New York State DOH
Health Home Care Management Reporting Tool (HH-CMART)
Bi Weekly Support Calls – Session #15
July 24, 2013

AGENDA

- Next Submission Data Requirement
- Data Element Color Codes
- HH-CMART Overview
- Things to Remember
- Questions and Answers
- Resources

Questions?

- Please submit your questions in writing to the webinar

- If you would like to ask your questions, raise your hand (making sure you have entered your audio pin code) and we will unmute the call one at a time

Next Submission Data Requirement

What to Submit

- Data for ALL elements in the HH-CMART tool
- This will include all data for the first two quarters of 2013 (January – June 2013)
- The report date field for this report is 2/2013
- All dates in HH CMART elements (#11, 15, 35) are the actual dates of service

When to Submit

- Monday, August 5, 2013

How to Submit

- Lead Health Homes will send data on all members using the HH CMART tool. File will be sent to DOH using the HCS Secure File Transfer application to 'Laura Morris'

Data Elements Color Codes

We recommend that if you have questions about a specific field to access the February 13, 2013 Health Home Care Management Assessment Reporting Tool (HH-CMART) Introductory Webinar. Below is a summary of the four element types by data collection needs for each element by reporting period.

- **Orange** Elements
  - Needs to be reviewed for new information each report.
- **Pink/Red** Elements
  - Enter information once. Remains the same throughout reporting period.
- **Green** Elements
  - Changes each reporting period.
- **Blue** Elements
  - DOH populates/fills in.

HH-CMART Overview

- Member Level Sub Elements
  - Elements 1-9
- Outreach (Prior to Engagement) Elements
  - Elements 14, 15, 17-23
- Individual Counts After Engagement
  - Elements 21-23
- Updated Status Elements
  - Elements 24-28
- Care Management Service Modules
  - Elements 29-34
- HH FACT-GP Scoring Module
  - Elements 35-49

Things to remember

- The HH-CMART tool is for data submission purposes only and is not intended to be used for billing purposes.

- If a client has a Managed Care Organization that is not in the PlanId drop down list (Field #1), the Health Home CMART allows manual entry in fields. If a PlanId is not in the drop down list, verify it is a plan with DOH. It can be enter it manually once verified.
  - *Reminder: uploading data into the HH CMART tool will wipe out any manual entries, so save those for last.*

- **During Outreach**: All attempts are counted. Each attempt should be a legitimate attempt to locate the individual. Attempts should be varied.
  - *Example* – First attempt: Call the person and if needed leave message
  - Second attempt: Send an individualized letter with a pre-written Health Home information brochure
  - Third attempt: Contact a contracted provider previously seen by the individual, to assist with locating the person

Questions and Answers

- **Is there only one care management service per visit?**
  - For Care Management services section (elements #29-34)- Indicate if the care plan was updated during the reporting period (#29), and then count the primary service provided **ONCE** for each visit or intervention(#30-34). Identify the main focus for each intervention encounter and count one Care Management service per intervention. Intervention encounter should not be counted in multiple categories, even if it applies to more than one.
  - **Example**: A home visit to discuss the member's self-management plan may also touch on new needs to update in the care plan or involve contacting a community support organization. The visit would be counted as #29 Plan Update Yes, and as an intervention in the MemberSupport category as '1'. It would not be counted in CareManage, HealthPromote, Transition Care and CommSocial.

- **Question HH6 is a yes/no question. How is that scored?**
  - Question 6 is in the Fact/GP HH Functional questionnaire section and is scored on a Yes and No basis. Score 8 points for NO and 0 for YES using the scoring template spreadsheet provided by DOH.
  - A score of “0” indicates that the member was homeless in the last 7 days; a score of “8” if they were housed. Any value submitted other than “0” or “8” will cause DOH to contact you for revision.

Questions and Answers since last webinar

- **Q: The Contact Date field - For TCM legacy clients who were opened prior to April 1, 2012, should we use April 1st (2012) as the "contact date"?**

  A: You would use the date of initial contact or interaction of when your client started Health Home services. If the initial contact was in 2011 but the member started HH services in April 1 of 2012, then we want you to put down the date they were contacted for HH services - April 1, 2012

- **Q: There are confusing errors when running the HH-CMART data through the tools error reports. For those who did not engage in CM (#17 EngagedCM=NO) we put that they DID NOT OPT OUT for #16. Is there something else that should be entering for those who neither engaged nor opted out?**

  A: The error is occurring because the answer to # 16 - Did not opt out means the person **did not refuse to participate.** The answer then for #17 the answer was **NO**, did not participate. Those two responses don't agree, so the error is flagged. If members are not engaging in CM, then there should be one of three scenarios:

  - **Scenario 1** – The member is not able to be contacted. They did not engage in CM, and element #16 would be NOT APPROPRIATE HH. (We know this may not be the case, but we're using this response as a proxy for person not be offered CM).
  - **Scenario 2** – The member is contacted, is appropriate for CM , but refuses to participate. They did not engage in CM and answer to #16 would be **Opted out**.
  - **Scenario 3** – The member is contacted and found not to be appropriate for HH service. They did not engage in CM and answer to #16 would be **Not appropriate for CM**.

Questions and Answers since last webinar

- **Q: Are quarter 1 and quarter 2 being summed together and submitted or should the quarters be separate records and essentially there could be two records for one client?**

  A: The August 5th submission should include all information/activity on a Health Home member from January 2013- June 2013; There will be only one record for each client. Future submissions will cover only one quarter but the August 5th, 2013 submission date will include information/activity for the first two quarters of 2013.

- **Q: Should we include all the data we have submitted to DOH from the beginning? Will you want us to include clients in the report due in November (Q3) who had no activity during the Q3 reporting period? For example – a client who was discharged during reporting period 2/2013 sent in for August 5 report, and so had no activity in reporting period 3/2013 – should we keep this client in the Q3 report or should we remove this client?**

  A: Each quarter's report should be based on the activity of the quarter. It is not intended to be cumulative - in either the records of members within the file or in the element values for a member. For members who were not enrolled in the Health Home for a quarter, the record should not be included in the quarter submission file (member discharged before Q3 and would not be included in Q3 report because already submitted on Q2 report)

Feedback and Help

- We encourage your feedback
  - **To aid in Case Scenario development** in order to clarify fields so that there is similar thinking behind how to fill in HH-CMART data similarly across all Health Homes
  - Email the Health Home Team at

    HH2011@health.state.ny.us

    with the Subject : *HH-CMART*

    Or Call the Health Home provider line – 518.473.5569

- Health Home website, Assessment and Quality Metrics menu, Process Measures section:

  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/process_measures.htm

Ongoing Support

- Weekly support calls are **Bi-Weekly,** Wednesdays from 10 a.m. to 11 a.m.
  - The next call – TBD. DOH will send announcement for registration.

- Slides from all webinars can be accessed by visiting the Health Home website at:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm