

Health Home -  
Care  
Management  
Assessment  
Reporting Tool  
(HH-CMART)

Version  
2.2

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**Technical Requirement  
Specifications for  
Medicaid Health Homes**



**Medicaid Health Homes**  
**HH-CMART Technical Requirement Specifications**  
**Version 2.2**

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***A. Overview***

Care management is defined as **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 and needs.** For people in Medicaid health homes, care management for individuals is required to address care needs, coordinate services and arrange efficient quality health care to promote health outcomes.

A Health Home is a care management service model whereby all of the professionals involved in a member’s care communicate with one another so that all needs (medical, behavioral health and social service) are addressed in a comprehensive and coordinated manner. This is done primarily through a “care manager” who oversees and coordinates access to all of the services a member requires, including ensuring that the member receives services necessary to stay healthy. Health Home services are provided through partnerships between health care providers, health plans and community based organizations. Health Home providers must have the capacity to perform core services specified by Centers for Medicare and Medicaid Services (CMS) which include: 1) comprehensive care management; 2) care coordination and health promotion; 3) comprehensive transitional care; 4) patient and family support; 5) referral to community and social support services; and 6) use of health information technology to link services. Health Homes must provide at least one of the first 5 core functions (exclusive of HIT) per month to meet minimum billing standards. **Throughout the document, the term, Health Home, includes the Health Home staff or their subcontractor performing care management services.**

The Health Home Care Management Assessment Reporting Tool (HH-CMART) is a tool for the collection of standardized care management data for members assigned to Health Homes. The data will provide the Department of Health (DOH) with information about care management services to evaluate the volume and type of interventions and the impact care management services have on outcomes for people receiving these services. The data requirements include submission of specified data about care management services provided to members in Health Homes. The submission file will include information for all Medicaid members involved in Health Home care management programs during the reporting period.

***B. Submission Requirements***

**I. Organizations Required to Report**

All Health Homes designated by NYS DOH after January 1, 2012 must report care management files using the specifications for all members who are assigned to the Health Home for the reporting period.

**II. Reporting Schedule**

All data files are due to NYS DOH by the **first Monday of the second month following the close of the reporting period.** For example, the third quarter reporting period is from July 1 to Sep 30 each year. Therefore the HH-CMART file is due to DOH by **the first Monday in November,** which is the first Monday of the second month following the close of the period.

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**III. What to Report**

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

- 1) Member-Level Care Management Information – The submission tool will contain a section for submitting member-level information regarding care management. 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) Care Management Service Module - The submission tool will contain a module for submitting information regarding the care management services provided during the reporting period. These elements may be entered manually or imported into the submission tool and are specified in both Section C.IV below and Table 2 of Appendix I.
- 3) HH FACT-GP Module - The submission tool will contain a module for submitting results from the Health Home FACT-GP Functional Assessment tool. The Functional Assessment tool will be used to assess every member upon engagement, annually and at discharge. The elements may be entered manually or imported into the submission tool and are specified in both Section C.V below and Table 3 of Appendix 1.

HH-CMART files will include care management data for Medicaid members who were: 1) in outreach and engagement with the Health Home during the reporting period and/or 2) were in active care management (enrollment) with the Health Home at any point during the reporting period. The Health Homes will coordinate with the care management staff providing services to collect the data for the reporting period. The Health Homes will enter the information into the HH-CMART (manually or through a file import into the tool). The information will be for all members whether the member is in a managed care plan, FFS or is in a converting TCM slot. The Health Home will submit the HH-CMART for all members who were assigned to the Health Home for any part of the reporting period. The Health Home will send the completed HH-CMART to the DOH by the deadline for the reporting period. Each member assigned to Health Homes should be in the HH-CMART as one row for each reporting period.

**HH-CMART Data flow**



Health Homes will only include data for all Medicaid recipients who are in active outreach/engagement and/or care management (enrollment) in the Health Home during the reporting period. Information for clients who are not Health Home members, but who are receiving care management services from the care management organization should not be included in the file.

Health Homes that contract with other organizations or vendors for care management services should gather the data from their subcontractors and include the information in the care management files used for HH-CMART.

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The HH-CMART tool (Access Database) and an accompanying user's manual will be distributed prior to data submission.

**IV. Where to Report**

The Health Home CMART data submission tool must be submitted to the Department via the “Health Home CMART File Upload” application on the Health Commerce System (HCS) as a zipped file. This requires a user ID and password; all Health Homes have access to the HCS. After you login to the HCS, select ‘Health Home CMART File Upload’ from the Applications tab and follow the instructions for attaching and sending the file. This application will email the file securely to the Health Home team who will then confirm receipt of the file. Transmitting files through the HCS is necessary due to the identifiable content of the files. Files sent via email (whether encrypted or not) will not be accepted. The file name should include the name of the Health Home (i.e. CarePartner.mdb).

**V. Questions**

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

***C. Reporting Requirements***

**I. Definitions**

Care Management Program - A care management program is defined by having **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**. All members assigned to Health Homes will be involved in a care management program.

Triggering for Health Home Care Management – Triggering is the beginning of efforts to engage a member in care management. When a member is assigned to a Health Home, the Health Home is notified the member is in need of care management. The Health Home provides, or arranges for a subcontractor to provide, care management. The Trigger Date 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.

Outreach Effort – Outreach activities are conducted by Health Home or care management subcontractor staff to engage (or re-engage) members in Health Homes. Attempts to contact members in person, via phone/text, or with individualized mailings/emails are included in the counts of outreach effort. Outreach activities also include verbal interactions with members to establish relationships necessary for engagement (or re-engagement) and active case management. Activities conducted prior to engagement (or re-engagement) are considered outreach. Activities that continue after the member agrees to participate in the Health Home should not be included in the counts for this element. Even though the Health Home cannot bill for services during the

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second three months of the Outreach Period, any activities undertaken during this time to engage the member should be documented.

Hiatus Period – A hiatus period is a three month span during which the Health Home cannot bill for outreach efforts for any member who has not be able to be engaged in the Health Home in the previous three months. Ongoing outreach efforts can be undertaken during the hiatus period; hiatus period signifies the billing status for the member.

Engagement (or Re-engagement) in Health Home – The member agrees to participate in the Health Home and is engaged in active care management. The Health Home should endeavor to have all consents signed at the same time, but participation is not immediately dependent on this. The agreement to engage (enroll) in the Health Home ends the Outreach period. A member re-engages in care management when the member agrees to participate in active care management following a period of inactivity, such as when a member is lost to contact or cannot be located.

Active Care Management – After the member has engaged (enrolled) in the Health Home, the actual provision of Health Home services is referred to as active care management.

## **II. Eligible Population**

- Eligible Member – Members included on Health Home Assignment Record. Other community referrals meeting Health Home criteria can be considered eligible.
- Age – No age restriction; Includes both adults and children.

## **III. 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 1 in Appendix II provides a sample flow chart of the care management process and data points. Chart 1 was intended to provide a framework for how to think about your specific process in terms of the data elements required for this submission. Since each organization's process is unique, Chart 1 should not be treated as a fixed process but as a framework for understanding how your own process would crosswalk to the data elements for the submitted file.

- **Definitions:**
  - “Missing” response values should be used to indicate that information was not available for that member for that element.
  - Blank cells are valid only for members who are not included in the element population.
- **Data Completion:**
  - The member-level elements can either be entered manually into the submission tool *or* imported (using the template that can be found at: [http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/index.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm) near the bottom of the page under Process Measures (HH-CMART) called HH CMART Import Template (XLS)) into the tool following the specifications outlined here and in the HH-CMART User's Manual

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(which can be found on the Health Home website at [http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/docs/hh\\_smart\\_manual.pdf](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_smart_manual.pdf) ).

- Members in active outreach *only* during the reporting period should be submitted as one record/data row. If the member is *engaged* in two *separate* care management segments with the HH during the reporting period, then two records will be submitted for that member for that HH, with separate outreach information and engagement dates for each segment.
- **Please see the HH-CMART Quick Reference Guide (XLSX) for a summary of the following changes:**
  - Eight Elements will be completed by DOH from the Patient Tracking System and will be left blank. These are Elements 5, 6, 8, 18, 19, 25, 26, and 28.
  - Elements 1 through 17 apply to all members in active outreach or engagement during the reporting period. Elements 18-49 only apply to members who are engaged (enrolled) in the Health Home.
    - For Elements 11 and 15, a blank cell will be used to indicate the date field does not apply to the member.
    - If a member is not in active care management at any point during the reporting period, Elements 18 – 49 will be blank.
  - Elements 3, 20-23, and 29-34 will change for each reporting periods that a member is engaged in a Health Home. For example, counts of interventions will involve only interventions conducted between the start and end date of the reporting period.
  - The eight elements completed by DOH, as well as elements 2, 4 and 7 should not change once entered.
  - Any element not mentioned above should be reviewed for *possible* revision for each reporting period. There are two reasons these elements might change:
    - 1) There was a change in the member’s information or HH status (for example the member has a new PlanID, or their HH case was closed, or a FACT-GP was administered); or
    - 2) The person was in outreach during the current or prior reporting period so elements related to outreach will change until the member is either engaged (enrolled) or decisively not engaged (i.e., they were not appropriate for care management or they opted out).

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
1.	PlanID	OMC Plan ID for MMC/SNP MMIS # for MLTC	Text Field, 1111111	Value as assigned for Plans. 8888888 for FFS members. Required for reporting.	All Health Home Members
2.	HHID	Lead Health Home MMIS #	Text Field	Value as assigned. Required for reporting.	All Health Home Members

- Plans may have different identification numbers for different purposes. For the HH-CMART file submission, we are using the organization’s Office of Managed Care (OMC) Plan ID for Medicaid managed care plans (MMC) and Special Need Plans and the MMIS for Medicaid managed long term care (MLTC) plans. If there is any question about what the appropriate

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ID is for the plan, open the HH-CMART tool and select the plan's name from the drop down list for the ID number. The number to the left of the plan name is the Plan ID you should use. FFS members are not enrolled in a plan and the field should be filled with '8888888'.

- Health Home IDs are the MMIS number. It will be the ID for the lead Health Home and be the same number for all members in the Health Home's file.
- PlanID and HHID are required for each member. The fields cannot be blank. The records will not save or import into the HH-CMART without values in the fields. The Health Home identification number is necessary to aggregate results by the Health Homes.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
3.	ReportDate	Date of HH-CMART Report	Numeric Field Q/YYYY	Quarter value of reporting period. Jan-Mar = 1/YYYY Apr-Jun = 2/YYYY July-Sep = 3/YYYY Oct-Dec = 4/YYYY	All Health Home Members

- ReportDate is required for each member. The field cannot be blank. The records will not save or import into the HH-CMART without values in the field. The report date should reflect the quarter for the reporting period included in the submission.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
4.	CIN	Medicaid Client Identification Number	Text Field, AA11111A	Value as specified. Required for reporting.	All Health Home Members
5.	LastName	Last Name of Member	Text Field	DOH will fill in the field using Medicaid data system.	All Health Home Members
6.	FirstName	First Name of Member	Text Field	DOH will fill in the field using Medicaid data system.	All Health Home Members
7.	DOB	Date of Birth of Member	Numeric Field, MM/DD/YYYY	Date prior to TriggerDate. 09/09/9999 (Missing)	All Health Home Members

- A valid CIN is required for each member. The field cannot be blank. The records will not save or import into the HH-CMART without values in the field. The CIN should be the CIN from the reporting period.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
8.	TriggerDate	This is equivalent to the "Begin Date" on the Health Home Patient Tracking System for the first record submission for the member.	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System 'Begin Date'.	All Health Home Members

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- *Assigning the trigger date –*
  - Trigger date is equivalent to the ‘Begin Date’ on the Health Home Patient Tracking System for the first record submission for the member.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
9.	ProgramType	Primary focus of care management program for member.	Text Field	HH BEHAVIORAL HEALTH HH CHRONIC ADULT HH CHILDREN HH DEV DISABLED HH LONG TERM CARE HH SUBSTANCE USE HH HIV NOT ABLE TO CONTACT REVIEW PENDING MISSING	All Health Home Members

- Members should be placed in the category based on the primary care management program in which the member enrolled.
  - HH Behavioral Health
  - HH Chronic Adult
  - HH Children
  - HH Developmentally Disabled
  - HH Long Term Care
  - HH Substance Use
  - HH HIV
- A member is assigned to a category based on the **primary issue** for care management.
  - **EXAMPLE 1**, a member with a behavioral health diagnosis also has needs for health monitoring and preventive services, but the primary interventions in care management focus on behavioral health needs or services related to behavioral health issues. The member should be assigned to HH Behavioral Health.
  - **EXAMPLE 2**, a member with complex chronic conditions is enrolled in care management may also need some intervention for depression or other behavioral health issues, but the focus of care management activities involves the coordination of the complex health issues. The member should be assigned to HH Chronic Adult.
- The ‘NOT ABLE TO CONTACT’ option should be selected when the HH/provider has not been able to determine the primary program because the member has not been contacted. This should be consistent with element #10 (AbleContact).

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- The ‘REVIEW PENDING’ option should be selected when the HH/provider *has contacted the member but* has not been able to determine the primary program because the member *has not been reviewed for appropriateness and/or assessed for care management*. This should be consistent with elements #13 (AppropriateCM) and/or #14 (AssessedCM).

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
10.	AbleContact	Indicates whether Health Home was able to contact the member regarding engagement in care management.	Text Field	YES NO YES_HIATUS PERIOD NO_HIATUS PERIOD TCM-HH CONVERSION	All Health Home Members
11.	ContactDate	Date of initial contact or interaction between the member/legal representative/family and care management staff.	Numeric Field, MM/DD/YYYY	Date on or after TriggerDate. 09/09/9999 (Missing) Blank (Not Contacted)	All Health Home Members

- Contact for ‘AbleContact’ is defined as a verbal interchange between member/legal representative/family and Health Home staff. Letters/emails sent to members should not be counted as contact, nor should leaving messages/texts for members. Member reply to email or text would qualify as contact.
- If the Health Home is **unable to contact** the member regarding possible engagement in the Health Home using their specified outreach protocol, then the AbleContact field should be indicated as ‘NO’ for the reporting period.
- If the member was not able to be reached during the first three months of assignment to the Health Home, the member is ineligible for billing for outreach in the subsequent three months. If the member is in the hiatus period at the end of the reporting period, then AbleContact field should be indicated as ‘YES—HIATUS PERIOD’ or ‘NO – HIATUS PERIOD’ if contact was or was not made during this period. If the member has not been engaged by the end of the three months of the hiatus period, billing for outreach can again resume.
- For members who were previously enrolled in a Targeted Care Management (TCM) program and were converted directly from the TCM into the HH (and hence not contacted regarding engagement in care), the AbleContact field should be completed as ‘TCM-HH CONVERSION’.
- The ContactDate field should be completed for members who were contacted (AbleContact = ‘YES’ or ‘YES\_HIATUS PERIOD’). If the member was not contacted (AbleContact = ‘NO’, ‘NO\_HIATUS PERIOD’ or ‘TCM-HH CONVERSION’), the date field should be left blank. A Missing value should be used for members who were contacted, but the contact date is not known.

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Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
12.	OutreachEffort	Count of in-person (street-level), phone/text contacts, individualized mailings/ emails in attempts to locate and interact with member	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing)	All Health Home Members

- OutreachEffort is the count of attempts to contact members to engage or re-engage them in participating in the Health Home during the reporting period. If **no** outreach activities were conducted, for any reason, during the reporting period, zero (0) should be entered. Examples of reasons for no outreach activity are that the member was converted to the HH from TCM or the member was engaged (enrolled) in the HH in a prior reporting period or the member is in the hiatus period.
  - The Health Home’s care management program should have specified policies for outreach to members within a specified number of days of the assignment date.
  - The count for outreach effort includes all interactions or attempts for interactions prior to member's agreement to participate in the Health Home or to resume participation following a period of inactivity or inability to locate the member for a period. The interaction where the member/legal representative agrees to participate in the Health Home should not be included in the count.
  - In accordance the Health Home Provider Manual, outreach must be “active, ongoing and progressive” and documented in the care management record.
  - Outreach efforts should be reported for all members who had outreach efforts regardless of whether the member/family agrees to participate in the Health Home.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
13.	AppropriateCM	Indicates whether the member met at least one of the criteria for Health Home	Text Field	YES NO NOT ABLE TO CONTACT REVIEW PENDING	All Health Home Members
14.	AssessedCM	Indicates whether the member received an initial assessment for care management.	Text Field	YES NO NOT ABLE TO CONTACT REVIEW PENDING	All Health Home Members

- Appropriateness for care management may be determined through a review of data, a short assessment or a comprehensive assessment depending on the Health Home’s process.
  - AppropriateCM should be completed to reflect whether a member meets at least one of the criteria for Health Home.

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- If a Health Home finds a member does not meet the criteria for participation in the Health Home, the AppropriateCM field should be set to 'NO'.
- Defining an assessment –
  - At a minimum, the comprehensive assessment should include the following areas:
    - Physical/functional
    - Psychosocial
    - Environmental/residential
    - Care-giver capability
    - Medication lists and/or compliance
  - An initial contact or review of a priority problem *does not* constitute a comprehensive assessment.
  - The assessment does not refer to the functional assessments (such as FACT-GP) which may be done initially at the beginning of engagement in the Health Home.
- The 'NOT ABLE TO CONTACT' option should be selected when the HH/provider has not been able to review the member for appropriateness (for element #13) or assess the member for care management (element #14) *because the member has not yet been contacted*. This should be consistent with element #10 (AbleContact).
- The 'REVIEW PENDING' option should be selected when the *HH/provider has contacted a member* and intends to review the member for appropriateness (for element #13) or conduct an assessment for care management (for element #14) but has not done so yet or has not completed the review or assessment yet.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
15.	AssessDate	Date when an initial comprehensive assessment and care plan was completed.	Numeric Field, MM/DD/YYYY	Date on or after TriggerDate. 09/09/9999 (Missing) Blank Cell (Not Assessed)	All Health Home Members

- AssessDate should be the date on which the relevant areas of the comprehensive assessment were explored and the care plan is developed. If an assessment and care plan were not completed (AssessCM='NO' or 'NOT ABLE TO CONTACT' or 'REVIEW PENDING'), this element should be blank. The completion of the assessment and care plan may occur over more than one interchange. In those instances, the date of the subsequent interchange where the assessment and care plan is finally completed should be entered.

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Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
16.	OptOut	Indicates if member or member's legal representative refused to participate in care management.	Text Field	OPTED OUT DID NOT OPT OUT NOT APPROPRIATE HH NOT ABLE TO CONTACT REVIEW PENDING	All Health Home Members

- For members offered care management services, their response should be recorded as 'OPTED OUT' or 'DID NOT OPT OUT'.
- For members who were not offered care management services because the Health Home's assessment of the member found the member to not qualify for criteria of Health Home eligibility, this element should be indicated as 'NOT APPROPRIATE HH'. This should be consistent with element #13 (AppropriateCM).
- For members whom the Health Home has not yet contacted, 'NOT ABLE TO CONTACT' should be indicated. This should be consistent with element #10 (AbleContact).
- 'REVIEW PENDING' should be indicated for those members to whom *the HH/provider has contacted but not offered program enrollment* because the members have not been reviewed for appropriateness and/or assessed for care management. This should be consistent with element #13 (AppropriateCM) and/or #14 (AssessedCM) as appropriate. 'REVIEW PENDING' should be used if the member has been offered care management, but is still deciding whether to participate.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
17.	EngagedCM	Indicates if member agreed to participate in the care management program	Text Field	YES NO	All Health Home Members
18.	EngageCMDate	Date that member or member's legal representative agreed to participate in care management	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System 'Begin Date'.	HH members who engaged in a care management program.
19.	ConsentDate	Date that member or member's legal representative signed consent to share member's information	Numeric Field MM/DD/YYYY	DOH will fill in the field using Patient Tracking System 'Consent Date'.	HH members who engaged in a care management program.

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- Defining Care Management Engagement – Engagement in care management is the agreement between the member/legal representative and the care manager to participate in care management. A member is considered engaged in care management when the care manager and the member/legal representative both agree there is a need for care management and the member/legal representative agrees to participate. This is the point at which the member enters active care management (and is actively enrolled).
- Engagement in CM date is equivalent to the ‘Begin Date’ on the Health Home Patient Tracking System for the first record submission for the member with the Outreach/Enrollment Code is ‘E’ in the Patient Tracking System. If a member does not engage in care management (EngagedCM = ‘NO’), the engagement date will be blank.
- The consent date is equivalent to the ‘Consent Date’ on the Health Home Patient Tracking System. The consent date is the date that the member/legal representative signed the appropriate consent for data sharing among the Health Home partners and includes the signing of a valid consent for data collection from the RHIO/HIE.
- For Elements 18 through 49, the ‘Element Population’ is changed to only those members who engaged in care management. The fields should not be completed for members who did not engage in care Management (EngagedCM=‘NO’).

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
20.	Intensity	The <u>maximum</u> level of intensity of care management for the individual during the reporting period	Text Field	HIGH MEDIUM LOW MISSING Blank Cell (Not engaged)	HH members who engaged in a care management program.

- Intensity is defined as the frequency of interventions necessary to carry out the activities in the care plan by the HH care management staff. Intervention frequency by the HH care management staff includes activities such as interacting with member/legal representative/family, health care providers and community based programs to arrange or monitor services and progress. Services and interventions conducted **by Health Home** or care management **contracted vendors** should be included, while interventions conducted **by providers, other organizations, or health plans** should not be included in the interventions used to determine frequency for intensity.
- Indicate the maximum level of intensity of interventions for the member during the reporting period using the following categories:
  - High – Care management staff intervention (such as contact) more than weekly
  - Medium – Care management staff intervention (such as contact) weekly to every other week
  - Low – Care management staff intervention (such as contact) less than every other week (such as monthly or quarterly)

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- When the frequency of care management interventions varies for a member during the reporting period, the level of intensity reported for that member should be the maximum level during the reporting period.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
21.	CountMail	Count of mail/email interventions by care management staff for or with member during the reporting period	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Engaged)	HH members who engaged in a care management program.
22.	CountPhone	Count of phone/text interventions by care management staff for or with member during the reporting period	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Engaged)	HH members who engaged in a care management program.
23.	CountPerson	Count of in-person interventions by plan staff for or by care management staff for or with member during the reporting period	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.

- Defining an intervention –
  - Interventions are defined as activities conducted to carry out the care plan for the member. Activities performed for purposes other than carrying out the care plan, such as trying to locate a member, are not counted as interventions for these elements.
  - **Interventions conducted as part of outreach** (prior to engagement or re-engagement in care management) **should be excluded**. (Outreach interventions are captured in Element 12).
  - 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 reporting period** and should not include interventions from any other reporting periods. **Counts are not cumulative from the initiation of care management**.
  - The interventions conducted during the reporting period may involve the health care providers, the member and legal representative/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 **Health Home** or care management **contracted vendors** should be counted.

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- Interventions conducted by providers, other organizations, or health plans should not be counted.
- These elements capture the count of interventions conducted for or with the member during the reporting period. Each intervention should be assigned to one the three following categories as appropriate:
  - *Mail* – count individualized letters or emails sent during the reporting period. Mailings or email messages of ONLY pre-written materials not specific to the individual should not be included.
  - *Phone* – count phone call or text interactions made during the reporting period. Both incoming and outgoing phone call/text interactions should be counted. Automated voice messages, attempted phone calls, leaving voice mail messages, or text messages with no reply should not be counted.
  - *In-person meeting* – count each interaction during the reporting period.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
24.	CaseClosed	Indicates whether the care management was closed during the reporting period.	Text Field	CLOSED OPEN Blank Cell (Not Engaged)	HH members who engaged in a care management program.

- Members who refuse to continue participation in care management or are disenrolled from the Health Home (voluntary or involuntary) should have CaseClosed as ‘CLOSED’. Health Homes should follow Health Home policies for criteria for discontinuing assignment to the Health Home.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
25.	ClosureDate	Date that the care management was closed.	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System ‘End Date’.	HH members who engaged in a care management program.

- ClosureDate is equivalent to the ‘End Date’ on the Health Home Patient Tracking System. Closure date is based on the Health Home’s care management policies for determining case closure.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
26.	ReasonClosure	Indicates reason for closure of care management.	Text Field	DOH will fill in the field using Patient Tracking System ‘Segment End Date Reason Code’.	HH members who engaged in a care management program.

- Health Home members whose care management was closed should have one of the reasons for closure indicated. DOH will use the ‘Segment End Date Reason Code’ and use the

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following groupings for analysis purposes with the Segment End Date Reason Codes shown in the parenthesis.

- Met program goals (21)
- Disenrolled from Health Home (01,03,07,23)
- Refused to continue (02,12,15,17,18)
- Lost to follow-up (14,16)
- Not eligible (04,05,06,08,09,10,11,13,19)
- Moved insurance coverage (20,22)

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
27.	CaseReopened	Indicates whether a member is located and reengaged in care management after case closure.	Text Field	REOPENED NOT REOPENED MISSING NOT CLOSED Blank Cell (Not Engaged)	HH members who engaged in a care management program.

- This element should indicate ‘REOPENED’ if there is a subsequent engagement of care management initiated during the reporting period, *regardless of program or reason for care management.*
- Distinguishing when care management is reopened -
  - If care management services for the member has been closed (due to inactivity or other reason) and there is a new assessment and new care plan started during the reporting period, then this should be considered a reopening of care management and CaseReopened should be ‘REOPENED’.
  - If care management has been closed and the subsequent reopening of care management does not start during the reporting period, the case should be considered closed (i.e. ‘NOT REOPENED’), for that reporting period. The reopening of the case will be documented in the CaseReopened field in the appropriate quarter reporting period when the reopening occurs.
  - If care management has been inactive, and the member is located and re-engaged and the same assessment and care plan are used, then these activities should be considered part of the initial care management record. In this situation, CaseReopened would be ‘NOT CLOSED’ because the care management was not closed and CaseClosed should be set to ‘OPEN’.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
28.	DateReopened	Date when a member is reengaged in care management after case closure.	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System with ‘Begin Date’ which follows an ‘End Date’.	HH members who engaged in a care management program.

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- The DateReopened will be determined through the Patient Tracking System. The date of the case reopened will be through the first ‘Begin Date’ following an ‘End Date’ in the Patient Tracking System.

**IV. Care Management Service Module**

The specification of each care management service module elements is provided in this section, along with additional reporting guidelines, clarifications and an overview of how to enter the information into the data submission tool. *These elements are required for all health home members who are engaged during the reporting period.* Table 2 in Appendix I provides a single table of these elements and their general specifications.

- **Identifying, categorizing and counting care management interventions**
  - Each **separate intervention should be counted once** for an appropriate category. (There should be a one-to-one match between the care management types of intervention and the care management service module elements (for reporting purposes only). Please use the most significant type if more than one applies to the intervention.
  - Only interventions which were conducted should be counted; updates scheduled but not completed should not be included.
  - The counts of interventions 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.**
  - The activities conducted during the reporting period for care management may involve the member and legal representative/family, the health care providers, 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 Health Home or care management contracted vendors should be counted.
  - Interventions conducted **by providers, other organizations, or health plans** should not be counted.

Field	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
29.	PlanUpdate	Indicates whether the member’s care plan was reviewed, updated and/or modified during the reporting period.	Text Field	YES NO MISSING Blank Cell (Not Engaged)	HH members who engaged in a care management program.
30.	CareManage	Counts of activities in the reporting period to assess needs, monitor progress with member/legal representative and care team, modify or update the care plan or goals.	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Engaged)	HH members who engaged in a care management program.

- PlanUpdate captures an indicator of whether the member’s care plan was reviewed, updated and modified, if necessary, at least once during the reporting period.

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- CareManage captures the count of interventions for comprehensive care management activities (gathering information about needs or progress, revising or modifying the care plan, and interacting with member and providers about modifications to the care plan) conducted for or with the member during the reporting period.

Field	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
31.	HealthPromote	Counts of activities in the reporting period to assist in scheduling and keeping appointments, advocate and arrange for needed services and monitor delivery of services.	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.

- The element captures the count of interventions for health promotion activities (assistance in scheduling and keeping appointments, advocating for services and arranging services) conducted for or with the member during the reporting period.

Field	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
32.	TransitionCare	Counts of activities in the reporting period to evaluate care needs at transitions, arrange safe transition plan, update care team, update information with providers and care plan	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.

- The element captures the count of interventions for addressing transitions in care (evaluating care needs, safe transition plan, continued care arrangements and updating providers and care plan) conducted for or with the member during the reporting period.

Field	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
33.	MemberSupport	Counts of activities in the reporting period to self – management, family/legal representative meetings, peer supports, educate member rights	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.

- The element captures the count of interventions for providing member/family supports (self-management education, conducting family meetings, arranging peer or community support programs, and educating member on rights) conducted for or with the member during the reporting period.

Field	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
34.	CommSocial	Counts of activities in the reporting period to collaborate with CBO for services or needs.	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.

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- The element captures the count of interventions for addressing community based services (arranging and coordinating community based services and supports) conducted for or with the member during the reporting period.

<b>V. HH FACT-GP Functional Assessment Scoring Module</b>
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The Health Home FACT-GP Functional Assessment tool should be used to assess every member upon engagement, annually and at discharge. The date of the FACT-GP assessment should be recorded in the field, DateFACTHH. The reason that the functional assessment was done (Initial, Annual, Discharge) will be reported in the field, ReasonFACTHH. The scores from the FACT-GP+HH Scoring Sheet should be used to fill the appropriate fields. If the FACT-GP+HH Scoring Sheet is not completed for the reporting period for a member, the fields will be left blank.

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
35.	DateFACTHH	Date that the function assessment, FACT-GP+HH was completed	Numeric Field MM/DD/YYYY	Date on or after Trigger Date 09/09/9999(Missing) Blank Cell (FACT-GP+HH Not Done)	HH members who engaged in a care management program.
36.	ReasonFACTHH	Indicates the reason the FACT-GP+HH was completed	Text Field	INITIAL ANNUAL DISCHARGE Blank Cell (Not Assessed)	HH members who engaged in a care management program.
37.	PWB	PWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program.
38.	SWB	SWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program.
39.	EWB	EWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
40.	FWB	FWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
41.	FACTGP	FACT-GP Total Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
42.	HH1	Health Home 1 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing)	HH members who engaged in a care management program

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Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
				Blank Cell (Not Assessed)	
43.	HH2	Health Home 2 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
44.	HH3	Health Home 3 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
45.	HH4	Health Home 4 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
46.	HH5	Health Home 5 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
47.	HH6	Health Home 6 Score Domiciled or Homeless per definition	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
48.	HHSubscale	HH Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
49.	HHFACTGP	Health Home FACT-GP Summary Score	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program

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

- I. Table 1: Required Elements for Member-Level Reporting***
  - II. Table 2: Required Element for Care Management Service Module***
  - III. Table 3: Required elements for HH FACT-GP Functional Assessment Scoring Module***
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**Table 1: Required Elements for Member-Level Reporting – 2015 Measurement Year**

Number	Import Field Name	Element Description	Import Format	Valid Response Values <sup>1</sup>	Element Population
1.	PlanID	OMC Plan ID for MMC/SNP MMIS # for MLTC	Text Field, 1111111	Value as assigned for Plans. 8888888 for FFS members. Required for reporting.	All Health Home Members
2.	HHID	Lead Health Home MMIS #	Text Field	Value as assigned. Required for reporting.	All Health Home Members
3.	ReportDate	Date of HH-CMART Report	Numeric Field Q/YYYY	Quarter value of reporting period. Jan-Mar = 1/YYYY Apr-Jun = 2/YYYY July-Sep = 3/YYYY Oct-Dec = 4/YYYY Required for reporting.	All Health Home Members
4.	CIN	Medicaid Client Identification Number	Text Field, AA11111A	Value as specified. Required for reporting.	All Health Home Members
5.	LastName	Last Name of Member	Text Field	DOH will fill in the field using Medicaid data system.	All Health Home Members
6.	FirstName	First Name of Member	Text Field	DOH will fill in the field using Medicaid data system.	All Health Home Members
7.	DOB	Date of Birth of Member	Numeric Field, MM/DD/YYYY	Date prior to TriggerDate. 09/09/9999 (Missing)	All Health Home Members
8.	TriggerDate	This is equivalent to the “Begin Date” on the Health Home Patient Tracking System for the first record submission for the member.	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System ‘Begin Date’.	All Health Home Members

1 – “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.

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Number	Import Field Name	Element Description	Import Format	Valid Response Values <sup>1</sup>	Element Population
9.	ProgramType	Primary focus of care management program for member.	Text Field	HH BEHAVIORAL HEALTH HH CHRONIC ADULT HH CHILDREN HH DEV DISABLED HH LONG TERM CARE HH SUBSTANCE USE HH HIV NOT ABLE TO CONTACT REVIEW PENDING MISSING	All Health Home Members
10.	AbleContact	Indicates whether Health Home was able to contact the member regarding engagement in care management.	Text Field	YES NO YES_HIATUS PERIOD NO_HIATUS PERIOD TCM-HH CONVERSION	All Health Home Members
11.	ContactDate	Date of initial contact or interaction between the member/legal representative/family and care management staff.	Numeric Field, MM/DD/YYYY	Date on or after TriggerDate. 09/09/9999 (Missing) Blank Cell (Not contacted)	All Health Home Members
12.	OutreachEffort	Count of in-person (street-level), phone/text contacts, individualized mailings/ emails in attempts to locate and interact with member	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing)	All Health Home Members
13.	AppropriateCM	Indicates whether the member met at least one of the criteria for Health Home	Text Field	YES NO NOT ABLE TO CONTACT REVIEW PENDING	All Health Home Members
14.	AssessedCM	Indicates whether the member received an initial assessment for care management.	Text Field	YES NO NOT ABLE TO CONTACT REVIEW PENDING	All Health Home Members

1 – “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.

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Number	Import Field Name	Element Description	Import Format	Valid Response Values <sup>1</sup>	Element Population
15.	AssessDate	Date when an initial comprehensive assessment and care plan was completed.	Numeric Field, MM/DD/YYYY	Date on or after TriggerDate. 09/09/9999 (Missing) Blank Cell (Not Assessed)	All Health Home Members
16.	OptOut	Indicates if member or member's legal representative refused to participate in care management.	Text Field	OPTED OUT DID NOT OPT OUT NOT APPROPRIATE HH NOT ABLE TO CONTACT REVIEW PENDING	All Health Home Members
17.	EngagedCM	Indicates if member agreed to participate in the care management program	Text Field	YES NO	All Health Home Members
18.	EngageCMDate	Date that member or member's legal representative agreed to participate in care management.	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System 'Begin Date'.	HH members who engaged in a care management program.
19.	ConsentDate	Date that member or member's legal representative signed consent to share member's information.	Numeric Field MM/DD/YYYY	DOH will fill in the field using Patient Tracking System 'Consent Date'.	HH members who engaged in a care management program.
20.	Intensity	The <u>maximum</u> level of intensity of care management planned for the individual during the reporting period	Text Field	HIGH MEDIUM LOW MISSING Blank Cell (Not engaged)	HH members who engaged in a care management program.
21.	CountMail	Count of mail/email interventions by care management staff for or with member during the reporting period	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Engaged)	HH members who engaged in a care management program.
22.	CountPhone	Count of phone/text interventions by care management staff for or with member during the reporting period	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Engaged)	HH members who engaged in a care management program.

1 – “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.

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Number	Import Field Name	Element Description	Import Format	Valid Response Values <sup>1</sup>	Element Population
23.	CountPerson	Count of in-person interventions by plan staff for or by care management staff for or with member during the reporting period	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.
24.	CaseClosed	Indicates whether the care management was closed during the reporting period.	Text Field	CLOSED OPEN Blank Cell (Not Engaged)	HH members who engaged in a care management program.
25.	ClosureDate	Date that the care management was closed.	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System 'End Date'.	HH members who engaged in a care management program.
26.	ReasonClosure	Indicates reason for closure of care management.	Text Field	DOH will fill in the field using Patient Tracking System 'Segment End Date Reason Code'.	HH members who engaged in a care management program.
27.	CaseReopened	Indicates whether a member is located and reengaged in care management after case closure.	Text Field	REOPENED NOT REOPENED MISSING NOT CLOSED Blank Cell (Not Engaged)	HH members who engaged in a care management program.
28.	DateReopened	Date when a member is reengaged in care management after case closure.	Numeric Field, MM/DD/YYYY	DOH will fill in the field using Patient Tracking System with 'Begin Date' which follows an 'End Date'.	HH members who engaged in a care management program.

1 – “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.

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**Table 2: Required Elements for Care Management Service Module**

Number	Import Field Name	Element Description	Import Format	Valid Response Values <sup>2</sup>	Element Population
29.	PlanUpdate	Indicates whether the member's care plan was reviewed, updated and/or modified during the reporting period.	Text Field	YES NO MISSING Blank Cell (Not Engaged)	HH members who engaged in a care management program.
30.	CareManage	Counts of activities in the reporting period to assess needs, monitor progress with member/legal representative and care team, modify or update the care plan or goals.	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Engaged)	HH members who engaged in a care management program.
31.	HealthPromote	Counts of activities in the reporting period to assist in scheduling and keeping appointments, advocate and arrange for needed services and monitor delivery of services.	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.
32.	TransitionCare	Counts of activities in the reporting period to evaluate care needs at transitions, arrange safe transition plan, update care team, update information with providers and care plan	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.
33.	MemberSupport	Counts of activities in the reporting period to self-management, family/legal representative meetings, peer supports, educate member rights	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.
34.	CommSocial	Counts of activities in the reporting period to collaborate with CBO for services or needs.	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing), Blank Cell (Not Engaged)	HH members who engaged in a care management program.

1 – “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.

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**Table 3: Required Elements for HH-FACT GP Assessment**

Number	Import Field Name	Element Description	Import Format	Valid Response Values	Element Population
35.	DateFACTHH	Date that the function assessment, FACT-GP+HH was completed	Numeric Field MM/DD/YYYY	Date on or after Trigger Date 09/09/9999(Missing) Blank Cell (FACT-GP+HH Not Done)	HH members who engaged in a care management program.
36.	ReasonFACTHH	Indicates the reason the FACT-GP+HH was completed	Text Field	INITIAL ANNUAL DISCHARGE Blank Cell (Not Assessed)	HH members who engaged in a care management program.
37.	PWB	PWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program.
38.	SWB	SWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program.
39.	EWB	EWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
40.	FWB	FWB Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
41.	FACTGP	FACT-GP Total Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
42.	HH1	Health Home 1 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
43.	HH2	Health Home 2 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
44.	HH3	Health Home 3 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program

1 – “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.

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<b>Number</b>	<b>Import Field Name</b>	<b>Element Description</b>	<b>Import Format</b>	<b>Valid Response Values</b>	<b>Element Population</b>
45.	HH4	Health Home 4 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
46.	HH5	Health Home 5 Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
47.	HH6	Health Home 6 Score Domiciled or Homeless per definition	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
48.	HHSubscale	HH Subscale Score	Numeric Field, Tens, whole number (00)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program
49.	HHFACTGP	Health Home FACT-GP Summary Score	Numeric Field, Hundreds, whole number (000)	Value greater than or equal to zero. 999 (Missing) Blank Cell (Not Assessed)	HH members who engaged in a care management program

1 – “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.

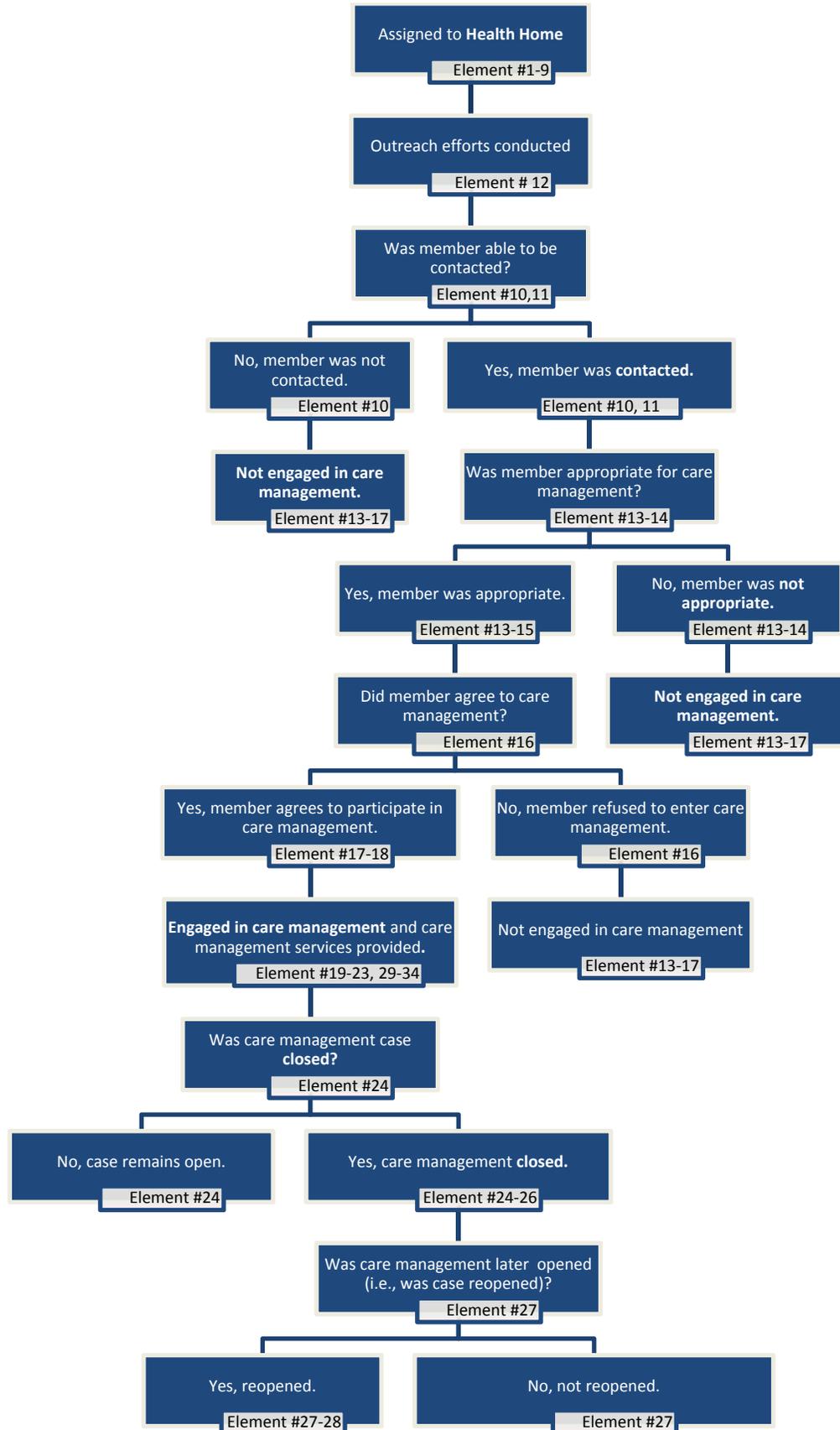
*E. Appendix II: Flow Charts of Care Management Decision Points*

**I. Chart 1: Mapping the Care Management Elements for HH-CMART Reporting Process**

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**Chart 1: Sample Map of Decision Points of Care Management Elements for HH-CMART Reporting Process**



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***F. Appendix III: NYS Medicaid Health Plan Reference Sheet***

**I. Reference Sheet 1: NYS Medicaid Plan IDs and Plan Names by Product**

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**Reference Sheet 1: NYS Medicaid Plan IDs and Plan Names by Product**

Product	PlanID	PlanName
MEDICAID	2010186	Affinity Health Plan
MEDICAID	1090384	CDPHP
MEDICAID	1390598	Excellus BlueCross BlueShield
MEDICAID	2060193	Fidelis Care New York
MEDICAID	2090194	Healthfirst PHSP, Inc.
MEDICAID	1140685	HealthNow New York Inc.
MEDICAID	2180196	Health Plus, an Amerigroup Company
MEDICAID	1050178	HIP (EmblemHealth)
MEDICAID	2040287	Hudson Health Plan
MEDICAID	1070680	Independent Health's MediSource
MEDICAID	1130185	MetroPlus Health Plan
MEDICAID	1080383	MVP
MEDICAID	2161013	Total Care
MEDICAID	1260187	UnitedHealthcare Community Plan
MEDICAID	2190696	Univera Community Health
MEDICAID	1240287	WellCare of New York
MEDICAID	8888888	Fee-For-Service

Product	PlanID	PlanName
SNP	S99B001	Amida Care
SNP	S99A008	MetroPlus Health Plan
SNP	S99B010	VNSNY CHOICE Select Health

Product	PlanID	PlanName
MLTC	03458546	Aetna Better Health
MLTC	03481927	AgeWell New York
MLTC	03560441	Alphacare
MLTC	03466800	Archcare Community Life
MLTC	03114514	ArchCare Senior Life
MLTC	03072740	Catholic Health – LIFE
MLTC	01234037	CenterLight PACE
MLTC	02710185	CenterLight Select
MLTC	03506989	Centers Plan for Healthy Living
MLTC	03320725	Complete Senior Care
MLTC	01674982	Eddy Senior Care
MLTC	01825947	Elant Choice
MLTC	01278899	ElderOne
MLTC	03173113	Elderplan
MLTC	03253707	Elderplan dba Homefirst
MLTC	03234044	ElderServe dba RiverSpring
MLTC	03549135	Extended MLTC
MLTC	02188296	Fallon Health Weinberg
MLTC	01788325	Fidelis Care at Home
MLTC	02927631	Fidelis Medicaid Advantage Plus
MLTC	01827572	GuildNet
MLTC	02942923	Guildnet Medicaid Advantage Plus
MLTC	03522947	Hamaspik Choice
MLTC	03239801	Health Insurance Plan
MLTC	03173080	Healthplus, An Amerigroup Company, MAP
MLTC	02644562	Healthplus, An Amerigroup Company, MLTC
MLTC	03416231	HIP MLTC
MLTC	03866960	iCircle
MLTC	01865329	Independence Care System
MLTC	03476427	Integra MLTC
MLTC	03690851	Kalos Health
MLTC	03466906	Metroplus MLTC
MLTC	03420808	MHI Healthfirst Complete Care
MLTC	03594052	Montefiore MLTC
MLTC	03580307	North Shore-LIJ Health Plan
MLTC	01519162	PACE CNY
MLTC	03581413	Prime Health Choice
MLTC	02104369	Senior Health Partners
MLTC	01778523	Senior Network Health
MLTC	02932896	Senior Whole Health - MAP
MLTC	03459881	Senior Whole Health partial
MLTC	03056544	Total Senior Care
MLTC	03439663	United Health Personal Assist
MLTC	03420399	Village Care MAX
MLTC	03529059	VNA Homecare Options
MLTC	01750467	VNS Choice Partial
MLTC	02914056	VNS Choice Plus MAP
MLTC	02825230	Wellcare Advocate Partial