Health Plan CMART

HP-CMART VERSION 3.8 SPECIFICATION

Last revised: October 2021

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

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Summary of Changes

Changes (v3.8)

- October 2021
  - Dates for 2022 submission updated
  - Segments Start file deleted
  - Segments End file deleted
  - Added Foster Care as a Special Population
  - Error Code Key updated
  - Details about Foster Care added to Appendix A

Overview

Care management is defined as the delivery of member-specific interventions by a multidisciplinary team, led by a dedicated care manager. Care management activities are based on a current assessment and, where applicable, a person-centered plan of care. The interventions should result in coordinated, efficient, and quality care to achieve the member's goals and optimize health outcomes for people with complex health issues and needs. For people in Medicaid health plans, care management is required to address care needs, coordinate services, and arrange efficient quality health care to promote health outcomes. The care manager should ensure enrollees receive needed medical, behavioral, and social services in accordance with the goals of the member. Where a plan of care is required, health plans are encouraged to utilize health information technology to create, document, execute, and update the plan of care.

Throughout this document, the term health plan includes the health plan staff or their subcontractor of health plan care management services. (Health Home services are not included.)

The Health Plan Care Management Assessment Reporting Tool (HP-CMART) is a tool for the collection of standardized care management data for Medicaid members who received care management services provided by the health plans, special needs plans (SNP), or Health and Recovery Plans (HARP), at any time during the measurement year. Members of special populations (SP) can be found within these aforementioned plans and should also be included: personal care services (PCS), consumer directed personal assistances services (CDPAS), residential health care facility (RHCF) for long term placement, AIDS adult/adult day health care, other long-term services and supports (LTSS), medically fragile children, adults in receipt of Home and Community Based Services (HCBS), children in receipt of HCBS, homeless, children/youth placed in foster care, and clotting factor recipients (more detail about these special populations can be found in Appendix A).

The HP-CMART data will provide the New York State Department of Health (NYSDOH) with information about care management services regarding the volume and type of interventions for all members.

Reporting Schedule

HP-CMART submissions are due to NYSDOH by the first Monday of May following the close of the measurement year.

Measurement Timeframe	Due Date
January 1-December 31, 2021	1st Monday in May 2022; **May 2, 2022**
January 1-December 31, 2022	1st Monday in May 2023; **May 1, 2023**

What to Report

Health plans are required to provide NYSDOH with the following information submitted via the HP-CMART:

Interventions

The submission will contain data regarding care management services (interventions) provided to health plan members during the measurement year. These elements must be extracted from the health plan's Electronic Healthcare Record (EHR).

The health plans will coordinate with the care management staff providing services to collect the data for the measurement year. Health plans are expected to submit HP-CMART data from all affiliated vendors that provide health plan care management services to health plan members. (Health Home services are not included.) HP-CMART data should be extracted from the health plan's EHR, **NOT** collected manually. HP-CMART submissions will include data for Medicaid members who received care management services provided by the health plan, SNP, or HARP at any time during the measurement year. **Beginning with 2021 data submitted in 2022, segments will no longer be collected as part of CMART.**

How to Submit

The health plan HP-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. 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.

Setting up your CMART application

1) Login to Health Commerce System (HCS) – User ID and Password required
2) Click on 'My Content' tab in top banner
3) Select 'All Applications' from list
4) Select 'C' after Browse by

5) Scroll down to ‘CMART File Upload’ – If there is a ‘+’ at the end of the row, click on it (‘CMART File Upload’ into ‘My Applications’ list on home page of HCS)

6) Click on ‘CMART File Upload’

Steps to submit HP-CMART submission

1) Login to Health Commerce System (HCS) – User ID and Password required
2) Click on ‘CMART File Upload’ on left under ‘My Applications’
3) Click on ‘CMART File Upload’ button
4) Enter a ‘Subject’, we recommend your plan name, plan ID, and the year of the CMART submission
5) Enter email message into ‘Notes’
6) Click ‘Launch the Upload Wizard’
    a. Click ‘Add File’
    b. Browse and select the zipped file containing the CMART data submission file you want to upload
    c. Click ‘Open’
    d. Click ‘Upload’
    e. Click ‘Close’
7) Click ‘Send’

NOTE: The zipped file will be sent to the HCS CMART mailbox and DOH will run an error report on the submission.

Reporting Requirements

The specifications for each submission element are provided below, along with additional reporting guidelines and clarifications. The submission should be a comma-separated values (CSV) text file with the following name:

INTERVENTIONS.CSV

This file should be submitted as a zip file to NYSDOH via the HCS. Format the file name as **“[Health Plan Name]_PlanID-YYYY.zip”** where:

- **“[Health Plan Name]”** is the name of the health plan, SNP, or HARP.
- **“PlanID”** is the health plan’s ID (see list in Appendix B).
- **“YYYY”** is the measurement year submitted.

After the health plan submits data, NYSDOH will run an error check report. The results from the error report will be sent to the health plan for any necessary data cleaning.

The final submission is due Monday, May 2, 2022. We will accept test submissions beginning Monday, March 21, 2022. Health plans can submit full files or an extract during the test period for error checks. The error check report will be run on test and final submissions to assist health plans in cleaning the submission data.

Note: Beginning with 2021 data submitted in 2022, segment starts, and segment ends will no longer be collected as part of CMART. Any remaining open segments will be closed with a segment end date of 1/1/2021.

File Definition:

File Specification: INTERVENTIONS

The Interventions file includes all health plan interventions/contacts. For purposes of HP-CMART reporting, this term is used broadly.

- The NYSDOH defines the term intervention as all actions taken by the care manager to conduct or arrange for member assessment, person-centered planning, or develop/achieve identified member goals. Interventions to report include all interactions during the measurement year between the health plan and:
  - Outreach members
  - Mainstream, SNP, HARP health plan active/enrolled members
  - Health plan supervisors (member specific meetings, not general-purpose staff meetings)
  - Health plan 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 plan and an outside provider, should not be reported.
- Health plans are expected to report all interventions (completed and not completed) for a member during the measurement year. Health plans will submit more than one row of data per member, where the health plan attempts or completes more than one intervention for the member during the measurement year.
- It is possible for there to be more than one intervention per member per day.
- All interventions from all care managers should be included.
- The interventions file should only include members who received an intervention during the measurement year.

- The file should be **CSV (**called **INTERVENTIONS.CSV)**.
- CSV file must include all columns described below and cannot have additional columns beyond those described below.
- 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 result in errors. All columns require an entered value.**

File Spec: INTERVENTIONS				
#	**Field Name**	**Data Type**	**Col Width**	**Details/Comments**
1	MBR_ID	Varchar	8	This field may not be NULL.
2	PLAN_ID	Varchar	8	This field may not be NULL.
3	HROB	Varchar	1	This field may not be NULL. Y = Yes N = No
4	SPEC_POP	Varchar	2	This field may not be NULL. 01 = Clotting Factor Recipients 02 = Medically Fragile Children 03 = Children in Receipt of HCBS 04 = Adults in Receipt of HCBS 05 = RHCF 06 = PCS 07 = CDPAS 08 = AIDS Adult/Adult Day Health Care 09 = Other LTSS Services 10 = In Receipt of CFCO 11 = Homeless 12 = Foster Care 99 = Not a Special Population Member
5	INTERVENTION_DATE	Date	8	This field may not be NULL. MMDDYYYY A health plan may submit more than one intervention per member per day.
6	MODE	Integer	1	This field may not be NULL. 1 = Letter (mail), 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 plan. **Note:** Only one MODE per contact.

7	TARGET	Integer	1	This field may not be NULL. 1 = Member 2 = Co-worker, Senior Care Manager, Supervisor (Health plan) 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
8	COMPLETED	Integer	1	This field may not be NULL. 1 = TRUE, 5 = FALSE, 9 = Not Recorded TRUE only if contact is successful and the member responds. This field should be 9 where MODE = 1 Letter (Mail).
9	MONITOR	Integer	1	This field may not be NULL. Intervention Type: 1 = TRUE, 5 = FALSE
10	OUTREACH	Integer	1	This field may not be NULL. Intervention Type: 1 = TRUE, 5 = FALSE
11	ACTIVE/ENROLLED	Integer	1	This field may not be NULL. Intervention Type: 1 = TRUE, 5 = FALSE

File Definitions:

MBR_ID: Member's eight-digit Medicaid ID. This is also referred to as the Medicaid CIN. The MBR_ID **MUST** match the Medicaid ID submitted by the health plan to claims and encounters. In the unlikely event a member's Medicaid ID changes during enrollment, health plans should submit the member's Medicaid ID as it was at the time of the event (interventions).

PLAN_ID: Should reflect the plan of the member at the time of the intervention. Plans should use the plan ID listed in Appendix B. A submission file should have only one PLAN_ID.

HROB (High Risk Obstetrics): The member is in an HROB care management program or not.

SPEC_POP: Member's special population status. This is the status indicator for members who meet the special populations definition. According to the Medicaid

Managed Care Model Contract, a Person-Centered Services Plan (PCSP) is required to be completed from the results of an assessment of the medical, environmental, and social needs for each of the special populations defined in **Appendix A**. Each PCSP must include participation of the entire collaboration of services – the member, physicians, nurses, social workers, service providers, and family members – and include all services and supports to meet the assessed needs and personal goals.

The special populations are listed above in order of intensity. If a member falls into more than one special population category, choose the lowest numbered category for that member (choosing the most intensive special population).

INTERVENTION_DATE: This is the date of the intervention. This date should fall within the measurement year (January 1 – December 31). **Format the date as MMDDYYYY with no intervening "- "or "/".**

NOTE: Health plans should only submit data for events which happen during the measurement year.

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 plan should report only the last mode used. For example, an enrolled member uses a cellphone to call their care manager to inform her of an ED visit. The care manager is at the hospital and agrees to come see the member in-person. In this example, the health plan should not report two interventions because there is only one distinct intervention. Nor should the health plan report a single intervention with two modes. In this example, the health plan should report the mode of intervention used last during the intervention (in this case, in-person).

HP-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 plans may individually determine the appropriateness of these intervention modes.

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

TARGET: This is the person or organization to whom the intervention is directed. Most reported interventions are between the health plan and the member. An intervention may be between the health plan 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 plan's discretion to determine which target to report. Whichever target is the primary focus of the intervention should be the one reported.

COMPLETED: HP-CMART v3 requires health plans to report **all** interventions and to identify which interventions were completed. This allows health plans to better document the scale of care management efforts.

- A complete intervention results in at least some interaction with the member or the member's collaborative team.
- When the intervention mode = 1 (Letter), completed should be reported as 9 (Not recorded). Interventions by mail will not affect the health plan'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),3 (In-person), or 6 (Video Conference), health plans should record phone or in-person interventions as complete when contact is made with the member. The intervention should be considered incomplete if no contact was made via phone or in-person. A similar standard should be applied to mode 6 (Video Conference).
- When the intervention mode is 4 (Email) or 5 (SMS/Text), health plans should continue to identify interventions which result in at least some interaction with the member. For example, an 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 sent to addresses which are known to be valid.

INTERVENTION TYPE: The final three columns of the **INTERVENTIONS.CSV** file detail the type of intervention.

Every row of the intervention file is required to have a 1 in 'Monitor', 'Outreach', or 'Active/Enrolled'.

- **MONITOR:**
  - Care manager or other plan employee reaches out to the member as part of an ongoing monitoring/maintenance service.
- **OUTREACH:**
  - Care manager or outreach specialist attempts to contact the member to offer them health plan care management services.
- **ACTIVE/ENROLLED:**
  - Care manager performs or arranges for member assessment.

- Care manager or interdisciplinary team creates, updates, or reviews the person-centered plan of care.
- Care manager follows up with member or service providers to examine the progress and completion of the plan of care.
- Care manager contacts member or service providers to address/support identified member goal/objective/need.

Error Check Report

The software that the error/validation report runs through is proprietary. There is not a free version to send out with the error report. The error report key was created for plans to see what is being looked at in the error program. It is up to the plans (or their vendors) to create an internal error check. Each health plan, HARP, and SNP is encouraged to review the error code key (below) and work with their individual IT departments to create this check.

HP-CMART entries listed in the error check files do not meet the HP-CMART specifications. Only entries with errors will be included in the error check report. Any rows of data not in the error check report are accepted as valid by DOH. Health Plans may re-submit error rows that have been updated to the specifications document.

After the health plan's data is submitted to the NYSDOH, staff will run error checks and create an error report on the submitted data. Error checks are explained in greater detail later in this document.

An error report will be sent to each plan via the HCS to the designated HP-CMART contact persons for plans to see the data that was submitted for the error rows. The error report is an Excel file that contains two worksheets/tabs as described below:

1. **Rows_Members:** number of rows, distinct members, missing data, and rows of errors for each of the CSV file and the two mismatch files
2. **Interventions:** All Interventions data and Error_Code number for each row with errors

Error Code Key

Error Code	Name	Description
1	Invalid CIN	CIN is not valid or CIN is not enrolled in plan at given date
2	Health plan ID incorrect	Health plan ID is not in health plan list for CMART
3	Date Not in the Measurement Year	The date of the intervention is not in the current measurement year
4	HROB response invalid	The HROB code is not valid
5	Special Population response invalid	The SPEC_POP code is not valid
6	Mode response invalid	The MODE code is not valid
7	Target response invalid	The TARGET code is not valid
8	Completed response invalid	The COMPLETE code is not valid
9	Letter Mode not 9	The COMPLETED code for MODE = 1 (Letter) is NOT 9
10	Monitor response invalid	The MONITOR code is not valid
11	Outreach response invalid	The OUTREACH code is not valid
12	Active/Enrolled response invalid	The ACTIVE/ENROLLED code is not valid
13	Intervention Type Conflict	More than one of the following intervention types (MONITOR, OUTREACH, ACTIVE/ENROLLED) = 1
14	Intervention Error	COMPLETED = 1 and MONITOR, OUTREACH, and ACTIVE/ENROLLED = 5

Error Descriptions

The errors that can occur in each of the **INTERVENTIONS** file submitted:

Interventions file:

Error #1: Invalid CIN

- CIN is **not** valid or CIN is **not** enrolled in plan at given date
- Encounter data and capitation payments are used to check member enrollment in health plan
  - An encounter or capitation payment needs to be made to the plan for the member during the time period of the intervention date
  - If the member was in a different line of business for your plan or other product line that does not contribute to CMART, then switched to Medicaid Managed Care, only the dates they are in the Medicaid Managed Care plan are considered valid.
  - A 31-day grace period from the closest encounter is used to determine if the member is within the plan at the time of the intervention.

Error #2: Health Plan ID incorrect

- Health Plan ID is not in the list in **Appendix B** of this specification document or **not** in the health plan ID of the submission file
- All records for each submission need to have the same health plan ID
  - Please make sure that all records that come to you via a vendor have the health plan ID that is listed in **Appendix B** of this specification document
  - More than 1 health plan ID is in the submission file

Error #3: Date **NOT** in the measurement year

- The date of the intervention is not in the current measurement year

Error #4: HROB response invalid

- The HROB code is **NOT** Y or N

Error #5: Special Population response invalid

- The SPEC_POP code is **NOT** 01-12 or 99

Error #6: Mode response invalid

- The MODE code is **NOT** 1-6

Error #7: Target response invalid

- The TARGET code is **NOT** 1-6

Error #8: Completed response invalid

- The Completed code is **NOT** 1, 5, or 9

Error #9: Letter mode **NOT** 9

- When MODE = 1 Letter (mail), COMPLETE is **NOT** 9

Error #10: Monitor response invalid

- The Monitor code is **NOT** 1 or 5

Error #11: Outreach response invalid

- The Outreach code is **NOT** 1 or 5

Error #12: Active/Enrolled response invalid

- The Active/Enrolled code is **NOT** 1 or 5

Error #13: Intervention type conflict

- Only one of the following intervention types can be = 1
    - MONITOR
    - OUTREACH
    - ACTIVE/ENROLLED

Error #14: Intervention Error

COMPLETED = 1 (true) and MONITOR, OUTREACH, and ACTIVE/ENROLLED = 5 (false)

Questions

For questions about the specifications and general reporting guidelines, call the Health Plan Team in the Office of Quality & Patient Safety (518) 486-9012 or email **CareManagement_OQPS@health.ny.gov**.

Appendix A

Other Special Populations

Special Population Number	Population	Requirement and Citation
01	Clotting Factor Recipients *	Plans must coordinate with providers to develop an individualized care plan and patient–specific care management to ensure that enrollees have appropriate and timely clotting factor supplies and services. A person-centered plan of care is required for enrollees. - Transition Policy Paper Section III
02	Medically Fragile Children	This population is subject to the Long-Term Services & Supports (LTSS) requirements at Appendix S. This would include mandatory Patient-Centered Specialty Practice (PCSP) provision. - Contract Section 10.20(b)(i)
03	Children in Receipt of Home & Community Based Services (HCBS) †	Plans are required to ensure PCSP for their enrollees, including maintaining plan of care for enrollees who opt out of Health Home and monitoring access to care for all enrollees. - 1115/1915c Children's Waiver
04	Adults in Receipt of Home & Community Based Services (HCBS)	The contractor must provide or arrange for provision of care coordination/care management. A person-centered plan of care is required for enrollees. - Contract Sections 10.1, 10.41
05	Residential Health Care Facility (RHCF) for Long Term Placement	Services provided as listed in Appendix S the responsibility of the contractor, local departments of social services (LDSS), and facility. A person-centered plan of care is required for enrollees. - Contract Section 10.40(a)
06	Personal Care Services (PCS)	The contractor will conduct such assessments and ensure the enrollee's care plan is developed in compliance with person-centered services planning requirements in accordance with Section 10.35 of this agreement. - Contract Section 10.33(b)
07	Consumer Directed Personal Assistances Services (CDPAS)	Services must be provided in a manner that is consistent with Appendix S. A person-centered plan of care is required for enrollees. - Contract Section 10.36(a)
08	AIDS Adult/ Adult Day Health Care	Services must be provided in a manner that is consistent with Appendix S. A person-centered plan of care is required for enrollees. - Contract Section 10.39(a)

Special Population Number	Population	Requirement and Citation
09	Other LTSS Services (Private Duty Nursing, Skilled Nursing, Home Health Services)	Requires care management for services identified in the PCSP. - Contract Appendix S(c)(3)
10	In Receipt of Community First Choice Option (CFCO) ‡	The member has an institutional level of care as determined by the functional assessment used by that population (Uniform Assessment System (UAS)) and are living in their own home or a family member's home. - Transition requirement
11	Homeless Population §	The member self-identifies as homeless to the care manager or has the homeless indicator on the electronic Department of Homeland Security (DHS) file from New York Medicaid Choice. - Transition Policy Paper Section II
12	Foster Care Services (FCS)**	The Medicaid Managed Care Plan will provide care management for Children/youth placed in foster care including those in direct placement foster care and placement in the care of Voluntary Foster Care Agencies to ensure the enrollee's access to services, or as requested by the LDSS/29-I Health facility or upon provider recommendation - Transition of Children placed in Foster Care Section IX. F.

* Transition of Clotting Factor Products and Services from Medicaid Fee-for-Service to Medicaid Managed Care (https://www.health.ny.gov/health_care/medicaid/redesign/2017/2017-05_clotting_factor_guidelines.htm)

† 1115/1915c Children's Waiver

‡ Community First Choice Option (CFCO) (https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm)

§ Policy and Guidance to Transition the Homeless Population into Medicaid Managed Care; April 2012 (https://www.health.ny.gov/health_care/medicaid/redesign/docs/guidance_for_homeless_transition.pdf)

** Foster Care Services (FCS) (https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/vfca_mmc_transition_policy_paper.pdf)

Appendix B

Plan IDs	
Mainstream Plans	
Affinity Health Plan	2010186
CDPHP	1090384
Empire BlueCross BlueShield Health Plus	2180196
Excellus BlueCross BlueShield	1390598
Fidelis Care New York, Inc.	2060193
HealthFirst PHSP	2090194
HealthNow New York Inc.	1140685
HIP (EmblemHealth)	1050178
Independent Health's MediSource	1070680
MetroPlus Health Plan	1130185
Molina Healthcare	2161013
MVP Health Care	1080383
UnitedHealthCare Community Plan	1260187
HARP Plans	
Affinity-Enriched Health	4342307
CDPHP	4342316
Empire BlueCross BlueShield HealthPlus	4004537
Excellus Health Plan, Inc.	4342343
Fidelis-NYS Catholic-HealthierLife	4004486
Healthfirst Personal Wellness Plan	4003696
HIP-EmblemHealth Enhanced Care Plus	4082293
Independent Health's MediSource Connect	4342325
MetroPlus Enhanced	4053201
Molina Healthcare	4342292
MVP Harmonious Health Care Plan	4342334
UnitedHealthcare Community Plan-Wellness4ME	4054091
SNP Plans	
Amida Care	S99B001
MetroPlus Health Plan	S99A008
VNSNY CHOICE Select Health	S99B010