassessment date by adding the member to their UAS-NY case list and reviewing the most recent CANS-NY date and information. The current CANS-NY and acuity will apply until the next CANS-NY is due following the rules above (every 6 months or earlier if significant event). If the new CMA determines the CANS-NY needs to be updated prior to the next due date, the HHCM will need to select the appropriate reassessment type.
If your CMA is accepting a transferred member from another Health Home, an Initial CANS-NY upon Enrollment is due within 30 days from the member's enrollment date with your CMA and the regular CANS-NY procedures apply.

If a member does not officially transfer from CMA to CMA but is discharged and reenrolled into a new CMA, or the same CMA, within the same HH, the previous CANS-NY will still be active for the full 6-month timeframe regardless of a break in services. Be sure to identify prior episodes of care for members to confirm if a CANS-NY is still active for any new enrollment with your CMA. Please refer to the steps in #1 to determine if an Initial CANS-NY Upon Enrollment should be selected based on the scenario for the child/youth.

CANS-NY Errors and Resolution

When adding a member to the UAS-NY case list and selecting the type of CANS-NY you are completing, errors can occur. The following errors will impact billing and must be corrected to correctly align the CANS-NY with the enrolled member MAPP information:

1.) Incorrect member date of birth
2.) Incorrect member CIN
3.) Selecting the wrong Health Home the member is enrolled with
4.) Selecting the incorrect CANS-NY type

If the incorrect date of birth or incorrect CIN is entered in the member case, it must be fixed immediately upon noticing the error in the member's case in UAS-NY. If you select the wrong Health Home or CANS-NY type when entering the CANS-NY, you must recomplete the entire CANS-NY within the month it was initially completed, and it must replicate the exact answers that were selected on the CANS-NY with the error.

For incorrect CANS-NY assessment type:

- If discovered within the same month as required AND "CANS-NY Upon Enrollment" was needed to receive the one-time only CANS-NY fee, an additional CANS-NY can be completed in the UAS-NY. Otherwise error in assessment types should not generate a new CANS-NY due to data integrity, as it does not impact billing.
- If discovered later than the month the assessment with the error was completed, an additional CANS-NY cannot be completed in the UAS-NY to correct the billing error for the CANS-NY payment.

For incorrect Health Home:

- If discovered within the same month as required, you are able to recomplete the CANS-NY as outlined in Appendix B.
- If discovered later than the month the assessment was completed, an additional CANS-NY can be completed in the UAS-NY. However, CMAs should be aware that depending on how late the errored assessment is identified with the wrong Health Home, billing may be lost for the months the assessment did not appropriately transmit to the MAPP HHTS. In addition, the completion of a CANS-NY to correct a wrong Health Home error alters the timeline reassessment period.

Please reference Appendix B, Approved Reasons and Processes to Correct CANS-NY Errors in UAS for further guidance on how to recomplete the CANS-NY.

Enrolled Member CIN Change

The following steps must be followed if the CIN changes while your member is enrolled to ensure UAS, MAPP, and Netsmart are all in alignment and billing is not impacted:

1. CMA must notify the Health Home (HHUNY Help Desk) that the Member CIN has changed and effective date for this change
2. Health Home will update the MAPP Enrollment segment and the Netsmart chart information to reflect the new CIN. Health Home will end the segment with end reason "Member has new CIN" and include the new CIN in the comments field
3. Once the Health Home confirms with the CMA that all records have been updated in MAPP and Netsmart, then the CMA can go into UAS-NY and update the Member record in UAS-NY to reflect the new CIN
4. Once the CIN is updated in UAS-NY, MAPP will show the CANS-NY acuity and latest completion date from the member based on the CANS-NY that was completed prior to the CIN change. Continue to follow the 6-month schedule for the member as if the CIN never changed.
5. If a member requires a reassessment due to a significant event when the CIN changes, then you would also do a reassessment prior to 6-months if necessary and that would be the member's acuity moving forward
6. By default, the CANS-NY Initial Fee will be voided under the CANS Assessment area in MAPP for CIN #1 and then be applied to the CANS-NY Assessment area in MAPP for CIN #2. Because it is the same member, the Health Home will not actually void the claim that was previously paid under CIN #1 and will ignore the claim that is generated for CIN #2. Only one payment per member per episode for the CANS-NY fee is allowed.

Quality Assurance and Monitoring:

CHHUNY CMAs are required to review UAS-NY Aggregate Reports on a weekly basis to identify any user error when entering the CANS-NY type, Health Home, or member information in order to reduce billing errors. If a CMA is identified as having frequent errors without addressing them upon notification, CHHUNY will require that the CMA have Care Manager Supervisors review all CANS-NY prior to finalization in UAS-NY until errors are being addressed in a timely manner.

CHHUNY will assure quality monitoring of this process is in place that will include:

- Billing audits to assure the appropriate number of contacts and modality occurred to bill at the assigned acuity rate per the CANS-NY outcome.
- Billing Support Error review to determine missing CANS-NY, data entry errors, and other reasons that billing may be impacted as related to the CANS-NY. CMAs will be notified immediately regarding billing support errors.
- Bi-annual Comprehensive Quality chart audits to be completed by the HH to confirm the following:
    - All procedures outlined above are followed for completion and reassessment of CANS-NY
    - Summary documents from completed CANS-NY are uploaded to the member's chart
    - CANS-NY errors are identified and corrected
    - Functional Assessment Consent, DOH 5230, is included in the member's chart

Policy Review:

This policy and its procedures will be reviewed annually and updated as necessary.

Appendix A

HHSC CANS–NY Algorithms for Determining Health Home Per Member Per Month Fees and Documentation Guidance

The attached documents provide information regarding the algorithms applied to the CANS–NY assessments tools (ages 0–5 and ages 6–21) for the purpose of determining the Health Home Per Member, Per Month (PMPM) fee for children under 21 and in a Health Home designated to serve children. The Health Home PMPM for children, i.e., referred to as High, Medium, or Low (HML) Health Home care management acuity is a measure of the level of care management required to serve a child in the Health Home program. Algorithms are provided for High and Medium. Children that do not meet the High or Medium algorithm will be assigned Low Health Home care management acuity.

Health Homes and care management agencies must ensure the care plan and case records for members served include supporting documentation for elements required by the standards for Health Home plans of care, the CANS–NY assessment and the Health Home PMPM care management acuity.

The attached list provides examples of supporting documentation that can be obtained from professionals and providers, including those that assist with completing the CANS–NY. Where providers may not be able provide documentation of a particular situation, then well documented case notes from discussions the care manager has with relevant involved professionals, providers and family members may be acceptable. Example from the CANS–NY assessment of such a circumstance: The child has a sibling who is experiencing some mild developmental or behavioral problems. It may be that the child has at least one healthy sibling.

Health Home Serving Children
Division of Program Development and Management
New York State Department of Health
Office of Health Insurance Programs

The link to the DOH website containing this information and a PDF version of this document can be found here:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/supporting_docs.htm#i

Case Record and Plan of Care Supporting Documentation	
• Medical assessment (30-day/recent medical) • Review of medical history • HIV risk assessment • Dental assessment • Mental and behavioral health screening(s) • Mental and behavioral health assessment(s) • Medication review • Review of mental health/psychiatric history (past, present, trauma and abuse history) • Mental health treatment plan and recommendations • Developmental assessment • (10+) substance abuse assessment • Psychological assessment • Assessment of past trauma and presenting trauma symptoms • CSEC Rapid Indicator screening tool • Domestic violence screening and assessment • CONNECTION summary progress note (OCFS) • CONNECTION history (OCFS) • School records (such as Attendance, IEP, behavioral reports/concerns) • Previous Family Assessment and Service Plan (FASPs) (OCFS) • Juvenile Justice, Probation and or Diversion program records • Records received from other jurisdictions/states • Family team conferences (such as Child Safety, Placement Transition meetings and preservation/change conferences) documentation • Permanency planning meetings • Intra-agency team meetings (with mental health specialist, nurse, placement specialist, etc.) • Medicaid application	• Recent hospital discharge summaries • Primary care progress notes • Specialist progress notes • Psychologist assessment (either school or community): often includes parent scales/rating tools • Clinical Documentation (psychosocial, psychological, any clinical rating scales or assessments) • Multidisciplinary evaluation records to establish eligibility for the Early Intervention Program (EIP) (inclusive of: assessment of developmental functioning in the areas of cognition, social emotional development, communication development, adaptive development, physical development) • Individualized Family Service Plan (IFSP) or Supplemental evaluations included in IFSP (in-depth assessment in a particular area of developmental) • Optional Family Assessment where available (family-directed assessment of the families resources, priorities and concerns related to the child's development and the capacity of the family to enhance the child's development.) • Service coordination/case management log notes • Service Provider session/progress notes (including services focused on caregivers, family training, family counseling, family support group, etc.) • Physical examine for Pediatrics and Development Neuropsychiatry (PDN) • Prior Approval transmittal for PDN • Assessments, including PPRI, NCTD, etc.

Health Home Acuity (Medium)	Health Home Acuity (High)
A child meets "Medium" Acuity if he/she meets: •[Criterion (2.1a OR 2.1b OR 2.1c OR 2.1d) AND (Criterion 2.2 OR Criterion 2.3)] **OR** •any two of Criterion (2.1a, 2.1b, 2.1c, 2.1d)	A child meets "High" Acuity if he/she meets: •[Criterion (3.1a OR 3.1b OR 3.1c OR 3.1d) AND Criterion 3.2 AND Criterion 3.3] **OR** •any two of Criteria (3.1a, 3.1b, 3.1c, 3.1d) AND Criterion 3.3
Criterion 2.1a: Trauma Symptoms/Adverse Childhood Experiences o Two or more identified Adverse Childhood Experiences **OR** o at least one item rated a '1' or higher on the Trauma Symptoms module (Module 91) or Behavioral Health module (Module 92)	**Criterion 3.1a: Trauma Symptoms** o At least one item rated a '3' on the Trauma Symptoms module (Module 91) **OR** o two or more items rated a '2' on the Trauma Symptoms module (Module 91) and/or Behavioral Health module (Module 92)
Criterion 2.1b: Behavioral Health o At least one item rated a '2' or '3' on the Behavioral Health module (Module 92)	**Criterion 3.1b: Behavioral Health** o At least one item rated a '3' on the Behavioral Health module (Module 92) **OR** o two or more items rated a '2' on the Behavioral Health module (Module 92)
Criterion 2.1c: Medical Health o At least one item rated a '2' or '3' on the Medical Health module (Module 93)	**Criterion 3.1c: Medical Health** o At least one item rated a '3' on the Medical Health module (Module 93) **OR** o two or more items rated a '2' on the Medical Health module (Module 93)
Criterion 2.1d: Child Development o At least one item rated a '2' or '3' on the Child Development domain (Domain D)	**Criterion 3.1d: Child Development** o At least one item rated a '3' on the Child Development domain (Domain D) **OR** o two or more items rated a '2' on the Child Development domain (Domain D)

Health Home Acuity (Medium)	Health Home Acuity (High)
Criterion 2.2: Child Needs & Functioning and Child Risk Behaviors o A rating of '2' on any of the following items: ▪ Attachment (Item 36) ▪ Living Situation (Item 37) ▪ Sleep (Item 39) ▪ Physical Limitations (Item 40) ▪ Recreational/Play (Item 42) ▪ Social Functioning (Item 43) ▪ Self-harm (Item 69) ▪ Aggressive Behavior (Item 70) ▪ Fire Setting (Item 71) ▪ Problematic Social Behavior (Item 72) ▪ Preschool/Child Care Behavior (Module 94, Item B) ▪ Preschool/Child Care Achievement (Module 94, Item C)	**Criterion 3.2: Child Needs & Functioning and Child Risk Behaviors** o Any one of the following Child Needs & Functioning (Domain C) and Child Risk Behavior (Domain F) items rated a '3' **OR** o two or more ratings of '2' on any of the following items: ▪ Attachment (Item 36) ▪ Living Situation (Item 37) ▪ Sleep (Item 39) ▪ Physical Limitations (Item 40) ▪ Recreational/Play (Item 42) ▪ Social Functioning (Item 43) ▪ Self-harm (Item 69) ▪ Aggressive Behavior (Item 70) ▪ Fire Setting (Item 71) ▪ Problematic Social Behavior (Item 72) ▪ Preschool/Child Care Behavior (Module 94, Item B) ▪ Preschool/Child Care Achievement (Module 94, Item C)
Criterion 2.3: Caregiver Strengths & Needs o At least one Caregiver Strengths & Needs item (Domain A) rated a '2' or '3': ▪ Physical Health (Item 1) ▪ Developmental (Item 2) ▪ Mental Health (Item 3) ▪ Substance Use (Item 4) ▪ Partner Relationship (Item 5) ▪ Caregiver Adjustment to Trauma (Item 6) ▪ Legal (Item 7) ▪ Organization (Item 11) ▪ Supervision (Item 12) ▪ Decision-Making (Item 14) ▪ Parenting Stress (Item 15) ▪ Informal Supports (Item 20) ▪ Knowledge of Condition (Item 23) **OR** o the Intensity of Treatment item (Item F) in the Medical Health module (Module 93) is rated a '2'	**Criterion 3.3: Caregiver Strengths & Needs** o Any one of the following Caregiver Strengths & Needs items (Domain A) rated a '2' or '3': ▪ Physical Health (Item 1) ▪ Developmental (Item 2) ▪ Mental Health (Item 3) ▪ Substance Use (Item 4) ▪ Partner Relationship (Item 5) ▪ Caregiver Adjustment to Trauma (Item 6) ▪ Legal (Item 7) ▪ Organization (Item 11) ▪ Supervision (Item 12) ▪ Decision-Making (Item 14) ▪ Parenting Stress (Item 15) ▪ Informal Supports (Item 20) ▪ Knowledge of Condition (Item 23) **OR** o the Intensity of Treatment item (Item F) in the Medical Health module (Module 93) is rated a '3'

Health Home Acuity (Medium)	Health Home Acuity (High)
Child meets "Medium" Acuity if he/she meets: • Criterion (2.1a OR 2.1b OR 2.1c OR 2.1d OR 2.1e) AND Criterion (2.2 OR 2.3 OR 2.4) AND Criterion 2.5	Child meets "High" Acuity if he/she meets: • Criterion (3.1a OR 3.1b OR 3.1c OR 3.1d OR 3.1e) AND Criterion (3.2 OR 3.3 OR 3.4) AND Criterion 3.5
Criterion 2.1a: Trauma Symptoms o At least one item rated a '3' on the Trauma Symptoms module (Module 84) **OR** o two or more items rated a '2' on the Trauma Symptoms module (Module 84) and/or Behavioral Health Module (Module 85)	**Criterion 3.1a: Trauma Symptoms** o At least two items rated a '3' on the Trauma Symptoms module (Module 84) and/or Behavioral Health module (Module 85) **OR** o three or more items rated a '2' or '3' on the Trauma Symptoms module (Module 84) and/or Behavioral Health module (Module 85)
Criterion 2.1b: Behavioral Health o At least one item rated a '3' on the Behavioral Health module (Module 85) **OR** o two or more items rated a '2' on the Behavioral Health module (Module 85)	**Criterion 3.1b: Behavioral Health** o At least two items rated a '3' on the Behavioral Health module (Module 85) **OR** o three or more items rated a '2' or '3' on the Behavioral Health module (Module 85)
Criterion 2.1c: Medical Health o At least one item rated a '3' on the Medical Health module (Module 88) **OR** o two or more items rated a '2' on the Medical Health module (Module 88)	**Criterion 3.1c: Medical Health** o At least two items rated a '3' on the Medical Health module (Module 88) **OR** o three or more items rated a '2' or '3' on the Medical Health module (Module 88)
Criterion 2.1d: Developmental o At least one item rated a '3' on the Developmental module (Module 87) **OR** o two or more items rated a '2' on the Developmental module (Module 87)	**Criterion 3.1d: Developmental** o At least two items rated a '3' on the Developmental module (Module 87) **OR** o three or more items rated a '2' or '3' on the Developmental module (Module 87)
Criterion 2.1e: Substance Use o At least one item rated a '3' on the Substance Use module (Module 86) **OR** o two or more items rated a '2' on the Substance Use module (Module 86)	**Criterion 3.1e: Substance Use** o At least two items rated a '3' on the Substance Use module (Module 86) **OR** o three or more items rated a '2' or '3' on the Substance Use module (Module 86)

Health Home Acuity (Medium)	Health Home Acuity (High)
Criterion 2.2: Impairment in Self Care o At least one item rated a '3' on the Activities of Daily Living module (Module 89) **OR** o two or more items rated a '2' on the Activities of Daily Living module (Module 89) **OR for youth 14 or older,** o At least one item rated a '3' on the Independent Activities of Daily Living module (Module 91) **OR** o two or more items rated a '2' on the Independent Activities of Daily Living module (Module 91)	**Criterion 3.2: Impairment in Self Care** o At least two items rated a '3' on the Activities of Daily Living module (Module 87) **OR** o three or more items rated a '2' or '3' on the Activities of Daily Living module (Module 87) **OR for youth 14 or older,** o At least two items rated a '3' on the Independent Activities of Daily Living module (Module 91) **OR** o three or more items rated a '2' or '3' on the Independent Activities of Daily Living module (Module 91)
Criterion 2.3: Child Needs & Functioning o At least one the following Child Needs & Functioning items rated a '3' **OR** o two or more ratings of '2': ▪ Living Situation (Item 40) ▪ Peer Interactions (Item 42) ▪ Decision-Making/Judgment (Item 43) ▪ Sleep (Item 44) ▪ Physical Limitations (Item 45) ▪ Recreational (Item 47) ▪ Juvenile Justice/Legal (Item 48) ▪ School Behavior (Item 50) ▪ School Achievement (Item 51) ▪ School Attendance (Item 52)	**Criterion 3.3: Child Needs & Functioning** o At least two the following Child Needs & Functioning items rated a '3' **OR** o three or more ratings of '2' or '3': ▪ Living Situation (Item 40) ▪ Peer Interactions (Item 42) ▪ Decision-Making/Judgment (Item 43) ▪ Sleep (Item 44) ▪ Physical Limitations (Item 45) ▪ Recreational (Item 47) ▪ Juvenile Justice/Legal (Item 48) ▪ School Behavior (Item 50) ▪ School Achievement (Item 51) ▪ School Attendance (Item 52)
Criterion 2.4: Risk Factors & Behaviors o At least one Risk Factors & Behaviors item (Domain E) rated a '3' **OR** o two or more Risk Factors & Behaviors items (Domain E) rated a '2'	**Criterion 3.4: Risk Factors & Behaviors** o Any two Risk Factors & Behavior items (Domain E) rated a '3' **OR** o three or more Risk Factors & Behaviors items (Domain E) rated a '2' or '3'

Health Home Acuity (Medium)	Health Home Acuity (High)
Criterion 2.5: Caregiver Strengths & Needs ○ At least one of the following Caregiver Strengths & Needs items (Domain A) rated a '2' or '3': ▪ Physical Health (Item 1) ▪ Developmental (Item 2) ▪ Mental Health (Item 3) ▪ Substance Use (Item 4) ▪ Legal (Item 7) ▪ Organization (Item 11) ▪ Supervision (Item 12) ▪ Decision-making (Item 14) ▪ Parenting Stress (Item 15) ▪ Informal Supports (Item 20) ▪ Knowledge of Condition (Item 23) **OR** ○ the Intensity of Treatment item (Item F) in the Medical Health module (Module 88) is rated a '2' **OR for youth who do not have a caregiver,** ○ a score of 2 or 3 on the Self-Care Management item (Item D) in the Transitions to Adulthood module (Module 90)	**Criterion 3.5: Caregiver Strengths & Needs** ○ Any one of the following Caregiver Strengths & Needs items (Domain A) rated a '3' **OR** ○ two or more of the following Caregiver Strengths & Needs items (Domain A) rated a '2' or '3': ▪ Physical Health (Item 1) ▪ Developmental (Item 2) ▪ Mental Health (Item 3) ▪ Substance Use (Item 4) ▪ Legal (Item 7) ▪ Organization (Item 11) ▪ Supervision (Item 12) ▪ Decision-making (Item 14) ▪ Parenting Stress (Item 15) ▪ Informal Supports (Item 20) ▪ Knowledge of Condition (Item 23) **OR** ○ the Intensity of Treatment item (Item F) in the Medical Health module (Module 88) is rated a '3' **OR for youth who do not have a caregiver,** ○ a score of 3 on the Self-Care Management item (Item D) in the Transitions to Adulthood module (Module 90)

APPENDIX B

Approved Reasons and Processes to Correct CANS-NY Errors within the UAS-NY

The following outlines the approved process and the indicated errors that might occur by an assessor that would need to be corrected due to the impact upon billing and transmittal to the MAPP HHTS.

Entering a "First Time" CANS-NY and Selecting the Correct Assessment Type and Health Home

1) To enter a first time CANS-NY for the Health Home program within the UAS-NY, it is necessary for ALL children to be FIRST referred through the Health Home MAPP HHTS Referral Portal and an enrollment segment completed prior to completing a CANS-NY within the UAS-NY. By creating an enrollment segment, the HH Care Manager (CM) will have the Health Home information that is NECESSARY to match within the CANS-NY for the member. Once the HH CM can verify the Health Home assignment for the member, then the CANS-NY can be entered and completed within the UAS-NY by signing and finalizing the assessment.
    a. REMINDER: The Functional Assessment Consent Form 5230 and Health Home Enrollment Consent Form 5200 or 50555 are necessary for the completion of the CANS-NY and enrollment segment. PLEASE NOTE: If the MAPP HHTS selected Health Home for the

member does not match the Health Home on the CANS-NY for the member, you will not be able to bill for the assessment or acuity level. The entire CANS-NY Assessment for the member will have to be recompleted, as the assessment CAN NOT be deleted and/or edited once signed and finalized.

2) It is necessary to choose the correct CANS-NY Assessment Type for billing and for tracking the CANS-NY information. All initial CANS-NY for Health Homes, the Assessment Type should be CANS-NY Assessment upon Enrollment.
    a. PLEASE NOTE: Completing a CANS tool for another program other than Health Home, does not correspond with the CANS-NY developed for the Health Home program (unless your agency is a NYC VFCA IV-E program). Therefore, Reassessment or Existing CANS-NY Assessment Types SHOULD NOT be selected for the initial Health Home CANS-NY. The Assessment Type selected should be CANS-NY Assessment upon Enrollment, which also triggers the one-time only CANS-NY assessment fee. The entire CANS-NY Assessment for the member will have to be recompleted, as the assessment CAN NOT be deleted and/or edited once signed and finalized.

Process to Correct CANS-NY Errors within the UAS-NY

When selecting the incorrect Health Home in a CANS-NY, which does not match the Health Home assignment in the MAPP HHTS, or choosing the incorrect assessment type for appropriate transmittal to the MAPP HHTS for billing, the following process should be followed:

A. Contact the Lead Health Home and inform the agency that there is an incorrect CANS-NY Assessment that needs to be recompleted
B. Once authorized to proceed by the Lead Health Home, print the completed incorrect CANS-NY Assessment to utilize as a guide to complete a new/corrected CANS-NY Assessment, with IDENTICAL responses
C. Complete the new CANS-NY Assessment with the corrected choice of Health Home and/or Assessment Type
D. The CANS-NY Assessment responses and acuity MUST be identical to the previous CANSNY (This process CANNOT be utilized to change acuity outcomes or when there is a change of circumstances for the member)
E. The new CANS-NY should be recompleted immediately upon recognizing an error with selecting the incorrect Health Home, assessment type and/or transmittal to the MAPP HHTS
F. The Lead Health Home will be responsible to review and ensure that the process is completed accurately, and that CANS-NY responses and acuity are identical.

Please Note: That if you have completed a CANS-NY with the assessment type of CANS-NY Assessment upon Enrollment more than once with the same Health Home identified, without breaks in service and transmitted to the MAPP HHTS, then you MUST notify the Health Home immediately so that the one-time only assessment payment will not be billed twice.

Once the CANS-NY Assessment tool is signed and finalized, it cannot be unlocked to change answers to questions or change the acuity score. The CANS-NY tool should be reviewed for accuracy prior to signing and finalizing. Those new to the CANS-NY Assessment tool might want a supervisor to review prior to

finalizing. All ratings should be based upon supporting documentation, which will be requested and reviewed during a CANS-NY audit.

Health Home Serving Children Division of Program Development and Management
New York State Department of Health
Office of Health Insurance Programs