Health Home CMART

HH-CMART VERSION 3.7 SPECIFICATIONS

Last revised: June 2020

Office of Quality and Patient Safety
NEW YORK STATE | DEPARTMENT OF HEALTH

Contents

Changes

Changes made to the HHCMART3 specifications are shown below. Note that field codes are noted numerically. The complete description and definition of these codes can be found in documentation.

- February 2020: Additional Assessment information beginning Q4 2020
    - Addition of columns 7 through 23 in the assessments file specification which pertain to the first 10 questions on the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool by Center for Medicare and Medicaid Services (CMS) [vi].
- August 2018: Additional detail and clarification regarding nonbillable interventions.
    - Extensive search (electronically or otherwise) on a member is a nonbillable intervention.
- June 2018: Removal of Error Checks & QA Reports
    - Removed information and processes regarding the Error Checks & QA Reports.
    - Added additional details on a new process for test submissions.
- February 2018:
    - Removed line 'Incomplete interventions are not required to have an Intervention Type' from the intervention type section in the interventions file specification. This change was to create consistency throughout the rest of the documentation.
    - Added additional details regarding which target should be reported when multiple targets are together for an intervention on behalf of a member.
- October 2017: Updates
    - Added section on running the error report prior to submission to NYSDOH.
    - HCS file upload changed from "HH-CMART File Upload" to "CMART File Upload".
- July 28, 2017: Further Updates and Revisions for Q2 2017
    - Edits were made to the Interventions specification to remove old information which is no longer relevant regarding members in outreach hiatus. There were no practical changes to the specification. These changes were for clarity and accuracy.
- July 10, 2017: Updates for Q2 2017
    - **Health Homes no longer submit data for members who are only in Outreach Hiatus during the quarter.**
    - Adds a “Common Errors” section to each file description. Please review.
    - Adds a brief description of the Excel file error report and options for running a fixed-width error report.
    - Adds CSV as a valid option for submitting HHCMART data.
    - CSV QA report functions are less mature than the fixed-width report functions. We hope to improve this for Q3 2017.
    - Improved the documentation for date formatting.
    - Minor edits to the headings to de-emphasize calling all files .TXT.
- May 04, 2017: Adds the Appendix and Error Codes Cheat Sheet.
- March 29, 2017:
    - Fixes a small oversight in the error codes from the interventions file. On page 13, the specs stated:

      “If “mode = letter” and the “Completed” column is not left blank, the line will be rejected with Error Code 8

This statement was deleted. Since the February 27 release of the specifications, no column in the HHCAMRT3 files should be blank. This was an oversight.

  - Deletes a stray comment.
  - Removes the yellow highlighting seen in the previous release of the specifications.
  - Adds the Changes section to the document, to track changes made to the specification over time. Because this changes all the pages in the document, the Release Date and version on the title page have been changed (Version 3.1).
- February 29, 2017
  - Allows Health Homes to submit 1 or 5 for COMPLETED when the MODE is 4, 5, or 6. Only when MODE is 1 should COMPLETED be 9.
  - For May 1 submission, COMPLETED may be 9 when MODE is 1, 4, 5, 6 because of the late date of this change.
  - Improves the definition and documentation field for the COMPLETED field for INTERVENTIONS.TXT.
  - Error code tables define which error codes are part of the Full Report. All other error codes are part of both the Full Report and Basic Report.
- February 27, 2017
  - Adds a code 9 for the COMPLETED field in INTERVENTIONS.TXT.
  - No field in HHCMART3 should ever be left blank.
  - Adds code 6 for the MODE field in INTERVENTIONS.TXT.
  - Adds error code 0 to all three HHCMART3 files.
  - Removes error code 5 for all three HHCMART3 files.
  - Better definition for what Health Homes should submit for ASSESSMENT.TXT.
  - Various small enhancements to definitions, based on feedback from the Health Homes.

Overview

Care management is defined as the delivery of member-specific interventions by a multidisciplinary team, led by a dedicated care manager. Care management decisions will be based on a current comprehensive assessment and plan of care. The interventions should result in coordinated, efficient, and quality care to achieve the plan of care goals and optimize health outcomes for people with complex health issues and needs. For people in Medicaid Health Homes, care management is required to address care needs, coordinate services and arrange efficient quality health care to promote health outcomes. Together, the multidisciplinary team and care manager will assure enrollees receive needed medical, behavioral and social services in accordance with the plan of care. Health Homes are encouraged, as feasible, to utilize Health Information Technology (HIT) to create, document, execute, and update the plan of care. Health Homes are further encouraged to utilize HIT to make the plan of care available to all members of the multidisciplinary team working with each member.

Health Home services are provided through partnerships between health care providers, health plans and community based organizations. Health Home providers must have the capacity to perform core services specified by Centers for Medicare and Medicaid Services (CMS) which include:

1) comprehensive care management
2) care coordination and health promotion
3) comprehensive transitional care
4) patient and family support
5) referral to community and social support services
6) use of health information technology to link services

Health Homes must provide at least one of the first 5 core functions (exclusive of HIT) to each member per month to meet minimum billing standards. Throughout this document, the term Health Home, includes the Health Home staff or their subcontractor performing care management services.

The Health Home Care Management Assessment Reporting Tool (HH-CMART) is a tool for the collection of standardized care management data for members assigned to, receiving outreach from, or enrolled with Health Homes. The data will provide the Department of Health (DOH) with information about care management services regarding the volume and type of interventions, the number of assessments, and the number of plans of care for all members. The data requirements include submission of specified data about care management services provided to members in Health Homes. The submission will include information about all Medicaid members involved in Health Home care management programs during the reporting period.

HH-CMART version 3.0 and higher are a significant revision. Data submitted in the HH-CMART v2 specification will not be accepted after May 1, 2017. In January 2017, the Office of Quality and Patient Safety (OQPS) will publish the Error Checks code and other materials to support Health Homes in making their first HH-CMART v3 submission.

Submission Requirements

All Health Homes designated by New York State (NYS) DOH after January 1, 2012 must submit HH-CMART data using the specifications found in this document. This requirement includes both Adult and Children Health Homes. Further reporting requirements are detailed below.

Reporting Schedule

HH-CMART submissions are due to NYS DOH by the first Monday of the second month following the close of the reporting period. The last day for submitting HH-CMART data, including revisions to rejected rows, is the last day of the second month following the close of the reporting period.

Reporting Period	Due Date	Last Date to Submit Revisions
Q1: January 1-March 31	1st Monday in May	May 31
Q2: April 1-June 30	1st Monday in August	August 31
Q3: July 1-September 30	1st Monday in November	November 30
Q4: October 1-December 31	1st Monday in February	February 28 (29 in Leap Years)

What to Report

Health Homes are required to provide NYS DOH with the following information submitted via the Health Home Care Management Assessment Reporting Tool (HH-CMART):

1) **Interventions**
   The submission will contain data regarding care management services (interventions) provided to Health Home members during the reporting period. These elements must be extracted from the Health Home's Electronic Healthcare Record (EHR).
2) **Assessments**
   The submission will contain a data regarding member assessments performed during the reporting period. These elements must be extracted from the Health Home's EHR.
3) **Plans of Care**
   The submission will contain data regarding member plans of care developed during the reporting period. These elements must be extracted from the Health Home's EHR.

The Health Homes will coordinate with the care management staff providing services to collect the data for the reporting period. Health Homes are expected to submit HH-CMART data from all affiliated Care Management Agencies and other subcontractors. HH-CMART data should be extracted from the Health Home's EHR, not collected manually. HH-CMART submissions will include data for Medicaid members who are assigned to, in outreach with, or enrolled with the Health Home at any time during the reporting period. The data submitted will include all members whether the member is in a managed care plan, Fee for Service (FFS), or is in a converting Targeted Case Management (TCM) slot. Data regarding clients receiving care management services from the care management organization but are not assigned to or members of the Health Home, should not be included. Data submitted should include both adult and child Health Home members.

How to Submit

The Health Home HH-CMART data submission must be submitted to the Department via the "CMART File Upload" application on the Health Commerce System (HCS) as a zipped file. This requires a user ID and password. All Health Homes have access to the HCS. After logging into the HCS, select 'CMART File

Upload' from the Applications tab and follow the instructions for attaching and sending the file. This application will email the file securely to the OQPS Health Homes team who will then confirm receipt of the file and run error checks on the submitted data. Transmitting files through the HCS is mandatory due to the identifiable content of the files. Files sent via email (whether encrypted or not) will not be accepted.

Error Checks & QA Reports

The State no longer will assist in the maintenance and troubleshooting of the QA report used for HH-CMART reporting. It is now each Health Home's responsibly to create their own QA report or edit checks to provide clean CMART data to the State. Health Homes can submit test submissions up to one month prior to the due date, the State will run its internal report and provide feedback to the Health Homes. Once the due date has passed, the Department will accept either the Health Home's last test submission as final or the Health Home's first submission for the quarter, if they did not send in any test submissions. After the due date has passed, re-submissions for any reason will not be accepted. As done previously, any errors within the final data submission will be rejected by the State and not included in future analysis with CMART data.

HH-CMART reports will be sent to designated HH-CMART contact persons by the OQPS staff member assigned to the Health Home via HCS. Any questions regarding the new process should be sent to the OQPS staff member assigned to your Health Home.

Reporting Requirements

The specifications for each submission element are provided below, along with additional reporting guidelines and clarifications. The submission itself will be comprised of three fixed-width or comma separated values (CSV) text files with the following names:

1. INTERVENTIONS.TXT or INTERVENTIONS.CSV
2. ASSESSMENTS.TXT or INTERVENTIONS.CSV
3. PLANS_OF_CARE.TXT or PLANS_OF_CARE.CSV

When submitted, these files will be submitted together as a single zip file, and submitted to the Office of Quality and Patient Safety (OQPS) via the HCS. The format of the file name shall be "HH-CMART_MMISID-YYYY-Qx.zip" where "MMISID" is the Health Home's current MMIS ID, "YYYY" is the current year and "Qx" is the reporting period quarter (Q1, Q2, Q3, or Q4).

The following sections describe each text file in the submission in greater detail.

File Definitions:

The three files that make up the HH-CMART v3 submission all start with the same three columns. These columns have the same definition in all three files. These data elements are defined below.

Col	Column Name	Data Type	Start Col	End Col
1	MBR_ID	Varchar	1	8
2	HH_MMIS_ID	Varchar	9	16
3	CMA_MMIS_ID	Varchar	17	24

MBR_ID: Member's eight digit Medicaid ID. This is also sometimes referred to as their Medicaid CIN. This must match the Medicaid ID submitted by the Health Home to the MAPP HHTS. In the unlikely event a member's Medicaid ID changes during enrollment, Health Homes should submit the member's Medicaid ID as it was at the time of the event (interventions, assessments, or plans of care).

HH_MMIS_ID: The Health Home's eight digit MMIS ID submitted in HH-CMART should match the MMIS ID submitted to the MAPP HHTS. If the Health Home's MMIS ID changes during a member's enrollment, Health Homes should submit the MMIS ID at the time of the event (interventions, assessments, or plans of care). A submission file may have only one HH_MMIS_ID. Any submission with more than one HH_MMIS_ID will contain many errors. The system will accept the most frequent MMIS ID, and reject all other rows.

CMA_MMIS_ID: The Care Management Agency's eight-digit MMIS ID submitted in HH-CMART should match the MMIS ID submitted to the MAPP HHTS. If the CMA's MMIS ID changes during a member's enrollment, Health Homes should submit the MMIS ID at the time of the event (interventions, assessments, or plans of care).

File Specification: INTERVENTIONS

The Interventions file includes all Health Home interventions/contacts. For purposes of HH-CMART reporting, this term is used broadly.

- The Department of Health defines the term intervention as all actions taken by the care manager or Health Home pursuant to the goals identified in members' plans of care. Interventions to report include all interactions during the reporting period between the Health Home/CMA and:
    - Enrolled members
    - Outreach members, but not those who are in hiatus status at the time of the intervention
    - Health Home/CMA supervisors (member specific meetings, not general-purpose staff meetings)
    - Health Home/CMA internal team meetings (member specific meetings, not general-purpose staff meetings)
    - Member's doctors, providers, etc.
    - Member's family
- Reportable actions are always member-specific. Contacts that are not member-specific, for example establishing a Memoranda of Understanding between the Health Home and an outside provider, should not be reported.
- The Department does not consider extensive search alone an intervention. Because all interventions require locating a member before contacting them, the Department considers the search process part of the intervention. Interventions must include care management services and the intervention mode should be the mode of communication used to contact the target of the intervention. Therefore, searching alone for a member (electronically or otherwise) is considered a nonbillable intervention and should not be submitted through CMART.
- Health Homes are expected to report all interventions for a member during the reporting period. Health Homes will submit more than one row of data per member, where the Health Home attempts or completes more than one intervention for the member during the reporting period.
- It is also possible for there to be more than one intervention per member per day.
- Members who do not receive an intervention during the reporting period should be omitted from the submitted data**.**
- **As of Q2 2017, Health Homes should not report members who are only in Outreach Hiatus status during the quarter.**
- The file should be fixed-width (called INTERVENTIONS.TXT) or CSV (called INTERVENTIONS.CSV).
    - For fixed-width files, start/end columns are documented in the following table.
    - CSV files may not have additional columns beyond those shown here.
    - Data submitted in a fixed-width file, should not include column names. The first row in the file should be data.
    - Data submitted in a CSV file should include column names. The first row should be the column names in the following table.

- **Null, Blank values, and spaces, will be ignored. All columns require an entered value.**

File Spec: INTERVENTIONS					
#	Field Name	Data Type	Start Col	End Col	Details/Comments
1	MBR_ID	Varchar	1	8	This field may not be NULL.
2	HH_MMIS_ID	Varchar	9	16	This field may not be NULL.
3	CMA_MMIS_ID	Varchar	17	24	This field may not be NULL.
4	INTERVENTION_DATE	Date	25	32	MMDDYYYY A Health Home may submit more than one intervention per member per day. This field may not be NULL.
5	MODE	Int	33		1 = Letter, 2 = Phone, 3 = In-Person (Face to face) 4 = Email, 5 = SMS/Text, 6 = Video Conference (Microsoft Skype, Google Hangouts, Apple Facetime) *Submit only intervention modes approved for use by the Health Home.* Only One MODE per contact. This field may not be NULL.
6	TARGET	Int	34		1 = Member 2 = Co-worker, Senior Care Manager, Supervisor (Health Home or CMA) 3 = Multidisciplinary Team/Case Review Meeting (Internal/External) 4 = External Doctor/Provider (Anyone who provides care or service to the member.) 5 = Family of Member (Includes close friends who function as de-facto family.) 6 = Other This field may not be NULL.
7	COMPLETED	Int	35		1 = TRUE, 5 = FALSE, 9 = Not Recorded TRUE only if contact is successful and the member responds. Further guidance below. This field should be 9 where MODE = Letter (1) This field may not be NULL.
8	OUTREACH	Int	36		**Intervention Type:** 1 = TRUE, 5 = FALSE Outreach and the other intervention goals are mutually exclusive. When OUTREACH = TRUE, the remaining intervention goal columns must be FALSE. When OUTREACH = FALSE & COMPLETED = TRUE, at least one of intervention goal columns must be TRUE. None of these fields may be NULL.
9	CARE_MANAGE[i]	Int	37		
10	CARE_COORD_HEALTH_PROMOTE[ii]	Int	38		
11	TRANSITION_CARE[iii]	Int	39		
12	PATIENT_FAMILY_SUPPORT[iv]	Int	40		
13	COMM_SOCIAL[v]	Int	41		

File Definitions:

INTERVENTION_DATE: This is the date of the intervention. This date should be during the reporting period. It should be in the format of MMDDYYYY with no intervening "-" or "/". The format is the same if data is submitted via a fixed-width file or CSV.

MODE: This is the mode of communication used in the intervention. If there is more than one mode of intervention used during the intervention, the Health Home should report only the last mode used. For example, an enrolled member uses a cell-phone to call their care manager to inform her of an ED utilization. The Care Manager is at the hospital and agrees to come see the member in-person. In this example, the Health Home should not report two interventions, because there is only one distinct intervention. Nor should the Health Home report a single intervention with two modes. In this example, the Health Home should report the mode of intervention used last during the intervention.

HH-CMART v3 includes several new intervention modes. These include 4 (Email), 5 (SMS/Text), and 6 (Video Conference). These new modes were added to broaden the specificity of the data reported. Health Homes may individually determine the appropriateness of these intervention modes.

- Health Homes must report only on interventions using communication modes approved by the Health Home.
- Where the Target is another care manager or provider, no distinction need be made between E-mail and secure on-line tools such as the HCS. For purposes of HH-CMART reporting these can be treated as the same communication mode.
- Health Homes are expected to comply with HIPAA and Health Home policy regarding the use of digital communications.

TARGET: Most reported interventions are between the Health Home and the member. That said, an intervention may be between the Health Home and another provider or the member's family. Any action taken on behalf of a specific member and meets one of the Intervention Types should be reported. If any intervention is taken on behalf of a member between two or more outside targets it is at the Health Home's discretion to determine which target to report. Whichever target is the primary focus of the intervention should be the one reported.

COMPLETED: HH-CMART v3 requires Health Homes to report all interventions and to identify which interventions were completed. HH-CMART v2 required Health Homes to report only completed interventions. This change allows Health Homes to better document the scale of care management efforts.

- **A complete intervention results in at least some interaction with the member.**
- When the intervention mode = 1 (Letter), completed should be reported as 9 (Not recorded). Interventions by mail will not affect the Health Home's intervention completion rate.
- Interventions made using any mode other than 1 (Letter) should be identified as 1 (TRUE) or 5 (FALSE).
- When the interventions mode is 2 (phone) or 3 (in-person), or 6 (Video Conference), Health Homes should use the same criteria as during the HH-CMART v2. Any phone or in-person intervention which would have been reported on the HH-CMART v2 should be

reported in HH-CMART v3 as complete. Otherwise, the intervention should be considered incomplete. A similar standard should be applied to the new mode 6 (Video Conference).

- When the intervention mode is 4 (Email) or 5 (SMS/Text) Health Homes should continue to identify interventions which result in at least some interaction with the member. For example, a SMS/text message to remind a member of an upcoming appointment would only be complete if the member responds. Email and text messages which result in no interaction with the client should be reported as incomplete, even when going to addresses which are known to be good.

Intervention Type: The final seven columns of the INTERVENTIONS.TXT file detail the type of intervention.

- **OUTREACH:**
  - Care manager or outreach specialist attempts to contact the prospective enrollee to offer them Health Home services.
  - Members who have been reported to MAPP as enrolled cannot have an outreach intervention during the time period in which they are enrolled.
- **CARE_MANAGE:**
  - Care manager or interdisciplinary team creates, updates, or reviews the assessment or patient centered plan of care. Includes performing an assessment (comprehensive or targeted), monitoring goal progress, or updating the plan of care.
  - Care manager follows up with member or service providers to monitor the progress and completion of the plan of care.
  - Applies to enrolled members only.
- **CARE_COORD_HEALTH_PROMOTE:**
  - Care manager coordinates and arranges for the provision of services and supports adherence to treatment recommendations.
  - Care manager facilitates regular case review meetings with external providers or multidisciplinary team.
  - Care manager promotes evidence-based wellness and prevention by linking enrollees with resources for services such as smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
  - Applies to enrolled members only.
- **TRANSITION_CARE:**
  - Care manager or interdisciplinary team creates or reviews a transition plan for a member discharged from a hospital or residential/rehabilitation facility.
  - Care manager follows up with member or service providers to monitor the progress and completion of the transition plan.
  - Applies to enrolled members only.
- **PATIENT_FAMILY_SUPPORT:**
  - The Health Home engages the member via peer support, support groups and self-care programs.
  - Care manager discusses advance directives with enrollee, family, or caregiver.
  - Care manager communicates or shares information with individuals and their families and other caregivers.
  - Applies to enrolled members only.

- **COMM_SOCIAL:**
    - Care manager coordinates with community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of community-based services.
    - Applies to enrolled members only.

File Specification: ASSESSMENTS

The assessments file includes all comprehensive assessments.

- Health Homes are expected to submit all comprehensive assessments completed or updated during the reporting period. If your Health Home, or downstream CMAs use additional assessment tools which are not comprehensive, these should not be submitted in HH-CMART. Community Mental Health Assessment (CMHA) and Child and Adolescent Needs and Strengths (CANS) assessments should not be submitted in the HH-CMART.
- The file should be fixed-width (called ASSESSMENTS.TXT) or CSV (called ASSESSMENTS.CSV).
    - For fixed-width files, start/end columns are documented in the following table.
    - CSV files may not have additional columns beyond those shown here.
    - Data submitted in a fixed-width file, should not include column names. The first row in the file should be data.
    - Data submitted in a CSV file should include column names. The first row should be the column names in the following table.
- **As of Q2 2017, Health Homes should not report members who are only in Outreach Hiatus status during the quarter.**
- **Null, Blank values, and spaces, will be ignored. All columns require an entered value.**
- Health Homes are expected to report all assessments for a member during the reporting period. Health Homes will submit more than one row of data per member, where the Health Home attempted or completed more than one assessment for the member during the reporting period.
- Beginning Q4 2020, Health Homes are expected to submit the first 10 questions of the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool [vi] with all comprehensive assessments completed or updated during the reporting period for adult Health Home members. These fields correspond to columns 7 through 23 of the assessments file specifications. Health Homes Serving Children (HHSC) are not required to collect the HRSN screening tool, but should complete all fields in the assessment file using 0, the HHSC option, for HRSN fields.

File Spec: ASSESSMENTS					
#	Field Name	Data Type	Start Col	End Col	Comments
1	MBR_ID	Varchar	1	8	This field may not be NULL.
2	HH_MMIS_ID	Varchar	9	16	This field may not be NULL.
3	CMA_MMIS_ID	Varchar	17	24	This field may not be NULL.
4	COMPLETED	Int	25		1 = TRUE, 5 = FALSE TRUE only if the assessment was completed. This field may not be NULL.
5	ASSESS_DATE	Date	26	33	MMDDYYYY This field may not be NULL.
6	INITIAL_ASSESSMENT	Int	34		1 = TRUE, 5 = FALSE True if this is their initial assessment, else False. Do not count assessments from previous enrollments. This field may not be NULL.
7	LIVING	Int	35		1= Steady place, 2= Worried, 3= No steady place, 0 = HHSC This field may not be NULL.
8	LIVING_PESTS	Int	36		1 = TRUE, 5 = FALSE, 0 = HHSC This field may not be NULL.
9	LIVING_MOLD	Int	37		1 = TRUE, 5 = FALSE, 0 = HHSC This field may not be NULL.
10	LIVING_LEAD	Int	38		1 = TRUE, 5 = FALSE, 0 = HHSC This field may not be NULL.
11	LIVING_HEAT	Int	39		1 = TRUE, 5 = FALSE, 0 = HHSC This field may not be NULL.
12	LIVING_OVEN	Int	40		1 = TRUE, 5 = FALSE, 0 = HHSC This field may not be NULL.
13	LIVING_SMOKE	Int	41		1 = TRUE, 5 = FALSE, 0 = HHSC This field may not be NULL.
14	LIVING_LEAKS	Int	42		1 = TRUE, 5 = FALSE, 0 = HHSC This field may not be NULL.
15	LIVING_NONE	Int	43		1 = TRUE, 5 = FALSE, 0 = HHSC If this field is marked TRUE, then fields 8 -14 must be FALSE. This field may not be NULL.
16	FOOD_WORRIED	Int	44		1= Often, 2= Sometimes, 3= Never, 0 = HHSC This field may not be NULL.

17	FOOD_MONEY	Int	45		1= Often, 2= Sometimes, 3= Never, 0 = HHSC This field may not be NULL.
18	TRANSPORTATION	Int	46		1=YES, 5=NO, 0 = HHSC This field may not be NULL.
19	UTILITIES	Int	47		1=YES, 5=NO, 9= Shut Off, 0 = HHSC This field may not be NULL.
20	SAFETY_PHYSICAL	Int	48		1=Never, 2=Rarely, 3=Sometimes, 4=Fairly often, 5=Frequently, 0 = HHSC This field may not be NULL.
21	SAFETY_INSULT	Int	49		1=Never, 2=Rarely, 3=Sometimes, 4=Fairly often, 5=Frequently, 0 = HHSC This field may not be NULL.
22	SAFETY_THREATEN	Int	50		1=Never, 2=Rarely, 3=Sometimes, 4=Fairly often, 5=Frequently, 0 = HHSC This field may not be NULL.
23	SAFETY_SCREAM	Int	51		1=Never, 2=Rarely, 3=Sometimes, 4=Fairly often, 5=Frequently, 0 = HHSC This field may not be NULL.

File Definitions:

COMPLETED: If the assessment was completed, this should be TRUE (1). If not, it should be FALSE (5). Each Health Home should use its own policies and procedures to determine if an assessment is complete.

ASSESS_DATE: This date should be during the reporting period. It should be in the format of MMDDYYYY with no intervening "-" or "/". The format is the same if data is submitted via a fixed-width file or CSV.

- If COMPLETED = TRUE: The date the assessment was finalized or approved.
- If COMPLETED = FALSE: The date the Health Home stopped trying to complete the assessment.

INITIAL_ASSESSMENT: If this is the first assessment during the member's current enrollment, this column should be TRUE (1). If not, it should be FALSE (5). If a member had a previous enrollment which was reported to the MAPP HHTS as having ended, those assessments should not be considered for this determination.

LIVING: Question 1 in the AHC HRSN Screening Tool by CMS.

LIVING_PESTS: Question 2 in the AHC HRSN Screening Tool by CMS. Check all that apply.

LIVING_MOLD: Question 2 in the AHC HRSN Screening Tool by CMS. Check all that apply.

LIVING_LEAD: Question 2 in the AHC HRSN Screening Tool by CMS. Check all that apply.

LIVING_HEAT: Question 2 in the AHC HRSN Screening Tool by CMS. Check all that apply.

LIVING_OVEN: Question 2 in the AHC HRSN Screening Tool by CMS. Check all that apply.

LIVING_SMOKE: Question 2 in the AHC HRSN Screening Tool by CMS. Check all that apply.

LIVING_LEAKS: Question 2 in the AHC HRSN Screening Tool by CMS. Check all that apply.

LIVING_NONE: Question 2 in the AHC HRSN Screening Tool by CMS. If this is marked TRUE (1), fields 8-14 of the assessments file should be marked FALSE (5).

FOOD_WORRIED: Question 3 in the AHC HRSN Screening Tool by CMS.

FOOD_MONEY: Question 4 in the AHC HRSN Screening Tool by CMS.

TRANSPORTATION: Question 5 in the AHC HRSN Screening Tool by CMS.

UTILITIES: Question 6 in the AHC HRSN Screening Tool by CMS.

SAFETY_PHYSICAL: Question 7 in the AHC HRSN Screening Tool by CMS.

SAFETY_INSULT: Question 8 in the AHC HRSN Screening Tool by CMS.

SAFETY_THREATEN: Question 9 in the AHC HRSN Screening Tool by CMS.

SAFETY_SCREAM: Question 10 in the AHC HRSN Screening Tool by CMS.

File Specification: PLANS_OF_CARE

The plans of care file include all member-specific plans of care.

- Health Homes are expected to submit a complete list of all plans of care completed or updated during the reporting period.
- The file should be fixed-width (called PLANS_OF_CARE.TXT or CSV (called PLANS_OF_CARE.CSV).
    - For fixed-width files, start/end columns are documented in the following table.
    - CSV files may not have additional columns beyond those shown here.
    - Data submitted in a fixed-width file, should not include column names. The first row in the file should be data.
    - Data submitted in a CSV file should include column names. The first row should be the column names in the following table.

- **As of Q2 2017, Health Homes should not report members who are only in Outreach Hiatus status during the quarter.**
- **Blank values, or spaces, will be ignored. All columns require an entered value.**
- Health Homes are expected to report all plans of care for a member during the reporting period. Health Homes will submit more than one row of data per member, where the Health Home attempted or completed more than one plan of care for the member during the reporting period.

File Spec: PLANS_OF_CARE					
#	Field Name	Data Type	Start Col	End Col	Comments
1	MBR_ID	Varchar	1	8	This field may not be NULL.
2	HH_MMIS_ID	Varchar	9	16	This field may not be NULL.
3	CMA_MMIS_ID	Varchar	17	24	This field may not be NULL.
4	COMPLETED	Int	25		1 = TRUE, 5 = FALSE TRUE only if the plan of care was completed. This field may not be NULL.
5	PLAN_DATE	Date	26	33	MMDDYYYY This field may not be NULL.
6	INITIAL_PLAN	Int	34		1 = TRUE, 5 = FALSE True if this is their initial plan of care, else False. Do not count plans of care from previous enrollments. This field may not be NULL.

File Definitions:

COMPLETED: If the plan of care was completed, this should be TRUE (1). If not, it should be FALSE (5). Each Health Home should use its own policies and procedures to determine if a plan of care is complete.

PLAN_DATE: This date should be during the reporting period. It should be in the format of MMDDYYYY with no intervening "-" or "/". The format is the same if data is submitted via a fixed-width file or CSV.

- If COMPLETED = TRUE: The date the plan of care was finalized or approved.
- If COMPLETED = FALSE: The date the Health Home stopped trying to complete the plan of care.

INITIAL_PLAN: If this is the first plan of care during the member's current enrollment, this column should be TRUE (1). If not, it should be FALSE (5). If a member had a previous enrollment which was reported to the MAPP HHTS as having ended, those plans of care should not be considered for this determination.

FACT_GP

In HH-CMART v3.0, Health Homes no longer submit FACT GP/Health Home Functional assessments to DOH. Health Homes may continue to assess members using these tools, but they are no longer required to do so.

Questions

For questions about the specifications and general reporting guidelines, contact the Health Home Team in Office of Quality & Patient Safety by calling (518) 486-9012 or by emailing the Care Management BML mailbox at: CareManagement_OQPS@health.ny.gov.

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[i] See Health Homes Provider Manual: Billing and Guidance (PDF) for more details.
[ii] See Health Homes Provider Manual: Billing and Guidance (PDF) for more details.
[iii] See Health Homes Provider Manual: Billing and Guidance (PDF) for more details.
[iv] See Health Homes Provider Manual: Billing and Guidance (PDF) for more details.
[v] See Health Homes Provider Manual: Billing and Guidance (PDF) for more details.
[vi] See AHC Screening Tool Explanation - CMS Innovation Center (PDF) for more details.