

Health Home Patient Tracking System

File Specifications Document



Introduction

Overview

The purpose of the Health Home Patient Tracking System is to facilitate communication between the New York State Department of Health (DOH) and the Health Home Data Management Providers (DMP) regarding the status of Medicaid members eligible for Health Home services.

For Medicaid members enrolled in Managed Care, the DMP is a member's Managed Care Plan. For Fee for Service (FFS) members, the Provider-led Health Home is the DMP. Managed Care DMPs are responsible for assigning members to appropriate Health Home s and exchanging data with both those Health Home s and DOH. Fee for service DMPs are responsible for exchanging data with both DOH and their partnering Care Management Agencies.

NYS DOH will identify Medicaid members that are eligible for Health Home services. Managed Care Plans will receive a list of the members enrolled in their Managed Care Plan. Provider-led Health Home s will receive a list of Fee for Service members that have existing connections with their network of providers or reside in one of the counties that the Health Home serves.

Using the DOH supplied loyalty file and encounter data, Managed Care Plans will assign their members to Provider-led Health Home s. Provider-led Health Home s will use the lists they receive from DOH and Managed Care Plans to assign Medicaid members to Care Management Agencies. Care Management Agencies will begin engaging and enrolling Medicaid members into Health Home services. Care Management Agencies will also collect and report their transactions to the Health Home.

Data Management Providers must compile the Health Home information they receive from downstream providers into a single file and submit that file to DOH. These files must be processed before a claim is submitted so it is crucial that the data is submitted promptly and accurately. Claims without properly submitted Health Home assignments will be denied for payment.

Converting Care Management Agencies will bill Medicaid directly for all Health Home services, but they are never Data Management Providers.

For additional information regarding the Health Home program, please see the links below:

- Health Home website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm
- Health Home Medicaid Update: <http://www.health.ny.gov/healthcare/medicaid/program/update/2012/april12muspec.pdf>
- Health Home Provider Manual: COMING SOON

OHIP Datamart Portal

The OHIP Datamart Portal is an application housed in the Health Commerce System (HCS) that will allow the download and upload of fixed length text files by DOH and DMP. DMPs are the entities that are responsible for submitting the Patient Tracking file to DOH each month.

Each data management provider will assign employees as HCS contacts to retrieve and submit files through the Datamart Portal. Files that do not conform to the formatting and logic outlined in this document will not be accepted.

The OHIP Datamart Portal is accessed at <https://commerce.health.state.ny.us/>. Log in to the HCS Portal using your assigned user ID and password. Click on the Applications tab at the top of the page. Browse to the NYSDOH Insurance Program Data Portal and click on the link.

Once you are on the OHIP Data Portal application, click on the Health Home tab on the top menu. On the left is a menu of Health Home applications. Use the Data Management application to submit and receive files.

More instructions to come...

Data Sent to Data Management Provider by DOH

The following section will provide a brief explanation of the two record types (Assignment Records and Error Reports) available for DMPs to download from the Portal site. Field descriptions and explanations of accepted values can be found in **Appendix A: Field Descriptions** at the end of this document.

Health Home Assignment Record

An assignment record is used by DOH to communicate to the DMP Medicaid members that are eligible for Health Home services. Every month DOH will release a file to DMP containing information about Health Home eligible members that should be used to identify, locate, and outreach/enroll them into Health Home services. Medicaid members will be released to the Health Homes based on DOH's targeting criteria.

The DMP will receive an email notice on the first Tuesday following the first Saturday of the month notifying them that a Health Home assignment file is available for download. Fee for Service DMPs will be responsible for disseminating the information to their partnering Care Management Agencies. Managed Care DMPs will be responsible for assigning members to appropriate Health Home s and disseminating the member information to the assigned Health Home.

Assignment Record					
Field #	Field	Start Pos	Length	End Pos	Format
1	Medicaid member ID	1	8	8	AA11111A, Alphanumeric
2	Medicaid member First Name	9	30	38	Alpha
3	Medicaid member Last Name	39	30	68	Alpha
4	Date of Birth	69	8	76	MMDDYYYY, Numeric
5	County of Fiscal Responsibility	77	60	136	Alpha
6	Gender	137	1	137	Character (M/F)
7	DOH Assignment Date	138	8	145	MMDDYYYY, Numeric
8	Managed Care Plan MMIS ID	146	8	153	Numeric
9	Managed Care Plan Name	154	40	193	Alpha
10	Health Home MMIS ID	194	8	201	Numeric

11	Health Home Name	202	40	241	Alpha
12	DOH Medicaid member Address Line 1	242	40	281	Alphanumeric
13	DOH Medicaid member Address Line 2	282	40	321	Alphanumeric
14	DOH Medicaid member City	322	40	361	Alphanumeric
15	DOH Medicaid member State	362	2	363	Alpha
16	DOH Medicaid member Zip Code	364	9	372	Numeric
17	DOH Medicaid member Phone	373	10	382	Numeric
18	Date of Patient Acuity	383	8	390	MMDDYYYY, Numeric
19	Acuity Score	391	7	397	Decimal, 99V9999
20	Risk Score	398	6	403	Decimal, 999V99
21	Outpatient Rank	404	6	409	Decimal, 999V99
22	DOH Composite Score	410	6	415	Decimal, 999V99
23	Service 1: Last Service Date	416	8	423	MMDDYYYY, Numeric
24	Service 1: Last Service Provider Name	424	40	463	Alphanumeric
25	Service 1: Last Service Address Line 1	464	40	503	Alphanumeric
26	Service 1: Last Service Address Line 2	504	40	543	Alphanumeric
27	Service 1: Last Service City	544	40	583	Alphanumeric
28	Service 1: Last Service State	584	2	585	Alpha
29	Service 1: Last Service Zip Code	586	9	594	Numeric
30	Service 1: Last Service Phone Number	595	10	604	Numeric
31	Service 2: Last Service Date	605	8	612	MMDDYYYY, Numeric
32	Service 2: Last Service Provider Name	613	40	652	Alphanumeric
33	Service 2: Last Service Address Line 1	653	40	692	Alphanumeric
34	Service 2: Last Service Address Line 2	693	40	732	Alphanumeric
35	Service 2: Last Service City	733	40	772	Alphanumeric
36	Service 2: Last Service State	773	2	774	Alpha
37	Service 2: Last Service Zip Code	775	9	783	Numeric
38	Service 2: Last Service Phone Number	784	10	793	Numeric
39	Service 3: Last Service Date	794	8	801	MMDDYYYY, Numeric
40	Service 3: Last Service Provider Name	802	40	841	Alphanumeric
41	Service 3: Last Service Address Line 1	842	40	881	Alphanumeric
42	Service 3: Last Service Address Line 2	882	40	921	Alphanumeric
43	Service 3: Last Service City	922	40	961	Alphanumeric
44	Service 3: Last Service State	962	2	963	Alpha
45	Service 3: Last Service Zip Code	964	9	972	Numeric
46	Service 3: Last Service Phone Number	973	10	982	Numeric
47	Service 4: Last Service Date	983	8	990	MMDDYYYY, Numeric
48	Service 4: Last Service Provider Name	991	40	1030	Alphanumeric
49	Service 4: Last Service Address Line 1	1031	40	1070	Alphanumeric
50	Service 4: Last Service Address Line 2	1071	40	1110	Alphanumeric
51	Service 4: Last Service City	1111	40	1150	Alphanumeric
52	Service 4: Last Service State	1151	2	1152	Alpha
53	Service 4: Last Service Zip Code	1153	9	1161	Numeric
54	Service 4: Last Service Phone Number	1162	10	1171	Numeric
55	Service 5: Last Service Date	1172	8	1179	MMDDYYYY, Numeric
56	Service 5: Last Service Provider Name	1180	40	1219	Alphanumeric
57	Service 5: Last Service Address Line 1	1220	40	1259	Alphanumeric
58	Service 5: Last Service Address Line 2	1260	40	1299	Alphanumeric

59	Service 5: Last Service City	1300	40	1339	Alphanumeric
60	Service 5: Last Service State	1340	2	1341	Alpha
61	Service 5: Last Service Zip Code	1342	9	1350	Numeric
62	Service 5: Last Service Phone Number	1351	10	1360	Numeric

Only applicable fields will contain data. Other fields will be filled with the appropriate number of blank spaces. For example, the Managed Care Plan MMIS ID field for a Fee for Service member would contain 8 blank spaces.

DOH Error Reports

There are two DOH Error Reports. The first error report is created during the initial file validation by DOH and the second error report is created after the final submission to WMS. The pre-processing error report is created immediately upon upload of a tracking file to the Portal and contains errors regarding file formatting and invalid values. It will deny records that do not comply with the formatting descriptions and logic outlined in the **Field Descriptions** section of this manual. Providers that submit their monthly file prior to the processing date (the first Tuesday of the month) can use this error report to correct problems identified by the pre-processing error report and resubmit the entire file (not just the records that were corrected) to the Portal. The post-processing error report contains errors related to overlapping segments or member ineligibility. Both error reports are appended to the same file which is available for download on the Data Management section of the Portal site.

The DOH Error Report consists of a line number from the original submission, basic identification information, and up to five error codes indicating why the record was rejected. Descriptions of the error codes are listed in **Appendix B: Error Reason Codes**. Both the pre-processing and post-processing Error Reports will follow the formatting rules below.

Error Report					
Field #	Field	Start Pos	Length	End Pos	Format
1	Error Input Line Number	1	6	6	Numeric
2	Record Type	7	1	7	Character (A/C/D/R)
3	Medicaid member ID	8	8	15	AA11111A, Alphanumeric
5	Begin Date	16	8	23	MMDDYYYY, Numeric
11	Error Reason Code 1	24	3	26	Numeric, Comma Delimited
12	Error Reason Code 2	27	3	29	Numeric, Comma Delimited
13	Error Reason Code 3	30	3	32	Numeric, Comma Delimited
14	Error Reason Code 4	33	3	35	Numeric, Comma Delimited
15	Error Reason Code 5	36	3	38	Numeric, Comma Delimited

Records Sent to DOH by Data Management Provider

Files submitted to the OHIP Portal will be processed by DOH on the first Tuesday of every month. The Health Home Patient Tracking file can contain data for any previous time periods. For example, the

Tracking file submitted in September 2012 cannot contain information regarding services provided in September 2012, but it can contain information for any prior month.

Files may be submitted at any time prior to the processing date each month. When uploaded, the file will be validated and all pre-processing errors will be available. You may use this error report to correct the file and resubmit the entire file as many times as necessary until the processing deadline. The latest file uploaded as of the processing date will become the file of record. It is important to upload the **entire file each time**, not just the corrected records, as only the most recently uploaded file will be processed into the DOH Health Home database.

Most records that fail a pre-processing edit will be rejected by DOH and will not be submitted to WMS. However, records that fail the test for current eligibility will be submitted to WMS because WMS may have more up to date eligibility information. These cases will be identified in your Error Report with Error Reason Code 024. If WMS also rejects these records, the WMS rejection will be indicated in the post-processing error report as Error Reason Code 002.

During processing, logic based edits will be applied to check for concurrent segments or inappropriate dates. Records that pass the post-processing edits will be sent to WMS for verification. After the WMS verification process you will have access to the post processing error report. Health Home claims should not be submitted for a Medicaid member that was rejected as part of the pre or post processing edit system. Rejected records can be corrected (if possible) and submitted for processing during the following month's Patient Tracking file submission process.

You may log onto the Portal at any time to retrieve the files you originally submitted and DOH error reports. Tracking Files may be in any of the following statuses.

File Status	Description
Uploaded	DOH received the file. Initial processing will begin immediately.
DOH Validated	The file has run through the first set of pre-processing edits. An error report outlining the records that failed the pre-processing edits will be available. Files in this status can be resubmitted with corrected data up until the file processing date.
DOH Processed	The file processing date has passed, the file has run through the port-processing edits, and accepted records have been submitted to WMS. The file can no longer be modified or resubmitted once it's in this status. Any files submitted after this status will be applied to the next monthly processing batch.
Final	DOH has submitted records to WMS for verification and has received a rejection list from WMS of records that failed WMS eligibility logic. The post processing error report containing records that failed the post processing edits and/or the WMS edits is available.

The following section provides a brief explanation of the record types (Add, Change, Delete, and Rejection) found in the Tracking File that Data Management Providers will send to DOH in addition to outlining specifications for each record type. Field descriptions and explanations of accepted values can be found in **Appendix A: Field Descriptions** at the end of this document.

All records are contained in a single fixed length text file. Each record type must conform to the following definitions.

Add/Change Record

This record is used to submit new or updated information to the Health Home tracking system. To begin a service segment an Add record should be submitted to DOH. To update a client from outreach to enrollment, an Add record should be submitted (the system will automatically end date the outreach segment). To end any other segment, a Change record should be submitted.

Add/Change Record					
Field #	Field	Start Pos	Length	End Pos	Format
1	Record Type	1	1	1	Character (A/C)
2	Medicaid member ID	2	8	9	AA11111A, Alphanumeric
3	Date of Birth	10	8	17	MMDDYYYY, Numeric
4	Gender	18	1	18	Character (M/F)
5	Begin Date	19	8	26	MMDDYYYY, Numeric
6	End Date	27	8	34	MMDDYYYY, Numeric
7	Outreach/Enrollment Code	35	1	35	Character (O/E)
8	Managed Care Plan MMIS ID	36	8	43	Numeric
9	Health Home MMIS ID	44	8	51	Numeric
10	Care Management Agency MMIS ID	52	8	59	Numeric
11	TCM/MATS/COBRA/CIDP Indicator	60	1	60	Character (Y/N)
12	TCM/MATS/COBRA/CIDP Slot Type	61	1	61	Character (N/E)
13	Referral Code	62	1	62	Character (R/T)
14	Segment End Date Reason Code	63	2	64	Numeric
15	Billing Provider MMIS ID	65	8	72	Numeric
16	Managed Care Assignment Date	73	8	80	MMDDYYYY, Numeric
17	Referral Date	81	8	88	MMDDYYYY, Numeric
18	Transfer Provider MMIS ID	89	8	96	Numeric
19	Date of earliest contact	97	8	104	MMDDYYYY, Numeric
20	Date of latest contact	105	8	112	MMDDYYYY, Numeric
21	Medicaid member Contact Address Line 1	113	40	152	Alphanumeric
22	Medicaid member Contact Address Line 2	153	40	192	Alphanumeric
23	Medicaid member Contact City	193	40	232	Alphanumeric
24	Medicaid member Contact State	233	2	234	Alpha
25	Medicaid member Contact Zip Code	235	9	243	Numeric
26	Medicaid member Contact Phone	244	10	253	Numeric
27	Medicaid member Contact Alternate Phone	254	10	263	Numeric

Rules:

1. The combination of Medicaid member ID, Managed Care Plan ID, Health Home ID, Care Management ID, Begin Date, CIDP/COBRA/MATS/TCM Slot indicator, and CIDP/COBRA/MATS/TCM Slot type are the primary key of the record (shown in bold above).
2. The segment may not overlap with any existing segments.

3. Use a Change record to change a non-primary key field. For a change record to be valid, the primary key fields must match exactly with the values stored in the Health Home Tracking System.
4. To change a primary key field, the segment must first be end dated using a Change record and the new information must be added using an Add record. If there is an error in any of the primary key fields, the record should be deleted using a Delete record and resubmitted with the correct information using an Add record.

Example: If Tommy started outreach in May, moved to enrollment in June, and switched Care Management Agencies in July, Tommy’s Health Home would submit an Add record for May, an Add record for June, and both a Change record (to end date the segment with the original Care Management Agency) and an Add record (to begin the segment with the new Care Management Agency) for July.

Delete Record

The delete record is used to remove an incorrectly entered outreach or enrollment event that never occurred. It should not be used to end date an existing segment.

Delete Record					
Field #	Field	Start Pos	Length	End Pos	Format
1	Record Type	1	1	1	Character (D)
2	Medicaid member ID	2	8	9	AA11111A, Alphanumeric
3	Begin Date	10	8	17	MMDDYYYY, Numeric
4	Managed Care Plan MMIS ID	18	8	25	Numeric
5	Health Home MMIS ID	26	8	33	Numeric
6	Care Management Agency MMIS ID	34	8	41	Numeric
7	TCM/MATS/COBRA/CIDP Indicator	42	1	42	Character (Y/N)
8	TCM/MATS/COBRA/CIDP Slot Type	43	1	43	Character (N/E)

Rules:

1. The primary key fields must match exactly with the values on file.

Example: Health Home B submitted an Add record for Sally in the file submitted to DOH for May, but realized in June that Sally did not receive services in May. Health Home B would submit a Delete record indicating that services for Sally never occurred and that the record Adding services should be deleted.

Rejection Record

The rejection record is used to reject a DOH assignment of a Fee for Service member to a Health Home. Providers should use this record to indicate to DOH that the current Medicaid member assignment is inappropriate and that a more suitable Health Home assignment is needed. Once rejected, the Medicaid member will not be assigned to the same Health Home in the future. Health Home s may use the Suggested Health Home field to suggest a more appropriate assignment; however, the Suggested Health Home field is not required. Rejection records can only be submitted to DOH by a Health Home, not a Managed Care Plan. Health Home s can indicate to Managed Care Plans that a Health Home

assignment is inappropriate, but the Managed Care Plan will be responsible for reassigning the Medicaid member to a more appropriate Health Home, not DOH. Managed Care Plans should use the Change and Add records to indicate to DOH if a Medicaid member's Health Home assignment has changed.

Rejection Record					
Field #	Field	Start Pos	Length	End Pos	Format
1	Record Type	1	1	1	Character (R)
2	Medicaid member ID	2	8	9	AA11111A, Alphanumeric
3	Rejection Reason Code	10	2	11	Numeric
4	Suggested Health Home	12	8	19	Numeric

Rules:

1. Can only be submitted to DOH by Health Home s, not Managed Care Plans.
2. Rejection records can only be submitted for Medicaid members that did not begin an outreach/engagement or an enrollment segment.

Example: Tim was assigned to Health Home A, but Health Home A knows that Tim just moved to a different county. Health Home A will submit a Rejection record to DOH with Segment End Date Reason Code 08: Member moved out of service county.

Appendix A: Field Descriptions

Listed below are descriptions of the fields found in all of the file formats along with acceptable values, field formatting, and editing logic (if applicable).

This key is used on each field to show fields that are primary keys, the record types that the field appears on, and which direction the field is transmitted.

- * Primary Key Field
- AC** Add/Change Record
- D** Delete Record
- HH** Health Home Assignment Record
- E** DOH Error Report
- R** Rejection Record
- ↑ Records Sent to DOH by Data Management Provider
- ↓ Records Sent to Data Management Provider by DOH

Acuity Score ↓ HH

Field Length: 7
 Format: Decimal, 99V9999

Description: Patient specific acuity factors are calculated using 3M Clinical Risk Group software. Raw acuity scores are then adjusted for a predicted functional status factor (i.e., Mental Health, Substance Abuse and higher medical acuity groups are "up-weighted" until functional status data become available to more accurately adjust clinical acuity). Patient specific adjusted acuity scores "predict" case management need based on a regression formula.

Begin Date* ↓ E ↑ AC D

Field Length: 8
 Format: MMDDYYYY, Numeric

Description: The begin date indicates when the segment (the unique combination of the primary key fields) began. When a member is first enrolled, the begin date will indicate when Health Home services started. If the member moved to a new Health Home, the begin date will indicate when the member started receiving services from the new Health Home. When a member in a converting care management slot moves from an Existing slot type to a New slot type, the begin date will indicate when a Care Management Agency will begin billing using the new rate code.

Editing Logic: This field must contain a valid date. The begin date must be greater than or equal to the DOH assignment date for Fee for Service members. The begin date must be less than the end date for the same segment. The begin date must always be the first day of the month. This date may not fall within an existing event segment. For members in converting TCM/MATS/COBRA/CIDP slots, the begin date should coincide with the effective date of the conversion to Health Home services.

Billing Provider MMIS ID*

↓ HH

↑ AC

Field Length: 8
Format: Numeric

Description: The Billing Provider MMIS ID is the provider who will submit a claim to Medicaid for payment. For members assigned to a converting Care Management Agency, the billing provider will be the Care Management Agency. For members enrolled in a Managed Care Plan but not assigned to a converting Care Management Agency, the Managed Care Plan will be the billing provider. For Fee for Service members not assigned to a converting Care Management Agency, the Health Home will be the billing provider. The Billing Provider MMIS ID will be determined using the criteria below.

Editing Logic: This field must contain a valid MMIS Provider ID and be the appropriate billing provider per the logic outlined below.

Care Management Provider ID: TCM/MATS/COBRA/CIDP Indicator = Y

Managed Care ID: Medicaid member in Managed Care **AND** TCM/MATS/COBRA/CIDP Indicator = N

Health Home ID: Medicaid member in Fee for Service **AND** TCM/MATS/COBRA/CIDP Indicator = N

Care Management Agency MMIS ID *

↑ AC D

Field Length: 8
Format: Numeric

Description: The MMIS Provider ID of the Care Management Agency performing care management. For the TCM/MATS/COBRA/CIDP Medicaid members, this is also the billing provider ID.

Editing Logic: This field must contain a valid MMIS Provider ID. A claim cannot be submitted for a member until the member is assigned to a Care Management Agency.

County of Fiscal Responsibility

↓ HH

Field Length: 60
Format: Alpha

Description: The county that is fiscally responsible for the Medicaid member.

Date of Birth

↓ HH

↑ AC

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The member's date of birth (DOB) that is on file with Medicaid. DOB is used to verify the identity of a member referred for Health Home services.

Editing Logic: The DOB This field must contain a valid date and must match the DOB that is on file for the member with Medicaid.

Date of Earliest Contact

↑ AC

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The Date of Earliest Contact is the date that the Care Management Agency was first able to meet one of the 5 Health Home core services. This field should only be filled in when a member first begins a new outreach/engagement or enrollment segment with a Care Management Agency.

Editing Logic: This field must contain a valid date. This date must be equal to or greater than the DOH assignment date.

Date of Latest Contact

↑ AC

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The Date of Latest Contact is the last date the Care Management Agency either saw the member or spoke with the member on the phone. This field should only be populated when the Segment End Date Reason Code is 14 – Lost to Services.

Editing Logic: This field must contain a valid date. This field should only be filled in when the Segment End Date Reason Code is 14 – Lost to Services.

Date of Patient Acuity

↓ HH

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This field will show the time period that the acuity and rank information is based on.

DOH Assignment Date ↓ HH

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that the Medicaid member was assigned by DOH to a Health Home for Fee for Service Medicaid. For Medicaid Managed Care this contains the date that the Medicaid member was released to a Managed Care plan for assignment to a Health Home.

Editing Logic: A member cannot begin Health Home services without a DOH Assignment Date, unless the member is referred to Health Home services (Referral Indicator = R or T).

DOH Composite Score ↓ HH

Field Length: 6
Format: Decimal, 999V99

Description: Combines each Medicaid member's risk score and outpatient rank to create a Health Home composite score. Plans should focus on enrolling Medicaid members assigned to them by DOH with the highest DOH scores first. Possible values range from 0 (lower need) – 200 (higher need).

DOH Medicaid member Address Line 1 ↓ HH

Field Length: 40
Format: Alphanumeric

Description: The most recent Medicaid member contact information from the Medicaid system.

DOH Medicaid member Address Line 2 ↓ HH

Field Length: 40
Format: Alphanumeric

Description: The most recent Medicaid member contact information from the Medicaid system.

DOH Medicaid member City ↓ HH

Field Length: 40
Format: Alphanumeric

Description: The most recent Medicaid member contact information from the Medicaid system.

DOH Medicaid member Phone ↓ HH

Field Length: 10
Format: Numeric

Description: The most recent Medicaid member contact information from the Medicaid system.

DOH Medicaid member State

↓ HH

Field Length: 2
Format: Alpha

Description: The most recent Medicaid member contact information from the Medicaid system.

DOH Medicaid member Zip Code

↓ HH

Field Length: 9
Format: Numeric

Description: The most recent Medicaid member contact information from the Medicaid system.

Error Input Line Number

↓ E

Field Length: 6
Format: Numeric

Description: The Error Input Line Number is listed on the DOH error report to indicate which line on the input file failed the edit(s). For records with invalid formats, this may be the only way to identify which record from the input file is being rejected.

Error Reason Code 1-5

↓ E

Field Length: 3
Format: Numeric, Comma Delimited
Accepted Values: See *Appendix B: Error Reason Codes*

Description: The DOH error reports will list up to five Error Reason Codes for a submitted record that was rejected. Valid Error Reason Codes are listed in *Appendix B: Error Reason Codes*.

End Date

↑ AC

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The End Date indicates when the segment (the unique combination of the primary key fields) ended. When a member disenrolls from Health Home services, the end date will indicate when Health Home services were discontinued. If a member moves from one Health Home to another, the end date is used to indicate the last day the first Health Home performed Health Home services. When a member in a converting care management slot moves from an Existing slot type to a New slot type, the end date indicates the last day for which the Care Management Agency will bill using the existing rate code. Unless a member is moving from outreach and engagement to enrollment, an end date must be submitted using a change record to indicate to DOH that a segment is ending. When a member is moving from outreach and engagement to enrollment, an end date is not needed to end date the

outreach segment. When an Add record for enrollment is submitted to DOH, the system will automatically end date any outreach segments that are open under the primary key.

Editing Logic: This field must contain a valid date. This date must be greater than the begin date and must always be the last day of the month. When a segment is complete, the segment must be ended using a change record, never a delete record. The end date may not cause the event segment to overlap with another existing segment. For open segments, the end date field should be filled with 8 blank spaces.

Gender

↓ HH

↑ AC

Field Length: 1
Format: Alpha
Accepted Values: M,F

Description: The member's gender that is on file with Medicaid. Gender is used to verify the identity of a member referred for Health Home services.

Editing Logic: The gender for the Medicaid member must match exactly with the gender on file with Medicaid.

Health Home MMIS ID*

↓ HH

↑ AC D

Field Length: 8
Format: Numeric

Description: The Health Home MMIS Provider ID. For Fee for Service members with a value of N in the TCM/MATS/COBRA/CIDP Indicator, this is the Billing Provider MMIS ID.

Editing Logic: This value will be assigned for all Medicaid members in Fee for Service Medicaid on the DOH Assignment record and the value coming in to DOH on the Add/Change record must match the DOH assignment for the individual. For Managed Care Medicaid members or referrals, this field must match a valid Health Home provider ID.

Health Home Name

↓ HH

Field Length: 40
Format: Alpha

Description: The name of the Health Home.

Last Service Address Line 1 (Service 1-5)

↓ HH

Field Length: 40
Format: Alphanumeric

Description: The contact information for the more recent service submitted to Medicaid for the Medicaid member.

Last Service Address 2 (Service 1-5)

↓ HH

Field Length: 40
Format: Alphanumeric

Description: The contact information for the more recent service submitted to Medicaid for the Medicaid member.

Last Service City (Service 1-5)

↓ HH

Field Length: 40
Format: Alphanumeric

Description: The contact information for the more recent service submitted to Medicaid for the Medicaid member.

Last Service Date (Service 1-5)

↓ HH

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date of the more recent service submitted to Medicaid for the Medicaid member.

Last Service Phone (Service 1-5)

↓ HH

Field Length: 10
Format: Numeric

Description: The contact information for the more recent service submitted to Medicaid for the Medicaid member.

Last Service State (Service 1-5)

↓ HH

Field Length: 2
Format: Alpha

Description: The contact information for the more recent service submitted to Medicaid for the Medicaid member.

Last Service Zip Code (Service 1-5)

↓ HH

Field Length: 9
Format: Numeric

Description: If the Care Management Agency has more recent contact information for a Medicaid member, they may submit that to DOH.

Managed Care Assignment Date

↑ AC

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date the Managed Care provider assigned a Medicaid member to a Health Home. Fee for Service Medicaid members will always contain 8 blank spaces in this field. This field will contain 8 blank spaces for individuals referred to Health Home services.

Editing Logic: This field must contain a valid date. If a Managed Care member is in outreach and engagement or enrollment, the Managed Care Assignment Date must be filled in.

Managed Care Plan MMIS ID*

↓ HH ↑ AC D

Field Length: 8
Format: Numeric

Description: The MMIS Provider ID for the Managed Care plan the Medicaid member is enrolled in. This field must be filled in unless the member is Fee for Service. For members enrolled in Managed Care with a value of N in the TCM/MATS/COBRA/CIDP Indicator, this is the Billing Provider MMIS ID.

Editing Logic: This field must contain a valid MMIS provider ID. The Managed Care Plan listed on a record must match exactly with the Managed Care Plan the member is enrolled in per Medicaid. This value should be left as 8 blank spaces for Medicaid members not in a Managed Care Plan.

Managed Care Plan Name

↓ HH

Field Length: 40
Format: Alpha

Description: The name of the Managed Care Plan.

Outpatient Rank

↓ HH

Field Length: 6
Format: Decimal, 999V99

Description: Ranks Medicaid members' utilization of outpatient services based on overall outpatient use. Medicaid members without any outpatient claims are assigned a value of 100%. The remaining Medicaid members receive a score based on how many services they received compared to other Medicaid members. Medicaid members with the most outpatient services receive low ranks (indicating that they have some sort of relationship with outpatient providers) and Medicaid members with fewer outpatient services (indicating that they probably do not have a relationship with outpatient providers) receive higher scores. Possible values range from 0-100.

Outreach/Enrollment Code

↑ AC

Field Length: 1
 Format: Alpha
 Accepted Values: O,E

Description: Specifies whether the segment is outreach or enrollment. If both outreach and enrollment occurred in the same month, only the enrollment event should be submitted for the entire month. To indicate that a member has moved from outreach and engagement to enrollment, the DMP need only submit an Add record beginning the new enrollment segment and the system will automatically end date the outreach segment.

Record Type

↑ AC D R

Field Length: 1
 Format: Alpha
 Accepted Values: A,C,D,R

Description: Defines the type of record that is being submitted to the system: Add (A), Change (C), Delete (D), or Rejection (R). The system will process the record based on the layout defined for the record type. Delete files will be processed first, the Change records will be processed second, and Add records will be processed last. Rejection records will be used to influence Health Home assignment.

Editing Logic: This field must contain a value of A,C,D, or R.

Medicaid member Contact Address Line 1

↑ AC

Field Length: 40
 Format: Alphanumeric

Description: If the DMP has more recent contact information for a Medicaid member, they may submit that to DOH using this field. A Change record should not be submitted only to add or update this field. Submitting updated information on this field will not update the member's Medicaid file. If the member's address on file with Medicaid is incorrect, the Health Home should facilitate updating the member's file through WMS.

Medicaid member Contact Address Line 2

↑ AC

Field Length: 40
 Format: Alphanumeric

Description: If the DMP has more recent contact information for a Medicaid member, they may submit that to DOH using this field. A Change record should not be submitted only to add or update this field. Submitting updated information on this field will not update the member's Medicaid file. If the member's address on file with Medicaid is incorrect, the Health Home should facilitate updating the member's file through WMS.

Medicaid member Contact City

↑ AC

Field Length: 40
Format: Alphanumeric

Description: If the DMP has more recent contact information for a Medicaid member, they may submit that to DOH using this field. A Change record should not be submitted only to add or update this field. Submitting updated information on this field will not update the member's Medicaid file. If the member's address on file with Medicaid is incorrect, the Health Home should facilitate updating the member's file through WMS.

Medicaid member Contact Phone

↑ AC

Field Length: 10
Format: Numeric

Description: If the DMP has more recent contact information for a Medicaid member, they may submit that to DOH using this field. A Change record should not be submitted only to add or update this field. Submitting updated information on this field will not update the member's Medicaid file. If the member's address on file with Medicaid is incorrect, the Health Home should facilitate updating the member's file through WMS.

Medicaid member Contact State

↑ AC

Field Length: 2
Format: Alpha

Description: If the DMP has more recent contact information for a Medicaid member, they may submit that to DOH using this field. A Change record should not be submitted only to add or update this field. Submitting updated information on this field will not update the member's Medicaid file. If the member's address on file with Medicaid is incorrect, the Health Home should facilitate updating the member's file through WMS.

Medicaid member Contact Zip Code

↑ AC

Field Length: 9
Format: Numeric

Description: If the DMP has more recent contact information for a Medicaid member, they may submit that to DOH using this field. A Change record should not be submitted only to add or update this field. Submitting updated information on this field will not update the member's Medicaid file. If the member's address on file with Medicaid is incorrect, the Health Home should facilitate updating the member's file through WMS.

Medicaid member First Name

↓ HH

Field Length: 30

Format: Alpha

Description: The first name of the Medicaid member as listed in the WMS system.

Medicaid member ID*

↓ HH E

↑ AC

D R

Field Length: 8

Format: AA11111A, Alphanumeric

Description: Identifies the member who is receiving the Health Home service.

Editing Logic: The member must have current Medicaid eligibility. If the member is not a referral and is in Fee for Service Medicaid, the member must be assigned by DOH to the Health Home submitting the record. If the member is in enrolled in a Managed Care Plan, they must be enrolled in the Managed Care Plan submitting the record.

Medicaid member Last Name

↓ HH

Field Length: 30

Format: Alpha

Description: The last name of the Medicaid member as listed in the WMS system.

Referral Date

↑ AC

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The Referral Date is the date a member was either referred for Health Home services or transferred to a different Health Home.

Editing Logic: This field must contain a valid date if the Referral Code is "R" or "T."

Referral Code

↑ AC

Field Length: 1

Format: Alpha

Accepted Values: T,R

Description: The Referral Code indicates if a Medicaid member is a new referral ("R") or if they have been transferred ("T") from one Health Home to another Health Home. A value of T should only be used in this field when a Health Home is beginning a new segment for a member that was transferred **TO THE HEALTH HOME** from another Health Home. If a Health Home wishes to transfer a member to another

Health Home, the *Referral Code* indicator should be left blank and the *Segment End Date Reason Code* should be populated with code 01: Transfer to another HH. If a member is neither a referral nor a transfer, this field should be blank.

Editing Logic: If the member is not a referral, then the Managed Care Plan ID and Health Home ID must match the assigned values for the Medicaid member. Referrals will be rejected if the referred member is already assigned to a Health Home.

Rejection Reason Code

↑ R

Field Length: 2
Format: Numeric
Accepted Values: See *Appendix D: Rejection Reason Codes*

Description: This field is used by Provider-led Health Home s when rejecting a DOH assignment. Managed Care Plans cannot submit rejection records to DOH. This must be a value listed on *Appendix D: Rejection Reason Codes*.

Risk Score

↓ HH

Field Length: 6
Format: Decimal, 999V99

Description: Risk scores predict the probability that Medicaid members will experience a negative outcome (e.g. inpatient admission, long term care, death) in the following year. The predictive model used to calculate the risk scores is based on prior year service utilization. Negative outcomes are less likely for Medicaid members with lower risk scores (0) and are more likely for Medicaid members with higher risk scores (100).

Segment End Date Reason Code

↑ AC

Field Length: 2
Format: Numeric
Accepted Values: See *Appendix C: Segment End Date Reason Codes*

Description: The reason why the segment is being end dated. Accepted values are listed in *Appendix C: Segment End Date Reason Codes*. This field should be left blank if the segment is open.

Editing Logic: This field must contain a value listed in *Appendix C: Segment End Date Reason Codes*. This field is only required for segments with an end date. If there is no end date specified, this field should be filled with 2 blank spaces.

Suggested Health Home MMIS Provider ID

↑ R

Field Length: 8
Format: Numeric

Description: This field is used when a Health Home would like to reject a DOH assignment. If there is a more appropriate Health Home assignment, please submit the Health Home's MMIS Provider ID to DOH using this field.

Editing Logic: This field is not required and need only be filled in if the Health Home has reason to believe that a specific Health Home would better serve the individual. If filled in, the Suggested Health Home assignment must contain a valid Health Home MMIS Provider ID.

TCM/MATS/COBRA/CIDP Indicator*

↑ AC

Field Length: 1
Format: Alpha
Accepted Values: Y,N

Description: During initial Health Home implementation, CIDP, COBRA, MATS, and TCM providers will bill Medicaid directly for Health Home services. Data Management Providers must use this field to indicate that the member's care management provider is a converting CIDP/COBRA/MATS/TCM provider and that the converting provider will bill Medicaid directly for the member's Health Home services, not the HH/MC Plan

Editing Logic: This field must be Y or N. If this field is Y, then the TCM/MATS/COBRA/CIDP Slot Type field must also be filled in.

TCM/MATS/COBRA/CIDP Slot Type*

↑ AC

Field Length: 1
Format: Alpha
Accepted Values: E,N

Description: The purpose of the TCM/MATS/COBRA/CIDP Slot Type is to signal to DOH what rate the member will be billed under. TCM/MATS/COBRA/CIDP providers will indicate through the tracking file if the Medicaid member is in a converting slot and will be billed using the existing legacy Health Home rate (E-existing) or if the Medicaid member is in a new slot and will be billed using the new Health Home rate (N-new).

Editing Logic: This field must be E, N or blank and should only be filled out if the TCM/MATS/COBRA/CIDP Indicator is Y.

Transfer Provider MMIS ID

↑ AC

Field Length: 8
Format: Numeric

Description: If the Medicaid member is being transferred to a different Health Home, this field contains the Provider MMIS ID of the health home that the Medicaid member is transferring to.

Editing Logic: This field must contain a valid MMIS Provider ID. This should be filled in when the Segment End Date Reason Code is 01 – Transfer to another HH.

DRAFT

Appendix B: Error Reason Codes

Listed below are the Error Reason codes, which describe why a record was rejected.

Edit Codes	Edit Description
001	Invalid Medicaid Member ID
002	No WMS (Medicaid) Eligibility (Post-processing edit)
003	Invalid DOB
004	Invalid Gender
005	Invalid assignment for Data Management Provider
006	Member assigned to another Health Home
007	Member in Managed Care Plan
008	Member in a different managed care plan
009	Managed Care Plan information filled in for FFS member
010	Invalid Billing Provider ID
011	Begin Date is not 1st of month
012	End Date is not last day of month
013	End Date is before Begin Date
014	Invalid Outreach/Enrollment Code
015	Invalid Gender Code
016	Invalid Record Type
017	Invalid Referral Indicator
018	Invalid TCM/MATS/COBRA/CIDP Indicator
019	Invalid TCM/MATS/COBRA/CIDP Slot Type
020	Begin Date is before DOH Assignment Date for FFS Member
021	Invalid MMIS ID for Care Management Agency
022	Invalid MMIS ID for Health Home
023	Invalid MMIS ID for Managed Care Plan
024	No Medicaid Eligibility before WMS verification (Pre-processing edit)
025	Invalid line length (i.e., too many/few characters)
026	Overlaps existing segment on file
027	Invalid format on line
028	Original record does not exist for Change or Delete operation
029	Most recent Outreach within 3 months
030	Begin Date in the future
031	Begin Date of Enrollment Prior to Outreach Segment

Appendix C: Segment End Date Reason Codes

Listed below are the Segment End Date Reason Codes, which describe a segment is being end dated.

Segment End Date Reason Codes	Edit Description
01	Transfer to another HH
02	Member Opted-Out
03	Changed Care Management Agency
04	Member Deceased
05	Member has a new CIN
06	Changed TCM/MATS/COBRA/CIDP slot type
07	Closed for disruptive or uncooperative behavior
08	Member moved out of service county
09	Member moved out of state
10	Change in functional eligibility
11	Incarcerated
12	Refused Consent (can only be used during outreach)
13	Patient of Inpatient Facility
14	Enrolled HH Patient Lost to Services
15	Patient dissatisfied with services
16	Inability to contact/locate patient
17	Found but not interested in enrolling in HH services
18	Found and expressed interest in HH but at a future date
19	Does not currently meet HH criteria
20	Switched Managed Care Plans
21	No longer requires HH services
22	Transition to FIDA (Fully-Integrated Duals Advantage) program
23	Member dis-enrolled
99	Other

Appendix D: Rejection Reason Codes

Listed below are the Rejection Reason Codes, which explains to DOH why a Health Home is rejecting a DOH Health Home assignment.

Rejection Reason Codes	Edit Description
01	Not suitable Health Home assignment
02	Member moved out of service county
03	Member moved out of state
04	Change in functional eligibility
05	Incarcerated
06	Member Deceased
07	Patient of Inpatient Facility
08	TBD
99	Other

DRAFT