HH CMART FAQS

1) FAQs Topics

- Able to Contact, Contact Date
- Care Management Services
- Consent
- FACT-GP
- HH Metrics
- Intervention Contacts
- Lost To Services
- Reporting Process Acuity
- Trigger Date ,Contact Date
- Outreach
- Managed Care Plan IDs
- Targeted Case Management (former)
- Software

2. Case Scenarios

#	Topic/ Category	Question	Answer
1	Able to Contact, Contact Date	**How is "Contact" defined for element #10-AbleToContact and #11-ContactDate?**	Contact is defined as a verbal interchange. Mailed information or messages are not completed contacts unless the member contacts the program as a result of this mailing/message. The verbal interchange can be by phone or in person and it can be with the member/family/representative.
2	Acuity	**Will the Fact GP & Functional Questionnaire scoring sheet influence the acuity score? Is there a connection between the Fact-GP scoring and the acuity score?**	The acuity score is NOT related to Fact-GP and Functional Questionnaire scoring. The Department is collecting these scores and looking at them in a more global sense. These assessment scores will be used internally to look at the overall health of the population.
3	Assessment Targeted Case Management (TCM)	**What AssessDate gets put in the HH CMART for a TCM converting enrollee?**	A comprehensive assessment must be completed for each Health Home enrollee and updated regularly to inform the care plan and any changes in the care plan. Assessment information is reported in HH CMART under **#14 Assess CM;** #15– **AssessDate** Answers for these fields should agree with #10 AbleContact **For converting TCM to Health Home members ONLY-** If the comprehensive assessment has recently been completed, the date of that assessment can be used, provided it is not greater than 3 months prior to the reporting period. That is the date that is placed in element #15– **AssessDate** ▸ If the comprehensive assessment was done more than 3 months prior to the reporting period, then a review and update of that assessment should be completed and the date that was done is the date placed in element # 15 – **AssessDate**

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4	Care Management Services	**Is there only one care management service per visit?**	Data should be counted for the **Primary service** provided. Therefore, you will count one mode to one service type and total interventions should equal total counts of CM services in section IV Care Management Service Module (page 16 of of October 3, 2013 Technical Requirement Specifications Document) Each visit or intervention should be counted uniquely only once for the **primary service** conducted. Often several issues are addressed which may be represent more than one of the service categories. For example, a home visit to discuss the member's self-management plan may also touch on new needs to update in the care plan or involve contacting a community support organization. The visit would be counted as an intervention in the MemberSupport (#33) category as '1'. It would not be counted once in Member and CarePlan and CommSupport.
5	Care Management Services	**What if a member has more than one Care Management Provider in a quarter and receives more than one FACT-GP Assessment, what is reported?**	If a member changes care management providers during the reporting period, the Health Home should include the results from the earliest assessment. For example, if the member did an assessment with CM Agency A in May and another with CM Agency B for the June, the results from the May assessment should be submitted by the Health Home to the Department.
6	FACT-GP	**Does the assessment have to be conducted face to face or can it be conducted telephonically?**	It is the Department's expectation that the FACT-GP and HH Functional Assessment as well as the comprehensive assessment be conducted face to face. If a face to face administration at disenrollment is not possible, telephonically can be allowed.

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7	FACT-GP, Consent	**Does the Health Home Consent(DOH-5055) need to be signed prior to the member completing the FACT-GP and the Health Home functional assessment?**	The Health Home member consent does not need to be signed at the time the patient agrees to engage in care management. However, the Health Home must decide how long the member can receive effective care coordination without having permission to access/share to the member's health information. The assessments may be performed prior to the member signing the Health Home consent, but the member's information cannot be shared until the Health Home Consent is signed by the member, legal guardian or representative.
8	FACT-GP	**On the Health Home Functional Questionnaire, Question HH6 measures Homelessness and is a yes/no question.** **How is that scored?**	Question HH6 is scored on a Yes and No basis. 8 points is scored for NO and 0 is scored for YES. A higher score represents better health, a score of "0" indicates that the member was homeless in the last 7 days; if they are housed, the score is "8". Official scoring guidelines for the FACT-GP and Health Home Functional Questionnaire, which include some reverse scoring methods, can be found on the Health Home website at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm
9	FACT-GP	**Do we need to report data on members who we do not have a FACT-GP for?**	All Health Homes need to submit completed scoring for each member. All members need a FACT-GP completed initially, annually and upon discharge.
10	FACT-GP	**How do we handle a member that refuses the DOH Required assessment?**	FACT-GP fields should be BLANK for missing data. The Care Manager is responsible to make sure the Member completes the assessment by assisting the Member with completing the assessment. Care managers should reassure the member, help them understand the purpose of the assessment, and how it can lead to an improvement in care. If a member continues to decline/refuse the full assessment, they would not likely benefit or be appropriate for Health Home Care Management services.

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11	HH Metrics	**What is the purpose of the HH CMART?**	The Health Home Care Management Assessment Reporting Tool is a database tool developed by the Office of Quality and Patient Safety in conjunction with OHIP Health Home Program to collect process metrics. The tool collects data for the intake and intervention phases of care management services for members involved in Health Homes. The HH-CMART database tool is used for the collection of standardized care management data for members assigned to Health Homes. The data will provide the NYS Department of Health with information about care management services provided to members, in order to evaluate the volume and type of interventions and the impact care management services have on outcomes for people receiving these services. The data collected in the HH-CMART will be used in conjunction with Medicaid claims data to evaluate impact to utilization and quality of care for members involved in Health Homes.
12	HH Metrics	**What will be the clinical/quality outcomes of the tracking tool?**	Health Home providers will be required to meet/adhere to the Health Home quality measures, many of which are based on HEDIS standards. Based on provider type and other programs' requirements (i.e. MCO), many providers will be required to meet all HEDIS standards. The comprehensive list of quality measures the State will track is available on the website in the State Plan Amendment (SPA). http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/statewide_hh_quality_measures.pdf

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			The HH-CMART data will be used to calculate process measures related to care management which include: contact rate, average outreach effort, refusal rate, engagement rate, mean time from initiation to engagement, care plan updates, mean counts of interventions and types of interventions.
13	HH Metrics	**How can Health Homes contact the Department about questions and updates?**	Support webinar/calls regarding the HH-CMART focus on training and discussions around technical issues. Providers are encouraged to ask questions and provide information on situations they encounter so the Department can develop case scenarios in order to assist with consistent data entry into the tool. For questions about the specifications and general reporting guidelines, email the Health Home Team with the subject of Quality Metrics via the Health Home website at: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action or call the Health Home Provider line at 518-473-5569.
14	Intervention Contacts	**Do text messages back and forth count as #10-AbleContact or #12-Outreach?**	If a communication in written form (i.e. Text) occurs with a confirmed exchange with the member, then #10-AbleContact should be Yes. It can also be counted as one (1) for #12-Outreach effort. As long as there is a confirmed interchange or conversation with the member, it can apply to both elements.
15	Intervention	**If you go to a patient's house for an appointment and they don't show up can we count that as in-person event or contact?**	Attempts that are not successful can only be counted in outreach effort (#12). If the member was engaged in care management, this would not count as an intervention since the activity was attempted, but not actually completed.

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16	MC Plan IDs	**Why do the MC plan IDs in the HH CMART not match the patient tracking system Plan IDs.**	See question #21.
17	Outreach Effort, TCM	**When trying to get the TCM member to sign the HH consent, we have to contact them regularly and want to count that under outreach effort.**	Outreach Effort is defined as those attempts by the Health Home or the care management agency to engage (or reengage in the case where a person needs a new care plan and has been lost to care management). In this case, all TCM-Conversation members were converted into Health Home Care management and did not need outreach as they were previously receiving services.
18	Outreach Effort, TCM	**One of our TCM members was engaged initially with Health Home services, but was lost to service. We had to do outreach for this member to re-engage them. How do I record that in the Health Home CMART tool?**	Members who are engaged (or active in care management) should not have outreach effort if they remained engaged the entire reporting period. Once the member has been engaged in active care management, or enrolled in health home services, and then they disengage for some reason and health home puts effort into locating, this is counted in Outreach effort. Outreach efforts continue to be counted until the time the member is located and re-engaged.

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19	Plan ID	**If a Member's MC plan status changes during the reporting period, do you want the PlanID from enrollment or the most current PlanID in element 1?**	If a MC plan status for a Health Home member during the reporting period changes, provide the most up to date or current Plan ID (#1). Plan ID Numbers can be found in the User's Manual and drop down list in the Health Home CMART Database Tool. These Plan IDs are not necessarily the same Plan ID for the health Home Tracking System.
20	Reporting Process	**Is the HH-CMART reporting data collected by the Health Home rather than the case management provider?**	The Health Homes will submit a single file that is a compilation of Health Home CMART data from all care management partners on each Health Home Member. The Health Home and Care Management partners must develop a process for the Health Home to collect the Health Home CMART data.
21	Reporting Process	**What is the difference in scope of usage, between CMART and the tracking sheets?**	The Health Home Tracking System was created to facilitate communication between the New York State Department of Health (DOH), Managed Care Plans (MCP), and Health Homes (HH) regarding the status of Medicaid members eligible for Health Home services. The Tracking System is used to identify eligible members, facilitate assignment file transfer, and collect member outreach and enrollment information. The Department will use this to auto populate some fields (#5, 6, 8, 18, 19, 25, 26, and 28) of the HH-CMART file. Because of this arrangement these fields in the HH-CMART Database tool are greyed out. The HH-CMART collects individual level 'care management' data delivered for each reporting period that captured information about the type pf program, number and type of care management interventions.

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22	Reporting Process	**What if an organization is using the HH-CMART for more than one Health Home?**	You should not use the same HH-CMART Tool for entering more than one Health Home's data. Care Management Agencies using the HH-CMART for two or more Health Homes should make a separate copy for each Health Homes prior to entering any data.
23	Reporting Process	**How does the Care Management agency get a copy of the Health Home CMART Tool (access database)?**	The Health Home CMART tool, as well as the template, are contained in a zip file that was sent out to the Health Homes. If the Health Home or Care Management Agency needs a new copy of the zip file, they should contact the Health Home program using the email Health Home webform on the Health Home website at this location: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
24	Reporting Process	**What will Health Homes be reporting to the State?**	Health Homes are required to provide NYS DOH with the following information submitted via the Health Home Care Management Assessment Reporting Tool (HH-CMART): **1)** Member-Level Care Management Information – The submission tool will contain a section for submitting member-level information regarding care management. **2)** Care Management Service Module - The submission tool will contain a module for submitting information regarding the care management services provided during the reporting period. **3)** FACT-GP & HH Functional Assessment Module - The submission tool will contain a module for submitting results from the FACT-GP & HH Functional Assessment. The FACT-GP& HH Function Assessment will be used to assess every member upon engagement, annually and at discharge.
25	Reporting Process	Do you continue to report on or does a case remain on HH-CMART once it is closed?	There are several scenarios with closed cases in the Health Home CMART. 1) Member is discharged from care management during Q4 and not reopened during Q4. The case is closed at the end of the reporting period and did not reopen during that period. **Element 24 = CLOSED, Element 27 = NOT REOPENED** 2) Member is discharged from care management during Q4 and reopened during Q4. There is a caveat here, that the same care plan is continued in this case. If the member is re-engaged and same care plan is used, the case is not identified as closed as of

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			the end of the reporting period, even if it was closed for a period during the reporting period. **Element 24 = OPEN, Element 27 = NOT CLOSED** 3) Member is discharged from care management before Q4 and reopened during Q4. There is a caveat here, that the same care plan is continued in this case. Same as above, if the case is open at the end of the reporting period, it is not reported as closed even if there was a closure for a part of that reporting period. In the prior reporting period, the case would have been closed at the end of the period. There is no need to revise a previous quarter's submission for this situation. For Q4, the case is open at the end of the reporting period. **Element 24 = OPEN, Element 27 = NOT CLOSED** 4) Member is discharged from care management before Q4 and reopened before Q4. If the member closes in a previous quarter AND starts a new segment for a new issue with a new assessment and care plan during Q4, a new segment is started for Q4. This is considered a reopening of care management for the member. The case would be indicated as OPEN at the end of the reporting period and as reopened. **Element 24 = OPEN, Element 27 = REOPENED** If a Member was discharged in a previous reporting period and did not reopen during the reporting period, the case should not be included in the member-level file for the reporting period.
26	Reporting Process	**How do I submit the Health Home CMART database tool to the Department?**	The CMART tool should be submitted using the Health Commerce System(HCS) **Health Home CMART File Upload** application. 1.Log into the HCS. 2.Click the 'Applications' tab at the top of the Home page. 3.Click on the 'H' tab at the top of the Applications page. 4.Find the "Health Home CMART File Upload" link. • Clicking on the link will bring you directly to the upload page. 5. Clicking on the "+" icon in the 'Add/Remove' column will add it to "My Applications" on left side of screen for future access. 6. Click "Browse" to choose the CMART tool for submission. Include any comments in the box. Click "Upload".

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			7.The file will be sent directly & securely to the NYSQARR BML email account. We will notify you of receipt.
27	Reporting Process	**Does the EngagedCM field ever change from quarter to quarter?**	It depends on the situation. IF a member is in outreach and then is engaged in the subsequent quarter the EngagedCM field will change from NO to YES. Once a member is engaged the EngagedCM field will remain YES throughout the life of the case and it will not change. See the two examples below for more clarification: EXAMPLE 1: If a Member is in outreach in Q1 (EngagedCM = NO) and then in Q2 the Member is engaged, the EngagedCM field becomes YES. In this situation the EngagedCM value does change. However, once it is changed to YES (or if originally YES) it will not change. EXAMPLE 2: If a member was originally engaged (Q1 = YES) or in outreach and then engaged (like example 1 above), and then lost to service - you will not edit the EngagedCM but would document this change in the CaseClosed field (CLOSED).

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28	Reporting Process	**The "HHID One Page Help Guide" – What is the purpose of this guide? How do I know what changes from one period to another based on this one page reference?**	This one page reference guide was created to give a better sense of the changes that need to be made from one submission to the other and what does not need to be changed. The fields that change from one submission to another for all members are below: • PlanID – This will only change if a member changes Health Plans. For reporting purposes, report the most updated PlanId for the member. • ReportDate – This is specific to the Quarter that is being reported. The fields that change from one submission to another for all ENGAGED members are below: • Intensity – Will change based on the frequency of contact during the reporting period. You will always report the highest level of intensity. • CountMail/CountPhone/CountPerson – These coutns should be "reset" when a new quarter begins. The counts reported for a member should be limited to the reporting period and should not include interventions from any other reporting periods. Counts are not cumulative from the initiation of care management. • CaseClosed/CaseReopened – See FAQ #19 for scenarios for change. • CareManage/HealthPromote/TransitionCare/MemberSupport/CommSocial – Just like CountMail/CountPhone/CountPerson, the counts are not cumulative from the initiation of care management. See FAQ#6 for more details about how to report these five fields. • FACT-GP and Health Home Functional Assessment Fields – These fields are left blank if assessment is not required for member in the reporting period. The FACT-GP and Health Home Functional Assessment are required to be completed upon enrollment to a Health Home, annual update, and discharge from a Health Home. All other fields will not change once originally entered into the database. The only exception to this rule is EngagedCM. See FAQ #29 for information on this exception.

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29	Software	**The Access Database is not loading the excel import. What can I do?**	Make sure you have a new copy of the HH-CMART Access Database. Sometimes there are issues with importing once tool has been used which is why the Department recommends saving a blank copy of the tool on your desktop and rename it as a separate document after entering data. If that does not work, other things to check. • The Excel document Column N should read EngagedCM notEngageCM. • All field names should match what is found in the technical specifications • There should be no spaces or punctuation in any of the field names. • Delete extra columns and extra rows at end of file and try again • Check the last column of the Excel file – AO or AY or something else. May have hidden columns with variables that do not belong or mis-spelled variables. • 64-bit software does not allow navigation through screen – error message • Make sure MS Access is installed on your computer – not working off a different application that embeds Access • Installed versions of Excel and Access should not differ too much (e.g., Access 1997 and Excel 2007) • Imported data are based on first tab in Excel file. If first tab contains errors, but the correct data are in second tab, will not import. • Data should match the specs, e.g., dates, numbers, text • Make sure the file is not password protected. It may not import if file has password.
30	Software	**Why does my data disappear after I import an excel template?**	When importing the tool, any previous data contained in the tool is deleted. Individual data cannot be carried over from a previous populated tool. Health Homes should export a file out from the Health Home CMART tool from the previous reporting period. This file should be named including quarter date, and saved in a location where all Health Home CMART data files are stored, so a separate file of what was submitted is recorded. A copy of this exported file could be used as the basis for the next reporting period's import file. See the user guide for file saving tips.
31	Trigger Date, Contact Date	**What is the difference between trigger date and contact date?**	The Trigger Date(#8) is the first day of the month when outreach and engagement began. It may be the same date as the engagement date. It is equivalent to the "Begin Date" on the Health Home Patient Tracking System for the first record submission for the member. The Contact Date (#11) is the first date the member/family/representative is involved in a verbal

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			interchange. TCM Converting members would be the date of that the Health Home began providing Health Home services.
32	Able Contact	**How does DOH suggest reporting a member who's been contacted but not assessed and has since been lost to follow-up? Our staff was unable to establish the interest or willingness to engage in services before being lost to follow-up. In this situation how would the following fields be filled out:** • **Program Type** • **OptOut** • **AppropriateCM**	**:** In this situation, all three fields should be set to REVIEW PENDING. While there was contact with the Member, there was never a definitive conversation about needs (Program Type, AssessedCM, and Appropriateness) nor a conversation about participation (OptOut).
33	Able Contact	**Since an individual, once successfully contacted, remains AbletoContact=Yes indefinitely, does this mean we should be submitting information on all clients who were once enrolled or contacted in outreach but were discharged from the health home prior to the CMART reporting period?**	You should not submit individuals who were discharged (CaseClosed = Yes) prior to the reporting period. Each row is a care management segment and you only submit those segments that were active. For 1 or more days during the reporting period. Thus, a AbleContact = Yes value should be kept constant for across periods once you are able to contact the individual in question. However, there is no reason to turn in a row where CaseClose = Yes more than once. Once you have closed the case, you would only submit information on that person if you re-engaged with that person, which would result in a new segment. Thus you would have a new initial contact date, etc.

Case Scenarios

Below are Scenarios to assist with correctly identifying the correct Care Management Service Module fields (#30-34). Data should be counted for the **Primary service** provided. Therefore, you will count one mode (#21, 22, and 23) to one service type and total interventions should equal total counts of CM services in section IV Care Management Service Module. It is important to remember that each visit or intervention should be counted uniquely only once for the **primary service** conducted. Often several issues are addressed which may be represent more than one of the service categories. These scenarios are examples of how an intervention could be documented in the Health Home CMART

1. Care manager meets with Member to help them prepare for a service they will attend alone (e.g., a list of questions for their medical visit, expectations for a court appearance, etc.)
   Intervention type: **CountPerson(#22)**
   Care Management Service Module: **MemberSupport(#33)**
2. Member calls upset about family problem; care manager provides supportive counseling and referrals for family services.
   Intervention type: **CountPhone(#23)**
   Care Management Service Module: **HealthPromote(#31)**

#	Topic/ Category	Question	Answer

3. Member is being evicted. Care manager provides several services (landlord advocacy, legal referral, contact with housing agencies, and assistance with applications for housing emergency funds)

Intervention type: Intervention type would depend on method of contact by Care manager.

Care Management Service Module: **CommSocial(#34)** – If the **primary service** was to contact community housing agency, Community Social support would be selected. This is an example where the type of service model chosen depends on the **primary service** provided.

4. Care manager attends a case conference of Member's medical, social work, and nursing staff at Member's medical provider site (Member is not present). Member status and needs are discussed.

Intervention type: **CountPerson(#22)**

Care Management Service Module: **CareManage(#30)**

5. Care manager discussed Member progress and advocates with Member's parole officer.

Intervention type: Intervention type would depend on method of contact by Care manager.

Care Management Service Module: **MemberSupport(#30)**

6. Care manager sends a peer or outreach worker to help Member advocate with social services.

Intervention type: **CountPerson(#22)**

Care Management Service Module: **MemberSupport(#33)**

7. Member has missed appointments and is not reachable by care management staff. Member appears for services at agency's syringe exchange program where they serve Member, update contact information, and ask him to contact care management. Is this a service that can/should be recorded in CMART? If so, how?

This is **NOT** a service that is reported in the HH-CMART file. This intervention is conducted by a different organization. The Care Manager is not conducting the intervention nor made any action to set up the intervention.