# Care Management Annual Reporting Tool (CMART)

# 2016

## Technical Requirement Specifications for Medicaid Managed Care Plans

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## *A. Overview*

Care management is defined as a **comprehensive assessment of a member's needs with an individualized care plan carried out through specific interventions designed to provide coordinated, efficient, quality care to achieve the care plan goals and optimize health outcomes for people with complex health issues**. For people in Medicaid managed care (MMC), health plans are required to provide case management and disease management services for individuals with chronic health conditions or complex health issues or situations.

The requirement for case management and disease management has been in place since 1997's Partnership Program implementation, and the requirement includes plan mechanisms to evaluate their care management programs. In 2008, the Medicaid managed care contract requirement for case management and disease management (section 10.19 and 10.20 of the Medicaid contract) was amended to include specific data requirements for the evaluation of plan-administered care management by the New York State Department of Health (NYS DOH). Since 2011 (measurement year 2010), NYS DOH has collected and evaluated case management and disease management services and outcomes through standardized measures. In 2014 (2013 measurement year), HIV SNP were required to provide similar information for their medical case management/care coordination programs (section 10.34 of the Medicaid contract).

For the purpose of the Care Management Annual Reporting Tool (CMART) requirements, case management and disease management will be collectively referred to as care management. The collection of standardized data provides NYS DOH with information about plan-administered care management programs to evaluate the number of individuals receiving these services, the types of conditions, and the impact plan-administered care management services have on outcomes. Plans are required to submit specific data elements, as described in this manual, for all Medicaid members involved in plan-administered care management programs during each calendar year.

HIV SNPs are to include active case management delivered during the measurement year. Active case management is defined as requiring care management interventions beyond routine assessment or monitoring. The services to include are the ones that you provide – not another community or other provider.

## *B. Submission Requirements*

### I. Definitions

**Care Management Program** - A care management program is defined by having a **comprehensive assessment of a member's needs with an individualized care plan carried out with specific interventions designed to achieve the goals and promote the best health outcome possible for the member**. Members who were identified for other educational programs or other types of outreach or care programs that do not involve individualized assessment and interventions specific to an individual should not be included in the data submission.

If your health plan conducts several care management programs with different areas of focus (e.g., asthma, prenatal care, diabetes), the data submission should include members from ***all of your care management programs***.

**Triggering for Care Management** – A member is triggered for care management when he/she is identified by the plan as an individual meeting at least one criterion which may indicate a need for care management services. For example, monthly claims reviews for specific diagnoses or a health risk assessment with specific responses to questions may be criteria used to identify

members in potential need of care management. Members generally trigger prior to or about the same time as initial contact with care management staff, unless the member self-refers.

**Enrollment in Care Management** – A member is enrolled in care management after the plan determines there is need based on assessment, and the member/family agree to participate in implementing the care plan.

**Trigger-only Event** – A trigger-only event represents situations where a member is identified as meeting one or more plan criteria for evaluation for care management services, and the member does not enroll in care management following this trigger. The member may not enroll in care management for a variety of reasons, such as he/she could not be contacted or upon assessment was not found to meet the plan's threshold for needing care management. Members may have more than one trigger-only event during the measurement year. Each trigger-only event does not need to be included in the member-level file. For members who never enrolled in care management during the measurement year, the earliest occurring trigger-only event (i.e., Initial Trigger-only Event) is included on the file. For members who do enroll in care management during the measurement year, no trigger-only events should be included in the file. Rather, the trigger event date associated with the enrollment will be included in the segment. (See section C.II: Eligible Population regarding determination of Initial Trigger-only Events)

**Care Management Segment** – A care management segment refers to the period when a member was involved in care management services. A segment reflects the entire period from date of trigger through interventions to the closure date for care management services. Members may have more than one care management segment during the measurement year. Each segment will be reported as a separate row in the member-level file. There is no requirement that that a care management segment must begin during the measurement year; instead it is only required that the member received care management services during the measurement year. **Members with at least one care management segment during the measurement year should not have any trigger-only events included in the file**. Rather, the trigger event date associated with the enrollment will be included in the segment. (See section C.II: Eligible Population regarding determination of Care Management Segments)

## II. Organizations Required to Report

**Article 44 licenses –** All **Medicaid** managed care organizations (HMOs, PHSPs and HIV SNPs) that executed contracts with NYS DOH prior to 2014 must submit care management files using these specifications for all members who are identified as possibly needing care management or who are enrolled in plan-administered care management programs during the measurement year.

## III. Reporting Schedule

All final data files are due to NYS DOH by the **second Monday of May** of the reporting year. The submission deadline for the 2016 CMART file (2015 measurement year) is **Monday, May 9, 2016.** Plans may begin submitting CMART files for review by DOH starting on April 11, 2016.

## IV. What to Report

Medicaid managed care plans are required to submit the following information via the CMART submission tool.

1) Member-Level Information –These elements can be manually entered or imported into the submission tool and are specified in both Section C.III below and Table 1 of Appendix I.

2) Plan-Level Information - These elements must be entered manually into the submission tool and are specified in both Section C.IV below and Table 2 of Appendix I.

Plans will include data for all Medicaid managed care plan enrollees who were identified for, or who participated in, plan-administered care management during the measurement year. Care management programs are defined as having a comprehensive assessment of a member's needs with an individualized care plan carried out with specific interventions designed to achieve the goals and promote the best health outcome possible for the member. Members who are involved in related plan-administered care management programs that do not have individualized care plans with interventions to address the member's unique needs **should not** be included in this data file. NYS DOH recognizes that the data collected in this evaluation are limited to individualized plan-administered care management programs only, and the results will not reflect all of the services being provided to members by plans.

HIV SNPs are to include members who received active case management delivered during the measurement year. Active case management is defined as requiring care management interventions beyond routine assessment or monitoring. The services to include are the ones that you provide – not another community-based provider.
For example, members who have periodic assessment/monitoring to ensure member's status is stable and does not have active needs would NOT be included.

Plans that contract with vendors to provide plan-administered care management services should obtain the data from their vendors and include the information in the member-level file and include the vendor staff assigned in the Full Time Equivalent (FTE) information. However, the FTE information needs to be specific to the activities involving the health plan's Medicaid and Family Health Plus members.

Members may be receiving care management services through providers, other organizations or Health Homes. Care management services provided by providers, other organizations or Health Homes should not be included in the plan's CMART file. Health Home care management services will be reported through the Health Home CMART (HH-CMART) by the Health Homes. Please note:

- If members are enrolled in a plan-administered care management program for part of the measurement year, such as prior to engaging in a Health Home, the member should be included in the plan's CMART with the information about the plan-delivered services. If the plan staff provides some services to a member in assistance with the Health Home, the plan delivered services should be included in the plan's CMART, but should be specific only to those delivered by the plan staff.
- If a member is triggered for care management and the plan determines the member is engaged in a Health Home, the member will be added to the plan's CMART as trigger only with the program type of Health Home, and will be noted as Not Enrolled in care management for the plan.
- Health Homes will be submitting information about the care management services they provide to members in the HH-CMART. Information about services provided by Health Homes should not be included in the plan's CMART files.

## V. How to Report

The 2015 CMART tool and an accompanying user's manual will be distributed prior to data submission. Plans may begin submitting CMART files for review by DOH starting April 11, 2016. Final files must be received by **May 9, 2016**.

**The CMART data submission tool must be submitted to the Department via the secure file transfer system on the Health Commerce System (HCS)** though it requires a user ID and password. All plans have access to the HCS. The secure file transfer is necessary because the files will contain protected health information. If you need access to the HCS, please contact your health plan's HCS coordinator. After you login to the HCS, select 'Secure File Transfer Application' from the Applications tab. Files sent via email (whether it is encrypted or not) will not be accepted. The file name should include the plan name. Select the recipient of the file as 'Amy Palmer'.

The steps for completion and submission of the data are as follows:

1. Plan completes the CMART for the measurement year (either through manual entry or file import);
2. Plan reviews the frequency and edit reports contained in the CMART to verify data completeness and to check for errors. Any errors should be corrected prior to submission;
3. Once the data are correct and complete in the CMART, a plan representative must submit the file to DOH via the HCS.
4. DOH will review the submission and the plan will be informed of any data issues. The plan will review these issues and respond appropriately. If the file needs to be revised following DOH review, the plan will make any necessary changes to the CMART data and submit the revised CMART via the HCS.

For care management segments which began prior to 2015 or are ongoing into 2016, plans should be including only services provided during 2015 in the 2016 CMART file. The 2015 CMART will contain data for all plan-administered care management services provided during 2015, the measurement year.

## VI. Questions

For questions about the specifications, general reporting guidelines, or CMART tool, contact:

- Email: nysqarr@health.state.ny.us
- Phone: (518) 486-9012; Health Plan CMART team

# *C. Reporting Requirements*

## *I. Eligible Population*

- **Product lines** – Medicaid managed care (MMC), Family Health Plus (FHP).
- **Age** – No age restriction; Includes both adults and children.
- **Plan Enrollment** – The member must have been enrolled with the plan in either MMC or FHP during the initial trigger-only event or at some point during the care management segment. There is no continuous enrollment requirement.
- **Care Management Eligibility** – The member must have received care management services as part of a plan-administered care management program for some part of the

measurement year ***or***, if not enrolled in care management during the measurement year, must have been identified as potentially eligible (i.e., triggered) for care management during the measurement year.

**PLEASE NOTE: Identifying the Care Management Segments or Initial Trigger-only Event**

There is a hierarchy for identifying what information to include in the member-level file. If a member received care management services from a plan-administered care management program during the measurement year, information from the care management segment(s) conducted in the measurement year should be included. **Members with more than one segment of care management will have more than one row in the member-level file.**

If the member triggered for care management at least once during the measurement year but never enrolled in care management, then include information about the initial trigger-only event. Specifications regarding determination of the initial trigger-only event are below. **Members with just trigger-only events should only be included in the member-level file once.**

Chart 1 in Appendix II provides a decision tree for use as a resource in determining the care management segment or initial trigger-only event for a member in the measurement year.

- **Care Management Segment** – For members who **received care management services or participated in care management** between January 1 and December 31 of the measurement year, each care management segment occurring during the measurement year will be included. There is no requirement that a care management segment must begin during the measurement year; instead it is only required that the member received care management services during the measurement year. There may be more than one segment for a member. If the member participated in more than one care management segment during the measurement year, each segment will be completed as a row in the member-level file.

  - **Care Management Segment Reporting Period** - For care management segments that are continuations from previous year (segment not closed prior to current measurement year) or segments that triggered AND enrolled in the current measurement year – Information for each segment should be limited to services provided **during the measurement year**. For all care management segments during the measurement year (January 1 through December 31), the care management services provided during the measurement year will be included in the file. For example, a segment that began in the previous measurement year (i.e., before January 1) which was still active during the measurement year will include information about care management services provided **only** during the measurement year (i.e., from January 1). If the segment is not concluded by December 31 of the measurement year, the segment should be included in the member-level file and marked as a 'NO' for CaseClosed. The information included in the segment will be limited to the services provided up to December 31 of the measurement year.

  - **Split-Year Care Management Segments** - If a member is **triggered in care management during the measurement year and is contacted or enrolled in care management during the first three months of the following measurement year**,

include contact and enrollment dates for these members through **March 31** of the following measurement year.

- **EXAMPLE 1**: A member is triggered in November 2015 and has had many contact attempts made. The member is not contacted until February 2016. This member's contact and enrollment data is included in the 2015 submission.

| CIN | TriggerDate | ContactDate | EnrollCMDate |
|---|---|---|---|
| AA11111A | 11/22/2015 | 2/3/2016 | 2/3/2016 |

- **EXAMPLE 2**: A member is triggered in December, 2015 and is contacted in March. The member does not enroll until April 2015. This member's contact data would be included in the 2015 submission but the enrollment data would not.

| CIN | TriggerDate | ContactDate | EnrollCMDate |
|---|---|---|---|
| AA11111A | 12/27/2015 | 3/17/2016 | |

- **EXAMPLE 3**: A member is triggered in December, 2015 and is contacted in January 2016. The member does not enroll. This member's contact data would be included in the 2015 submission.

| CIN | TriggerDate | ContactDate | EnrollCMDate |
|---|---|---|---|
| AA11111A | 12/30/2015 | 1/3/2016 | |

- The members shown in examples 1 and 2 would **ALSO** be submitted with the 2017 CMART (2016 Measurement Year) because both members had enrolled segments during the measurement year. The member in the third example would only be included in the 2017 CMART if they had a subsequent trigger during 2016.

o **Multiple Care Management Segments** - If a member is ***enrolled in care management two or more times during the measurement year***, each segment should be submitted. Each segment occurring during the measurement year will be a separate row in the member-level file.

- **EXAMPLE 4**: A member has three care management segments during the measurement year and one trigger-only event as follows: enrollment dates of December 2014 which is ongoing in January 2015, June 2015 and November 2015, and one trigger-only event in March 2015 which was not associated with enrollment. *In this example, the member would have three rows representing the three segments of care management services as illustrated below.* The March 2015 trigger-only event would not be included because the member did participate in a care management segment in the measurement year.

| CIN | TriggerDate | ProgramType | EnrollCMDate |
|---|---|---|---|
| AA11111A | 12/22/2014 | Chronic Adult | 1/3/2015 |
| AA11111A | 5/24/2015 | Chronic Adult | 6/04/2015 |
| AA11111A | 11/2/2015 | Chronic Adult | 11/24/2015 |

o **Care Management Segments for Simultaneous Programs** - If a member is ***enrolled in multiple care management programs simultaneously***, each care management segment is included as a separate row with information about the services provided for the specific program.

- **EXAMPLE 5:** A member's enrollment in two care management programs overlaps as follows: Chronic Adult Program – Enrolled February 2015, Closed May 2015; Behavioral Health Program – Enrolled March 2015,

Closed August 2015. In this example, the member would have two rows in the member level file as illustrated below:

| CIN | TriggerDate | ProgramType | EnrollCMDate |
|---|---|---|---|
| BB22222B | 1/1/2015 | Chronic Adult | 2/1/2015 |
| BB22222B | 3/1/2015 | Behavioral Health | 3/15/2015 |

- **Initial Trigger-only Event** – For members who did NOT participate in a care management segment between January 1 and December 31 of the measurement year, but triggered for care management at least once during the measurement year, the initial trigger-only event is the earliest occurring date of trigger for care management between January 1 and December 31 of the measurement year.

  - **Initial Trigger-only Event Reporting Period** – Include information from the entire initial trigger-only event (from trigger date through enrollment status). The majority of initial trigger-only event activities should occur within the measurement year, with some contact or assessment activities occurring in the following year for trigger dates occurring late in the measurement year. If a measurement year triggering event results in a care management enrollment in the following year then the trigger event should be included in the current measurement year submission.
    - **EXAMPLE 6:** A member has three trigger-only events, with none resulting in care management enrollment in the measurement year, as follows: January 2015, May 2015, and December 2015. In this example, the January 2015 trigger event would be considered the initial trigger-only event for the 2015 measurement year. Since the May and December events did not result in care management enrollment they would not be included in this submission. If the December 2015 trigger resulted in an enrollment in 2016 (through March 31, 2016), then the trigger event should be included with the care management segment in the current year's file.

## II. Member-Level Submission Elements

The specifications for each member-level element are provided below, along with additional reporting guidelines and clarifications. Table 1 in Appendix I provides a single table of the elements and their general specifications. Chart 2 in Appendix II provides a sample flow chart of the care management process and data points. Chart 2 was intended to provide a framework for how to think about your plan-specific process in terms of the data elements required for this submission. Since each plan's process is unique, Chart 2 *should not* be treated as a fixed process but as a *framework* for understanding how your plan's own process would crosswalk to the data elements for the submitted file.

- **Definitions:**
  - 'Missing' values (indicated by 9999) should be used to indicate that information was not available for that member for that element, but the element applied to the member.
  - Blank cells are valid only for members who were not included in the element population or when the element was not applicable to the member. (e.g., a member is not contacted by the care management staff, therefore, the variable 'ContactDate' would be left blank)

- **Data entry:**
  - **Elements 1 through 12 apply to all members in the file.** The values for each element will cover the various processes plans use during the intake phase of care management. For Element #9, a blank cell will be used to indicate the date field does not apply to the member.
  - **Elements 13 through 20 apply only to members who received care management services in the measurement year.** Blank cells for these elements indicate the member did not receive care management services during the measurement year.
  - The member-level elements can either be entered manually into the submission tool *or* imported into the tool following the specifications outlined here and in the CMART Users' Manual.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 1. | ClientID | OMC Plan ID | Text Field, 1111111 | Value as assigned. Required for reporting. | All Eligible Members |
| 2. | CIN | Medicaid Client Identification Number | Text Field, AA11111A | Value as specified. Required for reporting. | All Eligible Members |
| 3. | LastName | Last Name of Member | Text Field | Value as specified. | All Eligible Members |
| 4. | FirstName | First Name of Member | Text Field | Value as specified. | All Eligible Members |
| 5. | DOB | Date of Birth of Member | Numeric Field, MM/DD/YYYY | Date prior to TriggerDate. 09/09/9999 (Missing) | All Eligible Members |

- Plans may have different identification numbers for different purposes. For the CMART file submission, we are using the organization's Plan ID. If there is any question about what the appropriate ID is for your plan, then open the CMART tool, select your plan's name from the drop down list; the number to the left of your plan name is the Plan ID you should use.
- A valid CIN **must** be provided for every record and should represent the CIN from the measurement year.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 6. | TriggerDate | Date the member was identified as meeting plan-specified criteria indicating a potential need for care management services. | Numeric Field, MM/DD/YYYY | Must be in the measurement year or, if member enrolled in care management, can be prior to the measurement year. 09/09/9999 (Missing) | All Eligible Members |

- *Assigning the trigger date –*
  - For members who **<u>received care management services or participated in care management</u>** during the measurement year – use the date of the trigger event that leads to enrollment in the care management segment. For situations where

enrollment occurred early in the measurement year, the trigger date may be prior to the measurement year. If the member triggers for care management at the end of the measurement year AND the member enrolls in care management in the subsequent year (through March 31), the segment will be included in the current measurement year's CMART file.

- For members who were triggered and **not enrolled in care management** during the measurement year – use the date of the initial trigger-only event during the measurement year.
- See the 'Identifying the Care Management Segments or Initial Trigger-only Event' in Section C.II above for guidelines on handling members with multiple care management segments and/or triggering events in the measurement year.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 7. | ProgramType | Type of care management program. If enrolled, should be the program in which the member was enrolled. If not enrolled, should be the program reflecting the reason for trigger. | Text Field | BEHAVIORAL HEALTH<br>HIGH RISK OB<br>CATASTROPHIC<br>CHRONIC ADULT<br>HIV/AIDS<br>ONCOLOGY<br>PEDIATRICS<br>PROVIDER-BASED<br>UTILIZATION-BASED<br>MISSING | All Eligible Members |

- Members should be placed in one of the categories listed below based on the primary health issue for which they are enrolled in a care management program. For members who were not enrolled in care management, the member should be placed in a category based on the program they triggered for, or the program which best reflects the reason that member was triggered for care management. *The plan must assign each of their programs to one of the following 10 choices.*
  - Behavioral Health
  - High Risk OB
  - Catastrophic
  - Chronic Adult
  - HIV/AIDS
  - Oncology
  - Pediatrics
  - Provider-based - for members receiving all care management services from a Medical Home or Facility/Community Organization Care Management program
  - Utilization-based - Inpatient or ER use, high cost, service request
  - Missing – Should only be used if information is unavailable for a member
- If a member has **more than one issue**, select the *category that represents the primary issue for care management*.
  - **EXAMPLE 1**, a child with cancer could be categorized as Oncology or Pediatrics. If cancer care coordination is the primary focus for care management, the category selected would be Oncology.
  - **EXAMPLE 2**, a woman with a chronic condition is enrolled in care management for high risk OB care; the category selected would be High Risk OB, not Chronic Adult.
  - **EXAMPLE 3**, a member who receives care management from a behavioral health

clinic for the behavioral health services and plan care management for his/her diabetes would be categorized as Chronic Adult since this was the focus of the plan's services for the member.

- **NYS DOH does not require that plans conduct every type of care management program listed.** The options were intended to cover the various programs plans may have.
- If a member **received care management services from *both* the plan and a provider or health home care program**, then the program type for the *plan-administered care management program* should be selected.
  - If *plan staff is delivering care management in the setting of the provider offices or other location* then the program type selected should reflect the area of primary focus for care management for the member. Since plan staff is providing services, 'provider-based program' *should not* be selected in this situation, even though the plan staff is providing care management services in a provider setting.
- For a member **in a provider-based program for whom the *plan staff is not involved* in any way** with managing the member's care, the member should be *recorded as being triggered only* (i.e., not enrolled) and assigned to the appropriate program type (i.e., provider-based). In other words, members who are receiving care management services *exclusively* from a provider or other organization *should not be recorded as enrolled* in a plan-administered program.
  - If a member is triggered for care management and during outreach the plan learns the person is in care management with a provider or other organization AND plan staff will not be involved in managing the person's care, then the program type selected would be 'PROVIDER-BASED' for the trigger-only event.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 8. | AbleContact | Indicates whether plan was able to contact the member regarding possible enrollment in care management. | Text Field | YES<br>NO<br>NOT APPROPRIATE FOR CM | All Eligible Members |
| 9. | ContactDate | Date of initial contact or interaction between the member/family and care management staff. | Numeric Field, MM/DD/YYYY | Date on or after TriggerDate. Must be in the measurement year or, if member enrolled in care management, can be prior to the measurement year.<br>09/09/9999 (Missing)<br>Blank Cell (Not Contacted) | All Eligible Members |

- Defining Contact -
  - Contact is defined as a verbal interchange between member/family and care management staff. Letters sent to members should not be counted as contact, nor should leaving messages for members. Member replies to email and text messages would qualify as a verbal interchange.
  - If the plan is **unable to contact** the member regarding possible enrollment in care management using their specified outreach protocol **or does not attempt to contact the member**, then the AbleContact field should be indicated as 'NO'.

- If the plan does not attempt to contact the member because the plan **has determined the member is not appropriate** for care management, then AbleContact field should be indicated as "NOT APPROPRIATE FOR CM'.

- Contact Procedures -
  - Plans are required to provide a brief description of their policies regarding contacting members about care management as part of the Plan-Level Reporting (see Section C.IV for more information). NYS DOH does not have a specified requirement for contact procedures.
  - If your plan's care management programs have specified policies that require members to be contacted within a specific number days of the trigger date and each member will have these specific steps as part of the contact (or outreach) procedure then plans should use those procedures when filling in the elements about able to contact.
  - If your plan does not have a specified procedure regarding attempting contact, you should use 3 attempts by phone on different dates within 30 days of trigger as the contact procedure.

- The ContactDate field should be completed for members who were contacted (AbleContact='YES'). If the member was not contacted (AbleContact='NO' or 'NOT APPROPRIATE FOR CM'), the field should be left blank.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 10. | AppropriateCM | Indicates whether the member met at least one of the plan's criteria for needing care management services. | Text Field | YES<br>NO<br>NOT ABLE TO CONTACT | All Eligible Members |

- Appropriateness for care management may be determined through a review of data, a short assessment or a comprehensive assessment depending on the plan's process.

- This element should be completed to reflect your plan-specific process for determining whether a member meets your plan's criteria for care management. For example, plans which do not have additional criteria beyond those used to identify (trigger) a member for care management would complete this field as 'Yes' for all members in the submission because the trigger was the qualifying criteria. In contrast, plans that use one or more additional steps beyond the triggering criteria would record members as either 'Yes' or 'No' depending on whether the additional steps determined the member was or was not appropriate for placement in a care management program. Plans that determine appropriateness through contacting a member directly may select 'Not Able to Contact' if appropriateness could not be determined for this reason.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 11. | RefusedCM | Indicates if member or member's family refused to participate in care management. | Text Field | REFUSED<br>DID NOT REFUSE<br>NOT OFFERED CM | All Eligible Members |

- For members offered care management services, their response should be recorded as 'REFUSED' or 'DID NOT REFUSE'.
- For members who were not offered care management services for any reason (such as they were not contacted or were deemed not appropriate) this element should be indicated as 'NOT OFFERED CM'.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 12. | EnrolledCM | Indicates if member was successfully enrolled in a care management program. | Text Field | YES<br>NO | All Eligible Members |
| 13. | EnrollCMDate | Date that member or member's family agreed to participate in the segment of care management. | Numeric Field, MM/DD/YYYY | Date on or after TriggerDate. Must be in the measurement year or prior to the measurement year.<br>09/09/9999 (Missing)<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |

- Defining Care Management Enrollment –
  - Enrollment in care management is the agreement between the member and the care manager to participate in care management. A member is considered enrolled in care management when the care manager and the member/family both agree there is a need for care management and the member/family consents to participate (formally or informally).
- The enrollment date is the day the member is officially considered enrolled in a care management program. It may be the same as the assessment date or can be the date of the care plan depending on the process used by plans. If the member did not enroll in care management (EnrolledCM='NO'), the enrollment date should be blank.
- For Elements 13 through 20, the 'Element Population' is changed to only those members who received care management services during the measurement year (i.e. active in care management). These fields should remain blank for members who were not enrolled or did not participate in a care management program during the measurement year (EnrolledCM='NO').
- For members who were enrolled, but either refused to participate after enrolling (even if it is with the first care management intervention) or were not able to be contacted after enrolling, elements 13-20 should still be completed.
- For members receiving care management from a provider or other organization and…
  - For whom the *plan staff is not involved* in any way with managing the member's care, the member should be recorded as being triggered only (i.e., 'NO' for EnrolledCM) and *elements 13-20 will not be completed.*
  - For whom the *plan staff are involved* in providing care management services to the member, the member should be recorded as enrolled (i.e., 'YES' for EnrolledCM) and *elements 13-20 should be completed to reflect plan staff activities.*

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 14. | Intensity | The maximum level of intensity of care management needed for the individual during the segment of care management. | Text Field | HIGH<br>MEDIUM<br>LOW<br>MISSING<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |

- Indicate the maximum level of intensity associated with the member's care management segment using the following categories:
  - High – Contact needed more than weekly
  - Medium – Contact needed weekly to every other week
  - Low – Contact needed less than every other week (such as monthly or quarterly)
- When the frequency of contact varies for a member over the course of the care management segment, the level of intensity reported for that member should be the maximum level received across the entire care management segment during the measurement year.
  - **EXAMPLE**: If the initial contact with a member is every other week (medium) and then goes to two to three times a week for a period of time (high) and for the last two months goes to monthly or less (low), the intensity for that member would be 'High' since that was the maximum level of intensity during the entire segment.
- For members who were enrolled in care management but refused to participate with the first intervention or could not be contacted following enrollment, Intensity should be entered as 'Missing'.
- For members who are receiving care management from ***both*** the plan's staff and a provider, other organization or Health Home, the intensity should be a reflection of the *intensity of services provided by plan staff.*

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 15. | CountMail | Count of mail interactions by plan staff for or with member during care management segment in the measurement year. | Numeric Field, Hundreds, whole number (000) | Value greater than or equal to zero.<br>999 (Missing)<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |
| 16. | CountPhone | Count of phone interactions by plan staff for or with member during care management segment in the measurement year. | Numeric Field, Hundreds, whole number (000) | Value greater than or equal to zero.<br>999 (Missing)<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |
| 17. | CountPerson | Count of in-person interactions by plan staff for or with member during care management segment in the measurement year. | Numeric Field, Hundreds, whole number (000) | Value greater than or equal to zero.<br>999 (Missing),<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |

- Defining an intervention –
  - **Interventions conducted as part of outreach** (prior to enrollment in care management) **should be excluded**.
  - Each separate intervention should be **counted once** for an appropriate category.
  - Only interventions which were **conducted** should be counted; attempts should not be included.
  - The counts of interventions reported for a member should be **limited to the care management segment in the measurement year** and should not include interventions occurring before the measurement year or beyond the measurement year if the segment began prior to January 1 or continues beyond December 31 of the measurement year.
  - The counts should not include interventions provided from any other segments. Counts for other segments in the measurement year will be reported in their own rows.
  - The interventions conducted during the segment may involve the health care providers, the member and family, or other community based services. The interventions should be **specific to the individual** member's care or care management needs.
  - Interventions delivered by **all care management staff** (care managers and support staff) should be included.
  - Interventions conducted **by plan staff** should be counted.
    - If plan staff arranged for home care equipment and the provider's office arranged for a specialist appointment, the plan would count the home care intervention rather than both.
  - For **members enrolled in provider-based** care management programs**:**
    - Interventions *conducted by providers or other organizations, directly* should *not be counted.*
    - *Interventions conducted by the plan staff themselves* for members enrolled in both a plan program as well as a provider-based program should be *counted.*

For health plan analyses, cases involving both plan-administered and provider-based programs will

excluded from evaluation activities involving interventions as both components would be an incomplete reflection of care management the member received.

- These elements capture the count of interventions conducted for or with the member during their care management segment. Each intervention should be assigned to one the three following categories as appropriate:
  - *Mail* – count ONLY individualized letters or emails sent during the segment. Mailings or email messages of pre-written materials not specific to the individual should not be included.
  - *Phone* – count phone call/text message interactions made during the segment. Both incoming and outgoing phone call/text message interactions should be counted. For text messages, back and forth interactions that occur during one conversation count as one interaction (not one interaction for each text message). Automated voice messages, attempted phone calls, leaving voice mail, or text messages without replies should not be counted.
  - *In-person meeting* – count each interaction during the segment.

- For members who were enrolled but *could not be contacted following enrollment*, the number of interventions should be zero. For members who were *enrolled in care management but refused* to participate with first intervention, then the number of interventions should be one.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 18. | CaseClosed | Indicates whether the care management segment was closed during the measurement year. | Text Field | CLOSED<br>OPEN<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |

- Plans should use their care management policies for determining case closure.
  - If there is a plan policy for closing segments due to inability to reach the member, the segment should be considered closed as defined by the plan policy.
  - If there is no plan policy for closing segments due to inability to reach the member, the segment should be considered closed after three unsuccessful attempts within 30 days *or* no contact within 60 days unless there is a planned period of inactivity for the member, such as awaiting organ transplant.
  - OB programs which may have periods of inactivity would be an example of an exception to closing cases due to inactivity. OB programs should follow their policies on closure. Periods of inactivity prior to delivery do not indicate the segment should be closed.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 19. | ClosureDate | Date that the care management segment was closed. | Numeric Field, MM/DD/YYYY | Date after EnrollCMDate. Must be in the measurement year.<br>09/09/9999 (Missing)<br>Blank Cell (Not Enrolled or Not Closed) | Eligible members who received care management services during the measurement year. |

- Closure date should be based on the plan's care management policies for determining segment closure. If unable to determine the closure date the following guidance should be used –
  - If the care management goals were met, use the date indicating achievement of goals documented in the care management record.
  - If the member was disenrolled from the plan, use the disenrollment date.
  - If the member refused to continue participating in care management, use the date of refusal.
  - If the member was lost to follow up and attempts to contact were documented, use the date of the final attempt.
  - If no attempts to contact the member were documented, use 60 days from last documented contact.
  - If a member is in separate care management programs with overlapping segments, the closure date is the date the care management segment was completed. The other segments will have their own closure dates included in their rows.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values | Element Population |
|---|---|---|---|---|---|
| 20. | ReasonClosure | Indicates reason for closure of care management segment. | Text Field | MET PROGRAM GOALS<br>DISENROLLED FROM PLAN<br>REFUSED TO CONTINUE<br>LOST TO FOLLOW-UP<br>TRANSITIONED TO NON-PLAN CM<br>MISSING<br>NOT CLOSED<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |

- Members whose care management segment was closed should have one of the following reasons for closure indicated:
  - *Met program goals*
  - *Disenrolled from plan* - includes voluntary and involuntary disenrollment as well as if member dies
  - *Refused to continue* participation in care management
  - *Lost to follow-up* – If the member was enrolled in care management but the plan was unable to contact the member at any point during the care management segment (as specified by the plan's closure policy or based on the guidance provided for element #18 (CaseClosed)), the reason for closure should be 'LOST TO FOLLOW-UP'.
  - *Transitioned to non-plan CM* – Applies to members who were received plan-administered care management during the measurement year but moved into a non-plan-administered care management program (such as a Health Home).

## III. Plan-Level Submission Elements

The specification of each plan-level element is provided in this section, along with additional reporting guidelines and clarifications and an overview of how to enter the information into the data submission tool. *These elements are required for all plans.* Table 2 in Appendix I provides a single table of these elements and their general specifications.

- ***These elements must be entered into the data submission tool manually*** (they cannot be imported) ***following the specifications outlined here and in the CMART Users' Manual***.

| Element Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 1. | Care Management Programs and Populations | List each type of care management program administered by the plan. *Briefly* describe, if needed, the population served by each. The program titles must correspond to those specified for the ProgramType element (#7) collected in the member-level data submission. | BEHAVIORAL HEALTH<br>HIGH RISK OB<br>CATASTROPHIC<br>CHRONIC ADULT<br>HIV/AIDS<br>ONCOLOGY<br>PEDIATRICS<br>PROVIDER-BASED<br>UTILIZATION-BASED |

- **Method for Completing:**
  a. Choose a care management program type from the drop-down box provided. The plan must cross-walk their own program names to those types specified by the NYS DOH.
  b. In the accompanying text field provide a *brief* summary as needed (up to 250 characters) describing the population(s) served by this program type.
  c. Repeat this process using the remaining boxes until all of your plan's care management programs have been described. **Do not select any program types that your plan does not administer.**

- One program type category might encompass several of your care management programs. That is expected. Describe the population for each program included in a specified program type.
  - **EXAMPLE**: ProgramType of CHRONIC ADULT is selected and in the text field the description of "diabetes, hypertension and heart failure are target populations" is entered.

| Element Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 2. | Intervention Types | Describe the types of interventions that occur as part of your care management programs. Describe only the interventions specified and only those relevant to your plan. | • **Health knowledge** (treatment guidelines, medication, disease knowledge, self-management)<br>• **Health care arrangement** (appointments, referrals, care coordination)<br>• **Service need arrangement** (home care, equipment, community resources, transportation, community referrals)<br>• **Member progress monitor** (follow up, ongoing assessment, barrier identification) |

- **Method for Completing:**
  a. Choose a specified intervention type from the drop-down box provided.
  b. In the accompanying text field provide a *brief* summary (up to 250 characters) describing the activities included in this type of intervention at your plan.
  **c.** Repeat this process using the remaining boxes until all of your plan's care management intervention types have been described. **Do not select any intervention types that your plan does not administer.**

| Element Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 3. | Intensity Definitions | Describe your plan's definition of each level of intensity. The intensity categories correspond to those specified for the Intensity element (#14) collected in the member-level data submission. | HIGH – more than weekly<br>MEDIUM – weekly to every other week<br>LOW – less than every other week |

- **Method for Completing:**
  a. Provide a *brief* summary (up to 250 characters) describing your plan's definition of each intensity level in the appropriate text boxes provided. The categories are based on frequency of contact. Plan definitions can be mapped to each category using frequency of contact.
  **b. If a level of intensity is not used in the plan definitions, indicate this is not used in the text box.**

| Element Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 4. | Enrollment Process | Use the categories specified to order and describe each step in your plan's care management enrollment process, from identifying individuals through to program enrollment. | IDENTIFY<br>CONTACT<br>DETERMINE<br>APPROPRIATENESS ENROLL |

- **Method for Completing:**
  a. Step 1 in the care management process always is to identify members who are potential candidates for care management. Hence Step 1 is pre-filled to IDENTIFY. In the accompanying text box *briefly* describe (up to 250 characters) how your plan identifies potential individuals for care management (criteria or triggers used and data sources).
  b. From the next drop-down box choose the category that best describes the next step in your plan's enrollment process.
  c. *Briefly* describe the activities involved in this step.

d. Continue this process using the categories provided so that when done each step of your plan's enrollment process has been ordered sequentially.

- **Definitions:**
  a. **Identify** – to ascertain members who meet one or more criteria used to indicate possible need for care management.
  b. **Contact** – to have initial verbal interchange between plan staff and member/family about needs and care management services.
  c. **Determine Appropriateness** – to evaluate information that may indicate person's ability or appropriateness to participate in care management.
  d. **Enroll** – to agree to participate in care management interventions to achieve established goals.

- **Refer to Chart 2 in Appendix II for a sample flow chart of the care management decision points.** Chart 2 was intended to provide a framework for how to think about your plan-specific process in terms of the data elements required for this submission. Since each plan process is different, Chart 2 *should not* be treated as a fixed process but as a *framework* for describing and understanding your own process.

| Element Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 5. | Assessment Method | Indicate the most common method in which a care management assessment is completed for individuals during your plan's care management enrollment process. | IN PERSON<br>BY PHONE<br>VIA RECORD REVIEW<br>OTHER |

- **Method for Completing:** Choose *one* method of assessment from the drop-down box provided. This method should reflect the most common way in which assessments are completed for individuals during the care management enrollment process. If assessments are commonly completed using multiple methods, then the primary method of assessment should be selected.

- **Definitions:**
  - *Assessment* - An initial contact or review of a priority problem <u>*does not*</u> constitute an assessment. At a minimum, the assessment should include the following areas:
    - Physical/functional
    - Psychosocial
    - Environmental/residential
    - Care-giver capability
    - Medication lists and/or compliance
  - *In Person* – Method involves meeting with the individual face-to-face in order to complete the assessment.
  - *By Phone* – Method involves talking with the individual over the phone in order to complete the assessment.
  - *Via Record Review* – Method involves reviewing existing service and assessment records, *including administrative data*, in order to complete the assessment.

- *Other* – Assessment is completed using a method other than the direct contact or record review methods above.

| Element Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 6. | Closure Criteria | Indicate the structure of care management closure criteria at your plan and briefly describe the criteria. | HIGHLY STRUCTURED<br>MODERATELY STRUCTURED<br>UNSTRUCTURED |

- **Method for Completing:**
  a. Choose *one* level of care management closure criteria at your plan from the drop-down box provided. This level should reflect how structured the closure policy is *in general* across all care management program types.
  b. In the accompanying text field provide a *brief* summary (up to 250 characters) describing your plan's closure criteria.
- **Definitions:**
  a. *Highly Structured* – specific criteria and steps for formal closure of the segment used in all segments.
  b. *Moderately Structured* – common procedures followed by staff to consistently close segments.
  c. *Unstructured* – no policy or procedure; each care manager uses their best judgment about when to close segments.

| Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 7. | FTE Months by Staffing Level | Annual number of plan FTE months of all staff for care management for Medicaid managed care/Family Health Plus cases by specified type of staff. These are numeric fields with the format of hundreds rounded to the tenths decimal (000.0). | RN<br>LPN<br>LICENSED SOCIAL WORKER<br>OTHER SKILLED HEALTH PROF<br>SUPPORT STAFF/OUTREACH |

- **Method for Completing:** Enter the number of annual FTE months for each of the specified staff types in the boxes provided. If your plan does not employ one or more staffing categories for care management then enter zero (0) for that staffing category.

- **Definitions:**
  a. *FTE months:* The number of full time equivalents of care management staff performing care management activities for Medicaid managed care or Family Health Plus enrollees for each month in the measurement year, summed across all 12 months.
     - **EXAMPLE:** If a plan has 2 LSW care managers for six months and adds a third LSW care manager for the next six months, the total FTE months for 'Licensed Social Worker' is 30. (12 months + 12 months + 6 months= 30)
     - If staffing is not specific to product lines, the plan should prorate FTE by the proportion of segments for Medicaid/FHP members or by the proportion of Medicaid/FHP in plan membership.
     - If care management services involve use of a vendor, the skilled health professionals used by the vendor should be included in the FTE calculation;

however, the vendor FTE should be specific to the plan's contract or members.

b. *Staffing Categories:*
   - *RN, Licensed Social Worker and Other Skilled Health Professionals* – Skilled health professionals are individuals with a degree, licensure or certification in a health related field who have the ability to conduct assessments independently within the scope of practice for the degree/license/certification. (Other resources for criteria for skilled health professionals include CMSA's Standards of Practice – 2010 or URAC's Case Management Standards – CM 5 Staff Qualifications.)
   - *LPN*- Licensed Practical Nurses who support and conduct care management activities.
   - *Support Staff/Outreach* - Any other staff not captured in the other categories who support and conduct care management activities.

| Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 8. | Average Case Load | Average monthly care management case load of skilled health professional staff for Medicaid managed care/Family Health Plus. | This is a numeric field with the format of hundreds rounded to the tenths decimal (000.0). |

- **Method for Completing:** Enter the number in the field provided. The average case load is determined by the plan by calculating number of open care management segments for Medicaid and Family Health Plus members divided by the skilled health care staff. The monthly open segments are summed for the year and the monthly FTEs are summed for the year. The yearly total number of open segments divided by the yearly total of FTEs represents the average case load.

  For this data element, open segments include any active segments in the measurement year even if they began prior to the measurement year.

- **Definitions:** Refer to the FTE Months element (#7) above for the definition of skilled health professions.

| Number | Element Title | Element Description | Element Categories |
|---|---|---|---|
| 9. | Total Plan Enrollment | Number of unique Medicaid managed care and Family Health Plus members enrolled in the health plan as of December 31 of the measurement year. | This is a numeric field with the format of hundred thousands, rounded to a whole number (000,000). |

- **Method for Completing:** Enter the number in the field provided.
- For this element, plans should include only Medicaid managed care or Family Health Plus members enrolled in the health plan as of December 31 of the measurement year.
- Only Medicaid managed care or Family Health Plus enrollment should be included, i.e., do not include commercial, Medicare, CHP, Medicaid Advantage, or any other product enrollment.
- There are no continuous enrollment criteria to apply.

## *D. Appendix I: Tables of Required Elements*

### *I. Table 1: Required Elements for Member-Level Reporting*

### *II. Table 2: Required Element for Plan-Level Reporting*

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### *Table 1: Required Elements for Member-Level Reporting – 2016 Reporting Year* [1]

| Number | Import Field Name | Element Description | Import Format | Valid Response Values[2] | Element Population |
|---|---|---|---|---|---|
| 1. | ClientID | OMC Plan ID | Text Field, 1111111 | Value as assigned. Required for reporting. | All Eligible Members |
| 2. | CIN | Medicaid Client Identification Number | Text Field, AA11111A | Value as specified. Required for reporting. | All Eligible Members |
| 3. | LastName | Last Name of Member | Text Field | Value as specified. | All Eligible Members |
| 4. | FirstName | First Name of Member | Text Field | Value as specified. | All Eligible Members |
| 5. | DOB | Date of Birth of Member | Numeric Field, MM/DD/YYYY | Date prior to TriggerDate. 09/09/9999 (Missing) | All Eligible Members |

1 – For additional guidance on the submission requirements for these elements, refer to Section C.II of the 2016 Care Management Reporting Technical Specifications document.
2 – 'MISSING' should be used to indicate that information was not available for that member for that element. Blank cells are valid only for members who were not included in the element population.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values[2] | Element Population |
|---|---|---|---|---|---|
| 6. | TriggerDate | Date the member was identified as meeting plan-specified criteria indicating a potential need for care management services. | Numeric Field, MM/DD/YYYY | Must be in the measurement year or, if member enrolled in care management, can be prior to the measurement year. 09/09/9999 (Missing) | All Eligible Members |

1 – For additional guidance on the submission requirements for these elements, refer to Section C.II of the 2016 Care Management Reporting Technical Specifications document.
2 – 'MISSING' should be used to indicate that information was not available for that member for that element. Blank cells are valid only for members who were not included in the element population.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values[2] | Element Population |
|---|---|---|---|---|---|
| 7. | ProgramType | Type of care management program. If enrolled, should be the program in which the member was enrolled. If not enrolled, should be the program reflective of reason for trigger. | Text Field | BEHAVIORAL HEALTH<br>HIGH RISK OB<br>CATASTROPHIC<br>CHRONIC ADULT<br>HIV/AIDS<br>ONCOLOGY<br>PEDIATRICS<br>PROVIDER-BASED<br>UTILIZATION-BASED<br>MISSING | All Eligible Members |
| 8. | AbleContact | Indicates whether plan was able to contact the member regarding possible enrollment in care management. | Text Field | YES<br>NO<br>NOT APPROPRIATE FOR CM | All Eligible Members |
| 9. | ContactDate | Date of initial contact or interaction between the member/family and care management staff. | Numeric Field, MM/DD/YYYY | Date on or after TriggerDate. Must be in the measurement year or, if member enrolled in care management, can be prior to the measurement year.<br>09/09/9999 (Missing)<br>Blank Cell (Not Contacted) | All Eligible Members |
| 10. | AppropriateCM | Indicates whether the member met at least one of the plan's criteria for needing care management services. | Text Field | YES<br>NO<br>NOT ABLE TO CONTACT | All Eligible Members |

1 – For additional guidance on the submission requirements for these elements, refer to Section C.II of the 2016 Care Management Reporting Technical Specifications document.
2 – 'MISSING' should be used to indicate that information was not available for that member for that element. Blank cells are valid only for members who were not included in the element population.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values[2] | Element Population |
|---|---|---|---|---|---|
| 11. | RefusedCM | Indicates if member or member's family refused to participate in care management. | Text Field | REFUSED<br>DID NOT REFUSE<br>NOT OFFERED CM | All Eligible Members |
| 12. | EnrolledCM | Indicates if member was successfully enrolled in a care management program. | Text Field | YES<br>NO | All Eligible Members |
| 13. | EnrollCMDate | Date that member or member's family agreed to participate in care management. | Numeric Field, MM/DD/YYYY | Date on or after TriggerDate. Must be in the measurement year or prior to the measurement year.<br>09/09/9999 (Missing)<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |
| 14. | Intensity | The maximum level of intensity of care management needed for the individual during the segment of care management. | Text Field | HIGH<br>MEDIUM<br>LOW<br>MISSING<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |
| 15. | CountMail | Count of mail interactions by plan staff for or with member during care management segment in the measurement year. | Numeric Field, Hundreds, whole number (000) | Value greater than or equal to zero.<br>999 (Missing)<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |
| 16. | CountPhone | Count of phone interactions by plan staff for or with member during care management segment in the measurement year. | Numeric Field, Hundreds, whole number (000) | Value greater than or equal to zero.<br>999 (Missing)<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |

1 – For additional guidance on the submission requirements for these elements, refer to Section C.II of the 2016 Care Management Reporting Technical Specifications document.
2 – 'MISSING' should be used to indicate that information was not available for that member for that element. Blank cells are valid only for members who were not included in the element population.

| Number | Import Field Name | Element Description | Import Format | Valid Response Values[2] | Element Population |
|---|---|---|---|---|---|
| 17. | CountPerson | Count of in-person interactions by plan staff for or with member during care management segment in the measurement year. | Numeric Field, Hundreds, whole number (000) | Value greater than or equal to zero.<br>999 (Missing),<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |
| 18. | CaseClosed | Indicates whether the care management segment was closed during the measurement year. | Text Field | CLOSED<br>OPEN<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |
| 19. | ClosureDate | Date that the care management segment was closed. | Numeric Field, MM/DD/YYYY | Date after EnrollCMDate. Must be in the measurement year.<br>09/09/9999 (Missing)<br>Blank Cell (Not Enrolled or Not Closed) | Eligible members who received care management services during the measurement year. |
| 20. | ReasonClosure | Indicates reason for closure of the care management segment. | Text Field | MET PROGRAM GOALS<br>DISENROLLED FROM PLAN<br>REFUSED TO CONTINUE<br>LOST TO FOLLOW-UP<br>TRANSITIONED TO NON-PLAN CM<br>MISSING<br>NOT CLOSED<br>Blank Cell (Not Enrolled) | Eligible members who received care management services during the measurement year. |

1 – For additional guidance on the submission requirements for these elements, refer to Section C.II of the 2016 Care Management Reporting Technical Specifications document.
2 – 'MISSING' should be used to indicate that information was not available for that member for that element. Blank cells are valid only for members who were not included in the element population.

## *Table 2: Required Elements for Plan-Level Reporting – 2016 Reporting Year* [1]

| Element Number | Element Title | Element Description | Element Values |
|---|---|---|---|
| 1. | Care Management Programs and Populations | List each type of care management program administered by the plan. B*riefly* describe, if needed, the population served by each. The program titles must correspond to those specified for the Program Type element (#7) collected in the member-level data submission. | BEHAVIORAL HEALTH<br>HIGH RISK OB<br>CATASTROPHIC<br>CHRONIC ADULT<br>HIV/AIDS<br>ONCOLOGY<br>PEDIATRICS<br>PROVIDER-BASED<br>UTILIZATION-BASED |
| 2. | Intervention Types | Describe the types of interventions that occur as part of your care management programs. Describe only the interventions specified and only those relevant to your plan. | • **Health knowledge** (treatment guidelines, medication, disease knowledge, self-management)<br>• **Health care arrangement** (appointments, referrals, care coordination)<br>• **Service need arrangement** (home care, equipment, community resources, transportation, community referrals)<br>• **Member progress monitor** (follow up, ongoing assessment, barrier identification) |
| 3. | Intensity Definitions | Describe your plan's definition of each level of intensity. The intensity categories correspond to those specified for the Intensity (element #16) collected in the member-level data submission. | HIGH – more than weekly<br>MEDIUM – weekly to every other week<br>LOW – less than every other week |

1 – For additional guidance on the submission requirements for these elements, refer to Section C.III of the 2016 Care Management Reporting Technical Specifications document.

| Element Number | Element Title | Element Description | Element Values |
|---|---|---|---|
| 4. | Enrollment Process | Use the categories specified to order and describe each step in your plan's care management enrollment process, from identifying individuals through to program enrollment. | IDENTIFY<br>CONTACT<br>DETERMINE APPROPRIATENESS<br>ENROLL |
| 5. | Assessment Method | Indicate the most common method in which a care management assessment is completed for individuals during your plan's care management enrollment process. | IN PERSON<br>BY PHONE<br>VIA RECORD REVIEW<br>OTHER |
| 6. | Closure Criteria | Indicate the structure of care management closure criteria at your plan and briefly describe the criteria. | HIGHLY STRUCTURED<br>MODERATELY STRUCTURED<br>UNSTRUCTURED |
| 7. | FTE Months by Staffing Level | Annual number of plan FTE months of all staff for care management for Medicaid managed care/Family Health Plus cases by specified type of staff. These are numeric fields with the format of hundreds rounded to the tenths decimal (000.0). | RN<br>LPN<br>LICENSED SOCIAL WORKER<br>OTHER SKILLED HEALTH PROF<br>SUPPORT STAFF/OUTREACH |
| 8. | Average Case Load | Average monthly care management case load of skilled professional staff for Medicaid managed care/Family Health Plus. | This is a numeric field with the format of hundreds rounded to the tenths decimal (000.0). |
| 9. | Total Plan Enrollment | The number of unique Medicaid managed care and Family Health Plus members enrolled in the health plan as of December 31 of the measurement year. | This is a numeric field with the format of hundred thousands, rounded to a whole number (000,000). |

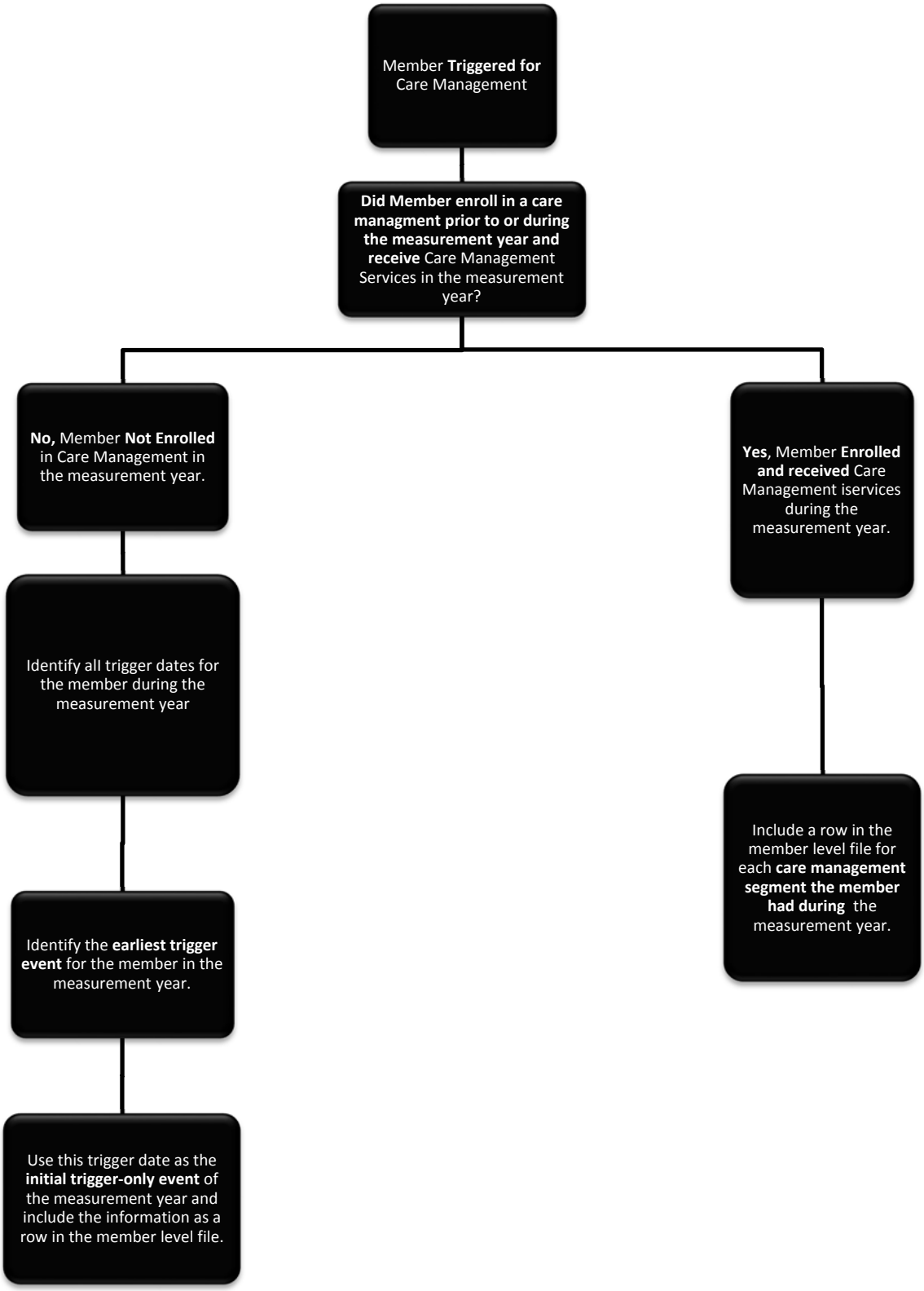
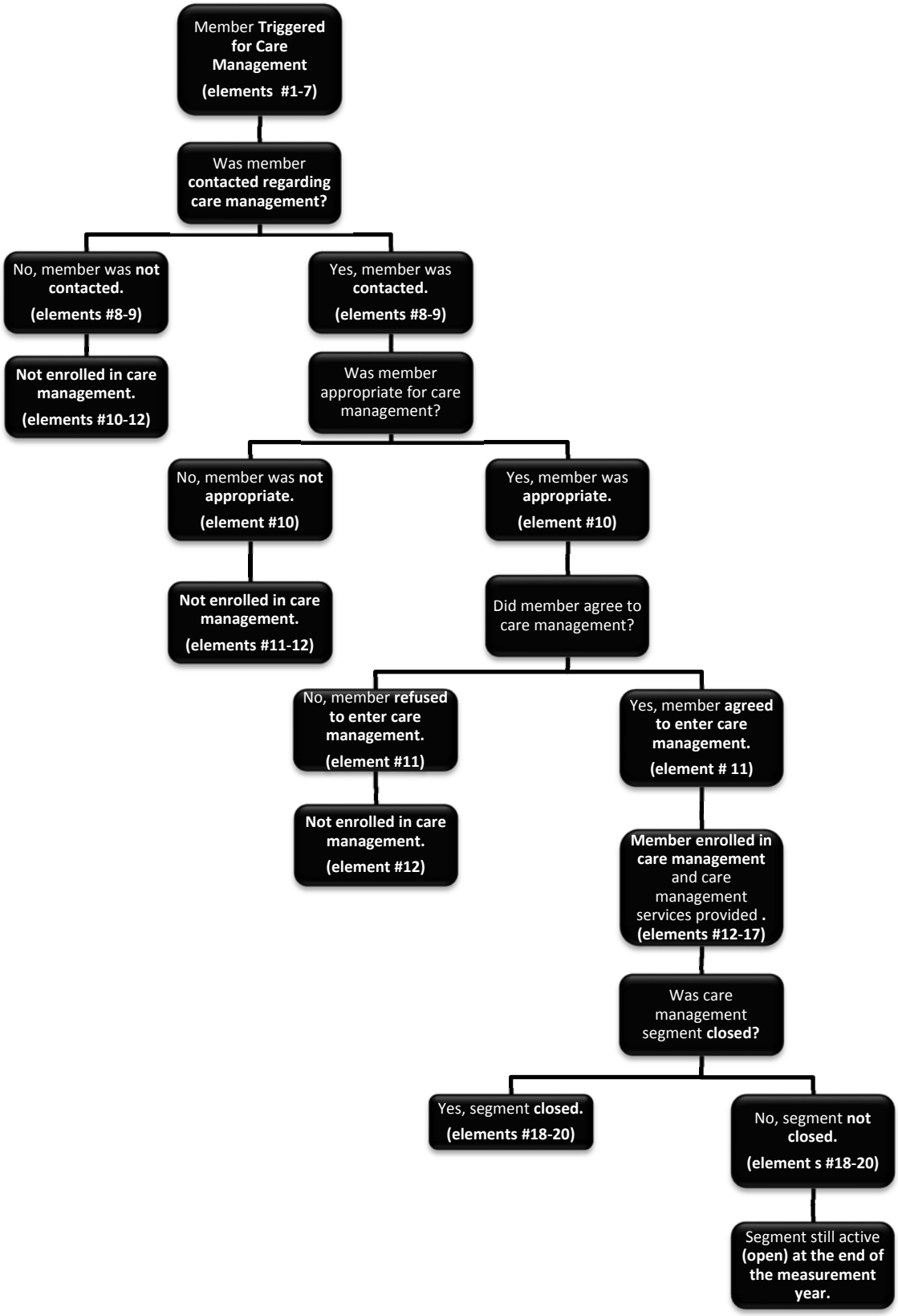
1 – For additional guidance on the submission requirements for these elements, refer to Section C.III of the 2016 Care Management Reporting Technical Specifications document.

## *E. Appendix II: Flow Charts of Care Management Decision Points*

### *I.* Chart 1: Determining the Segment of Care Management or Initial Trigger-only Event

### *II.* Chart 2: Sample Map of Decision Points for Care Management Process

**Chart 1: Determining the Care Management Segment or Initial Trigger-only Event: Flow Chart of Hierarchical Decision Points**



## Chart 2: Sample Map of Decision Points for Care Management Process