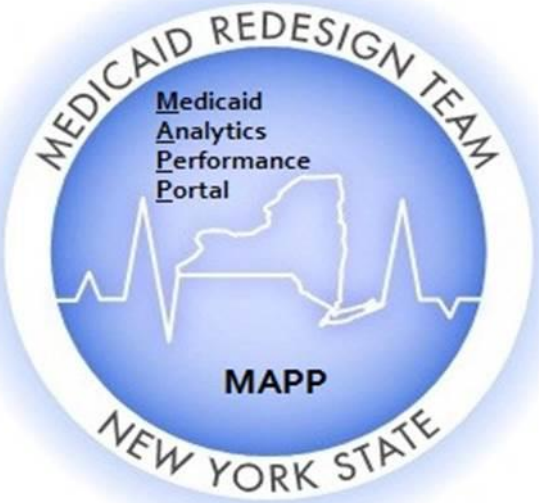
Medicaid Analytics Performance Portal Health Home Tracking System

File Specifications Document



September 15, 2015

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Version Log

Version	Release Date	Description of Change
0.1	July 29, 2015	Contains Billing Support file section only and Appendix A: Field Descriptions only contains fields found in Billing Support files
1.0	September 15, 2015	1. This release contains information on all files 2. Some of the appendices were reordered since release 0.1. 3. Editing logic regarding outreach billing instances added to Billing Support section 4. Changes to the Billing Support HML questions to accommodate new Adult Home billing logic 5. New field added to Billing Support Download file *6.* Descriptions added to *Appendix A: Field Descriptions*. However, Appendix A is still missing some field descriptions. These descriptions will be added to the next release.

Introduction

Purpose and Overview

The purpose of the **Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) File Specifications Document** is to explain how all of the MAPP HHTS files interact with the MAPP HHTS, including field definitions and code descriptions.

Throughout this document, the Medicaid Analytics Performance Portal Health Home Tracking System (MAPP HHTS) will be referred to as ***the system***. The original Health Home Tracking System Portal that Health Homes and Managed Care Plans use to upload and download fixed length text files will be referred to as the ***pre-MAPP HHTS***. The terms The New York State Department of Health, Managed Care Plan, Health Home, and Care Management Agency will be referred to as ***DOH***, ***MCP***, ***HH***, and ***CMA*** respectively. Also, individuals associated with MCPs, HHs, and CMAs accessing the MAPP HHTS will be referred to as ***users.***

Within the system, almost all actions can be performed through three different methods:

1. Individual online – performing actions for an individual member online one at a time.
2. Bulk online - using online filters to define a group of members and performing an action on that group of defined members online.
3. File Transfer – performing actions by uploading and downloading files.

The purpose of the MAPP HHTS File Specifications Document is to explain how system actions are performed using the file transfer method only, meaning that this document does not account for the other methods that can be used to perform actions within the system. While users can use a combination of methods when performing actions within the system, this document assumes that a user is only using the file upload method. For example, this document will state that a user must upload a certain file in order to complete a required action. Such a statement is meant to clarify to a user how a specific action is performed using the file transfer method, not to imply that a user can only use the file transfer method to perform the action within the system. This document does not explain how a user navigates to the MAPP HHTS nor how a user uploads a file to or downloads a file from the system. Users will learn how to navigate to the system and how to use all three methods during MAPP HHTS web based and instructor led trainings.

This document includes the basic file formats that are listed on the Health Home website at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/mapp_tracking_file_format.xlsx

However, the format tables included in this document contain two new column types. The first one is the "Required" column containing values of 'Y' – yes, 'N'-no, and 'C'-conditional. A value of 'Y' – yes, means that the field is required on the upload file and that records that do not contain an acceptable value in that field will be rejected. On a download file, a value of 'Y' means that the field will always be populated. A value of 'N' – no, means that the field is not required; records that do not have a value in these fields will be accepted. However, if a non-required field contains a value, then that submitted value must conform to any editing logic applied to the field or the record will be rejected. On a download file, a value of 'N' means that the field will not be populated. A value of 'C' – conditional, means that the field is required, but only in certain situations (usually because a related field contains a value of 'Y').

The second new column type is the "Source" column. This column indicates where data originates from. The table below explains what each column value means.

Source	Source Description
M'caid	Provided by official NYS Medicaid information
Gen	Generated by the system based on information in the system about the record (member's HML rate would be marked as 'Gen' since it is determined by the system using the member's monthly HML response and other information available in the system)
MCP	Submitted by Managed Care Plans
MCP/HH	Submitted by Managed Care Plans or Health Homes
HH	Submitted by Health Homes
CMA	Submitted by Care Management Agencies
HH/CMA	Submitted by Health Homes or Care Management Agencies
Ent'd	Displays on error report a concatenation of the information originally submitted on the rejected record
DOH/MCP	Submitted by DOH the Health Home Team or Managed Care Plans
User	Submitted by Managed Care Plans, Health Homes, or Care Management Agencies

MAPP HHTS Access

The MAPP HHTS is a subsection of the NYS DOH MAPP application, which is housed within the Health Commerce System (HCS). The MAPP HHTS is the system of record for the Health Home program.

Each MCP, DOH designated HH with a completed DEAA with DOH, and CMA that has a completed DOH approved BAA with a designated HH are able to access the system. Each provider that has access to the system has at least one user that is setup within the system with the gatekeeper (or admin) role. Individuals set up with the gatekeeper role within the system is responsible for setting up appropriate users from their organizations as MAPP HHTS users. All users must have an active HCS account as a Health Home user and will be set up by their organization's gatekeeper under one or all of the following user roles: worker, read only, gatekeeper, or screener. Worker and read only users are able to download the files discussed within this manual, but only workers can upload files into the system.

For more information on gaining access to the MAPP HHTS, please see *Appendix L: Reference and Contacts*.

Additional Information

The files described in this documents are organized into sub-sections based on the types of functions performed by each sub-section of files. Each file in a sub-section contains a description, a file format, and an editing logic section that explain respectively what functions that file performs, how the file is organized, and any editing that applies to the file.

Additionally, this document contains an extensive set of Appendices, which include field descriptions, code lists, and Health Home reference information. Please see *Appendix A: Field Descriptions* for detailed descriptions of accepted field values, field descriptions, and additional information on how fields are populated and edited.

Each file downloaded from the system is a "point in time" full file replacement snap shot of member statuses as of the moment that the file is requested. Once a file is downloaded, the data included in the downloaded file have the potential to change, so providers that are using their own system to track Health Home members should upload and download files as often as possible. Each file description section indicates how often a provider is

required to upload/download the file in addition to suggested "best practices" for uploading/downloading file, where applicable.

Lastly, all files can be uploaded into the system or downloaded from the system in either .csv or fixed length text file format. However, error files will only be available in the format of the corresponding uploaded file. Files uploaded into the system must not include a header row.

Assignment Files

The following section provides a brief explanation of how Health Home eligible members are identified; assigned to MCPs, HHs, and CMAs; and moved through the Health Home assignment statuses within the system using files. Each member has a distinct assignment status with the provider(s) that the member is associated with through an assignment.

The assignment process begins when DOH assigns potentially Health Home eligible members to the members' MCPs, which creates *pending* assignments with the members' MCPs. An MCP can then either accept a member in a *pending* MCP assignment status, meaning that the plan agrees to assign the member to a HH, or the plan can pend the *pending* assignment, meaning that the MCP is choosing not to act on the member's potential HH eligible status. An MCP would pend an assignment when the MCP knows that the member is either not eligible or not appropriate for the Health Home program or if there is not an appropriate HH assignment currently available for the member. Once an MCP accepts a *pending* assignment, the member's *pending* MCP assignment moves to an *active* MCP assignment status. An MCP can indicate that a *pending* MCP assignment is accepted and move it to an active status by either accepting the *pending* assignment or by the MCP assigning the member with a *pending* MCP assignment to a HH, which automatically moves that member from a *pending* to an *active* MCP assignment status and creates a new *pending* HH assignment status.

From there, HHs access their members with a *pending* HH assignment status, both fee for service member assigned to the HH by DOH or plan members assigned to the HH by the members' MCPs. The HH can either accept a *pending* HH assignment, meaning that the HH agrees to assign the member to a CMA, or can reject the *pending* assignment, meaning that the HH does not accept the assignment. An MCP member assignment rejected by the HH is returned to the member's MCP and a FFS member assignment that is rejected by the HH is returned to DOH for reassignment. A HH can move a member from a *pending* HH assignment to an *active* HH assignment by either accepting the *pending* HH assignment or by assigning a member with a *pending* HH assignment to a CMA, which will automatically move the member to an *active* HH assignment and create a *pending* assignment with the CMA. Additionally, when a HH creates a segment for a member with a *pending* HH assignment, the system automatically moves the member's corresponding HH assignment status from *pending* to *active.*

From there, CMAs access both fee for service and plan enrolled members assigned to them in a *pending* CMA assignment status. The CMA can either accept the *pendi*ng CMA assignment, meaning that the CMA agrees to start outreaching to the member, or the CMA can reject the *pending* CMA assignment, which sends the member back to the HH for reassignment. Additionally, if a HH or CMA creates a segment for a member with a *pending* CMA assignment, then the system will automatically move the member's assignment status from *pending* to *active.*

In the pre-MAPP HHTS, once a member moved into an outreach or an enrollment segment, the member was removed from the assignment file. While a member in an open outreach or enrollment segments is no longer included in a provider's assignment file in the system, the member's assignments do not go away. A member in an outreach or enrollment segment will always have an *active* "behind the scenes" assignment with the HH and CMA

that the member has a segment with; in addition, a member enrolled with a plan in outreach or enrollment will also have an *active* assignment with that MCP. The assignment files downloaded from the system only contain members that do not currently have an open outreach or enrollment segment and that have an *active*, *pending*, or *pended* assignment with the downloading provider as of the date of the download.

Since a member's Medicaid and Health Home status can change at any time, assignment files **should be downloaded daily** and **MUST** be downloaded **at least once a week**.

Managed Care Plan Assignment File

Description

This file is only accessible by MCPs and is comprised of plan enrolled members that do not have an open segment (not closed or canceled) that are currently assigned or referred to the user's MCP in either an *active*, *pending*, or *pended* MCP assignment status. This file includes three different types of assignments that are differentiated on the assignment file through the following values listed in the **Assignment Source** field. Members that were referred into the Health Home program (not identified as Health Home eligible ~~for~~ by DOH or MCP) by HHs and CMAs **THAT ARE NOT PROVIDING OUTREACH OR ENROLLMENT SERVICES TO THE MEMBERS** are listed with a value of 'Referral', members that were assigned to the MCP by DOH are listed with a value of 'DOH Identified', and members that the MCP identified as Health Home eligible and assigned to a HH that were not first assigned to the MCP by DOH are listed as 'MCP Identified'.

This file also includes a member's demographic and contact information, DOH recommended HH assignment, last five unique providers that the member saw according to recent Medicaid claim and encounters, current HH/CMA assignment status if applicable, and additional information that is optionally submitted into the system by the MCP through the MCP Final HH Assignment File.

Format

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
1	Member ID	1	8	8	Y	M'caid	AA11111A, Alphanumeric
2	First Name	9	30	38	Y	M'caid	Alpha
3	Last Name	39	30	68	Y	M'caid	Alpha
4	DOB	69	8	76	Y	M'caid	MMDDYYYY, Numeric
5	County of Fiscal Responsibility Code	77	2	78	Y	M'caid	Numeric
6	County of Fiscal Responsibility Desc	79	30	108	Y	M'caid	Alpha
7	Gender	109	1	109	Y	M'caid	Alpha (M/F)
8	HH Assignment Created Date	110	8	117	~~Y~~C	Gen	MMDDYYYY, Numeric
9	Managed Care Plan MMIS Provider ID	118	8	125	Y	M'caid	Numeric
10	Managed Care Plan Name	126	40	165	Y	MCP	Alpha
11	Health Home MMIS Provider ID	166	8	173	C	MCP	Numeric
12	Health Home NPI	174	10	183	C	M'caid	Numeric
13	Health Home Name	184	40	223	C	Gen	Alpha
14	Medicaid Eligibility End Date	224	8	231	C	M'caid	MMDDYYYY, Numeric

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
15	Medicare Indicator	232	1	232	Y	M'caid	Alpha (Y/N)
16	MDW Member Address Line 1	233	40	272	Y	M'caid	Alphanumeric
17	MDW Member Address Line 2	273	40	312	~~Y~~C	M'caid	Alphanumeric
18	MDW Member City	313	40	352	Y	M'caid	Alpha
19	MDW Member State	353	2	354	Y	M'caid	Alpha
20	MDW Member Zip Code	355	9	363	Y	M'caid	Numeric
21	MDW Member Phone	364	10	373	Y	M'caid	Numeric
22	Date of Patient Acuity	374	8	381	C	M'caid	MMDDYYYY, Numeric
23	Acuity Score	382	7	388	C	M'caid	00.0000, Numeric
24	Risk Score	389	6	394	C	M'caid	Decimal, 999V99
25	Outpatient Rank	395	6	400	C	M'caid	Decimal, 999V99
26	DOH Composite Score	401	6	406	C	M'caid	Decimal, 999V99
27	Service 1: Last Service Date	407	8	414	C	M'caid	MMDDYYYY, Numeric
28	Service 1: Last Service Provider Name	415	40	454	C	M'caid	Alpha
29	Service 1: Last Service Provider NPI	455	10	464	C	M'caid	Numeric
30	Service 1: Last Service Address Line 1	465	40	504	C	M'caid	Alphanumeric
31	Service 1: Last Service Address Line 2	505	40	544	C	M'caid	Alphanumeric
32	Service 1: Last Service City	545	40	584	C	M'caid	Alpha
33	Service 1: Last Service State	585	2	586	C	M'caid	Alpha
34	Service 1: Last Service Zip Code	587	9	595	C	M'caid	Numeric
35	Service 1: Last Service Phone Number	596	10	605	C	M'caid	Numeric
36	Service 2: Last Service Date	606	8	613	C	M'caid	MMDDYYYY, Numeric
37	Service 2: Last Service Provider Name	614	40	653	C	M'caid	Alpha
38	Service 2: Last Service Provider NPI	654	10	663	C	M'caid	Numeric
39	Service 2: Last Service Address Line 1	664	40	703	C	M'caid	Alphanumeric
40	Service 2: Last Service Address Line 2	704	40	743	C	M'caid	Alphanumeric
41	Service 2: Last Service City	744	40	783	C	M'caid	Alpha
42	Service 2: Last Service State	784	2	785	C	M'caid	Alpha
43	Service 2: Last Service Zip Code	786	9	794	C	M'caid	Numeric
44	Service 2: Last Service Phone Number	795	10	804	C	M'caid	Numeric
45	Service 3: Last Service Date	805	8	812	C	M'caid	MMDDYYYY, Numeric
46	Service 3: Last Service Provider Name	813	40	852	C	M'caid	Alpha
47	Service 3: Last Service Provider NPI	853	10	862	C	M'caid	Numeric

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
48	Service 3: Last Service Address Line 1	863	40	902	C	M'caid	Alphanumeric
49	Service 3: Last Service Address Line 2	903	40	942	C	M'caid	Alphanumeric
50	Service 3: Last Service City	943	40	982	C	M'caid	Alpha
51	Service 3: Last Service State	983	2	984	C	M'caid	Alpha
52	Service 3: Last Service Zip Code	985	9	993	C	M'caid	Numeric
53	Service 3: Last Service Phone Number	994	10	1003	C	M'caid	Numeric
54	Service 4: Last Service Date	1004	8	1011	C	M'caid	MMDDYYYY, Numeric
55	Service 4: Last Service Provider Name	1012	40	1051	C	M'caid	Alpha
56	Service 4: Last Service Provider NPI	1052	10	1061	C	M'caid	Numeric
57	Service 4: Last Service Address Line 1	1062	40	1101	C	M'caid	Alphanumeric
58	Service 4: Last Service Address Line 2	1102	40	1141	C	M'caid	Alphanumeric
59	Service 4: Last Service City	1142	40	1181	C	M'caid	Alpha
60	Service 4: Last Service State	1182	2	1183	C	M'caid	Alpha
61	Service 4: Last Service Zip Code	1184	9	1192	C	M'caid	Numeric
62	Service 4: Last Service Phone Number	1193	10	1202	C	M'caid	Numeric
63	Service 5: Last Service Date	1203	8	1210	C	M'caid	MMDDYYYY, Numeric
64	Service 5: Last Service Provider Name	1211	40	1250	C	M'caid	Alpha
65	Service 5: Last Service Provider NPI	1251	10	1260	C	M'caid	Numeric
66	Service 5: Last Service Address Line 1	1261	40	1300	C	M'caid	Alphanumeric
67	Service 5: Last Service Address Line 2	1301	40	1340	C	M'caid	Alphanumeric
68	Service 5: Last Service City	1341	40	1380	C	M'caid	Alpha
69	Service 5: Last Service State	1381	2	1382	C	M'caid	Alpha
70	Service 5: Last Service Zip Code	1383	9	1391	C	M'caid	Numeric
71	Service 5: Last Service Phone Number	1392	10	1401	C	M'caid	Numeric
72	MCP Assignment Created Date	1402	8	1409	~~C~~Y	Gen	MMDDYYYY, Numeric
73	DOH Recommended Health Home MMIS ID	1410	8	1417	C	M'caid	Numeric
74	DOH Recommended Health Home Name	1418	40	1457	C	Gen	Alpha
75	HARP Flag	1458	1	1458	Y	M'caid	Alpha (Y/N) If eligible or enrolled set to Y

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
76	Managed Care Plan Assignment Status	1459	40	1498	Y	Gen	Alpha (Pending, Active, Pended by MCP)
77	Health Home Assignment Status	1499	40	1538	C	MCP/HH	Alpha (Pending, Active, Rejected, Ended)
78	Suggested Alternative Health Home Assignment	1539	8	1546	C	HH	Numeric
79	Care Management Agency MMIS Provider ID	1547	8	1554	C	HH	Numeric
80	Care Management Agency Name	1555	40	1594	C	CMA	Alpha
81	CMA Assignment Status	1595	40	1634	C	HH/CMA	Alpha (Pending, Active, Rejected, Ended)
82	Assignment Source	1635	20	1654	Y	Gen	Alpha (DOH Identified, MCP Identified, Referral)
83	Plan Provided Secondary Address – Street 1	1655	40	1694	C	MCP	Alphanumeric
84	Plan Provided Secondary Address – Street 2	1695	40	1734	C	MCP	Alphanumeric
85	Plan Provided Secondary Address – Apt/Suite	1735	20	1754	C	MCP	Alphanumeric
86	Plan Provided Secondary Address – City	1755	40	1794	C	MCP	Alpha
87	Plan Provided Secondary Address – State	1795	2	1796	C	MCP	Alpha
88	Plan Provided Secondary Address – Zip	1797	9	1805	C	MCP	Numeric
89	Plan Provided Member Phone Number	1806	10	1815	C	MCP	Numeric
90	Plan Provided Member Language	1816	30	1845	C	MCP	Alpha

Editing Logic

1. Health Home assignment fields (# 8, 11-13)
    a. These fields will be blank until the MCP assigns a member to a HH using the MCP Final HH Assignment file. When the MCP submits an HH assignment, the **HH Assignment Created** will be populated with the date that the system processed the MCP Final HH Assignment file uploaded into the system by the MCP.
2. Member information fields derived from claims and encounters (# 22-26)
    a. These fields will not be populated for all members. Only members that were pre-identified as Health Home eligible will have this information populated. If these fields are blank, it does not mean that the member is not Health Home eligible; it simply means that DOH did not pre-identify the member as Health Home eligible based on historical claims and encounters.
3. Last five unique provider fields (# 27-71)

a. These fields are populated with the last five unique providers with whom the member had a service claim or encounter. This **excludes** claims like durable medical equipment, transportation, and pharmacy claims and **includes** physician, clinic, care management, inpatient, and emergency department claims.

b. For members that only have two claims within the system that match the criteria listed in 3a, only field numbers #27-44 will be populated. For members that are new to the Medicaid system, do not have any claims or encounters in the system, or simply do not have any claims or encounters that meet this criteria, these fields will be blank.

4. **Health Home Assignment Status** and **Suggested Alternative Health Home Assignment** fields (# 77-78)

   a. The **HH Assignment Status** field will contain a value if the MCP assigned a member to an HH. If an MCP user sees a value of 'Rejected' in this field, then that user knows that the HH that the MCP assigned the member to rejected the member's *pending* HH assignment. When the HH rejected the *pending* HH assignment created by the MCP, the system updated the member's assignment with that HH and kept the member's *active* MCP Assignment. The MCP should reassign a member with a 'rejected´ value in the **HH Assignment Status** field to another HH.

   b. The **Suggested Alternative Health Home Assignment** field will only be populated if the HH suggested another HH to which the member should be assigned when rejecting the *pending* HH assignment.

   ~~b.~~c. Only the most recent HH information will be displayed in these fields. For instance, if an MCP first assigned a member to HH A in March and then reassigned the member to HH B in June, the information listed in these fields on or after June will apply to HH B, not HH A.

5. CMA assignment fields (# 79-81)

   a. These fields will only be populated if the HH has assigned the member to a CMA. An MCP user that sees a value of 'rejected' in the **CMA Assignment Status** field~~,~~ knows that the HH assigned the member to the CMA listed in fields 79 & 80 and that the CMA rejected the assignment. This tells the MCP that the HH that the MCP assigned the member to (fields 11-13) now has to reassign the member to another CMA.

6. Plan supplied fields (# 83-90)

   a. These fields will be blank unless the MCP submits information in these fields for the member using the MCP Final HH Assignment file.

7. **Medicaid Eligibility End Date**

   a. Some Medicaid eligible members have indefinite Medicaid eligibility, meaning that their Medicaid eligibility never expires. Within the Medicaid system, these members are listed with a Medicaid eligibility end date of 12/31/9999. The new system will not use 12/31/9999 to indicate that a member is indefinitely Medicaid eligible. This means that any member listed in Medicaid with an end date of 12/31/9999 will be listed in the MAPP HHTS without a value in the **Medicaid Eligibility End Date** field.

Managed Care Plan Final Health Home Assignment File

Description

This file is only uploaded by MCP users and is used to assign a current plan member to a HH and to upload plan supplied member contact and language information into the system. The contact and language information submitted in this file upload are not required. If an MCP submits this information into the system using the MCP Final HH Assignment file, the submitted values will be included in the MCP Assignment and the HH Assignment files and will be stored as evidence under the ***Personal Information*** tab on the member's ***Home Page***.

Format

Managed Care Plan Final Health Home Assignment File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Member ID	1	8	8	Y	AA11111A, Alphanumeric
2	Health Home MMIS Provider ID	9	8	16	C	Numeric
3	Pend Reason Code	17	2	18	C	Numeric
4	Plan Provided Secondary Address – Street 1	19	40	58	C	Alphanumeric
5	Plan Provided Secondary Address – Street 2	59	40	98	C	Alphanumeric
6	Plan Provided Secondary Address – Apt/Suite	99	20	118	C	Alphanumeric
7	Plan Provided Secondary Address – City	119	40	158	C	Alpha
8	Plan Provided Secondary Address – State	159	2	160	C	Alpha
9	Plan Provided Secondary Address – Zip	161	9	169	C	Numeric
10	Plan Provided Member Phone Number	170	10	179	C	Numeric
11	Plan Provided Member Language	180	30	209	C	Alpha

Editing Logic

Listed below are the systems actions that can be performed within the system using the MCP Final HH Assignment file in addition to edits applied when an MCP Final HH Assignment file is uploaded to the system.

1. Assign a member with an *active*, *pending*, or *pended* MCP assignment, **NO** corresponding segments that are not closed or cancelled, **AND NO** HH or CMA assignments **to a HH.**
    a. Submit a record containing the member's CIN in the **Member ID** field and the MMIS Provider ID of the HH that MCP is assigning the member to in the **Health Home MMIS Provider ID** field.
2. Reassign a member **with** an *active* or *pending* HH assignment, **NO** corresponding segments that are not closed or cancelled, **AND NO*** ~~HH or~~ CMA assignments **to a new HH**.
    a. To switch a member's HH assignment from HH A to HH B, include the member on the MCP Final HH Assignment file with the MMIS Provider ID of the new HH that the MCP would like to reassign the member to in the **Health Home MMIS Provider ID** field. This will end the member's original HH assignment (HH A in this example) and create a *pending* assignment with the newly assigned HH (HH B in this example).
    b. Any *active* or *pending* CMA assignments made by the original HH will be ended along with the HH assignment once the MCP submits the MCP Final HH Assignment file reassigning the member to a new HH.
    c. This will not change the member's *active* MCP assignment status.
    *If the member had a *pending* or *active* CMA Assignment, then the system would have end dated the *pending* or *active* CMA assignment.
3. Assign a member that **does not** have an active assignment in the system (member does not have an assignment with the MCP or any other provider in the system) and does not have a segment in the system.

a. For example, an MCP user identifies a new plan member that is Health Home eligible and appropriate for the program, but was not pre-identified as Health Home eligible by DOH.
b. To enter the member into the system and create an *active* MCP assignment (no HH assignment yet), the MCP user would:
    i. Submit a record containing the member's CIN~~,~~ and do not include information in the **Health Home MMIS Provider ID** or **Pend Reason Code** fields.
c. To enter the member into the system to create an *active* MCP assignment and a *pending* HH assignment, the MCP user would:
    i. Submit a record containing the member's CIN and the MMIS Provider ID of the HH that MCP is assigning the member to in the **Health Home MMIS Provider ID** field AND do not populate the **Pend Reason Code** field.

4. **Pend** the assignment for a member with a *pending* or a *pended* MCP assignment
    a. To pend a member's MCP assignment, the **Health Home MMIS Provider ID** field must be blank and the **Pend Reason Code** field must be populated with one of the valid pend reason codes listed in *Appendix F: Assignment Pend Reason Codes*. Please note that the assignment pend reason codes are different than the segment pend reason codes.
5. Uploading MCP supplied address information into the system.
    a. The plan supplied address fields (#4-10) can be populated anytime the MCP Final HH Assignment file is uploaded to the system and are always optional. **However, when these fields are populated, the following edits are used to ensure that only valid address information is submitted into the system.**
        i. **Plan Provided Secondary Address – Street 1** field must contain at least 3 characters when the **Plan Provided Secondary Address – Apt/Suite** field is empty
        ii. The **Plan Provided Secondary Address – Zip** must contain a valid zip code format. This 9 character field must contain either the five digit zip code format (xxxxx) or the nine digit zip code plus four format (xxxxxxxxx).
        iii. The **Plan Provided Secondary Address – City** field must contain letters only.
        iv. Values submitted to the system in field # 4-10 will be stored as Plan Supplied address evidence in *person information* tab of a member's home page.
        v. When submitting address information, all of the main address fields (4, 7-9) must be populated with a valid value for the record to be accepted. For instance, if the **Plan Provided Secondary Address – State** contains a value of 'NY', then the record will only be accepted if fields 4, 7, and 9 are also populated with valid values.
6. Uploading MCP supplied language information into the system.
    a. The **Plan Provided Member Language** field (#11) is not required. However, when it is populated, it must contain one of the languages listed in *Appendix N: Plan Supplied Language Values*. If a record is submitted with a value in the **Plan Provided Member Language** field that is not listed in *Appendix A*, the record will be accepted, but the unaccepted value listed in the **Plan Provided Member Language** field will not be recorded within the system.
7. Member must be enrolled in the user's MCP as of the file submission date, per the member's Medicaid information in the system, for the system to accept the record. The Medicaid information in the system can be up to a week behind the official Medicaid system, so if a member is newly enrolled in the user's MCP, the user may have to wait up to a week before the system recognizes that the member is enrolled in the user's MCP and accepts the record.
8. The MMIS Provider ID submitted in the **Health Home MMIS Provider ID** field must be a valid HH MMIS Provider ID that has an active relationship with the submitting user's MCP as of the file submission date.

9. Members submitted in this file cannot have an outreach or enrollment segment in the system in any status except *Closed* or Canceled.
10. A record cannot contain a value in both the **Health Home MMIS Provider ID** and the **Pend Reason Code** fields.
11. A record will be rejected for an action that has already taken place. For example, if the member has already been assigned to HH A and the MCP user uploads the file for that member with HH A listed in the **Health Home MMIS Provider ID**, then the record will be rejected.
12. As of the file submission, a member submitted on this file cannot have a coverage code or a recipient R/E code that is incompatible with the Health Home program (see *Appendix L: Reference and Contacts* for links to recipient R/E codes and coverage codes that are not compatible with the Health Home program).

Error Report: Managed Care Plan Final Health Home Assignment File

Description

This file is created upon validating or processing an MCP Final HH Assignment file containing at least one error. An Error Report: MCP Final HH Assignment file will not be created for an MCP Final HH Assignment file that does not contain rejected records. The Error Report: MCP Final HH Assignment file will contain one record for each record in the MCP Final HH Assignment file that contains an error.

Format

Error Report: Managed Care Plan Final Health Home Assignment File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Line Number	1	6	6	Y	Numeric
2	Member ID	7	8	14	Y	AA11111A, Alphanumeric
3	Health Home MMIS Provider ID	15	8	22	C	Numeric
4	Error Reason	23	30	52	Y	Alphanumeric
5	Pend Reason Code	53	2	54	C	Alphanumeric

Editing Logic

The **Error Reason** field will be populated with a description of why the record was rejected. The field will only contain one error description. If a record hits more than one error, only the first error will be displayed in the **Error Reason** field. This error file contains both file format errors and logic errors. For more information on errors, please review *Appendix B: File Error Reason Codes*.

Health Home Assignment File

Description

This file is accessible by both HHs and CMAs and is comprised of members that are currently assigned/referred to the user's organization in either an *active* or *pending* assignment status with the downloading provider, but do not have an outreach or enrollment segment in any status, except closed or cancelled.

This file includes a member's demographic and contact information, current HH/CMA assignment status if applicable, the member's last five unique providers according to recent Medicaid claim and encounters, and additional information that is optionally submitted into the system by the MCP through the MCP Final HH Assignment File.

Format

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
1	Member ID	1	8	8	Y	M'caid	AA11111A, Alphanumeric
2	First Name	9	30	38	Y	M'caid	Alpha
3	Last Name	39	30	68	Y	M'caid	Alpha
4	DOB	69	8	76	Y	M'caid	MMDDYYYY, Numeric
5	County of Fiscal Responsibility Code	77	2	78	Y	M'caid	Numeric
6	County of Fiscal Responsibility Desc	79	30	108	Y	M'caid	Alpha
7	Gender	109	1	109	Y	M'caid	Alpha (M/F)
8	HH Assignment Created Date	110	8	117	~~C~~Y	Gen	MMDDYYYY, Numeric
9	Managed Care Plan MMIS Provider ID	118	8	125	C	M'caid	Numeric
10	Managed Care Plan Name	126	40	165	C	M'caid	Alpha
11	Health Home MMIS Provider ID	166	8	173	Y	Gen	Numeric
12	Health Home NPI	174	10	183	Y	M'caid	Numeric
13	Health Home Name	184	40	223	Y	M'caid	Alpha
14	Medicaid Eligibility End Date	224	8	231	~~Y~~C	M'caid	MMDDYYYY, Numeric
15	Medicare Indicator	232	1	232	Y	M'caid	Alpha (Y/N)
16	DOH MDW Member Address Line 1	233	40	272	Y	M'caid	Alphanumeric
17	DOH MDW Member Address Line 2	273	40	312	~~Y~~C	M'caid	Alphanumeric
18	DOH MDW Member City	313	40	352	Y	M'caid	Alpha
19	DOH MDW Member State	353	2	354	Y	M'caid	Alpha
20	DOH MDW Member Zip Code	355	9	363	Y	M'caid	Numeric
21	DOH MDW Member Phone	364	10	373	Y	M'caid	Numeric
22	Date of Patient Acuity	374	8	381	C	M'caid	MMDDYYYY, Numeric
23	Acuity Score	382	7	388	C	M'caid	00.0000, Numeric
24	Risk Score	389	6	394	C	M'caid	Decimal, 999V99
25	Outpatient Score	395	6	400	C	M'caid	Decimal, 999V99
26	DOH Composite Score	401	6	406	C	M'caid	Decimal, 999V99
27	Service 1: Last Service Date	407	8	414	C	M'caid	MMDDYYYY, Numeric
28	Service 1: Last Service Provider Name	415	40	454	C	M'caid	Alpha
29	Service 1: Last Service Provider NPI	455	10	464	C	M'caid	Numeric
30	Service 1: Last Service Address Line 1	465	40	504	C	M'caid	Alphanumeric
31	Service 1: Last Service Address Line 2	505	40	544	C	M'caid	Alphanumeric
32	Service 1: Last Service City	545	40	584	C	M'caid	Alpha
33	Service 1: Last Service State	585	2	586	C	M'caid	Alpha
34	Service 1: Last Service Zip Code	587	9	595	C	M'caid	Numeric

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
35	Service 1: Last Service Phone Number	596	10	605	C	M'caid	Numeric
36	Service 2: Last Service Date	606	8	613	C	M'caid	MMDDYYYY, Numeric
37	Service 2: Last Service Provider Name	614	40	653	C	M'caid	Alpha
38	Service 2: Last Service Provider NPI	654	10	663	C	M'caid	Numeric
39	Service 2: Last Service Address Line 1	664	40	703	C	M'caid	Alphanumeric
40	Service 2: Last Service Address Line 2	704	40	743	C	M'caid	Alphanumeric
41	Service 2: Last Service City	744	40	783	C	M'caid	Alpha
42	Service 2: Last Service State	784	2	785	C	M'caid	Alpha
43	Service 2: Last Service Zip Code	786	9	794	C	M'caid	Numeric
44	Service 2: Last Service Phone Number	795	10	804	C	M'caid	Numeric
45	Service 3: Last Service Date	805	8	812	C	M'caid	MMDDYYYY, Numeric
46	Service 3: Last Service Provider Name	813	40	852	C	M'caid	Alpha
47	Service 3: Last Service Provider NPI	853	10	862	C	M'caid	Numeric
48	Service 3: Last Service Address Line 1	863	40	902	C	M'caid	Alphanumeric
49	Service 3: Last Service Address Line 2	903	40	942	C	M'caid	Alphanumeric
50	Service 3: Last Service City	943	40	982	C	M'caid	Alpha
51	Service 3: Last Service State	983	2	984	C	M'caid	Alpha
52	Service 3: Last Service Zip Code	985	9	993	C	M'caid	Numeric
53	Service 3: Last Service Phone Number	994	10	1003	C	M'caid	Numeric
54	Service 4: Last Service Date	1004	8	1011	C	M'caid	MMDDYYYY, Numeric
55	Service 4: Last Service Provider Name	1012	40	1051	C	M'caid	Alpha
56	Service 4: Last Service Provider NPI	1052	10	1061	C	M'caid	Numeric
57	Service 4: Last Service Address Line 1	1062	40	1101	C	M'caid	Alphanumeric
58	Service 4: Last Service Address Line 2	1102	40	1141	C	M'caid	Alphanumeric
59	Service 4: Last Service City	1142	40	1181	C	M'caid	Alpha
60	Service 4: Last Service State	1182	2	1183	C	M'caid	Alpha
61	Service 4: Last Service Zip Code	1184	9	1192	C	M'caid	Numeric
62	Service 4: Last Service Phone Number	1193	10	1202	C	M'caid	Numeric
63	Service 5: Last Service Date	1203	8	1210	C	M'caid	MMDDYYYY, Numeric

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
64	Service 5: Last Service Provider Name	1211	40	1250	C	M'caid	Alpha
65	Service 5: Last Service Provider NPI	1251	10	1260	C	M'caid	Numeric
66	Service 5: Last Service Address Line 1	1261	40	1300	C	M'caid	Alphanumeric
67	Service 5: Last Service Address Line 2	1301	40	1340	C	M'caid	Alphanumeric
68	Service 5: Last Service City	1341	40	1380	C	M'caid	Alpha
69	Service 5: Last Service State	1381	2	1382	C	M'caid	Alpha
70	Service 5: Last Service Zip Code	1383	9	1391	C	M'caid	Numeric
71	Service 5: Last Service Phone Number	1392	10	1401	C	M'caid	Numeric
72	HARP Flag	1402	1	1402	Y	M'caid	Alpha (Y/N)
73	Managed Care Plan Assignment Status	1403	40	1442	C	MCP	Alpha (Pending, Active, Pended by MCP)
74	Health Home Assignment Status	1443	40	1482	Y	MCP/HH	Alpha (Pending, Active, Rejected, Ended)
75	Suggested Alternative CMA Assignment	1483	8	1490	C	CMA	Numeric
76	Care Management Agency MMIS Provider ID	1491	8	1498	C	HH	Numeric
77	Care Management Agency Name	1499	40	1538	C	M'caid	Alpha
78	CMA Assignment Status	1539	40	1578	C	HH/CMA	Alpha (Pending, Active, Rejected, Ended)
79	Assignment Source	1579	20	1598	Y	Gen	Alpha (DOH Identified, MCP Identified, Referral)
80	Plan Provided Secondary Address – Street 1	1599	40	1638	C	MCP	Alphanumeric
81	Plan Provided Secondary Address – Street 2	1639	40	1678	C	MCP	Alphanumeric
82	Plan Provided Secondary Address – Apt/Suite	1679	20	1698	C	MCP	Alphanumeric
83	Plan Provided Secondary Address – City	1699	40	1738	C	MCP	Alpha
84	Plan Provided Secondary Address – State	1739	2	1740	C	MCP	Alpha
85	Plan Provided Secondary Address – Zip	1741	9	1749	C	MCP	Numeric
86	Plan Provided Member Phone Number	1750	10	1759	C	MCP	Numeric
87	Plan Provided Member Language	1760	30	1789	C	MCP	Alpha

Editing Logic

When an HH user accesses this file, it contains both managed care enrolled and fee for service members that have an *active* or *pending* HH assignment with the downloading provider. Members enrolled in managed care will have an *active* MCP assignment status. For fee for service members, the **Managed Care Plan MMIS Provider ID, Managed Care Plan Name,** and the **Managed Care Plan Assignment Status** fields will be blank. For members that have been assigned to a CMA, the **CMA Assignment Status** field will contain one of three values: *pending,* meaning that the HH assigned the member to a CMA, but that the CMA has not yet accepted or rejected the member's assignment; *active*, meaning that the CMA accepted the member assignment made to the CMA by the HH; or *rejected* meaning that the HH assigned the member to a CMA, but that the CMA rejected the assignment. If the member has not yet been assigned to a CMA, then the **CMA Assignment Status** field will be blank.

When a CMA user accesses this file, it contains both managed care enrolled and fee for service members that have an *active* or *pending* CMA assignment with the downloading provider. Members enrolled in managed care will have *active* MCP and HH assignment statuses. F~~or f~~ee for service members will have an *active* HH assignment~~,~~ and the **Managed Care Plan MMIS Provider ID, Managed Care Plan Name,** and the **Managed Care Plan Assignment Status** fields will be blank. In the **CMA Assignment Status** field, members will either have a value of *pending*, meaning that the CMA has to either accept or reject the assignment, or a value of *active,* meaning that the CMA accepted the assignment made to the CMA by the HH.

Medicaid Eligibility End Date: Some Medicaid eligible members have indefinite Medicaid eligibility, meaning that their Medicaid eligibility never expires. Within the Medicaid system, these members are listed with a Medicaid eligibility end date of 12/31/9999. The new system will not use 12/31/9999 to indicate that a member is indefinitely Medicaid eligible. This means that any member listed in Medicaid with an end date of 12/31/9999 will be listed in the MAPP HHTS without a value in the Medicaid Eligibility End Date field.

Past Assignments

Description

The Past Assignments file includes members who were assigned to the downloading user's organization, but whose assignment with the user's organization ended without resulting in a segment. This file contains assignments that ended with the downloading provider within the past year. The purpose of this file is to explain to providers why a member assignment that did not result in a segment was ended. This file includes both member assignments that were rejected by the provider and member assignments that ended because something about the member changed, which triggered the member's removal from the provider's assignment file.

Please note that this file only includes members that were assigned to a provider and whose assignment did not result in a segment with the provider. For example, John was assigned to HH B by MCP A. HH B then enrolled John on 1/1/14. On 8/15/15, John moved to Florida, so HH B ended his enrollment and his HH B assignment as of 8/31/15. Although John's assignment was ended with HH B on 8/31/15, John will not be included on HH B's Past Assignment file, because John's assignment with HH B ended because John's segment with HH B ended, which excludes him from being included on the Past Assignments file. If a user from HH B needs to determine why John, or any other member with a closed segment with HH B, is no longer assigned to HH B, then the user should download the Enrollment Download file and review the record's **Segment End Date Reason Code**.

Format

Past Assignments Download File						
Field #	**Field0**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Member First Name	1	30	30	Y	Alpha
2	Member Last Name	31	30	60	Y	Alpha
3	Member ID	61	8	68	Y	AA1111A, Alphanumeric
4	DOB	69	8	76	Y	MMDDYYYY, Numeric
5	Assignment Start Date	77	8	84	Y	MMDDYYYY, Numeric
6	Assignment End Date	85	8	92	C	MMDDYYYY, Numeric
7	Assignment End Date Reason Code	93	2	94	C	Alphanumeric
8	Assignment End Date Reason Description	95	40	134	C	Alpha
9	Assignment Rejection Date	135	8	142	C	MMDDYYYY, Numeric
10	Assignment Rejection Reason Code	143	2	144	C	Alphanumeric
11	Assignment Rejection Reason Code Description	145	40	184	C	Alpha
12	Assignment Created Date	185	8	192		MMDDYYYY, Numeric

Editing Logic

A member can be removed from an assignment file for a number of reasons, including:

1. Member is no longer Medicaid eligible
2. Assigning entity ~~(MCP for plan members and DOH for FFS members)~~ changed the member's assignment
   a. **ALL users:**
      i. Member switched MCP status (see # 6)
      ii. **For member's DOH Identified Health Home eligible members:** When DOH re-runs the Health Home eligibility algorithm and determines that a member that was previously identified a Health Home eligible member prioritized for assignment is either no longer Health Home eligible or no longer prioritized for assignment.
   b. **HH users:** When MCP changes a plan enrolled member's HH assignment or when DOH changes the HH assignment for a fee for service member.
   ~~a.~~c. **CMA users:** When the HH changes a member's CMA assignment.

~~2.~~3. Member's coverage code changed to a coverage code that is incompatible with the Health Home program

~~3.~~4. Recipient R/E code added to a member's file that is incompatible with the Health Home program

~~4.~~5. Member started outreach or enrollment with another organization (only applies to HHs/CMAs)

~~5.~~6. Member switched MCP. This covers a few different situations:

a. Member moves from FFS to MCP: Rachel is a FFS member that is assigned to HH B based on a DOH HH assignment made on July 7, 2015 (Rachel does not have a segment in the system). On August 13, 2015, Rachel enrolls in MCP A. Once the system knows that Rachel is enrolled in MCP A, the system will end date Rachel's assignment with HH B and will create a *pending* MCP assignment with MCP A. An HH B user downloading the Past Assignments file on 8/21/15 will see that Rachel is included in the file download.

b. Member moves from one MCP to another MCP: Robert is enrolled in MCP A. On 3/5/15 MCP A assigns Robert to HH B and then on 3/20/15, HH B assigns Robert to CMA C. On 8/1/15, Robert enrolls in MCP F. Since Robert has changed MCPs, the system will automatically end Robert's

MCP A assignment in addition to end dating any HH or CMA assignments that were made while Robert was assigned to MCP A, as long Robert does not have any corresponding segments. MCP A, HH B, and CMA C users downloading the Past Assignments file on 8/21/15 will see that Robert is included in the file download. Since Robert is now associated with MCP F, the system will create a *pending* MCP assignment for Robert with MCP F.

c. Member moves from MCP to FFS: Amy is enrolled in MCP F and MCP F assigned Amy to HH B on June 3, 2015. On August 13, 2015, Amy leaves MCP F and becomes a FFS member. Once the system knows that Amy is no longer enrolled in MCP F, the system will end date Amy's assignments with MCP F and HH B and will create a *pending* HH assignment with HH K, which is Amy's DOH Recommended assignment. Both MCP F and HH B users downloading the Past Assignments file on 8/21/15 will see that Amy is included in the file download.

Additional file editing include:

~~6.~~7. The export will not include members who are currently assigned to a provider, but had past assignments with the provider that did not result in segments.

a. In June 2015, Larry was assigned to HH B by MCP A. In July 2015, Larry switched to MCP F, which triggered the system to end Larry's assignments with both HH B and MCP A and to create a *pending* MCP assignment with MCP F. After reviewing Larry's information, MCP F decides that HH B is the best assignment for Larry and assigns Larry to HH B. Although Larry's past assignment ended with HH B in June, since he is currently assigned to HH B, Larry will not be included in HH A's Past Assignment file.

~~7.~~8. The export will not include members' assignments that ended because the member's corresponding segment with the provider ended.

~~8.~~9. An ended member assignment **WILL BE** included on this file if a segment was created for the member and then that segment was canceled, as long as the member does not have another segment with the provider.

a. Rita was assigned to HH B in June 2015. On July 10, 2015, HH B submitted into the system an enrollment segment for Rita. On July 12, 2015 HH B realized that Rita's enrollment segment was submitted in error, so HH B submitted a delete record using the Tracking System Segment file on July 15, 2015. In August 2015, Rita's coverage code changed to a coverage code that is not compatible with the Health Home program. Even though HH B submitted a segment for Rita to the system, Rita will be included on HH B's Past Assignment file because HH B deleted Rita's segment, which placed it in the canceled status and because the segment was not related to the reason that Rita's assignment with HH B ended.

~~9.~~10. There will be one row for each member. If a member falls off the assignment file, comes back on the assignment file, and falls off again, only the latest instance will appear in the file.

Tracking File Records

Tracking File Records are used to create, delete, pend, or modify segments and to create, reject, accept, and end assignments. Both HHs and CMAs can submit Tracking File records to the system, but only HHs can use record type 'N' to create a new assignment and record type 'A' to accept a *pending* segment. MCPs cannot submit Tracking Files.

There are three different Tracking File Record upload file formats: Tracking File Segment Records, Tracking File Assignment Records, and the Tracking File Delete Record. These three file formats can be included in one file

uploaded to the system as a Tracking File upload file or these three file formats can be separated out into different files uploaded to the system as Tracking File upload files.

For more information on the Tracking File record types and the file formats that apply to each record type, see *Appendix I: Record Type Codes.*

Since Tracking File Records are used to track a member's assignment or segment status, the files discussed in the Tracking File Records section **must be submitted at least daily WHEN AT LEAST ONE MEMBER'S STATUS HAS CHANGED**. For example, listed below is a table outlining the member status changes that occurred for HH A members in the first week of March. For each day included in the table, the **File submission required?** Column indicates if the HH is required to submit a file that day, depending on the member status changes that occurred that day.

Determining Daily Tracking File Submission Requirement		
Date	**Member Status Changes**	**File submission required?**
Sunday, August 02, 2015	No change	No
Monday, August 03, 2015	Accepted 1,000 pending assignments from MCP A	Yes
Tuesday, August 04, 2015	No change	No
Wednesday, August 05, 2015	Started 10 members in O at 10:00 am, 15 in E at noon, and moved 10 from O to E at 3:30 pm	Yes
Thursday, August 06, 2015	No change	No
Friday, August 07, 2015	Need to reject 5 pending assignments from MCP B and need to delete 1 member segment submitted in error	Yes
Saturday, August 08, 2015	No change	No

As shown above, a daily Tracking File submission is not required if there are no changes to a provider's members' statuses during that day. Additionally, a provider does not have to submit a file every time a member's status changes during the day. For example, listed above for Wednesday 8/5/15, HH A does not need to submit a file at 10, noon, and 3:30; only one file submission for Wednesday 8/5/15 is required. Nor does HH A have to wait until the end of the day to submit their daily file to the system, if required, as long as HH A is consistent with daily file submission timing. For example, assuming that HH A submits a daily Tracking File every day around 3:00 pm, the daily file submitted by HH A on Wednesday 8/5/15 would only include the 10 members that began outreach at 10:00 am and the 15 members that began enrollment at noon. The 10 members that moved from outreach to enrollment at 3:30 pm would have to be submitted on Thursday's 8/6/15 file submission; this would change the table above since HH A is now required to submit a file on 8/6/15 to account for a member status change that occurred late in the day on Wednesday 8/5/15.

PLEASE NOTE that the accuracy of the system relies on **timely and accurate** submissions by providers. While DOH does not require more than one file submission in a day, providers that are able to submit more than one Tracking File in a day are strongly encouraged to submit Tracking Files as often as possible as member statuses change during the day. If possible, HH A is encouraged to submit a file to the system every time a member status change warrants it; for Wednesday 8/5/15 HH A would ideally submit a file at 10:00 am, noon, and 3:30 pm to ensure that the system is as up to date as possible.

Tracking File Assignment Records

Description

HHs use this file to accept, reject, and end member assignments from MCPs and DOH; to create assignments for their CMAs; and to accept, reject, and end member assignments on behalf of their CMAs. CMAs use this file to accept, reject, and end member assignments from HHs. MCPs cannot upload this file.

Format

Tracking File Assignment Records						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Record Type	1	1	1	Y	Alpha (S, R, E, N)
2	Member ID	2	8	9	Y	AA11111A, Alphanumeric
3	Rejection Reason	10	2	11	C	Numeric
4	Suggested Alternate Assignment	12	8	19	C	Numeric
5	Rejection Reason Comment	20	40	59	C	Alphanumeric
6	CMA Provider MMIS ID	60	8	67	C	Numeric
7	End Date Reason	68	2	69	C	Numeric
8	End Date Reason Comment	70	40	109	C	Alphanumeric
9	End Health Home Assignment	110	1	110	Y	Alpha (Y/N)

Editing Logic

1. For a HH to submit this file on behalf of a CMA, the HH must have an active assignment with the member and must have an active relationship with the CMA as of the file submission date, or the records associated with the CMA in the file will be rejected.
2. Unless otherwise stated, if a record contains values in fields that do not apply to the submitted record type, the system will accept the record but will ignore the values in the fields that don't apply to the record type
    a. Values submitted in the fields below for record types 'S' and 'N' will be ignored by the system
        i. Rejection Reason
        ii. Suggested Alternate Assignment
        iii. Rejection Reason Comment
        iv. End Date Reason
        v. End Date Reason Comment
    b. Values submitted in the fields below for record type 'R' will be ignored by the system
        i. End Date Reason
        ii. End Date Reason Comment
    c. Values submitted in the fields below for record type 'E' will be ignored by the system
        i. Rejection Reason
        ii. Suggested Alternate Assignment
        iii. Rejection Reason Comment
3. **Record Type 'R'(Reject Assignment)** is used by HHs to reject *pending* assignments from MCPs and DOH, by HHs to reject a pending CMA assignment that the HH made to a CMA on behalf of that CMA, and by CMAs to reject *pending* assignments made to the CMA by an HH.

a. **Rejection Reason** and **End HH Assignment** fields must be populated with an accepted value on all 'R' records or the record will be rejected.
   i. When a HH submits an 'R' record to reject an MCP or a DOH assignment ~~or to reject an assignment on behalf of a CMA~~, the **End HH Assignment** field should be populated with a value of 'Y'.
   ~~i.~~ii. When a HH submits an 'R' record to reject a *pending* CMA assignment on behalf of the HH's CMA, the **End HH Assignment** field should be populated with a value of 'N'.
   ~~ii.~~iii. When a CMA submits an 'R' record, the **End HH Assignment** field must be populated with a value of 'N'. If the **End HH Assignment** field is populated with a value of 'Y', then the record will be rejected.
b. Once an 'R' record type is processed, the system will populate the member's appropriate assignment status as 'Rejected' to signal to the provider that created the assignment that the assignment was rejected (HH assignment status to rejected from the MCP/DOH perspective or CMA assignment status to rejected from the HH perspective), will populate the rejection reason within the system with the value listed in the **Rejection Reason** field, and will record into the member's case the **Suggested Alternate Assignment** field value, if submitted.
   i. Angela is enrolled in MCP A. DOH assigned Angela to MCP A as a potentially HH eligible member on July 3, 2015. MCP A assigned Angela to HH B on July 15, 2015, who rejected her *pending* HH assignment on August 2, 2015 because Angela lives outside of HH B's service area. Listed below is how MCP A and HH B will see Angela on their files after HH B rejects the assignment created by MCP A:
      1. **MCP A–** Angela will be listed on the MCP Assignment file with an active MCP assignment, a value of '07152015' (7/15/15) in the **Assignment Date** field, a value of '07032015' (7/03/15) in the **DOH Assignment Date** field, and a value of 'Rejected' in the **Health Home Assignment Status** field.
      2. **HH B–** Angela will no longer be listed on HH B's Health Home Assignment file since HH B no longer has an assignment with Angela. Angela will be listed on HH B's Past Assignment file with a value of '08022015' (8/2/15) in the **Assignment Rejection Date** field, a value of '02' in the **Assignment Rejection Reason Code** field, and a value of 'Member moved out of service county' in the **Assignment Rejection Reason Code Description** field.
c. When an HH is rejecting an assignment from an MCP or DOH, the **CMA Provider MMIS ID** field must be blank and the member must have a *pending* HH assignment status.
d. If the HH is rejecting an assignment that the HH made to its CMA on behalf of that CMA, then the **CMA Provider MMIS ID** field must be populated with that CMAs MMIS Provider ID, ~~and~~ the member must have a *pending* assignment with that CMA, and the member must have an *active* assignment with the HH submitting the file.

4. **Record Type 'E'(End Assignment)** is used by HHs to end an *active* assignment made to the HH by an MCP or DOH, by HHs to end an *active* or *pending* CMA assignment, and by CMAs to end an *active* assignment made to the CMA by a HH.
   a. **End Date Reason** and **End HH Assignment** fields must be populated on all 'E' records with an accepted value or the record will be rejected.
      i. When an HH submits an 'E' record to end an assignment received from an MCP or DOH, the **End HH Assignment** field must be populated with a value of 'Y'.

ii. When an HH submits an 'E' record to end a CMA assignment, but the HH would like to keep their *active* HH assignment with the member, the **End HH Assignment** field must be populated with a value of 'N'.
iii. When a HH submits an 'E' record to end a CMA assignment and would also like to end their *active* HH assignment with the member, the **End HH Assignment** field must be populated with a value of 'Y'.
iv. When a CMA submits an 'E' record, the **End HH Assignment** field must be populated with a value of 'N'.

b. A member assignment can only be ended if the member does not have an *active, pending active, pended*, *pending pended, hiatus, pending cancelled, or pending closed* segment associated with the assignment.
c. If a HH submits a record type of 'E' and the **Care Management Agency MMIS ID** field does not contain a value, then the **End HH Assignment** field must contain a value of 'Y'.
d. Both HHs and CMAs can end a CMA assignment, but a CMA cannot end an HH assignment. When a CMA submits an 'E' record type, the **End HH Assignment** field must contain a value 'N'.
e. When an HH is ending an assignment made to the HH by an MCP or DOH, the **CMA Provider MMIS ID** field must be blank and the member must have an *active* HH assignment status.
f. When a HH is ending a CMA assignment that the HH made to the CMA, the **CMA Provider MMIS ID** field must be populated with that CMAs MMIS Provider ID and the member must have an *active or pending* assignment with that CMA.

5. **Record Type 'S' (Accept Assignment)** is used by HHs to accept a *pending* assignment made to the HH by an MCP or DOH, is used by HHs to accept a *pending* CMA assignment made by that HH to the CMA on behalf of that CMA, and is used by CMAs to accept *pending* assignments made to the CMA by an HH.
   a. **End Health Home Assignment** field must be populated with a value of 'N' when submitting an 'S' record or the record will be rejected.
   b. Once this file is processed, the system will move the member's assignment status from pending to *active*.
   c. For a HH to accept a *pending* assignment made to the HH by an MCP or DOH, the HH must submit an 'S' record with a value of 'N' in the **End HH Assignment** field and the **Care Management Agency MMIS ID** field must be blank.
   d. For a HH to accept a *pending* CMA assignment made by the HH on behalf of that CMA, the HH must submit an 'S' record with the ID of the CMA that the HH is accepting the assignment on behalf of in the **Care Management Agency MMIS ID** field and the **End HH Assignment** field must be populated with a value of 'N'.
   e. For a CMA to accept a *pending* CMA assignment, the CMA must submit an 'S' record with a value of 'N' in the **End HH Assignment** field and the **Care Management Agency MMIS ID** field must be blank.
6. **Record Type 'N' (New Assignment)** is used by HHs to assign a member to a CMA, to reassign a member from one CMA to another, or to end an existing CMA assignment without creating a new CMA assignment.
   a. HHs can create a new assignment using the 'N' record for members:
      i. That have an *active* HH assignment
      ii. That have a *pending* HH assignment
      iii. FFS members that are not currently in the system with an assignment
      iv. HHs cannot submit an 'N' record for MCP members that do not have an *active* or *pending* assignment with the HH.

b. Only HHs can submit record type 'N'. If a CMA submits a record type of 'N', the record will be rejected.
c. **To assign a member to a CMA**, the HH must submit an 'N' record type and enter the ID of the CMA that the HH is assigning the member to in the **Care Management Agency Provider MMIS ID** field (the HH and CMA must be listed within that system as having an active relationship as of the file submission date) and the **End HH Assignment** field must be populated with a value of 'N'. This will create a *pending* assignment for the CMA listed in the **Care Management Agency Provider MMIS ID** field.
    i. If the member had an *active* HH assignment, then submitting this file will create a *pending* CMA assignment.
    ii. If the member had a *pending* HH assignment, then submitting this file will create an *active* HH assignment and a *pending* CMA assignment.
    iii. If a HH submits an 'N' record for a member that is enrolled in an MCP and does not yet have an HH assignment, then the system will reject the record. If an HH would like an MCP enrolled member to be assigned to their HH, then the HH should either:
        1. Refer the member to their Health Home in the system using the referral wizard (this action is only available online), which will create a *pending* referral for the member's MCP that will be included on the MCP's Managed Care Plan Assignment file with the HH's MMIS Provider ID listed in the **Suggested Alternative Health Home Assignment** field, **OR**
        2. Call the MCP and ask that the MCP assign the MCP enrolled member to the HH.
d. To reassign a member in either an *active* or a *pending* CMA assignment from one CMA to a another CMA, the HH must submit an 'N' record type and enter the ID of the new CMA that the HH wants to reassign the member to in the **Care Management Agency Provider MMIS ID** field. This will end the member's assignment with the original CMA and create a *pending* assignment for the new CMA listed in the **Care Management Agency Provider MMIS ID** field.
e. To end a *pending* or *active* CMA assignment that the HH previously submitted without creating a new CMA assignment, that HH must submit an 'E' record type and populate the **Care Management Agency Provider MMIS ID** field and submit a value of 'N' in the **End HH Assignment** field . This will end the member's assignment with the original CMA. This will not create a new CMA assignment, nor will it affect the member's HH status.
f. The system will not allow an HH to assign a member to a CMA with which the member already has a *pending* or *active* CMA assignment.
g. If an HH submits an 'N' record type with a different CMA then the CMA that the member is currently assigned to, the system will end the member's current CMA assignment as of the date the file was uploaded with reason 'Changed CMA' and will create a *pending* CMA assignment the CMA listed in the **Care Management Agency Provider MMIS ID** field with a create date of the date that the file was uploaded.

7. When a HH is acting on behalf of a CMA
    a. The system will validate that the HH uploading the file is appropriately associated with both the member(member has an active assignment with the HH) and the CMA and that the member has the appropriate status with the CMA ID listed in the **Care Management Agency MMIS ID** field to perform the action.
    b. For example, if HH B submits an 'R' record with CMA C in the **Care Management Agency MMIS ID** field, the system will make sure that the member has a *pending* assignment with CMA C, that HH B has a contract with CMA C, and that HH B has an active HH assignment with the member.

8. The **Suggested Alternate Assignment** is not a required filed. However, when the **Suggested Alternate Assignment** field contains a value, that value must be a valid MMIS provider ID set up within the system as either a HH or a CMA. If a HH user is uploading the file with record type 'R' and the **Care Management Agency MMIS ID** field is blank, any ID submitted in the **Suggested Alternate Assignment** field must be associated with a HH in the system, or the record will be rejected. If a HH user is uploading the file with record type 'R' and the **Care Management Agency MMIS ID** field is populated, the ID submitted in the **Suggested Alternate Assignment** field must be associated with an existing MA in the system. If a CMA user is uploading the file with record type 'R', any ID submitted in the **Suggested Alternate Assignment** must be associated with an existing CMA in the system.

Tracking File Segment Records

Description

HHs use this file to create, modify, pend or accept outreach and enrollment segments and CMAs use this file to create, modify, or pend outreach and enrollment segments. MCPs cannot upload this file.

Format

Tracking File Segment Records							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
1	Record Type	1	1	1	Y	HH/CMA	Alpha (C/A/M/P)
2	Member ID	2	8	9	Y	HH/CMA	AA11111A, Alphanumeric
3	Date of Birth	10	8	17	Y	HH/CMA	MMDDYYYY, Numeric
4	Gender	18	1	18	Y	HH/CMA	Alpha (M/F)
5	Begin Date	19	8	26	Y	HH/CMA	MMDDYYYY, Numeric
6	End Date	27	8	34	C	HH/CMA	MMDDYYYY, Numeric
7	Outreach/Enrollment Code	35	1	35	Y	HH/CMA	Alpha (O/E)
8	Health Home MMIS ID	36	8	43	Y	HH/CMA	Numeric
9	Care Management Agency MMIS ID	44	8	51	Y	HH/CMA	Numeric
10	Direct Biller Indicator	52	1	52	N	HH/CMA	Alpha (Y/N)
11	TBD 1	53	1	53	N	HH/CMA	Character
12	TBD 2	54	1	54	N	HH/CMA	Character
13	Referral Code	55	1	55	C	HH/CMA	Alpha
14	Segment End Date Reason Code	56	2	57	C	HH/CMA	Numeric
15	Consent Date	58	8	65	N	HH/CMA	MMDDYYYY, Numeric
16	NYSID	66	9	74	N	HH/CMA	Alphanumeric
17	Segment End Date Reason Comment	75	40	114	C	HH/CMA	Alphanumeric
18	Pend Start Date	115	8	122	C	HH/CMA	MMDDYYYY, Numeric
19	Pend Reason Code	123	2	124	C	HH/CMA	Numeric

Tracking File Segment Records							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
20	Pend Reason Code Comment	125	40	164	C	HH/CMA	Alphanumeric
21	End Health Home Assignment	165	1	165	Y	HH/CMA	Alpha (Y/N)

Editing Logic

1. The HH listed in the **Health Home MMIS ID** field must have an active relationship with the CMA listed in the **Care Management Agency MMIS ID** field for the entire segment period.
    a. HH must submit a DEAA subcontractor packet to DOH for each CMA that the HH works with. Once DOH receives and approves a subcontractor packet between a HH and a CMA, DOH will create a relationship between the HH and the CMA, which will allow the HH and the CMA to work together within the system.
    b. The HH and CMA listed in the segment must have a relationship in the system for the entire period of the segment, or the record will be rejected.
    c. If the HH and CMA listed in the segment have a relationship in the system, but only for a portion of the time between the segment begin date and end date, then the record will be rejected. Either the segment begin/end dates must be adjusted so that the segment only occurs during the time that the HH and CMA had a relationship or the HH must work with DOH to change the HH/CMA relationship begin and end dates.
2. The system will reject a record that is attempting to take an action that has already been submitted to the system
    a. When determining if an action has already taken place, the system compares the submitted record to *active, pended, pending active, pending pended, pending canceled, pending closed* segments in the system using the following fields **Member ID, Begin Date, Outreach/Enrollment Code, Health Home MMIS ID,** and **Care Management Agency MMIS ID.**
3. The system will ignore any values submitted on the Tracking File Segment Records file in the **Direct Biller Indicator** field since this value is now collected on the Billing Support Upload file.
4. To be accepted, the **Member ID** field must be populated with a valid CIN:
    a. Medicaid eligible as of the begin date
    b. Does not have either a coverage code or a recipient R/E code that is incompatible with the Health Home program, as of the record **Begin Date**
    c. Does not have a segment in the system in an *active, pended, pending active, pending pended, pending canceled, or pending closed* that overlaps with the begin/end dates (if applicable) included in the record.
    d. Does not have a *pended* MCP assignment
5. **Record Type 'C' (Create Segment)** is used by HHs and CMAs to create an outreach or an enrollment segment.
    a. Segment status:
        i. When a 'C' record type is processed into the system **by an HH**, the system will create an *active* segment for the submitted record.
        ii. When a 'C' record type is processed into the system **by a CMA** that is not set up with auto approval by the HH associated with the submitted segment, the system will create a *pending active* segment for the submitted record.

iii. When a 'C' record type is processed into the system **by a CMA** that is set up with auto approval by the HH associated with the submitted segment, the system will create an *active* segment for the submitted record.

b. If an HH uploads a 'C' record matching the **Member ID, Begin Date, Outreach/Enrollment Code, Health Home MMIS ID** of a *pending* transfer in the system for the HH listed on the **Health Home MMIS ID** field, then the system will move the *pending* transfer into the *active* status. This will trigger the system to move the original enrollment segment into the *closed* status with the appropriate end date and will create a new *active* enrollment segment with the HH and CMA submitted in the record.

c. If a CMA uploads a 'C' record matching the **Member ID, Begin Date, Outreach/Enrollment Code, and Care Management Agency MMIS ID** in a *pending* transfer for their CMA, then the system will move the *pending* transfer into the *active* status. This will trigger the system to move the original enrollment segment into the *closed* status with the appropriate end date and will create a new *active* enrollment segment with the HH and CMA submitted in the record.

d. If an enrollment segment exists and it follows an outreach segment (for example, outreach from 1/1/14 – 3/31/14 and enrollment from 4/1/14 – 5/31/14) and that enrollment segment is later deleted, and re-entered with a start date prior to the original enrollment segment start date (3/1/14, for example) the system will accept the record and adjust the outreach segment end date (adjusted outreach segment would be 1/1/14 – 2/28/14).

e. End Health Home Assignment

   i. When creating a segment without an end date, this field must be ~~populated with a value of 'N'~~ blank.

   ii. When creating a segment with an end date, this this field should be populated with a value of 'N' if the HH would like to maintain their active assignment with the member after the segment is over and should be populated with a value of 'Y' if the HH does not want to maintain their active assignment with the member after the segment is over

~~f. If a HH user creates an enrollment segment and the start date is the same as start date of an active outreach segment start date, but the enrollment segment is with a different CMA than the CMA listed in the outreach segment, then the system will move the member's assignment with the CMA listed on the outreach segment to a *canceled* and create a new *active* CMA assignment for the CMA listed on the enrollment segment.~~

f. If a 'C' segment is submitted to create an enrollment segment that overlaps with an outreach segment in the system **AND** if the HH and CMA listed on the enrollment segment match the HH and CMA listed on the outreach segment, then the system will end date the outreach segment with an **End Date** that is the day before the submitted enrollment segment begin date **and** will create a segment for the submitted enrollment record.

g. If a 'C' segment is submitted to create an enrollment segment has the same begin date as an outreach segment in the system **AND** if the HH and CMA listed on the enrollment segment match the HH and CMA listed on the outreach segment, then the system will delete the outreach segment **and** will create a segment for the submitted enrollment record.

h. Referral Code Editing Logic

   i. HH A submits a segment for HH A and CMA B. Member is not assigned to HH A or CMA B.

      1. Referral Code must contain a value of 'R', or the record will be rejected

      2. Once segment is created, member will have an active referral record type with HH A and CMA B

   ii. HH A submits a segment for HH A and CMA B. Member is assigned to HH A, but does not have a CMA assignment

1. Referral Code must be blank, or the record will be rejected
2. Once segment is created, member will have an active assignment record type with HH A and CMA B

iii. HH A submits a segment for HH A and CMA B on 8/5/15. Member is assigned to HH A and has a pending* assignment with CMA C (CMA assignment creation date = 7/18/15)
    1. Referral Code must be blank, or the record will be rejected
    2. Once segment is created, member will have an active assignment record type with HH A and CMA B
    3. CMA C assignment has an assignment creation date of 7/18/15, does not have an assignment start date, and has an assignment end date of 8/5/15
    4. *If CMA C assignment was active, CMA C would have an assignment creation date of 7/18/15, an assignment start date, and an assignment end date of 7/31/15.

iv. HH A submits a segment for HH A and CMA B on 8/5/15 with begin date of 8/1/15. Member is not assigned to HH A, but has an active assignment with CMA B with an assignment creation date of 7/18/15 and an assignment start date of 7/25/15 (HH D assigned the member to CMA B. HH D assignment creation date and assignment start date both 7/6/15)
    1. Referral Code must contain a value of 'R'
    2. Once segment is created, member will have an active referral record type with HH A with a creation date and a start date of 8/1/15.
    3. There will be no change to CMA C assignment: active assignment with CMA B with an assignment creation date of 7/18/15 and an assignment start date of 7/25/15.

v. HH OR CMA submits a segment for HH A and CMA B. Member is assigned (either pending or active) to HH A and CMA B.
    1. Referral Code must be blank, or the record will be rejected
    2. Once segment is created, member will have an active assignment record type with HH A and CMA B

vi. CMA B submits a segment for HH A and CMA B. Member is not assigned to HH A or CMA B.
    1. Referral Code must contain a value of 'R', or the record will be rejected
    2. Once segment is created, member will have an active referral record type with HH A and CMA B

vii. CMA B submits a segment for HH A and CMA B. Member is assigned to HH A, but does not have a CMA B assignment
    1. Referral Code must contain a value of 'R', or the record will be rejected
    2. Once segment is created, member will have an active assignment record type with HH A and an active referral record type with CMA B

viii. CMA B submits a segment for HH A and CMA B on 8/5/15 with a begin date of 8/1/15. Member is assigned to HH A and has a pending* assignment with CMA C (CMA C assignment creation date = 7/18/15)
    1. Referral code must contain a value of 'R'
    2. Once segment is created, member will have an active assignment record type with HH A and an active referral record type with CMA B
    3. CMA C assignment has an assignment creation date of 7/18/15, does not have an assignment start date, and has an assignment end date of 8/5/15
    4. *If CMA C assignment was active, CMA C would have an assignment creation date of 7/18/15, an assignment start date, and an assignment end date of 7/31/15.

ix. CMA submits a segment for HH A and CMA B on 8/5/15 with begin date of 8/1/15. Member is not assigned to HH A, but has an active* assignment with HH F with an assignment creation date of 7/18/15 and an assignment start date of 7/25/15. CMA B has an active assignment with member with an assignment creation date and assignment start date of 7/30/15)

1. Referral Code must be blank, or the record will be rejected
2. Once segment is created, member will have an active referral record type with HH A with a creation date and a start date of 8/1/15.
3. Once segment is created, CMA B will have an active assignment record type with a creation and start date of 7/30/15
4. Once segment is created, member assignment with HH F will have a creation date of 7/18/15, an assignment start date of 7/25/15, and an assignment end date of 7/31/15
5. If the member assignment with HH F was in pending status instead of active status, member assignment with HH F will have a creation date of 7/18/15, no assignment start date, and an assignment end date of 7/31/15

6. **Record Type 'M' (Modify Segment)** is used by HHs and CMAs to modify an existing segment in the system in an *active, pended, pending active, pending pended, pending closed, pending canceled, closed, hiatus.*
   a. To determine which existing segment in the system needs to be modified, the system will match the following segments on the record to the segments in the system:
      i. **Member ID, Begin Date, Outreach/Enrollment Code, Health Home MMIS ID,** and **Care Management Agency MMIS ID**
      ii. If a provider would like to change any of the values previously submitted in the fields listed above, the provider must either
         1. Delete the record and resubmit the information, if the value that needs to be modified was incorrect and never should have been submitted to the system, OR
         2. End the segment and then create a new segment with the new values.
   b. If the file contains a consent date that differs from the date previously entered a record's corresponding enrollment, then the system will replace the consent date in the system with the date submitted in the **Consent** field in the file.
   c. If a user submits the file with a Record Type of 'M' and the only item that differs from what is already on file for the closed segment is the end date reason code, the system will replace the current end date reason code with the one listed in the file.
   d. **End Health Home Assignment** field is required when a HH is submitting an 'M' record or the record will be rejected.
   e. End Health Home Assignment
      i. When a CMA submits a segment with a '~~C'~~ M' record type, the **End Health Home Assignment** field must be populated with a value of 'N'.
      ii. When a HH submits a '~~C'~~ M' record to modify a segment without an end date, this field must be ~~populated with a value of 'N'~~ blank.
      iii. When a HH submits a '~~C'~~ M' record to modify a segment with an end date, this field should be populated with a value of 'N' if the HH would like to maintain their active assignment with the member after the segment is over and should be populated with a value of 'Y' if the HH does not want to maintain their active assignment with the member after the segment is over

7. **Record Type 'A' (Accept Segment)** is used by HHs to accept a *pending* segment associated with the submitting HH that was submitted by a CMA that is not set up with auto approval with the HH.
    a. To determine pending segment in the system needs to be accepted, the system will match the following segments on the submitted record to the segments in the system using the following fields: **Member ID, Begin Date, Outreach/Enrollment Code, Health Home MMIS ID,** and **Care Management Agency MMIS ID.** All other fields aside from the **Record Type** and the **End Health Home Assignment** fields will be ignored by the system.
    b. End Health Home Assignment
        i. When accepting a *pending active* or a *pending pended* segment without an end date, the **End Health Home Assignment** field must be populated with a value of 'N'.
        ii. When accepting a *pending active* or a *pending pended* segment with an end date or when accepting a *pending closed* segment, the submitting HH should use the End **Health Home Assignment** field to indicate to the system whether or not the active HH assignment with the member should be ended.
    c. For a HH to accept a *pending* segment made to the HH by a CMA, the HH must submit an 'A' record with a value of 'N' in the **End HH Assignment** field
    d. Once this file is processed, the system will remove the word pending from the member's segment status:
        i. *Pending active* becomes *active*; *pending pended* becomes *pended*; *pending closed* becomes *closed*; *pending canceled* becomes *canceled*
    e. If a HH does not want to accept a *pending* segment, then the HH should work with the CMA to modify or delete the *pending* segment.
8. **Record Type 'P' (Pend Segment)** is used by HHs and CMAs to pend an outreach or enrollment segment in an *active, pending active, hiatus,* or *pended* status.
    a. If a segment is still in the *active* status, but has an end date that will cause the segment to move into a *closed* status at the end of the month, then a user will not be able to submit an '~~R~~P' record to pend that segment.
    b. If a user submits the file with a Record Type of 'P' and the corresponding segment is already in a Pended status, then the system will end the previously pended segment and pend it again with the 'new' pend reason code, as long as the new pend reason code is different than the previously submitted pend reason code. If the pend reason codes are the same, then the system will reject the record.
    c. To move a segment out of the pend status, into an outreach or enrollment segment, simply submit a 'C' record to start the new segment. The system will populate the *pended* segment **End Date** field with an end date that is one day prior to the date listed in the submitted **Begin Date** field.
    d. To move a segment out of the pend status, end the member's CMA assignment and keep the member's HH assignment *active,* submit an 'M' record with the date that the pend should end in the **End Date** field, populate the **Segment End Date Reason Code** appropriately, and populate the **End Health Home Assignment** field with a value of 'N',
    e. To move a segment out of the pend status while ending the member's assignment with both the HH and the CMA, , submit an 'M' record with the date that the pend should end in the **End Date** fields, populate the **Segment End Date Reason Code** appropriately, and populate the **End Health Home Assignment** field with a value of 'Y'.

Tracking File Delete Records

Description

The delete record is used to delete from the system an incorrectly entered outreach or enrollment segment. The delete record should only be used to remove incorrect segment information that should never have been submitted into the system. Both HHs and CMAs use this file to delete an incorrectly submitted segment with which the uploading provider is associated (HH can only delete a segment if the uploading HH is listed in the segment's **Health Home MMIS Provider ID** field and a CMA can only delete a segment if the uploading CMA is listed in the segment's **Care Management Agency MMIS Provider ID** field). MCPs cannot upload this file.

Format

Delete Record						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Record Type	1	1	1	Y	Alpha (D)
2	Member ID	2	8	9	Y	AA11111A, Alphanumeric
3	Begin Date	10	8	17	Y	MMDDYYYY, Numeric

Editing Logic

1. Only segments in an *active, closed, pended, pending active, pending closed, or pending pended segment* status can be deleted.
2. There must be a segment record in the system that corresponds with the Member ID, the begin date, and the submitting provider in order for the delete record to be accepted.
    a. If the record is submitted by a HH, then the begin date listed on the delete record and HH uploading the delete record must be listed in the **Begin Date** and **Health Home MMIS Provider ID** fields, respectively, in order for the system to accept the delete record. If successfully submitted, the member will move into a *canceled* segment status.
    b. If the record is submitted by a CMA, then the begin date listed on the delete record and CMA uploading the delete record must be listed in the **Begin Date** and **Care Management Agency MMIS Provider ID** fields respectively for of the system to accept the delete record. If successfully submitted, the member will move into a *pending canceled* segment status, unless the HH associated with the segment that is being deleted marked the CMA as "auto approved." In that case, the HH has already indicated to the system that the HH does not need to review/accept the CMA segment actions and therefore the deleted record submitted by the auto approved CMA will move the segment directly into the *canceled* status.

Tracking File Error Report

Description

This file is created upon validating or processing a Tracking File Assignment Records, Tracking File Segment Records, or a Tracking File Delete Records file containing at least one error. A Tracking Error Report file will not be created for an uploaded Tracking File that does not contain rejected records. The Tracking Error Report file will contain one record for each record in the uploaded Tracking File that contains an error.

Format

Tracking File Error Report							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
1	Line Number	1	6	6	Y	Gen	Numeric
2	Record Type	7	1	7	~~Y~~C	HH/CMA	Alpha (C/A/M/P/D/S/R/E/N)
3	Member ID	8	8	15	~~Y~~C	HH/CMA	AA11111A, Alphanumeric
4	Begin Date	16	8	23	C	HH/CMA	MMDDYYYY, Numeric
5	Health Home MMIS ID	24	8	31	C	HH/CMA	Numeric
6	Care Management Agency MMIS ID	32	8	39	C	HH/CMA	Numeric
7	Error Reason Code 1	40	3	42	~~C~~Y	Gen	Numeric
8	Error Reason Code 2	43	3	45	C	**Gen**	**Numeric**
9	Error Reason Code 3	46	3	48	C	Gen	Numeric
10	Error Reason Code 4	49	3	51	C	Gen	Numeric
11	Error Reason Code 5	52	3	54	C	Gen	Numeric
12	Error Description1	55	70	124	Y~~C~~	Gen	Alphanumeric
13	Error Description2	125	70	194	C	Gen	Alphanumeric
14	Error Description3	195	70	264	C	Gen	Alphanumeric
15	Error Description4	265	70	334	C	Gen	Alphanumeric
16	Error Description5	335	70	404	C	Gen	Alphanumeric

Editing Logic

This error report contains error code fields and error code field descriptions for up to 5 errors per record. If more than 5 errors apply to the rejected record, only the first five errors will be displayed. For a complete list of the error codes and error code descriptions used in this file, please see *Appendix B: File Error Reason Codes.*

Member Downloads

Enrollment Download File

Description

The Enrollment Download file contains a record for every outreach and enrollment segment connected to the downloading provider in the system in the following statuses: *active, closed, hiatus, pended, pending active, pending closed, pending pended,* and *pending canceled.* This file is can be downloaded by MCPs, HHs, and CMAs.

For MCPs, this file will contain any member segments that overlap at least one month with the period of time that the member's enrolled in the MCP. For HHs, this file will contain all segments that contain the downloading provider's MMIS Provider ID in the **Health Home MMIS ID** field. For CMAs, this file will contain all segments that contain the downloading provider's MMIS Provider ID in the **Care Management Agency MMIS ID** field.

Format

Enrollment Download File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Member ID	1	8	8	Y	AA11111A, Alphanumeric
2	Begin Date	9	8	16	Y	MMDDYYYY, Numeric
3	End Date	17	8	24	Y	MMDDYYYY, Numeric
4	Outreach/Enrollment Code	25	1	25	Y	Alpha (O/E)
5	Health Home MMIS ID	26	8	33	Y	Numeric
6	Care Management Agency MMIS ID	34	8	41	Y	Numeric
7	Direct Biller Indicator	42	1	42	~~N~~C	Alpha (Y/N,NULL)
8	Referral Code	43	1	43	C	Alpha
9	Disenrollment Reason Code	44	2	45	C	Numeric
10	Consent Date	46	8	53	C	MMDDYYYY, Numeric
11	NYSID	54	9	62	C	Alphanumeric
12	Insert Date	63	8	70	Y	MMDDYYYY, Numeric
13	Latest Modified Date	71	8	78	Y	MMDDYYYY, Numeric
14	Status Start Date	79	8	86	Y	MMDDYYYY, Numeric
15	Status End Date	87	8	94	Y	MMDDYYYY, Numeric
16	Status	95	20	114	Y	Alpha (Active, Pended, Hiatus, Closed, Pending Active, Pending Pended, Pending Closed, Pending Canceled)
17	Segment End Date Description	115	40	154	C	Alpha
18	Segment Pend Reason Code	155	2	156	C	Alphanumeric
19	Segment Pend Reason Description	157	40	196	C	Alpha
20	Health Home Name	197	40	236	Y	Alpha
21	Care Management Agency Name	237	40	276	Y	Alpha
22	Member First Name	277	30	306	Y	Alpha
23	Member Last Name	307	30	336	Y	Alpha
24	Gender	337	1	337	Y	Alpha (M/F)
25	DOB	338	8	345	Y	MMDDYYYY, Numeric
26	HARP Flag 2012	346	1	346	Y	Alpha (Y/N)
27	HARP Flag 2014	347	1	347	Y	Alpha (Y/N)
28	HARP Current	348	1	348	Y	Alpha (Y/N)
29	Medicaid Eligibility End Date	349	8	356	~~Y~~C	MMDDYYYY, Numeric

Editing Logic

The following section describes Juanita and Paul's Health Home and Managed Care Plan affiliation over the past few years. Each provider is then listed with the description of the segments that would be included in the provider's Enrollment Download file.

1. **Juanita** was enrolled in MCP A from January 1, 2014 through present. Juanita had an outreach segment from 1/1/14 – 2/28/14 with HH B and CMA D and then started enrollment on 3/1/14 with HHA and CMA D.
    a. **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D

b. **Outreach/Enrollment Code:** E, **Begin Date**: 3/1/14, **End Date**: [blank], HH A, CMA D

2. **Paul** was a fee for service member when he started outreach with HH B and CMA C in March 2014. In April 2014, Paul became a member of MCP A and enrolled in HH B and CMA C effective 4/1/14. In May 2014, Paul switched to MCP F. In September, Paul switched his HH B enrollment from CMA C to CMA D.
    a. **Outreach/Enrollment Code:** O, **Begin Date**: 3/1/14, **End Date**: 3/31/14, HH B, CMA C
    b. **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
    c. **Outreach/Enrollment Code:** E, **Begin Date**: 9/1/14, **End Date**: [blank], HH B, CMA D
3. **MCP A**
    a. Juanita **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D
    b. Juanita **Outreach/Enrollment Code:** E, **Begin Date**: 3/1/14, **End Date**: [blank], HH A, CMA D
    c. Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
4. **HH B**
    a. Juanita **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D
    b. Paul **Outreach/Enrollment Code:** O, **Begin Date**: 3/1/14, **End Date**: 3/31/14, HH B, CMA C
    c. Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
    d. Paul **Outreach/Enrollment Code:** E, **Begin Date**: 9/1/14, **End Date**: [blank], HH B, CMA D
5. **CMA C**
    a. Paul **Outreach/Enrollment Code:** O, **Begin Date**: 3/1/14, **End Date**: 3/31/14, HH B, CMA C
    b. Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
6. **CMA D**
    a. Juanita **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D
    b. Juanita **Outreach/Enrollment Code:** E, **Begin Date**: 3/1/14, **End Date**: [blank], HH A, CMA D
    c. Paul **Outreach/Enrollment Code:** E, **Begin Date**: 9/1/14, **End Date**: [blank], HH B, CMA D
7. **MCP F**
    a. Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
    b. Paul **Outreach/Enrollment Code:** E, **Begin Date**: 9/1/14, **End Date**: [blank], HH B, CMA D

Medicaid Eligibility End Date: Some Medicaid eligible members have indefinite Medicaid eligibility, meaning that their Medicaid eligibility never expires. Within the Medicaid system, these members are listed with a Medicaid eligibility end date of 12/31/9999. The new system will not use 12/31/9999 to indicate that a member is indefinitely Medicaid eligible. This means that any member listed in Medicaid with an end date of 12/31/9999 will be listed in the MAPP HHTS without a value in the Medicaid Eligibility End Date field.

Enrollment Download Scenarios: HH A submits an outreach segment for Marco for March 2015 to May 2015. On May 31, 2015 the system runs a batch process that places Marco in the outreach hiatus status for June 2015 to August 2015. The enrollment download files will include the following records for Marco:

a. **On March 31, 2015:** Outreach segment with a **Begin Date**: 3/1/15, **End Date**: 5/31/15, **Status**: Active
b. **On June 1, 2015 the enrollment download will include:**
    - Outreach segment with a **Begin Date**: 3/1/15, **End Date**: 5/31/15, **Status**: Closed
    - Outreach segment with a **Begin Date**: 6/1/15, **End Date**: 8/31/15, **Status**: Hiatus
c. **On September 1, 2015 the enrollment download will include:**
    - Outreach segment with a **Begin Date**: 3/1/15, **End Date**: 5/31/15, **Status**: Closed, **Segment End Date Reason Code**: 31 Active to Hiatus
    - Outreach segment with a **Begin Date**: 6/1/15, **End Date**: 8/31/15, **Status**: Closed, **Segment End Date Reason Code**: 30 Hiatus to Closed

My Members Download File

Description

This is a file that can only be downloaded by a user from the online ***My Members*** screen, which displays the members that have an outreach/enrollment segment in any status, except for canceled, with the user's provider in addition to members that have an *active, pending, or pended* assignment without a corresponding segment with the user's provider. To download this file, a user must navigate to the ***My Members*** screen in the system, use the filters on that page to identify the population that the user is interested in, and then hit the *Download Search Results* button. This will prompt the system to create a file matching the file format below containing the member segments/assignments that meet the criteria selected by the user. ~~For more information about this screen, please see *Appendix N: My Members*.~~

Format

My Members Download File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Member ID	1	8	8	Y	AA11111A, Alphanumeric
2	First Name	9	30	38	Y	Alpha
3	Last Name	39	30	68	Y	Alpha
4	Date of Birth	69	8	76	Y	MMDDYYYY, Numeric
5	Managed Care Plan MMIS Provider ID	77	8	84	C	Numeric
6	Managed Care Plan Name	85	40	124	C	Alpha
7	Health Home MMIS Provider ID	125	8	132	C	Numeric
8	Health Home Name	133	40	172	C	Alpha
9	Care Management Agency Provider ID	173	8	180	C	Numeric
10	Care Management Agency Name	181	40	220	C	Alpha
11	Assignment Source	221	20	240	Y	Alpha (DOH Identified, MCP Identified, Referral)
12	Assignment Created Date	241	8	248	C	MMDDYYYY, Numeric
13	Pending Referral	249	1	249	C	Alpha (Y/N)
14	Referral Health Home MMIS Provider ID	250	8	257	C	Numeric
15	Referral Health Home Name	258	40	297	C	Alpha
16	Segment Record Type	298	1	298	Y	Alpha (Assignment or Referral O or E)
17	Segment Status	299	20	318	Y	Alpha (Pending, Pended, Active, Pending Active, Pending Pended, Pending Closed, Closed, Pending Canceled, or Hiatus)
18	Begin Date	319	8	326	C	MMDDYYYY, Numeric
19	End Date	327	8	334	C	MMDDYYYY, Numeric
20	End Date Reason	335	60	394	C	Alpha

My Members Download File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
21	Consent Date	395	8	402	C	MMDDYYYY, Numeric
22	Pend Reason	403	40	442	C	Alphanumeric
23	HARP	443	2	444	Y	Alpha (Blank, EL, or EN)
24	Pioneer ACO	445	1	445	Y	Alpha (Y/N)
25	Impacted Adult Home Member	446	1	446	Y	Alpha (Y/N)
26	Address 1	447	40	486	Y	Alphanumeric
27	Address 2	487	40	526	~~Y~~C	Alphanumeric
28	City	527	40	566	Y	Alphanumeric
29	State	567	2	568	Y	Alpha
30	Zip	569	9	577	Y	Numeric
31	Phone	578	10	587	Y	Numeric
32	County of Fiscal Responsibility Code	588	2	589	Y	Numeric
33	County of Fiscal Responsibility Description	590	30	619	Y	Alpha
34	Language	620	40	659	C	Alpha
35	Gender	660	1	660	Y	Alpha (M/F)
36	Medicaid Eligibility End Date	661	8	668	~~Y~~C	MMDDYYYY, Numeric
37	DOH Composite Score	669	6	674	C	Decimal, 999V99
38	Acuity Score	675	7	681	C	Decimal, 99V999
39	Date of Patient Acuity	682	8	689	C	MMDDYYYY, Numeric
40	Downloading Provider Assignment Created Date	690	8	697	C	MMDDYYYY, Numeric
41	DOH Recommended HH	698	8	705	C	Numeric
42	Suggested Alt Assignment	706	8	713	C	Numeric

Editing Logic

Since this file download can contain a mixture of segment and assignment information, based on the filters selecting on the ***My Members*** screen prior to file download, some of the fields above will or will not be populated based on whether the record contains segment information of assignment information. The table below describes if/how each field will be populated based on the type of record.

Medicaid Eligibility End Date: Some Medicaid eligible members have indefinite Medicaid eligibility, meaning that their Medicaid eligibility never expires. Within the Medicaid system, these members are listed with a Medicaid eligibility end date of 12/31/9999. The new system will not use 12/31/9999 to indicate that a member is indefinitely Medicaid eligible. This means that any member listed in Medicaid with an end date of 12/31/9999 will be listed in the MAPP HHTS without a value in the Medicaid Eligibility End Date field.

My Members Fields	Segment Record	Assignment Record
Member ID	Will always be populated	
First Name	Will always be populated	
Last Name	Will always be populated	
Date of Birth	Will always be populated	
Managed Care Plan MMIS Provider ID		

My Members Fields	Segment Record	Assignment Record
Managed Care Plan Name	For Managed Care members, the MCP that the member is enrolled with as of the file download. For fee for service members, these fields will be blank.	
Health Home MMIS Provider ID	If a member has a HH assignment with record type “assignment” or a segment with a corresponding HH assignment with record type “assignment”, that health home name and ID will be populated here. If a member does not have a HH assignment with record type “assignment”, these fields will be blank.*	
Health Home Name		
Care Management Agency Provider ID	CMA listed on segment. For a segment record, these fields will always be populated.	CMA that member is assigned to. If member is not assigned to a CMA, then these fields will be blank.
Care Management Agency Name		
Assignment Source	Will always be populated with the source of the member's assignment	
Assignment Created Date	Will always be blank	Will always be populated with the date of the member’s most recent assignment**
Pending Referral	Will always be blank	Will always be populated
Referral Health Home MMIS Provider ID	If a member has a HH assignment with record type “referral” or a segment with a corresponding HH assignment with record type “referral”, that health home name and ID will be populated here. If a member does not have a HH with record type “referral”, these fields will be blank.*	
Referral Health Home Name		
Segment Record Type	Will always be populated	Will always be blank
Segment Status	Will always be populated	Will always be blank
Begin Date	Will always be populated	Will always be blank
End Date	Will be populated if the segment is closed	Will always be blank
End Date Reason	Will be populated if the segment is closed	Will always be blank
Consent Date	Will only be populated if consent date has been submitted for the member	Will always be blank
Pend Reason	Will only be populated if the segment is pended	Will always be blank
HARP	Will always be populated	
Pioneer ACO	Will always be populated	
Impacted Adult Home Member	Will always be populated	
Address 1	Will always be populated	
Address 2	Will always be populated	
City	Will always be populated	
State	Will always be populated	
Zip	Will always be populated	
Phone	Will always be populated	
County of Fiscal Responsibility Code	Will always be populated	
County of Fiscal Responsibility Description	Will always be populated	

My Members Fields	Segment Record	Assignment Record
Language	Will be populated if language information has been submitted into the member's evidence either by a user online or through the MCP Final HH Assignment file upload.	
Gender	Will always be populated	
Medicaid Eligibility End Date	Will always be populated	
DOH Composite Score	Will be populated if available	
Acuity Score	Will be populated if available	
Date of Patient Acuity	Will be populated if available	
Downloading Provider Assignment Created Date	Will always be blank	Will be populated with the member's assignment created date with the downloading provider
DOH Recommended HH	Will always be blank	Will only be populated when MCP downloads the file. When HH or CMA downloads the file, this field will be blank
Suggested Alt Assignment	Will always be blank	Will be populated when a downstream provider suggests an alternative assignment while rejecting an assignment. This field will always be blank when a CMA downloads this file

**For all members, only two of the four fields are populated, depending on the record type of the HH assignment. If the member has both an assignment and a referral, there will be two rows for the member in the download – one row populating the assignment related fields and the other row populated the referral related fields. Regardless of the user downloading the file, these fields are populated based on the data conditions described.*

Please use the logic below to determine the most recent assignment that will populate the* ***Assignment Created Date *field.*

1. *Does the member has a pending or active CMA assignment?*
    a. *Yes – CMA assignment created date displayed*
    b. No – see #2
2. *Does the member has a pending or active HH assignment?*
    a. *Yes – HH assignment created date displayed*
    b. No – see #3
3. *Does the member has a pending or active MCP assignment?*
    a. *Yes – MCP assignment created date displayed*
    b. No – field should be blank

Manage Assignments Download File

Description

This is a file that can only be downloaded by a user from the online ***Manage Assignments*** screen, which displays the members that have a *pended or pending* assignment/referral/transfer with the user's organization. To download this file, a user must navigate to the ***Manage Assignments*** screen in the system, use the filters on that page to identify the population that the user is interested in, and then hit the *Download Search Results* button. This will prompt the system to create a file matching the file format below containing the member assignments that meet the criteria selected by the user. ~~For more information about this screen, please see *Appendix O: Manage Assignments.*~~

Format

Manage Assignments Download File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Member ID	1	8	8	Y	AA11111A, Alphanumeric
2	Member First Name	9	30	38	Y	Alpha
3	Member Last Name	39	30	68	Y	Alpha
4	Record Type	69	10	78	Y	Alpha (Assignment, Referral, Transfer)
5	Status	79	7	85	Y	Alpha (Pending, Pended)
6	Created By	86	40	125	Y	Alpha
7	Source	126	20	145	Y	Alpha
8	Created Date	146	8	153	Y	MMDDYYYY, Numeric
9	Transfer Effective Date	154	8	161	C	MMDDYYYY, Numeric
10	Actor	162	40	201	Y	Alpha
11	Other	202	60	261	C	Alpha

CIN Search Download File

Description

This is a file that can only be downloaded by a user from the online ***Member CIN Search*** screen, which is accessible by all users in the system and allows a user to look up either an individual member or a group of members using the member's CIN. To download this file, a user must navigate to the ***Member CIN Search*** screen in the system, search for at least one member CIN and then hit the *Download Search Results* button. This will prompt the system to create a file matching the file format below containing information for the submitted member CINs. ~~For more information about this screen, please see *Appendix P: Member CIN Search.*~~

Format

CIN Search Download File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Member ID	1	8	8	Y	AA11111A, Alphanumeric

CIN Search Download File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
2	DOB	9	8	16	Y	MMDDYYYY, Numeric
3	Gender	17	1	17	Y	Alpha (M/F)
4	Medicaid Effective Date	18	8	25	~~Y~~C	MMDDYYYY, Numeric
5	Medicaid End Date	26	8	33	~~Y~~C	MMDDYYYY, Numeric
6	Medicaid Coverage Code	34	2	35	C	Numeric
7	Medicaid Coverage Description	36	40	75	C	Alpha
8	Managed Care Plan MMIS Provider ID	76	8	83	C	Numeric
9	Managed Care Plan Name	84	40	123	C	Alpha
10	Managed Care Plan Enrollment Date	124	8	131	C	MMDDYYYY, Numeric
11	Managed Care Plan Assignment Status	132	40	171	C	Alpha
12	Assigned Health Home MMIS Provider ID	172	8	179	C	Numeric
13	Assigned Health Home Name	180	40	219	C	Alpha
14	Assigned HH Assignment Status	220	40	259	C	Alpha
15	Enrolled Health Home MMIS Provider ID	260	8	267	C	Numeric
16	Enrolled Health Home Name	268	40	307	C	Alpha
17	Assigned CMA MMIS Provider ID	308	8	315	C	Numeric
18	Assigned CMA Name	316	40	355	C	Alpha
19	Assigned CMA Assignment Status	356	40	395	C	Alpha
20	Enrollment CMA MMIS Provider ID	396	8	403	C	Numeric
21	Enrollment CMA Name	404	40	443	C	Alpha
22	Segment Type	444	1	444	C	Alpha (O/E)
23	Segment Status	445	40	484	C	Alpha
24	Direct Biller Indicator	485	1	485	C	Alpha (Y/N)
25	Begin Date	486	8	493	C	MMDDYYYY, Numeric
26	End date	494	8	501	C	MMDDYYYY, Numeric
27	Provider 1 Service Date	502	8	509	C	MMDDYYYY, Numeric
28	Provider 1 Provider Name	510	40	549	C	Alpha
29	Provider 1 Address 1	550	40	589	C	Alphanumeric
30	Provider 1 Address 2	590	40	629	C	Alphanumeric
31	Provider 1 City	630	40	669	C	Alpha
32	Provider 1 State	670	2	671	C	Alpha
33	Provider 1 Zip	672	9	680	C	Numeric
34	Provider 1 Phone	681	10	690	C	Numeric
35	Provider 2 Service Date	691	8	698	C	MMDDYYYY, Numeric
36	Provider 2 Provider Name	699	40	738	C	Alpha
37	Provider 2 Address 1	739	40	778	C	Alphanumeric
38	Provider 2 Address 2	779	40	818	C	Alphanumeric
39	Provider 2 City	819	40	858	C	Alpha
40	Provider 2 State	859	2	860	C	Alpha
41	Provider 2 Zip	861	9	869	C	Numeric
42	Provider 2 Phone	870	10	879	C	Numeric

CIN Search Download File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
43	Provider 3 Service Date	880	8	887	C	MMDDYYYY, Numeric
44	Provider 3 Provider Name	888	40	927	C	Alpha
45	Provider 3 Address 1	928	40	967	C	Alphanumeric
46	Provider 3 Address 2	968	40	1007	C	Alphanumeric
47	Provider 3 City	1008	40	1047	C	Alpha
48	Provider 3 State	1048	2	1049	C	Alpha
49	Provider 3 Zip	1050	9	1058	C	Numeric
50	Provider 3 Phone	1059	10	1068	C	Numeric
51	Provider 4 Service Date	1069	8	1076	C	MMDDYYYY, Numeric
52	Provider 4 Provider Name	1077	40	1116	C	Alpha
53	Provider 4 Address 1	1117	40	1156	C	Alphanumeric
54	Provider 4 Address 2	1157	40	1196	C	Alphanumeric
55	Provider 4 City	1197	40	1236	C	Alpha
56	Provider 4 State	1237	2	1238	C	Alpha
57	Provider 4 Zip	1239	9	1247	C	Numeric
58	Provider 4 Phone	1248	10	1257	C	Numeric
59	Provider 5 Service Date	1258	8	1265	C	MMDDYYYY, Numeric
60	Provider 5 Provider Name	1266	40	1305	C	Alpha
61	Provider 5 Address 1	1306	40	1345	C	Alphanumeric
62	Provider 5 Address 2	1346	40	1385	C	Alphanumeric
63	Provider 5 City	1386	40	1425	C	Alpha
64	Provider 5 State	1426	2	1427	C	Alpha
65	Provider 5 Zip	1428	9	1436	C	Numeric
66	Provider 5 Phone	1437	10	1446	C	Numeric
67	Recent Care Management Biller 1 Provider ID	1447	8	1454	C	Numeric
68	Recent Care Management Biller 1 Provider Name	1455	40	1494	C	Alpha
69	Recent Care Management Biller 1 Service Date	1495	8	1502	C	MMDDYYYY, Numeric
70	Recent Care Management Biller 2 Provider ID	1503	8	1510	C	Numeric
71	Recent Care Management Biller 2 Provider Name	1511	40	1550	C	Alpha
72	Recent Care Management Biller 2 Service Date	1551	8	1558	C	MMDDYYYY, Numeric
73	Recent Care Management Biller 3 Provider ID	1559	8	1566	C	Numeric
74	Recent Care Management Biller 3 Provider Name	1567	40	1606	C	Alpha
75	Recent Care Management Biller 3 Service Date	1607	8	1614	C	MMDDYYYY, Numeric
76	Recent Care Management Biller 4 Provider ID	1615	8	1622	C	Numeric
77	Recent Care Management Biller 4 Provider Name	1623	40	1662	C	Alpha

CIN Search Download File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
78	Recent Care Management Biller 4 Service Date	1663	8	1670	C	MMDDYYYY, Numeric
79	Recent Care Management Biller 5 Provider ID	1671	8	1678	C	Numeric
80	Recent Care Management Biller 5 Provider Name	1679	40	1718	C	Alpha
81	Recent Care Management Biller 5 Service Date	1719	8	1726	C	MMDDYYYY, Numeric
82	Recent Care Management Biller 6 Provider ID	1727	8	1734	C	Numeric
83	Recent Care Management Biller 6 Provider Name	1735	40	1774	C	Alpha
84	Recent Care Management Biller 6 Service Date	1775	8	1782	C	MMDDYYYY, Numeric
85	Medicaid Recipient Exemption Code 1	1783	2	1784	C	Numeric
86	Medicaid Recipient Exemption Description 1	1785	40	1824	C	Alpha
87	Medicaid Recipient Exemption Code 2	1825	2	1826	C	Numeric
88	Medicaid Recipient Exemption Description 2	1827	40	1866	C	Alpha
89	Medicaid Recipient Exemption Code 3	1867	2	1868	C	Numeric
90	Medicaid Recipient Exemption Description 3	1869	40	1908	C	Alpha
91	Medicaid Recipient Exemption Code 4	1909	2	1910	C	Numeric
92	Medicaid Recipient Exemption Description 4	1911	40	1950	C	Alpha
93	Medicaid Recipient Exemption Code 5	1951	2	1952	C	Numeric
94	Medicaid Recipient Exemption Description 5	1953	40	1992	C	Alpha
95	Error Field	1993	40	2032	C	Alpha

Acuity Download File

Description

The Acuity Download file contains the Health Home adjusted acuity score history for the members that had at least one month of outreach or enrollment with the downloading provider (if HH or CMA downloading) or that had at least one month outreach or enrollment while a member of the downloading MCP.

For dates of service ~~prior to 1/1/16~~that are paid using the HML methodology, the adjusted acuity score is multiplied by the appropriate base rate to determine how much a 1386 or 1387 rate code claim will pay. The Acuity Download file does not include the base acuity score, which is a factor in a member's monthly HML determination. This file will become obsolete for service dates that are paid based on the HML methodology.

Format

Acuity Download						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Member ID	1	8	8	Y	AA11111A, Alphanumeric
2	Begin Date	9	8	16	Y	MMDDYYYY, Numeric
3	End Date	17	8	24	Y	MMDDYYYY, Numeric
4	Acuity Score	25	7	31	Y	00.0000, Numeric

Editing Logic

Records that contain an acuity score that does not have an end date will contain a value of '12319999' in the **End Date** field in the Acuity Download file.

Billing Support

The Billing Support functionality within the system enables CMAs, HHs, and MCPs to exchange billing information regarding **ALL** Health Home members, including Managed Care and Fee for Service members that are working with both converting CMAs and CMAs that are not converting providers. The Billing Support function available within the system is more robust and contains more member information than the Billing Support function available within the pre-MAPP HHTS. As a result, the Billing Support information that was entered into the Billing Support section of the pre-MAPP HHTS **will not be converted into the system's Billing Support section**. As a result, when a user signs into the Billing Support section of the system, the user will only see specific billing instance service dates depending on how the user's members' segments were submitted to DOH.

PLEASE NOTE THAT THE MAPP HHTS BILLING SUPPORT ONLY FACILITATES *THE EXCHANGE* OF HEALTH HOME BILLING INFORMATION. BILLING SUPPORT *DOES NOT SUBMIT A HEALTH HOME CLAIM* TO NYS MEDICAID.

A billing instance is a distinct month during which a Medicaid eligible member is either in outreach or enrollment in the system with a segment status of active, closed, or pended with segment pend reason code 01: Patient of Inpatient Facility (please see the **Health Homes Provider Manual: Billing Policy and Guidance** for more information regarding billing for members during an inpatient stay). A billing instance represents a month during which a member *could* receive a billable service; the existence of a billing instance *does not mean* that a billable service was provided to the member for the billing instance service date *nor that a Health Home claim should be submitted to eMedNY*. Billing instances are either potential, added, or voided. Potential billing instances are created by the system for all current and previous member months that meet the billing instance criteria. Billing instances are not created for future service dates.

For example, if a user logs into Billing Support on July 31, 2015, the user will see billing instances for their members that meet the billing instance criteria through July 1, 2015. The user will not see billing instances for service dates after July 1, 2015, even for members that meet the billing instance criteria and do not have a segment end date. When the user logs into Billing Support on August 1, 2015, the user will see billing instances for members that meet the billing instance criteria through August 1, 2015.

For member segments that were entered into the pre-MAPP HHTS and converted into the system, only billing instances for service dates on or after August 1, 2015 will be created, regardless of the converted member's segment begin date.

For example, in May 2015 Marco was entered into the pre-MAPP HHTS in an enrollment segment with HH B and CMA C with a begin date of May 1, 2015. As of September 5, 2015, Marco still has an active enrollment segment with HH B and CMA C. A user associated with HH B that signs into Billing Support on September 5, 2015 will see two billing instances for Marco: one for 8/1/15 and one for 9/1/15. Marco will not have billing instances for service dates 5/1/15-7/1/15 because Marco was originally entered into the pre-MAPP HHTS and therefore the system only created billing instances for Marco for service dates on or after August 1, 2015. In addition, even though Marco does not have an end date and will have a billing instance for October 2015 (unless his enrollment segment is end dated effective 9/30/15) users will not see Marco's 10/1/15 billing instance in the system until the user signs into the system in October.

For member segments that are directly entered into the system (were not originally entered into the pre-MAPP HHTS), the system will create a billing instance for every month that meets the billing instance criteria, going back to the segment's begin date.

For example, in May 2015 Jamie enrolled in the Health Home program with HH B and CMA C with a begin date of May 1, 2015. However, due to an administrative oversight, an enrollment segment was not created for Jamie within the pre-MAPP HHTS. On August 17, 2015, Jamie was entered into an enrollment segment within the system with a begin date of 5/1/15 with HH B and CMA C. As of September 10, 2015, Jamie still has an active enrollment segment with HH B and CMA C. A user associated with CMA C views Billing Support on September 10, 2015 and sees five billing instances for Jamie for service dates 5/1/15 through 9/1/15. Unlike Marco, Jamie will have billing instances going back to her begin date of 5/1/15 since she was enrolled directly into the system, not originally entered into the pre-MAPP HHTS and then converted into the system. In addition, even though Jamie does not have an end date and will have a billing instance in October 2015 (unless her segment is end dated effective 9/30/15), users will not see Jamie's 10/1/15 billing instance in the system until the user signs into the system in October.

Billing Support Upload File

Description

The purpose of the Billing Support Upload file is for a user to 1) indicate whether or not a billable service was provided for a billing instance service date or to void a previously added billing instance submission, and 2) to submit member information needed to support a Health Home claim for members that received a billable service.

The Billing Support Upload file is uploaded either by a CMA user or by a HH user on behalf of a CMA. A HH submitting this file on behalf of a CMA does not have to indicate that the file is being submitted on behalf a CMA. A HH submitting on behalf of numerous CMAs can either upload a separate file for each CMA or upload one file containing billing information for members associated with different CMAs. An MCP cannot upload the Billing Support Upload file; however, the data successfully submitted into the system in this file are included in the Billing Support Download file, which MCP, HH, and CMA users can download from the system.

Beginning with dates of service on or after September 1, 2015, organizations **MUST ATTEST THAT A BILLABLE SERVICE OCCURRED FOR A BILLING INSTANCE SERVICE DATE BY ADDING A MEMBER'S BILLING INSTANCE AND CONFIRMING THAT A BILLABLE SERVICE OCCURRED WITHIN BILLING SUPPORT PRIOR TO THE APPROPRIATE BILLER SUBMITTING THAT MEMBER'S MONTHLY HEALTH HOME CLAIM.** Although there is no edit in eMedNY that denies Health Home claims that are not correctly documented within Billing Support, DOH will compare submitted Health Home claims to Billing Support to identify providers that inappropriately submit Health Home

claims. These identified providers will have to either correct information submitted to the system or must void the inappropriately submitted claims.

As a reminder, through December 2015 converting CMAs will continue to bill eMedNY directly for both fee for service and managed care members to whom they provide Health Home services using either their legacy 18XX Health Home rate codes, the 1853 Health Home Plus rate code, or the regular Health Home rate codes 1386 and 1387; HHs will continue to bill eMedNY directly for fee for service members receiving services from CMAs that are not converting providers using the regular Health Home rate codes 1386 and 1387 or the 1853 Health Home Plus rate code; MCPs will continue to bill eMedNY directly for their plan members receiving services from CMAs that are not converting providers using the regular Health Home rate codes 1386 and 1387 or the 1853 Health Home Plus rate code. While providers are required to submit the High, Medium, Low (HML) Assessment per member per month for dates of service on or after October 1, 2015, providers will not submit claims to eMedNY under the new HML rate codes until dates of service on or after January 1, 2016.

Within the first few months of MAPP HHTS implementation, there are two possible ways that the Billing Support Upload file can be used depending on the billing instance service date and the submitting provider's preferences. The subsections below describe how providers can use the Billing Support Upload file based on a billing instance's service date.

Dates of Service prior to September 30, 2015

For billing instances with service dates prior to September 30, 2015, providers must submit the Billing Support Upload file containing records for all of their members that received a billable service. However, providers are not required to submit all the fields of the upload file for members with August and September 2015 dates of service.

At the very least, providers must submit fields 1) **Add/Void Indicator**, 2) **Member ID**, 3) **Service Date** and 28) **CMA Direct Biller Indicator**. Ideally, providers would also populate field 4) **Diagnosis Code** for all members, but this field is not required. For providers that decide not to complete the HML Assessment information and only submit the minimally required fields, **a record should only be submitted if a billable service was provided**. If a billable service is not provided for service dates prior to 10/1/15, then a record with a value of 'A' in the **Add/Void Indicator** field **should not** be submitted to the system.

Although providers are not *required* to submit HML Assessment information until October 1, 2015, *DOH strongly encourages* providers to submit HML Assessment information into MAPP HHTS **as soon as possible**. Many of the HML Assessment questions (fields 7-18, 20-27) are conditionally required, meaning that they are only required if you respond 'Yes' to a previous question. Please see the *Editing Logic* section below and *Appendix A: Field Descriptions* for more information on the High, Medium, Low (HML) monthly billing assessment fields.

Dates of Service on or after October 1, 2015

For dates of service on or after October 1, 2015, providers must submit the Billing Support Upload file containing HML Assessment information for all of their members. While providers will submit HML Assessment information for dates of service on or after October 1, 2015, converting programs will continue to bill eMedNY directly and providers will continue to bill the existing Health Home rate codes (18xx, 1386, 1387, 1853) through December 2015.

Many of the HML Assessment fields (7-18, 20-27) are conditionally required, meaning that they are only required if you respond 'Yes' to a previous question. Please see the *Editing Logic* section below and *Appendix A: Field Descriptions* for more information on the High, Medium, Low (HML) monthly billing assessment questions.

Format

This Billing Support Upload file format below includes two "Required" columns. Each column indicates the fields' "Required" statuses for a specific date of service range: 1) **Req'd** (for dates of service on or after October 1, 2015) and 2) **Required 8/1/15** (for August-September 2015 dates of service).

Billing Support Upload File								
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**	**Required 8/1/15**
1	Add/Void Indicator	1	1	1	Y	HH/CMA	Alpha (A/V)	Y
2	Member ID	2	8	9	Y	HH/CMA	AA11111A, Alphanumeric	Y
3	Service Date	10	8	17	Y	HH/CMA	MMDDYYYY, Numeric	Y
4	Diagnosis Code	18	10	27	N	HH/CMA	Alphanumeric	N
5	Pre-Conditions of member	28	16	43	C	HH/CMA	Numeric	C
6	Description of "Other" pre-condition	44	40	83	C	HH/CMA	Alphanumeric	C
7	HIV Status	84	1	84	Y	HH/CMA	Alpha (Y/N)	N
8	HIV Viral Load	85	1	85	C	HH/CMA	Numeric	N
9	HIV T-Cell Count	86	1	86	C	HH/CMA	Numeric	N
10	Member Housing Status	87	1	87	Y	HH/CMA	Alpha (Y/N)	N
11	HUD Category	88	1	88	C	HH/CMA	Numeric	N
12	Incarceration	89	1	89	Y	HH/CMA	Alpha (Y/N/U)	N
13	Incarceration Release Date	90	8	97	C	HH/CMA	MMDDYYYY, Numeric	N
14	Mental Illness	98	1	98	Y	HH/CMA	Alpha (Y/N/U)	N
15	Mental Illness Stay Discharge Date	99	8	106	C	HH/CMA	MMDDYYYY, Numeric	N
16	Substance Abuse	107	1	107	Y	HH/CMA	Alpha (Y/N/U)	N
17	Substance Abuse Discharge Date	108	8	115	C	HH/CMA	MMDDYYYY, Numeric	N
18	SUD Active Use/Functional Impairment	116	1	116	Y	HH/CMA	Alpha (Y/N)	N
19	Core Service Provided	117	1	117	Y	HH/CMA	Alpha (Y/N)	Y
20	AOT Member	118	1	118	Y	HH/CMA	Alpha (Y/N)	N
21	AOT Minimum Services Provided	119	1	119	C	HH/CMA	Alpha (Y/N)	N
22	ACT Member	120	1	120	Y	HH/CMA	Alpha (Y/N)	N
23	ACT Minimum Services Provided	121	1	121	C	HH/CMA	Alpha (Y/N)	N
24	AH Member qualifies for Adult Home Plus Care Management	122	1	122	C	HH/CMA	Alpha (Y/N)	N
25	AH Member transitioned to community	123	1	123	C	HH/CMA	Alpha (Y/N)	N

Billing Support Upload File								Required 8/1/15
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format	
26	AH Member continues to quality	124	1	124	C	HH/CMA	Alpha (Y/N)	N
27	AH Member interested in transitioning	125	1	125	C	HH/CMA	Alpha (Y/N)	N
28	CMA Direct Biller Indicator	126	1	126	Y	HH/CMA	Alpha (Y/N)	Y

Editing Logic

1. Please see field descriptions in *Appendix A: Field Descriptions* for field descriptions, accepted field values, and additional information on conditionally required Billing Support Upload file fields.
2. When submitting a record for a billing instance that is associated with an outreach segment, the following fields are the only fields that are required:
    a. When submitting a record for a billing instance that is associated with an outreach segment, the following fields are the only fields that are required for service dates prior to 10/1/15:
        i. Add/Void Indicator
        ii. Member ID
        iii. Service Date
        iv. CMA Direct Biller Indicator
    b. When submitting a record for a billing instance that is associated with an outreach segment, the following fields are the only fields that are required for service dates ~~prior to~~ on or after 10/1/15:
        i. Add/Void Indicator
        ii. Member ID
        iii. Service Date
        iv. Core Service Provided
        v. ACT Member (ACT Minimum Services Provided, if value of 'Y' in ACT Member field)
        vi. CMA Direct Biller Indicator

Acceptable service dates:

c. For member segments that were entered into the pre-MAPP HHTS, the system will only accept records for service dates on or after August 1, 2015 for which a billing instance with the submitting provider exists.
    i. Example: Marco was entered into the pre-MAPP HHTS on May 3, 2015 with an enrollment segment with HH B and CMA C with a begin date of 5/1/15 and no end date. On 8/17/15, a user from CMA B looks up Marco in Billing Support and sees that Marco has one billing instance for service date 8/1/15. On August 26, 2015 CMA C worker uploads a Billing Support Upload file containing three records with an **Add/Void Indicator** value of 'A' for Marco (service dates 7/1/15 - 9/1/15). The record for service date 8/1/15 is accepted, but the records for service dates 7/1/15 and 9/1/15 are rejected. The record for 7/1/15 is rejected because Marco's enrollment segment that spans service date 7/1/15 was submitted to the pre-MAPP HHTS and therefore a billing instance was not created within the system for Marco prior to service date 8/1/15. The record for 9/1/15 is rejected because the service date is in the future, which means there is not yet a billing instance in the system for Marco for 9/1/15.

d. For member segments that were directly entered into the system (were not entered into the pre-MAPP HHTS), the system will accept records for all service dates for which a billing instance with the submitting provider exists.
    i. Example: On June 20, 2015 Juan enrolled in the Health Home program with HH B and CMA C with a begin date of June 1, 2015. However, due to an administrative oversight, an enrollment segment was not created for Juan within the pre-MAPP HHTS. On 8/17/15, a HH B user enters an enrollment segment for Juan with HH B and CMA C with a begin date of 6/1/15 and an end date of 8/31/15 (Juan moved and was transferred to a new HH effective 9/1/15). The user sees in Billing Support that Juan has three billing instances (service dates 6/1/15, 7/1/15 and 8/1/15). On September 6, 2015, the user uploads a Billing Support Upload file containing four records for Juan for service dates 6/1/15 - 9/1/15. The records for service dates 6/1/15 - 8/1/15 are accepted because they correspond to billing instances for segments that were submitted for Juan into the system. However, the record for service date 9/1/15 is denied because Juan does not have a billing instance with HH B on 9/1/15.

3. The system will reject a record submitted for a member that does not have a billing instance with the submitting provider as of the submitted service date.
4. To indicate that a billable service was provided for a billing instance:
    a. For service dates prior to 10/1/15 when the HML fields are not populated
        i. Submit a record with a value of 'A' in the **Add/Void Indicator** field. Leave the **Core Service Provided** field blank; if the record is submitted with a value of 'N' in the **Core Service Provided** field, then the record will be rejected.
    b. For service dates prior to 10/1/15 when the HML fields **ARE** populated **OR** for service dates on or after 10/1/15
        i. Submit a record with a value of 'A' in the **Add/Void Indicator** field and a value of 'Y' in the **Core Service Provided** field.
5. To indicate that a billable service was **NOT** provided for a billing instance:
    a. For service dates prior to 10/1/15 when the HML fields are not populated
        i. Do not submit a record.
    b. For service dates prior to 10/1/15 when the HML fields **ARE** populated **OR** for service dates on or after 10/1/15
        i. Submit a record with a value of 'A' in the **Add/Void Indicator** field and a value of 'N' in the **Core Service Provided** field.
6. To indicate that a record previously submitted with a value of 'A' in the **Add/Void Indicator** field was submitted in error and should be voided, a record must be submitted containing an **Add/Void Indicator** value of 'V' and the **Member ID** & **Service Date** fields must match the values submitted in the original billing instance record that is being voided. The system will ignore fields 4-28 on the Billing Support Upload file (system will not validate or record values submitted in these fields) when the **Add/Void Indicator** contains a value of 'V'.
7. The system will reject a record containing an **Add/Void Indicator** value of 'A' submitted for a member and service date that has already been submitted with an **Add/Void Indicator** value of 'A'.
8. The system will reject a record containing an **Add/Void Indicator** value of 'V' for a member and service date for which no add indicator was previously submitted.
9. The system will reject a record containing an **Add/Void Indicator** value of 'V' submitted for a member and service date that has already been submitted with an **Add/Void Indicator** value of 'V'.

10. The system will reject a record submitted for a member that does not have a billing instance in the system with the submitting provider, even if the member is associated with the provider within the system as of the service date.
    a. Example – A record submitted for a member with a pended enrollment with a pend reason of incarceration will be rejected. Even though the member is associated and enrolled with the submitting provider as of the billing instance service date, the member does not have the appropriate segment status to qualify for a billing instance on the service date.
11. The system will reject a record submitted for a member that is not associated with the submitting provider as of the billing instance service date, regardless of the provider's association with the member during other service dates.
    a. Example – Tim is an MCP A member August –September, enrolled in HH B in August, and then enrolled in HH D in September. MCP A will see billing instance service dates for August and September. HH D can view and submit billing instance service date 9/1/15, but cannot view or submit billing instance service date 8/1/15. HH B can view and submit billing instance service date 8/1/15, but cannot view or submit billing instance service date 9/1/15.

Billing Support Error File

Description

This file is created upon validating or processing a Billing Support Upload file containing at least one error. A Billing Support Error file will not be created for a Billing Support Upload file that does not contain rejected records. The Billing Support Error file will contain one record for each record in the Billing Support Upload file that contains an error.

The **Error Reason** field will be populated with a description of why the record was rejected. The field will only contain one error description. If a record hits more than one error, only the first error will be displayed in the **Error Reason** field. This error file contains both file format errors and logic errors. For more information on Billing Support errors, please review the *Billing Support Upload: Editing Logic* section and *Appendix B: File Error Reason Codes*.

Format

Billing Support Error File							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
1	Original Record from File	1	140	140	Y	Ent'd	Alphanumeric
2	Error Reason	141	40	180	Y	Gen	Alpha

Billing Support Download File

Description

The purpose of the Billing Support Download file is to provide MCPs, HHs, and CMAs with monthly billing information for members that they are associated with in the MAPP HHTS. This file contains a combination of information that was submitted into the system by HHs and CMAs, supplied by NYS Medicaid, and generated by the system based on information supplied by HHs/CMAs and NYS Medicaid. Included in the file format is a column indicating the source of each field.

The Billing Support Download file contains a single record for each potential, added, and voided member billing instance that is associated with the downloading provider. For example, MCP A has a total of 5 billing instances in August and then 10 new billing instances are added to Billing Support in September. A billing file downloaded by MCP A on 8/20/15 will contain 5 records and a billing file downloaded by MCP A on 9/13/15 will contain 15 billing instances.

As stated previously, there are three types of billing instances: potential, added, and voided. A **potential billing instance** is a service date that meets the billing instance criteria and has therefore been created within the system as a billing instance, but has not yet been added to the system (user has not yet submitted a record containing the billing instance service date with a value of 'A' in the **Add/Void Indicator** field). An **added billing instance** is a service date that meets the billing instance criteria and has been added to the system (appropriate user submitted a record containing the billing instance service date with a value of 'A' in the **Add/Void Indicator** field). A **voided billing instance** is a service date that meets the billing instance criteria, was previously added to the system (appropriate user submitted a record containing the billing instance service date with a value of 'A' in the **Add/Void Indicator** field), but has since been voided (appropriate user submitted a record containing the billing instance service date with a value of 'V' in the **Add/Void Indicator** field for a previously added billing instance).

Potential billing instances are identified within the Billing Support Download file with a blank value in the **Add/Void Indicator** field. Added billing instances are identified within the Billing Support Download file with a value of 'A' in the **Add/Void Indicator** field. Voided billing instances are identified within the Billing Support Download file with a value of 'V' in the **Add/Void Indicator** field.

All billing instances start in a *potential* status in the system. This means that the Billing Support Download file will contain one record for each potential billing instance. Once a user submits an **Add/Void Indicator** value of 'A' for a potential billing instance, that potential billing instance record becomes an added billing instance record in the download and the blank **Add/Void Indicator** is field is updated to contain a value of 'A'. Within the newly downloaded Billing Support Download file, there is still only one record for that billing instance containing a value of 'A' in the **Add/Void Indicator** field. If that same billing instance is voided, then a **NEW** billing instance record is added to the Billing Support Download file to indicate to users that the previously added billing instance, and any claims submitted to eMedNY based on that added billing instance, need to be voided. This means that the billing instance will have **two records** within the Billing Support Download file: the original added billing instance and the voided billing instance. *The submission of a Billing Support Upload file with an **Add/Void Indicator** value of 'V' does not delete the previously uploaded record with an **Add/Void Indicator** value of 'A', it only adds an additional record to the Billing Support Download file showing that the previously added billing instance must be voided.*

For example, in August 2015 Tina, a member of MCP A, is enrolled in the Health Home Program with HH B and CMA C with a begin date of 8/1/15. On September 3, 2015, a user from MCP A downloads the Billing Support Download file and sees that Tina has two records within the file for service dates 8/1/15 and 9/1/15. Since neither of Tina's records in the Billing Support Download file have a value in the **Add/Void Indicator** field, MCP A user knows that these records represent Tina's potential billing instances and that the CMA has not yet added these billing instances to billing support. On September 10, 2015, a user from HH B submits a Billing Support Upload file on behalf of CMA C with two records for Tina containing a value of 'A' in the **Add/Void Indicator** field and a value of 'Y' in the **Core Service Provided** field for service dates 8/1/15 and 9/1/15. The MCP user downloads the Billing Support Download file on September 12, 2015 and sees that there are still two records for Tina in the file. Since both of Tina's records in the Billing Support Download file now have a value of 'A' in the **Add/Void Indicator** field a value of 'Y' in the **Core Service Provided** field, MCP A user knows that these billing instances were added and that services were provided. Therefore, MCP A submits claims to eMedNY for Tina for 8/1/15 and 9/1/15. On

September 30, 2015, CMA C user realizes that Tina did not receive a billable service in September and that the 9/1/15 billing instance needs to be voided, so CMA C submits a Billing Support Upload file for Tina for service date 9/1/15 with a value of 'V' in the **Add/Void Indicator** field. On September 31, 2015, MCP A downloads the Billing Support Download file and now sees **three** records for Tina:

1. service date 8/1/15; **Add/Void Indicator** 'A'; **Date HML Assessment Entered** 9/10/15
2. service date 9/1/15; **Add/Void Indicator** 'A'; **Date HML Assessment Entered** 9/10/15
3. service date 9/1/15; **Add/Void Indicator** 'V'; **Date HML Assessment Entered** 9/30/15

This indicates to the MCP A user that the billing instance added for service date 9/1/15 on 9/10/15 was added in error. Since MCP A already submitted to eMedNY a Health Home claim for Tina for 9/1/15, this indicates to the MCP A that the 9/1/15 Health Home claim must be voided. Both the original added billing instance record and the subsequent voided billing instance record are included in the download file and will remain in the download file so that MCP A has a record to support why the original claim was submitted to eMedNY for Tina for 9/1/15 and documentation to support why MCP A voided Tina's 9/1/15 claim.

For the first few months of MAPP HHTS implementation, the Billing Support Download file will be populated differently, depending on the billing instance service date. The subsections below describe how fields will be populated in the Billing Support Download file based on the billing instance's service date.

Service Dates of ~~Service~~ August 1, 2015 – September 30, 2015

For service dates of ~~service~~ 8/1/15 and 9/1/15, CMAs and HHs are able to submit HML Assessment fields on their Billing Support Upload file, but they are not required to submit values in these fields. As a result, the 8/1/15 and 9/1/15 added billing instances included on a Billing Support Download file may or may not include values in the HML Assessment fields. Any HML Assessment field that is conditionally required and therefore not required on the Billing Support Upload file will contain either a value of '0' or will be blank (please see the *Editing Logic* section for more information) on the Billing Support Download file if the provider submitted HML Assessment information, but did not have to respond to the field due to the conditional requirements explained in the *Billing Support Upload* section and in the field descriptions in *Appendix A*. If a member's HH/CMA decides not to complete the HML Assessment fields for these billing instances, then the **Rate Description** and **Rate Amount** fields on the download will be blank. In addition, the **Rate Code** field and the payment verification fields (57-68) will be blank for August – December 2015 service dates, since this feature will not be available until providers start billing the HML Health Home rate codes effective January 1, 2016.

Another function of the Billing Support Download is to display the provider that is responsible for submitting a Health Home claim to eMedNY for a member's billing instance service date. **PLEASE NOTE THAT THE MAPP HHTS BILLING SUPPORT ONLY FACILITATES THE EXCHANGE OF HEALTH HOME BILLING INFORMATION. BILLING SUPPORT DOES NOT SUBMIT A HEALTH HOME CLAIM TO NYS MEDICAID**. The appropriate biller's provider information is displayed in fields **Billing Entity MMIS ID** and **Billing Entity Name** for added billing instances with a value of 'Y' in the **Core Service Provided** field. The system uses the following logic to determine the **Billing Entity MMIS ID** and **Billing Entity Name** for each added billing instance:

1. Does the member have a value of 'Y' in the **CMA Direct Biller Indicator** field?
    a. Yes – CMA is biller
    b. No – see #2
2. Is the member enrolled in a Mainstream Managed Care Plan?
    a. Yes – MCP is biller

b. No - Health Home is biller (for both FFS members and members enrolled in non-mainstream MC Plans)

Service Dates of ~~Service~~ October 1, 2015 – December 31, 2015

For service dates of ~~service~~ 10/1/15 - 12/1/15, CMAs and HHs are required to submit HML Assessment fields on their Billing Support Upload file. HML Assessment fields that are conditionally required and therefore do not always need to be populated on the Billing Support Upload file will contain either a value of '0' or will be blank (please see *Appendix H: High, Medium, Low (HML) Assessment* for more information) on the Billing Support Download file if the provider submitted HML Assessment information but did not have to respond to the field due to the conditional requirements explained in the *Billing Support Upload* section and in the field descriptions in *Appendix A*. In addition, the **Rate Code** field and the payment verification fields (57-68) will be blank for August – December 2015 service dates, since this feature will not be available until providers start billing the HML Health Home rate codes effective January 1, 2016.

Another function of the Billing Support Download is to display the provider that is responsible for submitting a Health Home claim to eMedNY for a member's billing instance service date. The appropriate biller's provider information is displayed in fields **Billing Entity MMIS ID** and **Billing Entity Name** for added billing instances with a value of 'Y' in the **Core Service Provided** field. The system determines the appropriate **Billing Entity MMIS ID** and **Billing Entity Name** for 10/1/15-12/1/15 dates of service using the same logic used for dates of service 8/1/15 and 9/1/15:

1. Does the member have a value of 'Y' in the **CMA Direct Biller Indicator** field?
    a. Yes – CMA is biller
    b. No – see #2
2. Is the member enrolled in a Mainstream Managed Care Plan?
    a. Yes – MCP is biller
    b. No - Health Home is biller (for both FFS members and members enrolled in non-mainstream MC Plans)

Service Dates ~~of Service~~ on or after January 1, 2016

The Billing Support Download file for dates of service on or after January 1, 2016 is the same as the files downloaded for dates of service 10/1/15 – 12/1/15, except that the logic used to determine the appropriate biller is different (see the flowchart in Appendix J: Determining the Billing Entity Post 1/1/16) and the **Payment Verification** fields are now populated.

Once providers start to submit claims under the Health Home HML rate codes with dates of service on or after 1/1/16, the system will start to populate the payment verification fields (57 – 68). Once a billing instance is added to the system indicating that a billable service was provided for a service date, the system will start querying NYS Medicaid claim information to identify specific paid or denied Health Home claims that are associated with a member's billing instance service date. Once a claim is submitted to eMedNY, it takes about a week or so for the system to access and pull that claim information into billing support.

While only one member will be reimbursed for a member's Health Home service for a specific month, it's possible that more than one denied claim exists in the NYS Medicaid claims system for a member's billing instance service date. As a result, the system uses the logic outlined below to determine what claim information should be displayed within Billing Support.

1. Are there any paid claims in the system?
    a. Yes:
        i. The system will populate fields 57 - 66 based on the paid claim in the system for the member's billing instance service date.
        ii. The system will compare the expected rate code (field #54 **Rate Code**) to the rate code on the paid claim (field #66 **Paid Claim Rate Code**). If the rate codes match, field #68 **Paid Claim Rate Code equals MAPP HML Rate Code** will be populated with a value of 'Y'. If the rate codes do not match, field #68 **Paid Claim Rate Code equals MAPP HML Rate Code** will be populated with a value of 'N'.
        iii. The system will compare the expected billing MMIS provider ID (field #20 **Billing Entity MMIS ID**) to the MMIS provider ID on the paid claim (field #64 **Paid Claim Provider ID**). If the MMIS provider IDs match, field #67 **Paid Claim Provider ID equals MAPP Billed Entity MMIS ID** will be populated with a value of 'Y'. If the MMIS provider IDs do not match, field #67 Paid Claim Provider ID equals MAPP Billed Entity MMIS ID will be populated with a value of 'N'.
    b. No – see #2
2. Are there any denied claims in the system?
    a. Yes – see # 3
    b. No – fields 57-68 will be blank
3. Did the billing provider identified in fields 20/21 submit the denied claim?
    a. Yes:
        i. The system will populate fields 57 - 66 based on the denied claim in the system for the member's billing instance service date.
        ii. The system will compare the expected rate code (field #54 **Rate Code**) to the rate code on the denied claim (field #66 **Paid Claim Rate Code**). If the rate codes match, field #68 **Paid Claim Rate Code equals MAPP HML Rate Code** will be populated with a value of 'Y'. If the rate codes do not match, field #68 **Paid Claim Rate Code equals MAPP HML Rate Code** will be populated with a value of 'N'.
        iii. The system will compare the expected billing MMIS provider ID (field #20 **Billing Entity MMIS ID**) to the MMIS provider ID on the denied claim (field #64 **Paid Claim Provider ID**). If the MMIS provider IDs match, field #67 **Paid Claim Provider ID equals MAPP Billed Entity MMIS ID** will be populated with a value of 'Y'. If the MMIS provider IDs do not match, field #67 Paid Claim Provider ID equals MAPP Billed Entity MMIS ID will be populated with a value of 'N'.
    b. No – fields 57-68 will be blank

Format

Billing Support Download File								Required	
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**	**Aug '15**	**Oct '15**
1	Add/Void Indicator	1	1	1	Y	HH/CMA	Alpha (A/V,Null)	Y	Y
2	Member ID	2	8	9	Y	HH/CMA	AA111111A, Alphanumeric	Y	Y
3	Service Date	10	8	17	Y	HH/CMA	MMDDYYYY, Numeric	Y	Y
4	Health Home MMIS ID	18	8	25	Y	HH/CMA	Numeric	Y	Y

Billing Support Download File								Required	
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format	Aug '15	Oct '15
5	Outreach/Enrollment Code	26	1	26	Y	HH/CMA	Alpha (O/E)	Y	Y
6	Member Fiscal County Code	27	2	28	Y	M'caid	Numeric	Y	Y
7	Managed Care Organization MMIS ID	29	8	36	C	M'caid	Numeric	C	C
8	Adjusted Acuity Score as of Service Date	37	7	43	C	M'caid	00.0000, Numeric	C	C
9	Diagnosis Code	44	10	53	N	HH/CMA	Alphanumeric	N	N
10	Medicaid Eligibility Status	54	1	54	Y	M'caid	Alpha (Y/N)	Y	Y
11	Pend Reason Code	55	2	56	C	HH/CMA	Numeric	C	C
12	Pend Reason Code Description	57	40	96	C	HH/CMA	Alphanumeric	C	C
13	Member Fiscal County Code Description	97	40	136	Y	M'caid	Alphanumeric	Y	Y
14	Date HML Assessment Entered	137	8	144	Y	Gen	MMDDYYYY, Numeric	C	Y
15	Care Management Agency Name	145	40	184	Y	Gen	Alpha	Y	Y
16	Care Management Agency ID	185	8	192	Y	HH/CMA	Alphanumeric	Y	Y
17	CMA Direct Biller Indicator	193	1	193	Y	HH/CMA	Alpha (Y/N)	Y	Y
18	Health Home Name	194	40	233	Y	Gen	Alphanumeric	Y	Y
19	Managed Care Plan Name	234	40	273	C	M'caid	Alphanumeric	C	C
20	Billing Entity MMIS ID	274	8	281	Y	Gen	Numeric	C	Y
21	Billing Entity Name	282	40	321	Y	Gen	Alphanumeric	C	Y
22	Member Zip Code	322	9	330	Y	M'caid	Numeric	Y	Y
23	Member First Name	331	30	360	Y	M'caid	Alpha	Y	Y
24	Member Last Name	361	30	390	Y	M'caid	Alpha	Y	Y
25	Member DOB	391	8	398	Y	M'caid	MMDDYYYY, Numeric	Y	Y
26	Member Gender	399	1	399	Y	M'caid	Alpha (M/F)	Y	Y
27	Base Acuity Score as of Service Date	400	7	406	C	M'caid	00.0000, Numeric	C	C
28	Pre-Conditions of member	407	16	422	C	HH/CMA	Numeric	C	C
29	Description of "Other" pre-condition	423	40	462	C	HH/CMA	Alphanumeric	C	C
30	Risk	463	6	468	C	M'caid	Numeric	C	C
31	Current HARP Status	469	2	470	Y	M'caid	Alpha (Blank, EL, or EN)	Y	Y
32	HIV Status	471	1	471	Y	HH/CMA	Alpha (Y/N)	C	Y
33	HIV Viral Load	472	1	472	C	HH/CMA	Numeric	C	C
34	HIV T-Cell Count	473	1	473	C	HH/CMA	Numeric	C	C
35	Member Living Status	474	1	474	Y	HH/CMA	Alpha (Y/N)	C	Y
36	HUD Category	475	1	475	C	HH/CMA	Numeric	C	C
37	Incarceration	476	1	476	Y	HH/CMA	Alpha (Y/N)	C	Y
38	Incarceration Release Date	477	8	484	C	HH/CMA	MMDDYYYY, Numeric	C	C

Billing Support Download File								Required	
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format	Aug '15	Oct '15
39	Mental Illness	485	1	485	Y	HH/CMA	Alpha (Y/N)	C	Y
40	Mental Illness Stay Discharge Date	486	8	493	C	HH/CMA	MMDDYYYY, Numeric	C	C
41	Substance Abuse	494	1	494	Y	HH/CMA	Alpha (Y/N)	C	Y
42	Substance Abuse Stay Discharge Date	495	8	502	C	HH/CMA	MMDDYYYY, Numeric	C	C
43	SUD Active Use/Functional Impairment	503	1	503	Y	HH/CMA	Alpha (Y/N)	C	Y
44	Core Service Provided	504	1	504	Y	HH/CMA	Alpha (Y/N)	Y	Y
45	AOT Member	505	1	505	Y	HH/CMA	Alpha (Y/N)	C	Y
46	AOT Minimum Services Provided	506	1	506	C	HH/CMA	Alpha (Y/N)	C	C
47	ACT Member	507	1	507	Y	HH/CMA	Alpha (Y/N)	C	Y
48	ACT Services Provided	508	1	508	C	HH/CMA	Alpha (Y/N)	C	C
49	Impacted Adult Home Class Member	509	1	509	Y	M'caid	Alpha (Y/N)	C	Y
50	AH Member qualifies for Adult Home Plus Care Management	510	1	510	C	M'caid	Alpha (Y/N)	C	Y
51	AH Member transitioned to community	511	1	511	C	HH/CMA	Alpha (Y/N)	C	C
52	AH Member continues to quality	512	1	512	C	HH/CMA	Alpha (Y/N)	C	C
53	AH Member interested in transitioning	513	1	513	C	HH/CMA	Alpha (Y/N)	C	C
54	Rate Code	514	4	517	Y	Gen	Numeric	N	N
55	Rate Description	518	30	547	Y	Gen	Alphanumeric	C	Y
56	Rate Amount	548	7	554	Y	Gen	Numeric, "0000.00"	C	Y
57	Claim Status	555	1	555	Y	M'caid	Alpha (P/D/Blank)	N	N
58	Date of Transaction	556	8	563	C	M'caid	MMDDYYYY, Numeric	N	N
59	Payment Cycle	564	4	567	C	M'caid	Numeric	N	N
60	Denial Reason Code	568	4	571	C	M'caid	Numeric	N	N
61	Denial Reason Code Description	572	25	596	C	M'caid	Alphanumeric	N	N
62	Denial Reason Code (2)	597	4	600	C	M'caid	Numeric	N	N
63	Denial Reason Code Description (2)	601	25	625	C	M'caid	Alphanumeric	N	N
64	Paid Claim Provider ID	626	8	633	C	M'caid	Numeric	N	N
65	Paid Claim Provider Name	634	40	673	C	M'caid	Alphanumeric	N	N
66	Paid Claim Rate Code	674	4	677	C	M'caid	Numeric	N	N
67	Paid Claim Provider ID equals MAPP Billed Entity MMIS ID	678	1	678	C	Gen	Alpha (Y/N)	N	N
68	Paid Claim Rate Code equals MAPP HML Rate Code	679	1	679	C	Gen	Alpha (Y/N)	N	N

Billing Support Download File								Required	
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format	Aug '15	Oct '15
69	Latest Transaction	680	1	680	R	Gen	Alpha (Y/N)	R	R

Editing Logic

1) The **Medicaid Eligibility Status** field will display the member's status as of the billing instance service date.
2) The Billing Support Download file only contains members that are associated with the downloading provider as of the service date
   a) Example – Marco is an MCP A member August –September. Marco is enrolled in HH B in August and then enrolled in HH D in September. MCP A will see billing instance service dates for August and September in the Billing Support Download file. HH D will see billing instance service date 9/1/15 in the Billing Support Download file. HH B can will see billing instance service date 8/1/15 in the Billing Support Download file.
3) Deleted Segments
   a) If a **potential billing instance's** corresponding segment is deleted, then the **potential billing instance** will no longer exist within the system. There will be no record of the **potential billing instance** within the system or on the downloaded file.
      i) John enrolled beginning 7/1/15. The 7/1/15 billing instance was never added. In July, the billing download file contains a record for John for a potential 7/1/15 billing instance. In August, John's 7/1/15 enrollment segment is deleted. The billing file downloaded in August does not contain a 7/1/15 billing instance for John.
   b) If an **added billing instance's** corresponding segment is deleted, then the **added billing instance** will remain within the system and the system will automatically create **a NEW voided billing instance** for that member/service date.
      i) Miriam enrolled 7/1/15 and a billing instance was added in July. In July, the billing download file contains a record for Miriam's added 7/1/15 billing instance. In August, Miriam's 7/1/15 enrollment segment is deleted. The billing file downloaded in August contains 2 records for Miriam:
         (1) 7/1/15 billing instance with value of 'A' **Add/Void Indicator** field
         (2) 7/1/15 billing instance with value of 'V' **Add/Void Indicator** field
   c) If a **voided billing instance's** corresponding segment is deleted, then the **voided billing instance** will remain within the system.
      i) Wayne enrolled 7/1/15 and a billing instance was added in July. In July, the billing download file contains a record for Wayne's added 7/1/15 billing instance. In August, Wayne's 7/1/15 billing instance is voided. The billing file downloaded in August contains both an added and a voided record for Wayne's 7/1/15 billing instance. In September, Wayne's 7/1/15 enrollment segment is deleted. In September, the billing download file contains 2 records for Wayne:
         (1) 7/1/15 billing instance with value of 'A' **Add/Void Indicator** field
         (2) 7/1/15 billing instance with value of 'V' **Add/Void Indicator** field

4) The Pend Reason Code and Pend Reason Code Description will be blank for all billing instances that are not in Pend status on the billing instance service date.
5) The Billing Support Download file will include all potential, added, and voided billing instances without date limits. This means that each month new potential billing instances will be included in the Billing Support Download file for members that meet the billing instance criteria for that month and records will be added anytime an added billing instance is voided. Once a user adds a billing instance into the system, it will always be included in the Billing Support Download file.
6) Conditionally Required Fields
   a) The following fields are populated with a value of '0' if they were not required on the Billing Support Upload file. The following fields are will be populated with a value of '0' if they were not required on the Billing Support Upload file. If these non-required fields were populated on the Billing Support Upload by the submitting provider, then the system will ignore the values submitted in these fields on the Billing Support Upload file and these fields will populate these fields with a value of '0' on the Billing Support Download file.
   b) HIV Viral Load
   c) HIV T-Cell Count
   d) HUD Category
7) For a record submitted with a service date prior to 10/1/15 that did not include HML information, the **Core Services Provided** field on the Billing Support Download file will be populated with a value of 'Y', even if the **Core Services Provided** field was blank in the Billing Support Upload file.
8) The following fields ~~are~~ will be blank if they were not required on the Billing Support Upload file. If these non-required fields were populated on the Billing Support Upload by the submitting provider, then the system will ignore the values submitted in these fields on the Billing Support Upload file and these fields will be blank on the Billing Support Download file.
   a) Incarceration Release Date
   b) Mental Illness Stay Discharge Date
   c) Substance Abuse Stay Discharge Date
   d) AOT Minimum Services Provided
   e) ACT Services Provided
   f) ~~UAS Assessment~~ AH Member qualifies for Adult Home Plus Care Management ~~Date~~
   g) ~~Assessment~~ AH Member transitioned to community ~~Refused~~
   h) ~~Date UAS Assessment~~ AH Member continues to quality ~~Refused~~
   ~~h)~~i) AH Member interested in transitioning
9) The following fields will be blank for dates of service prior to 10/1/15 if the submitting provider did not respond to the HML assessment questions:
   a) HIV Status
   b) HIV Viral Load
   c) HIV T-Cell Count
   d) Member Living Status
   e) HUD Category
   f) Incarceration
   g) Incarceration Release Date
   h) Mental Illness
   i) Mental Illness Stay Discharge Date
   j) Substance Abuse
   k) Substance Abuse Stay Discharge Date

l) SUD Active Use/Functional Impairment
m) AOT Member
n) AOT Minimum Services Provided
o) ACT Member
p) ACT Services Provided
q) Impacted Adult Home
r) Class Member
s) ~~UAS Assessment~~ AH Member qualifies for Adult Home Plus Care Management ~~Date~~
t) ~~Assessment~~ AH Member transitioned to community ~~Refused~~
u) ~~Date UAS Assessment~~AH Member continues to quality ~~Refused~~
~~u)~~v) AH Member interested in transitioning
~~v)~~w)Rate Description
~~w)~~x)Rate Amount

10) **Latest Transaction** field
    a) Used to indicate which Billing Instance for a service date is most recent, based on date and time of the HML submission. Value of 'Y' means that the record is the most recent record.

Partner Network Files

Partner Network File Upload

Description

This file is uploaded into the system by HHs only. MCPs and CMAs cannot upload this file into the system. The HHs use this file to submit to the system their network of providers. While this file must include the CMAs that a HH is working with, it must also include the HHs network of providers that have agreed to work with the HH to coordinate all of a member's needs. This information uploaded in this file serves three purposes:

1. DOH first reviewed this list during the initial Health Home application review to determine if provider had an adequate network to be designated as a Health Home. DOH continues to monitor this list to ensure that all designated HHs maintain a diverse and robust network or providers that are available to work with Health Home members.
2. DOH uses this network list to create member's Health Home assignments by comparing the NPIs listed in this file to a member's claim and encounter information to determine which HH has the best connection to the providers that the member has an existing relationship with.
3. These lists are posted to the Health Home website for community members to use when assisting a community referral in picking a Health Home.

This is a full file replacement, meaning that every time this file is uploaded it must include all providers that are currently working with the HH. This file must be uploaded every time a provider relationship with the HH either begins or ends.

Format

Partner Network File Upload						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Partner NPI	1	10	10	N	Numeric

Partner Network File Upload						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
2	Submitted Partner Name	11	100	110	N	Alpha
3	Begin Date	111	8	118	Y	MMDDYYYY, Numeric
4	Physician Indicator	119	1	119	Y	Alpha (N/Y)
5	Medical Services Provider	120	1	120	Y	Alpha (N/Y)
6	Hospital	121	1	121	Y	Alpha (N/Y)
7	OASAS Services	122	1	122	Y	Alpha (N/Y)
8	OMH Services	123	1	123	Y	Alpha (N/Y)
9	HIV/AIDS Provider	124	1	124	Y	Alpha (N/Y)
10	ACT	125	1	125	Y	Alpha (N/Y)
11	Community Services and Supports	126	1	126	Y	Alpha (N/Y)
12	Corrections	127	1	127	Y	Alpha (N/Y)
13	Housing	128	1	128	Y	Alpha (N/Y)
14	Local Government Unit (LGU)/Single Point of Access (SPOA)	129	1	129	Y	Alpha (N/Y)
15	Social Service District Office	130	1	130	Y	Alpha (N/Y)
16	DDSO	131	1	131	Y	Alpha (N/Y)
17	Residence	132	1	132	Y	Alpha (N/Y)
18	OPWDD Services	133	1	133	Y	Alpha (N/Y)
19	Pediatric Provider	134	1	134	Y	Alpha (N/Y)
20	Early Intervention Provider	135	1	135	Y	Alpha (N/Y)
21	OT/PT/Speech	136	1	136	Y	Alpha (N/Y)
22	Foster Care	137	1	137	Y	Alpha (N/Y)

Partner Network File Error Report

Description

This file is created upon validating or processing a Partner Network File Upload file containing at least one error. A Partner Network File Error Report file will not be created for an uploaded network file that does not contain rejected records. The Partner Network File Error Report file will contain one record for each record in the uploaded Tracking File that contains an error.

Format

Partner Network File Error Report						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
1	Submitted Line	1	6	6	Y	Numeric
2	Original Record from File	7	137	143	Y	Alpha
3	Error	144	20	163	Y	Alpha

Editing Logic

The **Error** field will be populated with a description of why the record was rejected. The field will only contain one error description. If a record hits more than one error, only the first error will be displayed in the **Error Reason** field. This error file contains both file format errors and logic errors. For more information on Partner Network File Upload errors, please see *Appendix B: File Error Reason Codes*.

Partner Network File Download

Description

This file contains the information submitted into the system by the HH on the Partner Network File Upload file, in addition to a few fields added to the file by DOH to provide official NYS Medicaid information regarding the provider, if applicable.

Format

Partner Network File Download						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
1	Partner NPI	1	10	10	C	Numeric
2	Is Partner NPI enrolled in NYS Medicaid?	11	1	11	Y	Alpha (N/Y)
3	Name associated with Partner NPI per NYS Medicaid	12	70	81	C	Alpha
4	Submitted Partner Name	82	100	181	C	Alpha
5	Begin Date	182	8	189	Y	MMDDYYYY, Numeric
6	Physician Indicator	190	1	190	Y	Alpha (N/Y)
7	Medical Services Provider	191	1	191	Y	Alpha (N/Y)
8	Hospital	192	1	192	Y	Alpha (N/Y)
9	OASAS Services	193	1	193	Y	Alpha (N/Y)
10	OMH Services	194	1	194	Y	Alpha (N/Y)
11	HIV/AIDS Provider	195	1	195	Y	Alpha (N/Y)
12	ACT	196	1	196	Y	Alpha (N/Y)
13	Community Services and Supports	197	1	197	Y	Alpha (N/Y)
14	Corrections	198	1	198	Y	Alpha (N/Y)
15	Housing	199	1	199	Y	Alpha (N/Y)
16	Local Government Unit (LGU)/Single Point of Access (SPOA)	200	1	200	Y	Alpha (N/Y)
17	Social Service District Office	201	1	201	Y	Alpha (N/Y)
18	DDSO	202	1	202	Y	Alpha (N/Y)
19	Residence	203	1	203	Y	Alpha (N/Y)
20	OPWDD Services	204	1	204	Y	Alpha (N/Y)
21	Pediatric Provider	205	1	205	Y	Alpha (N/Y)
22	Early Intervention Provider	206	1	206	Y	Alpha (N/Y)
23	OT/PT/Speech	207	1	207	Y	Alpha (N/Y)
24	Foster Care	208	1	208	Y	Alpha (N/Y)

Editing Logic

Field numbers 2 (**Is Partner NPI enrolled in NYS Medicaid?**) and 3 (**Name associated with Partner NPI per NYS Medicaid**) added to this file by DOH, for NPIs submitted on the Partner Network File Upload file that are enrolled in NYS Medicaid. If a submitted NPI is not enrolled in NYS Medicaid, then these two fields will be blank.

Appendix A: Field Descriptions

Listed below are field descriptions along with acceptable values, field formatting, and editing logic (if applicable). Please note that (Y/N) stand for Yes/No, unless otherwise stated. All other codes used within MAPP HHTS files are defined within the field descriptions below.

This key is used on each field to show the file types that the field appears on and which direction the field is transmitted.

A	Acuity Download	**MMD**	My Members Download
BD	Billing Support Download	**PND**	Partner Network Download
BE	Billing Support Error	**PNE**	Partner Network Error
BU	Billing Support Upload	**PNU**	Partner Network Upload
CD	CIN Search Download	**PAD**	Past Assignments Download
ED	Enrollment Download	**TFA**	Tracking File Assignment Records
EFA	Error Report: MCP Final HH Assignment	**TFE**	Tracking File Error
HHA	Health Home Assignment	**TFS**	Tracking File Segment Records
MAD	Managed Assignments Download	**TFD**	Tracking File Delete Record
MA	Managed Care Plan Assignment	↑	Files Uploaded to MAPP HHTS
MFA	MCP Final HH Assignment	↓	Files Downloaded from MAPP HHTS

ACT (Assertive Community Treatment) **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Description: This field is submitted to the Partner Network section of the system by HHs. HHs use this field to indicate providers in a HH's network that operate Assertive Community Treatment programs. The ACT indicator field included in the Partner Network Download file comes from the value submitted on the Partner Network Upload file. For more information on ACT services, please visit the NYS Office of Mental Health Assertive Community Treatment website: http://bi.omh.ny.gov/act/index

Editing Logic: This field must contain a value of either N or Y on the Partner Network Upload file or the record will be rejected. The system **does not** validate that an NPI submitted with a value of 'Y' in the **ACT** field is an ACT provider according to NY Medicaid.

ACT Member **↓BD ↑BU**

Field Length: 1

Format: Alpha (N/Y)

Description: This field is submitted by CMAs or by HHs on behalf of CMAs. Providers use this field to indicate members that are receiving Health Home services from an ACT (Assertive Community Treatment) CMA during the billing instance service month. For more information on ACT services, please visit the NYS Office of Mental Health Assertive Community Treatment website: http://bi.omh.ny.gov/act/index

Editing Logic: If a provider submits a record with a value of 'Y' in the **ACT Member** field in the Billing Support Upload file for a billing instance associated with a CMA that is not an ACT provider, then the system will accept the record, but will ignore the 'Y' value submitted in the **ACT Member** field in the Billing Support Upload file.

ACT Minimum Services provided/ACT Services Provided **↓BD ↑BU**

Field Length: 1

Format: Alpha (N/Y)

Description: This field is used by ACT providers to indicate whether or not their Health Home enrolled members received the minimum required ACT services. For more information on ACT services, please visit the NYS Office of Mental Health Assertive Community Treatment website: http://bi.omh.ny.gov/act/index

Editing Logic: If field #22 **ACT Member** on the Billing Support Upload file contains a value of 'Y', then field #23 **ACT Minimum Services Provided** must be populated with either 'Y' for yes the minimum required services were provided or 'N' for no the minimum required services were not provided. If field #22 **ACT Member** of the Billing Support Upload file contains a value of 'N', then this field should be blank and the system will ignore any value populated in this field.

Actor **↓MAD**

Field Length: 40

Format: Alpha

Description:

Editing Logic:

Address 1/ Address 2 **↓HHA ↓MA ↓MMD**

Field Length: 40

Format: Alphanumeric

Description: The most recent NYS Medicaid member contact information from NYS Medicaid's Medicaid Data Warehouse. If this information is incorrect, work with the member to correct this information corrected with NYS Medicaid. For more information on how to change member Medicaid information, please see *Appendix M: Reference and Contacts* (same as ***DOH MDW Address 1/2*** and ***MDW Member Address 1/2***).

Add/Void Indicator **↓BD ↑BU**

Field Length: 1

Format: Alpha (A/V) or Blank

Description: This field is used to indicate that a billing instance should move either from a potential billing instance (blank value in field) to an added billing instance (value of 'A' in the field) or from an added billing instance to a voided billing instance (value of 'V' in the field).

Editing Logic: The submission of a Billing Support Upload file with an **Add/Void Indicator** value of 'V' does not delete the previously uploaded record with an **Add/Void Indicator** value of 'A', it only adds an additional record to the Billing Support Download file showing that the previously added billing instance must be voided. For a detailed explanation of how this field works, please see the *Billing Support Download* section of this document.

Adjusted Acuity Score as of Service Date **↓BD**

Field Length: 7

Format: 00.0000, Numeric

Description: This is the member acuity score that is multiplied by the appropriate base rate within eMedNY to a 1386 or 1387 Health Home claim payment. To calculate the adjusted acuity scores, members are first grouped using the 3M Clinical Risk Group software. Each group is then assigned a base acuity score based on the CRG resource use. These 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"). Member specific adjusted acuity scores "predict" case management need based on a regression formula. These scores are multiplied by the appropriate base rate to calculate a member's PMPM claim payment under rate codes 1386 and 1387.

The adjusted acuity score listed on the Billing Support Upload file is the member's adjusted acuity score as of the record's service date. Once providers begin to bill the HML rate codes effective 1/1/16, the adjusted acuity score will become obsolete.

AOT Member **↓BD ↑BU**

Field Length: 1

Format: Alpha (Y/N)

Description: If a member is court ordered into an Assisted Outpatient Treatment (AOT) program, then this field must be populated with a value of 'Y' to indicate that the member is court ordered into an AOT program. If a member is not court ordered into an AOT program, then this field must be populated with a value of 'N' to indicate that the member is NOT court ordered into an AOT program.

For more information on the AOT program, please visit the Office of Mental Health AOT website at: http://bi.omh.ny.gov/aot/about

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AOT Minimum Services Provided **↓BD ↑BU**

Field Length: 1

Format: Alpha (Y/N)

Description: If a member is identified as court ordered into an Assisted Outpatient Treatment (AOT) program, then the provider must indicate in this field whether or not the member received the minimum services required for an AOT member. For more information on the AOT program, please visit the Office of Mental Health AOT website at: http://bi.omh.ny.gov/aot/about

Editing Logic: If field #20 **AOT Member** of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload field #21 **AOT Minimum Services Provided** must be populated with either a value of 'Y' or 'N'. If field #20 **AOT Member** of the Billing Support Upload file contains a value of 'N', then this field should be blank and the system will ignore any value populated in this field.

~~**Assessor received in reach form and made contact** **↑BU**~~

~~Field Length: 1~~

~~Format: Alpha (Y/N)~~

~~Description: This field only applies to Adult Home Stipulation Class members, as identified within the MAPP HHTS by DOH. Providers must indicate in this field whether or not they received an in-reach form for the member AND reached out to the Adult Home Class member.~~

~~Editing Logic: For members identified by DOH within the MAPP HHTS as Adult Home Class members, field # 24 **Assessor received in-reach form and made contact** on the Billing Support Upload file must contain a value of 'Y' if the provider has received an in-reach form for the member **AND** has made contact with the member. For members identified by DOH within MAPP as Adult Home Class members, field # 24 **Assessor received in-reach form and made contact** on the Billing Support Upload file must contain a value of 'N' if the provider has not received an in-reach form for the member **AND/OR** has not made contact with the member. If the member is not identified by DOH within the MAPP HHTS as an Adult Home Class member, field #24 **Assessor received in-reach form and made contact** should be blank and the system will ignore any value populated in this field.~~

Assigned HH Assignment Status **↓CD**

Field Length: 40
Format: Alpha

Description: (same as ***Health Home Assignment Status***)

Assignment Created Date **↓MMD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that a member assignment began in the *pending* status. For assignments created "behind the scenes" for segments created without an assignment, the **Assignment Created Date** will be the same as the **Assignment Start Date**.

Assignment End Date **↓PAD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that an assignment ends.

Assignment End Date Reason Code **↓PAD**

Field Length: 2
Format: Alphanumeric
Accepted Values: *Appendix G: Assignment End Date Reason Codes*

Description: A code that corresponds to the reason that a member's assignment ended. Depending on the action that triggered the ending of the assignment, this code is either submitted into the system by a user or is generated by the system (see *Appendix G* for more information).

Assignment End Date Reason Description **↓PAD**

Field Length: 40
Format: Alpha

Description: The description of the **Assignment End Date.**

Assignment Rejection Date **↓PAD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that a user rejected a *pending* assignment or a *pending* referral. If the *pending* referral or assignment was rejected using a file upload, than this field would be populated with the date that the file was uploaded into the system.

Assignment Rejection Reason Code **↓PAD**

Field Length: 2

Format: Alphanumeric

Accepted Values: *Appendix E: Assignment Rejection Reason Codes*

Description: A code that corresponds to the reason that a user rejected a *pending* assignment.

Assignment Rejection Reason Code Description **↓PAD**

Field Length: 40

Format: Alpha

Description: The description of the **Rejection Reason Code.**

Assignment Source **HHA ↓MA ↓MMD**

Field Length: 20

Format: Alpha (DOH Identified, MCP Identified, Referral)

Description: Members that were identified as HH eligible by DOH are listed as 'DOH Identified'. Members that were identified as HH eligible by the MCP, not assigned to the MCP by DOH, are listed as 'MCP Identified'. Members that referred into the Health Home program through the referral wizard, or members that entered into the Health Home program in a segment that contained a value of 'R' in the **Referral Indicator** field are listed as 'Referral'.

Assignment Start Date **↓PAD**

Field Length: 8

Format: MMDDYYYY, Numeric

Base Acuity Score as of Service Date **↓BD**

Field Length: 7

Format: 00.0000, Numeric

Description: The base acuity score is a way to "predict" case management need based on a regression formula. The base acuity score places a member into either High, Medium, or Low for the HML base acuity score question, which is one of the variables that places a member into an HML rate code each month. The base acuity scores are calculated by first grouping members using the 3M Clinical Risk Group software. Each group is then assigned a base acuity score based on the CRG resource use. The base acuity score **IS NOT** used to calculate a member's 1386/1387 claim payment.

Begin Date **↓AD ↓CD ↓ED ↓MMD ↓PND ↑PNU ↓TFE↑TFS ↑TFD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The begin date indicates when a value or a status becomes effective. On the EXPLAIN WHAT IT MEANS ON EACH GROUP OF FILES

Editing Logic: This field must contain a valid date. The begin date must be greater than or equal to the assignment date. The begin date must always be the first day of the month. For example, if the member received services on May 10, 2013, the Begin Date must be 5/1/13. This date may not fall within an existing service segment.

Billing Entity MMIS ID **↓ BD**

Field Length: 8

Format: Numeric

Description: This field is calculated by the system using the criteria listed below.

Editing Logic:

1. Does the member have a value of 'Y' in the **CMA Direct Biller Indicator** field?
    a. Yes – CMA is biller
    b. No – see #2
2. Is the member enrolled in a Mainstream Managed Care Plan?
    a. Yes – MCP is biller
    b. No - Health Home is biller (for both FFS members and members enrolled in non-mainstream MC Plans)

Billing Entity Name **↓ BD**

Field Length: 40

Format: Alphanumeric

Description: The name associated with the **Billing Entity MMIS ID** within NYS Medicaid's Medicaid Data Warehouse.

Care Management Agency ID **↓BD↓CD ↓ED ↓HHA ↓MA ↓MMD ↑TFE ↑TFS**

Field Length: 8

Format: Alphanumeric

Description: The MMIS Provider ID of the CMA performing Health Home services (same as ***Care Management Agency MMIS ID*** and ***Care Management Agency MMIS Provider ID*** and ***Care Management Agency Provider ID*** and ***CMA Provider MMIS ID*** and ***Assigned CMA MMIS Provider ID***).

Editing Logic: On the **Tracking File Segment Records** upload file, this field must contain a valid MMIS Provider ID that has a completed BAA with the Health Home listed on the record or the record will be rejected. Once a completed BAA is submitted to DOH and approved by DOH, DOH documents that HH/CMS relationship within the MAPP HHTS.

City **↓ MMD**

Field Length: 40

Format: Alphanumeric

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, the member must correct this information within NYS Medicaid. For more information on how to update Medicaid information, see *Appendix L: Reference and Contacts* (same as DOH MDW Member City and MDW Member City and City).

Claim Status ↓BD

Field Length: 1

Format: Alpha (P/D/Blank)

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's added billing instance service date. **Please note:** it may take up to a week for a claim submitted to NYS Medicaid to be available to the MAPP HHTS.

A value of 'P' in this field means that the claim was paid. A value of 'D' in this field means that the claim was denied. If an associated claim has not been submitted to NYS Medicaid, then this field will be blank.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016.

Class Member **↓BD**

Field Length: 1

Format: Alpha (Y/N)

Description: A member that is included in the Adult Home Stipulation Class member list. These members are identified within the MAPP HHTS by DOH.

CMA Assignment Status **↓HHA ↓MA↓CD**

Field Length: 40

Format: Alpha (Pending, Active, Rejected, Ended, or Blank)

Description: (same as ***Assigned CMA Assignment Status***)

CMA Direct Biller Indicator ↓BD **↑BU**

Field Length: 1

Format: Alpha (Y/N)

Description: This field indicates that the member's CMA will bill Medicaid directly for Health Home services provided for the service date. A value of 'Y' indicates that the CMA is a direct biller and that the member's HH/MCP cannot submit a claim to eMedNY for the member's Health Home services. A value of 'N' indicates that the CMA is not a direct biller and that the member's HH/MCP must submit a claim to eMedNY for the member's

Health Home services. HHs bill for FFS members and MCPs bill for their enrolled members when the **CMA Direct Biller Indicator** is populated with a value of 'N'.

PLEASE NOTE – This information used to be collected at the segment level on the Tracking File. Although the Tracking File Segments Record file still contains a field titled **Direct Biller Indicator**, the system ignores this field. As of MAPP HHTS go live, direct billing information is only collected on the Billing Support Upload file per billing instance service date.

Editing Logic: The MAPP HHTS contains a list of converting CMAs, which is maintained by DOH. If a record is submitted for a member's billing instance that is associated with a converting CMA, then the system will accept either a value of 'Y' or a value of 'N' in the **CMA Direct Biller Indicator** field. If a record is submitted for a member's billing instance that is associated with CMA that is not listed as a converted CMA in the system, then the system will only accept a value of 'N' in the **CMA Direct Biller Indicator** field.

CMA Provider MMIS ID **↑TFA**

Field Length: 8

Format: Numeric

Description: (same as ***Care Management Agency ID*** and ***Care Management Agency MMIS ID*** and ***Care Management Agency MMIS Provider ID*** and ***Care Management Agency Provider ID)***

Community Services and Supports **↓PND**

Field Length: 1

Format: Alpha (N/Y)

Consent Date **↓ED ↓MMD ↑TFS**

Field Length: 8

Format: MMDDYYYY, Numeric

Core Service Provided ↓BD ↑BU

Field Length: 1

Format: Alpha (Y/N)

Description: Providers populate this filed with a value of 'Y' if the member received at least one core service during the service month. If the member did not received a core service within the service month, then this field must be populated with a value of 'N'. For more information on what constitutes a Health Home core service, please see the Health Homes Provider Manual: Billing Policy and Guidance document available at the link in *Appendix M*.

Corrections **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

County of Fiscal Responsibility Code **↓HHA ↓MA ↓MMD**

Field Length: 2

Format: Numeric

Description: The NYS Medicaid's county code for the county that is fiscally responsible for the Medicaid member (same as ***Member Fiscal County Code***).

County of Fiscal Responsibility Description **↓HHA ↓MA ↓MMD**

Field Length: 30
Format: Alpha

Description: The description of the **County of Fiscal Responsibility Code** (same as ***County of Fiscal Responsibility Desc*** and ***Member Fiscal County Code Description***).

Created By **↓MAD**

Field Length: 40
Format: Alpha

Created Date **↓MAD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: Same as Assignment Created Date.

Current HARP Status ↓BD

Field Length: 2
Format: Alpha (Blank, EL, or EN)

Description: HARP stands for **Health and Recovery Plans, which are Managed Care Plans that covers certain Medicaid member that meet the HARP enrollment criteria.** For more information regarding HARP, please follow the link below to the NYS Office of Mental Health's *Behavioral Health Transition to Managed Care* website.

A value of 'EL' means that the member has been identified by DOH as HARP eligible, but that the member is not yet officially enrolled in a HARP. A value of 'EN' means that the member is officially enrolled in a HARP. If this field is blank, it means that the member is neither enrolled in a HARP nor identified by DOH as HARP eligible. However, if this field is blank it does not mean that the member has been deemed ineligible for HARP enrollment.

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/index.htm

Date HML Assessment Entered ↓BD

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This is the date that the High, Medium, Low Assessment was completed for a member's service date. For HML submitted to the system on a file, this field is populated with the date that the file was uploaded. For HML information entered online, this field is populated with the date that the online HML assessment was completed.

Editing Logic: This field will only contain a value if the HML Assessment was complete for the member's service date. This means that if the HML Assessment is not completed for service dates prior to 10/1/15, then this date

will be blank. If the HML Assessment is completed for service dates prior to 10/1/15, then this date will be populated with the appropriate date.

Date of Birth (DOB, Member DOB) **↓BD ↓CD ↓ED ↓MMD↓HHA ↓MA ↓PAD ↑TFS**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This field is populated with the most recent member information available from NYS Medicaid. If the NYS Medicaid information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix M: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. **Please note**: it may take up to a week for information corrected in NYS Medicaid's MDW to be listed within the MAPP HHTS.

Editing Logic: On file uploads, this field must contain a valid date that matches the information that is on file within NYS Medicaid's MDW. If the information in NYS Medicaid's MDW is incorrect, then the uploaded file must match the incorrect information that is listed in MDW until that incorrect information is corrected with NYS Medicaid.

Date of Patient Acuity **↓HHA ↓MA ↓MMD**

Field Length: 8

Format: MMDDYYYY, Numeric

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

Date of Transaction **↓BD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's service date.

This field indicates the date that a NYS Medicaid claim associated with the member's added billing instance service date was submitted to NYS Medicaid.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016.

DDSO **↓PND ↓PNU**

Field Length: 1

Format: Alpha (N/Y)

Denial Reason Code/ Denial Reason Code (2) **↓BD**

Field Length: 4

Format: Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's service date.

The denial reason code is pulled by the system from the eMedNY and represents a specific reason why a claim was denied by NYS Medicaid. The system will display up to the first two denial edits that a claim hits. If a claim hits three or more edits, then only the first two denial edits will be displayed.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016.

Denial Reason Code Description/ Denial Reason Code Description (2) **↓BD**

Field Length: 25
Format: Alphanumeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's service date.

The denial reason code description is pulled by the system from the eMedNY. It corresponds to a specific denial reason code and providers a description of why a claim was denied by NYS Medicaid.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016.

Description of "Other" pre-condition **↓BD ↓BU**

Field Length: 40
Format: Alphanumeric

Description: If field # 5 **Pre-Conditions of member** on the Billing Support Upload file contains code 16 'Other', then Billing Support Upload field #6 **Description of "Other" pre-condition** must be populated with a description of the 'Other' condition that qualifies the member for the Health Home program. If code 16 'Other' is not included in Billing Support Upload file field # 5 **Pre-Conditions of member**, then this field should be blank and the system will ignore any value populated in this field.

Please refer to section **1.2 Federal Health Home Population Criteria** on page 10 of **Health Homes Provider Manual** for more information on the chronic conditions that qualify a member for Health Home services (see *Appendix M: Reference and Contacts* a link to the HH Program Manual).

Diagnosis Code **↓BD ↓BU**

Field Length: 10
Format: Alphanumeric

Description: This field is used by HH and CMA users to indicate the diagnosis code that should be included on a member's Health Home claim. Providers may choose if/how to use this field to exchange information regarding the most appropriate diagnosis code that should be included on a member's Health home claim for a specific

service date. It is up to the appropriate biller to make the final determination regarding which diagnosis code is the most appropriate to be included on a Health Home claim. DOH cannot give billing providers coding advice.

Editing Logic: This field is not required. This field is a free text field that allows up to 10 characters. This field is not edited. Submitted diagnosis code information should conform to the applicable diagnosis code set, either ICD-9 or ICD-10, as of the record's service date.

Direct Biller Indicator **↓CD ↓ED ↑TFS**

Field Length: 1

Format: Alpha (Y/N)

Description: On the Tracking File Segment file, this is an obsolete field that is always ignored by the system. On the CIN Search Download and Enrollment Download file, this field will always be blank. This field was replaced by the **CMA Direct Biller Indicator** field.

Disenrollment Reason Code **↓ED ↑TFS**

Field Length: 8

Format: MMDDYYYY, Numeric

DOH Assignment Date **↓MA ↓MMD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that DOH first identified a member as HH eligible and assigned the member to an organization.

DOH MDW Member City **↓ HHA**

Field Length: 40

Format: Alphanumeric

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, the member must correct this information through the Local Department of Social Services. (same as MDW Member City and City)

DOH MDW Member Phone **↓ HHA**

Field Length: 10

Format: Numeric

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, the member must correct this information through the Local Department of Social Services. (same as ***MDW Member Phone*** and ***Phone***)

DOH MDW Member State **↓ HHA**

Field Length: 2

Format: Alpha

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, the member must correct this information through the Local Department of Social Services. (same as ***MDW Member State*** and ***State***).

DOH MDW Member Zip Code **↓ HHA**

Field Length: 9

Format: Numeric

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, the member must correct this information through the Local Department of Social Services. (same as ***MDW Member Zip Code*** and ***Member Zip Code*** and ***Zip***).

Early Intervention Provider **↓PND ↓PNU**

Field Length: 1

Format: Alpha (N/Y)

End Date **↓AD ↓CD ↓ED ↓MMD ↑TFS**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The end date indicates when a value or a status becomes effective. On the EXPLAIN WHAT IT MEANS ON EACH GROUP OF FILES

Editing Logic: This field must contain a valid date. The begin date must be greater than or equal to the assignment date. The begin date must always be the first day of the month. For example, if the member received services on May 10, 2013, the Begin Date must be 5/1/13. This date may not fall within an existing service segment.

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.

End Health Home Assignment **↑TFA ↑TFS**

Field Length: 1

Format: Alpha (Y/N)

Error Reason **↓BE↓EFA**

Field Length: 30 (EFA); 40 (BE)

Format: Alphanumeric (EFA); Alpha (BFE)

Accepted Values: *Appendix B: File Error Reason Codes*

Description: The **Error Reason** field will be populated with a description of why the record was rejected. The field will only contain one error description, so if a record hits more than one error, only the first error will be displayed in the **Error Reason** field.

First Name (Member First Name) **↓BD ↓ED ↓HHA ↓MAD ↓MA ↓MMD↓PAD**

Field Length: 30

Format: Alpha

Description: This field is populated with the most recent member information available from NYS Medicaid. If the NYS Medicaid information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix M: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. **Please note**: it may take up to a week for information corrected in NYS Medicaid's MDW to be listed within the MAPP HHTS.

Foster Care **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Gender/Member Gender **↓BD↓CD ↓ED ↓HHA ↓MA ↓MMD ↑TFS**

Field Length: 1

Format: Alpha (M/F)

Description: This field is populated with the most recent member information available from NYS Medicaid. If the NYS Medicaid information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix M: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. **Please note**: it may take up to a week for information corrected in NYS Medicaid's MDW to be listed within the MAPP HHTS.

Editing Logic: On file uploads, this field must contain a valid gender code that matches the information that is on file within NYS Medicaid's MDW. If the information in NYS Medicaid's MDW is incorrect, then the uploaded file must match the incorrect information that is listed in MDW until that incorrect information is corrected with NYS Medicaid.

Health Home MMIS ID **↓BD ↓CD ↓ED ↓EFA ↓HHA ↓MA ↑MFA ↓MMD ↓TFE ↑TFS**

Field Length: 8

Format: Numeric

Description: An MMIS Provider ID is a unique identification number assigned to a provider by NYS Medicaid when the provider enrolls in NYS Medicaid. The HH MMIS Provider ID is the MMIS Provider ID associated with a provider that has been designated by DOH as a Health Home. Each designated Health Home must have a unique MMIS

Provider ID (same as ***Enrolled Health Home MMIS Provider ID*** and ***Health Home MMIS Provider ID*** and ***Assigned Health Home ID***).

Health Home Name **↓BD ↓ED ↓HHA ↓MA ↓MMD**

Field Length: 40
Format: Alpha

Description: The program name associated with a Health Home MMIS Provider ID. The Health Home program name is submitted to DOH by designated Health Homes and is maintained by DOH within the MAPP HHTS.

Health Home NPI **↓HHA ↓MA**

Field Length: 10
Format: Numeric

Description: The NPI associated with the Health Home's MMIS Provider ID.

HIV Status **↓BD ↑BU**

Field Length: 1
Format: Alpha (Y/N)

Description: This field is submitted on the Billing Support Upload file to indicate if a member is HIV positive. A value if 'Y' means that the member is HIV positive and a value if 'N' means that the member is not HIV positive. If a provider does not know a member's HIV status, then this field should contain a value of 'N'.

HIV T-Cell Count **↓BD ↑BU**

Field Length: 1
Format: Numeric
Accepted Values: *Appendix H: High, Medium, Low (HML) Assessment*

Description: This field collects a member's T-Cell Count using the codes listed in *Appendix H*. This field is part of the High, Medium, Low (HML) Assessment and is one of the variables used to determine a member's monthly HML rate.

Editing Logic: If field # 7 **HIV Status** contains a value of 'Y', then field #9 **HIV T-Cell Count** must be populated with an accepted value. If field #7 **HIV Status** of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload field #9 **HIV T-Cell Count** must be populated with one of the accepted values. If field #7 **HIV Status** of the Billing Support Upload file contains a value of 'N', then this field should be blank and the system will ignore any value populated in this field.

HIV Viral Load **↓BD ↑BU**

Field Length: 1
Format: Numeric
Accepted Values: *Appendix H: High, Medium, Low (HML) Assessment*

Description: This field collects a member's HIV Viral Load using the accepted codes listed in *Appendix H*. This field is part of the High, Medium, Low (HML) Assessment and is one of the variables used to determine a member's monthly HML rate.

Editing Logic: If field #7 **HIV Status** of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload field #8 **HIV Viral Load** must be populated with one of the accepted values. If field #7 **HIV Status** of the Billing Support Upload file contains a value of 'N', then this field should be blank and the system will ignore any value populated in this field.

HIV/AIDS Provider **↓PND ↑PNU**

Field Length: 1

Format: Alpha (Y/N)

Hospital **↓PND ↑PNU**

Field Length: 1

Format: Alpha (Y/N)

Housing **↓PND ↑PNU**

Field Length: 1

Format: Alpha (Y/N)

HUD Category **↓BD ↑BU**

Field Length: 1

Format: Numeric

Accepted Values: *Appendix H: High, Medium, Low (HML) Assessment*

Description: This field collects a member's HUD Category using the codes in *Appendix H: High, Medium, Low (HML) Assessment*. This field is part of the High, Medium, Low (HML) Assessment and is one of the variables used to determine a member's monthly HML rate.

Editing Logic: If field #10 **Member Housing Status** of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload field #11 **HUD Category** must be populated with one of the accepted values. If field #10 **Member Housing Status** of the Billing Support Upload file contains a value of 'N', then this field should be blank and the system will ignore any values submitted in field #11 **HUD Category.**

Impacted Adult Home Member **↓BD ↓MMD**

Field Length: 1

Format: Alpha (Y/N)

Incarceration **↓BD ↑BU**

Field Length: 1

Format: Alpha (Y/N/U)

Description: This field is submitted on the Billing Support Upload file to indicate if a member was incarcerated, for any reason or for any length of time, within the last year. A value of 'Y' means that the member was incarcerated within the past year, a value of 'N' means that the member was not incarcerated within the past year, and a value of 'U' means that the member was incarcerated within the past year, but that the submitting provider does not know the member's release date.

Incarceration Release Date **↓BD ↑BU**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This field collects the release date for recently incarcerated members. This field is part of the High, Medium, Low (HML) Assessment and is one of the variables used to determine a member's monthly HML rate.

Editing Logic: If field #12 **Incarceration** of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload field #13 **Incarceration Release Date** must be populated with the date that the member was released. The submission must be a valid date and must conform to the date format listed above. If field #12 **Incarceration** of the Billing Support Upload file contains a value of 'N' or 'U', then this field should be blank and the system will ignore any value populated in this field.

Insert Date **↓ED**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: First date that a record was submitted into the system.

Is Partner NPI enrolled in NYS Medicaid? **↓PND**

Field Length: 1

Format: Alpha (N/Y)

Description: (same as ***Enrolled Health Home MMIS Provider ID*** and ***Health Home MMIS Provider ID***) 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.

Language **↓MMD**

Field Length: 40

Format: Alpha

Last Name (Member Last Name) **↓BD ↓ED ↓HHA ↓MAD ↓MA ↓MMD ↓PAD**

Field Length: 30

Format: Alpha

Description: This field is populated with the most recent member information available from NYS Medicaid. If the NYS Medicaid information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix M: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. **Please note**: it may take up to a week for information corrected in NYS Medicaid's MDW to be listed within the MAPP HHTS.

Latest Modified Date **↓ED**

Field Length: 8

Format: MMDDYYYY, Numeric

Line Number **↓EFA ↓TFE**

Field Length: 6

Format: Numeric

Local Government Unit (LGU)/Single Point of Access (SPOA) **↓PND ↑PNU**

Field Length: 1

Format: Alpha (Y/N)

Managed Care Plan Assignment Status **↓CD ↓HHA**

Field Length: 40

Format: Alpha (Pending, Active, Pended by MCP)

Managed Care Plan Enrollment Date **↓CD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that the member last enrolled with their current MCP.

Managed Care Plan MMIS Provider ID **↓BD ↓CD ↓HHA ↓MA ↓MMD**

Field Length: 8

Format: Numeric

Description: (same as ***Managed Care Organization MMIS ID***) An MMIS Provider ID is a unique identification number assigned to a provider by NYS Medicaid when the provider enrolls in NYS Medicaid. The MCP MMIS Provider ID, also referred to as the Plan ID, is the MMIS Provider ID associated with the member's Managed Care Plan.

Editing Logic: For fee for service members, this field will be blank. For all files but the Billing Support Download file, the value included in the Managed Care Plan MMIS Provider ID field is associated with the member's current MCP. On the Billing Support Download file, this field is populated with the MCP that the member was associated with as of the billing instance service date.

Managed Care Plan Name **↓BD ↓CD ↓HHA ↓MA ↓MMD**

Field Length: 40

Format: Alpha

Description: For fee for service members, this field will be blank.

Medicaid Eligibility Status **↓BD**

Field Length: 1

Format: Alpha (Y/N)

Description: This field indicates whether or not a member is Medicaid eligible as of the billing instance service date. A value of 'Y' means that the member is Medicaid eligible as of the billing instance service date and a value of 'N' means that the member is not Medicaid eligible as of the billing instance service date. **Please note**: it may take up to a week for a recently updated member eligibility status to be listed within the MAPP HHTS.

Medical Services Provider **↓PND ↑PNU**

Field Length: 1
Format: Alpha (N/Y)

Medicare Indicator **↓HHA↓MA**

Field Length: 1
Format: Alpha (N/Y)

Member Fiscal County Code **↓BD**

Field Length: 2
Format: Numeric

Description: This field is populated with the most recent member information available from NYS Medicaid. If the NYS Medicaid information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix M: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. **Please note**: it may take up to a week for information corrected in NYS Medicaid's MDW to be listed within the MAPP HHTS.

Member Fiscal County Code Description **↓BD**

Field Length: 40
Format: Alphanumeric

Description: This describes the county that is associated with a member's county code.

Member Housing Status/Member Living Status **↓BD ↑BU**

Field Length: 1
Format: Alpha (Y/N)

Description: This field is submitted on the Billing Support Upload file to indicate if a member is homeless, as defined by HUD categories 1 and 2. A value of 'Y' means that the member is homeless and a value of 'N' means that the member is not homeless.

Member ID/CIN **ALL FILES EXCEPT PARTNER NETWORK FILES**

Field Length: 8
Format: AA111111A, Alphanumeric

Description: This is a unique NYS Medicaid number used to identify Medicaid members. **Please note**: it may take up to a week for information recently updated with NYS Medicaid to be available within the MAPP HHTS. For example, if may take up to a week for the MAPP HHTS to recognize the CIN of a newly enrolled Medicaid member.

Editing Logic: This field must be populated with a valid member ID.

Member Zip Code **↓BD ↓ HHA↓ MA ↓ MMD**

Field Length: 9

Format: Numeric

Description: This field is populated with the most recent member information available from NYS Medicaid. If the NYS Medicaid information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix M: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. **Please note**: it may take up to a week for information corrected in NYS Medicaid's MDW to be listed within the MAPP HHTS (same as ***MDW Member Zip Code*** and ***DOH MDW Member Zip Code*** and ***Zip***).

Mental Illness **↓BD ↑BU**

Field Length: 1

Format: Alpha (Y/N/U)

Description: This field is submitted on the Billing Support Upload file to indicate if a member was discharged from an inpatient stay due to mental illness within the last year. A value of 'Y' means that the member was discharged from a mental illness inpatient stay within the past year, a value of 'N' means that the member was not discharged from a mental illness inpatient stay within the past year, and a value of 'U' means that the member means that the member was discharged from a mental illness inpatient stay within the past year, but the submitting provider does not know the member's discharge date.

Mental Illness Stay Discharge Date **↓BD ↑BU**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: If a member had an inpatient stay due to a Mental Illness within the past year, then this field collects the date that the member was discharged. This field is part of the High, Medium, Low (HML) Assessment and is one of the variables used to determine a member's monthly HML rate.

Editing Logic: If field #14 **Mental Illness** of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload field #15 **Mental Illness Stay Discharge Date** must be populated with the date that the member was discharged from the mental illness inpatient stay. The submission must be a valid date and must conform to the date format listed above. If field #14 **Mental Illness** of the Billing Support Upload file contains a value of 'N' or 'U', then this field should be blank and the system will ignore any values submitted in field #15 **Mental Illness Stay Discharge Date.**

If a provider knows that a member was recently discharged from an inpatient stay due to mental illness, but does not know the members' discharge date, then field #14 **Mental Illness** must be populated with a value of 'U' and field #15 **Mental Illness Stay Discharge Date** should be blank.

OASAS Services **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

OMH Services **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

OPWDD Services **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Original Record from File **↓BD**

Field Length: 140

Format: Alphanumeric

Description: This field is populated with a concatenation of the all the field values on the originally submitted record that was rejected.

OT/PT/Speech **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Outpatient Rank/Outpatient Score **↓HHA ↓MA**

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 **↓BD ↓ED ↑TFS**

Field Length: 1

Format: Alpha (O/E)

Description: (same as ***Segment Type***)Specifies whether the segment is outreach 'O' or enrollment 'E'. If both outreach and enrollment occurred in the same month, then the member should have an enrollment segment for that month.

Paid Claim Provider ID **↓BD**

Field Length: 8

Format: Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's added billing instance service date.

An MMIS Provider ID is a unique identification number assigned to a provider by NYS Medicaid upon enrollment into NYS Medicaid. This field indicates the MMIS Provider ID on the claim associated with the member's added billing instance service date. Although this field name includes the word "Paid," this field will always be populated when there is a NYS Medicaid claim associated with the member's billing instance service date, whether the claim was paid or denied.
Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016. **Please note:** it may take up to a week for a claim submitted to NYS Medicaid to be available to the MAPP HHTS.

Paid Claim Provider ID equals MAPP Billed Entity MMIS ID **↓BD**

Field Length: 1
Format: Alpha (Y/N)

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's added billing instance service date.

If the MMIS Provider ID in the **Paid Claim Provider ID** field matches the MMIS Provider ID in the **Billing Entity MMIS ID**, then this field will be populated with a value of 'Y'. If the MMIS Provider ID in the **Paid Claim Provider ID** field does not match the MMIS Provider ID in the **Billing Entity MMIS ID**, then this field will be populated with a value of 'N'. Although this field name includes the word "Paid," this field will always be populated when there is a NYS Medicaid claim associated with the added billing instance service date, whether the claim was paid or denied.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016. **Please note:** it may take up to a week for a claim submitted to NYS Medicaid to be available to the MAPP HHTS.

Paid Claim Provider Name **↓BD**

Field Length: 40
Format: Alphanumeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's added billing instance service date.

This is the NYS Medicaid name associated with the MMIS Provider ID listed in the **Paid Claim Provider ID** field. Although this field name includes the word "Paid," this field will always be populated when there is a NYS Medicaid claim associated with the member's billing instance service date, whether the claim was paid or denied.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016. **Please note:** it may take up to a week for a claim submitted to NYS Medicaid to be available to the MAPP HHTS.

Paid Claim Rate Code **↓BD**

Field Length: 4

Format: Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's added billing instance service date.

This field indicates the rate code on the claim associated with the record's member and service date. Although this field name includes the word "Paid," this field will always be populated when there is a NYS Medicaid claim associated with the member's added billing instance service date, whether the claim was paid or denied.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016. **Please note:** it may take up to a week for a claim submitted to NYS Medicaid to be available to the MAPP HHTS.

Paid Claim Rate Code equals MAPP HML Rate Code **↓BD**

Field Length: 1

Format: Alpha (Y/N)

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's added billing instance service date.

If the rate code in the **Paid Claim Rate Code** field matches the rate code in the **Rate Code** field, then this field will be populated with a value of 'Y'. If the rate code in the **Paid Claim Rate Code** field does not match the rate code in the **Rate Code** field, then this field will be populated with a value of 'N'. Although this field name includes the word "Paid," this field will always be populated when there is a NYS Medicaid claim associated with the member's added billing instance service date, whether the that claim was paid or denied.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016. **Please note:** it may take up to a week for a claim submitted to NYS Medicaid to be available to the MAPP HHTS.

Payment Cycle **↓BD**

Field Length: 4

Format: Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim associated with the member's added billing instance service date. Please see the *Billing Support Download File: Description* section for an explanation of how the system identifies a claim that is associated with a member's added billing instance service date.

The **Payment Cycle** is a four digit number that corresponds to a specific NYS Medicaid claims processing period. For more information on this cycle number, please see the eMedNY and payment cycle calendar links available in *Appendix: L Reference and Contacts*.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016. **Please note:** it may take up to a week for a claim submitted to NYS Medicaid to be available to the MAPP HHTS.

Pediatric Provider **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Pend Reason Code/Segment Pend Reason Code **↓BD ↓EFA ↑MFA ↑TFS**

Field Length: 2

Format: Alphanumeric

Accepted Values: *Appendix C* for pending a segment and *Appendix F* for pending an Assignment

Description: The value in the **Pend Reason Code** field on the MCP Final HH Assignment file and the Error Report: MCP Final HH Assignment file represents the reason that an MCP pended an assignment; acceptable values are listed in *Appendix F: Assignment Pend Reason Codes.*

The value in the **Pend Reason Code** field on the Billing Support Download file and the Tracking File Segment Records and the **Segment Pend Reason Code** field on the Enrollment Download file represents the reason that HH or CMA pended an outreach of enrollment segment; acceptable values are listed in *Appendix C: Segment Pend Reason Codes.*

Physician Indicator **↓PND ↑PNU**

Field Length: 1

Format: Alpha (Y/N)

Pioneer ACO **↓MMD**

Field Length: 1

Format: Alpha (Y/N)

Pre-Conditions of member **↓BD ↑BU**

Field Length: 16

Format: Numeric

Accepted Values: Please see *Appendix H: High, Medium, Low (HML) Assessment*

Description: A provider must indicate the chronic condition(s) that qualify a member for enrollment in the Health Home program. Please refer to section **1.2 Federal Health Home Population Criteria** on page 10 of **Health Homes Provider Manual** (link available in *Appendix M*) for more information on the chronic conditions that qualify a member for Health Home services.

Editing Logic: List all codes that explain why the member is Health Home eligible. Do not separate out codes with commas, spaces, or any other delimiter. For example, if a member's Diabetes and Heart Disease makes the member Health Home eligible, then this field should be populated with the diabetes code (08), the heart disease

code (10) and 12 blank spaces: '0810 '. If code 16 'Other' is submitted within this field, then field **Enter other field name** is required.

A member's pre-conditions(s) must be submitted on the Billing Support Upload file in field # 5 **Pre-Conditions of member**. This is a conditionally required field and must be populated for the service date that corresponds with a member's first month of enrollment with a Health Home. This field must be populated when a member is newly enrolled with a Health Home or when there is at least a one month break in a member's enrollment with a Health Home. The system will disregard the value submitted in this field in all other situations (service dates associated with an outreach segment, an enrollment segment that is not the initial enrollment segment with the Health Home, a new enrollment segment if the member was enrolled in with the same Health Home the previous month).

Example: John is newly enrolled with HH A and CMA B with a begin date of June 1, 2015 and an end date of September 30, 2015 (segment entered directly into MAPP HHTS, not converted). John is then enrolled with HH A and CMA C with a begin date of October 1, 2015 and an end date of October 31, 2015. John is then enrolled with HH A and CMA B with a begin date of December 1, 2015 and no end date.

Appropriate responses for *Pre-Conditions of member* based on example for service dates 6/1/15 – 1/1/16:

1. June 1, 2015 – valid response required
2. July 1, 2015 – response not required*
3. August 1, 2015 – response not required*
4. September 1, 2015 – response not required*
5. October 1, 2015 – response not required*
6. November 1, 2015 – member does not have a billing instance. No record to submit
7. December 1, 2015– valid response required
8. January 1, 2016 – response not required*

*any value submitted in field for these service dates will be ignored by system

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Rate Amount **↓BD**

Field Length: 7

Format: Numeric, "0000.00"

Description: This is the rate amount associated with the rate code for the billing instance service date.

Rate Code **↓BD**

Field Length: 4

Format: Numeric

Description: This is the rate code that the responsible biller must use to bill Medicaid for the Health Home services provided to the member for the billing instance service date. The system uses the logic outlined in *Appendix K* to determine the appropriate rate code for a member's billing instance service date.

Editing Logic: This field will be blank until providers begin to bill the High, Medium, Low Health Home rates effective January 1, 2016.

Rate Description **↓BD**

Field Length: 30

Format: Alphanumeric

Description: This field is populated differently depending on the billing instance service date. Please see Editing Logic below for more information.

Editing Logic: For billing instance service dates prior to 1/1/16, this field describes the rate code that *would be* appropriate for the billing instance service date **if the claim were to be paid under the High, Medium, Low Health Home rates; this field does not describe the rate code that a member should be billed under for the Health Home services provided for the billing instance service date**.

For billing instance service dates on or after 1/1/16, **this field describes the rate code that a member should be billed under for the billing instance service date**.

Record Type **↑TFS ↑TFE ↑TFD ↑TFA ↓MAD**

Field Length: 1 (all files except MAD); 10 (MAD only)
Format: Alpha
Accepted Values:

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.

Referral Code **↓ED ↑TFS**

Field Length: 1
Format: Alpha
Accepted Values: T, R, Blank

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.

Residence **↓PND ↑PNU**

Field Length: 1
Format: Alpha (Y/N)

Risk Score/Risk **↓BD ↓HHA ↓MA**

Field Length: 6

Format: Decimal, 999V99

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

Segment End Date Description **↓ED**

Field Length: 40

Format: Alpha

Accepted Values: See *Appendix D: Segment End Date Reason Codes*

Description: The reason why the segment is being end dated. Accepted values are listed in *Appendix D: 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 D: Segment End Date Reason Codes*. This field is only required for segments with an end date.

Segment Pend Reason Code **↓ED**

Field Length: 2

Format: Alphanumeric

Accepted Values: See *Appendix*

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

Segment Pend Reason Description **↓ED**

Field Length: 40

Format: Alpha

Accepted Values: See *Appendix*

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

Segment Type **↓CD ↓MMD**

Field Length: 1

Format: Alpha (O/E)

Description: (same as ***Outreach/Enrollment Code)***

Service 1-5: Last Service Address Line 1/Address Line 2 **↓HHA ↓MA**

Field Length: 40

Format: Alphanumeric

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

Service 1-5: Last Service City **↓HHA ↓MA**

Field Length: 40
Format: Alphanumeric

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

Service 1-5: Last Service Date **↓HHA ↓MA**

Field Length: 8
Format: MMDDYYYY, Numeric

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

Service 1-5: Last Service Phone **↓HHA ↓MA**

Field Length: 10
Format: Numeric

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

Service 1-5: Last Service Provider Name **↓HHA ↓MA**

Field Length: 40
Format: Alpha

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

Service 1-5: Last Service Provider NPI **↓HHA ↓MA**

Field Length: 10
Format: Numeric

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

Service 1-5: Last Service State **↓HHA ↓MA**

Field Length: 2
Format: Alpha

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

Service 1-5: Last Zip Code **↓HHA ↓MA**

Field Length: 9
Format: Numeric

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

Service Date **↓BD ↑BU**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The service date is associated with a billing instance and indicates the month during which a member meets the billing instance criteria.

Editing Logic: This field must conform to the date format listed above and must be the first of the month. Records submitted with a value that is not the first of the month or records submitted in the incorrect format will be rejected.

Social Service District Office **↓PND ↑PNU**

Field Length: 1
Format: Alpha (Y/N)

Substance Abuse **↓BD ↑BU**

Field Length: 1
Format: Alpha (Y/N/U)

Description: This field is submitted on the Billing Support Upload file to indicate if a member was discharged from an inpatient stay due to substance abuse within the last year. A value of 'Y' means that the member was discharged from a substance abuse inpatient stay within the past year, a value of 'N' means that the member was not discharged from a substance abuse inpatient stay within the past year, and a value of 'U' means that the member means that the member was discharged from a substance abuse inpatient stay within the past year, but the submitting provider does not know the member's discharge date.

Substance Abuse Discharge Date **↓BD ↑BU**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: If a member had an inpatient stay due to Substance Abuse within the last year, then this field collects the date that member was discharged from that inpatient stay. This field is part of the High, Medium, Low (HML) Assessment and is one of the variables used to determine a member's monthly HML rate.

Editing Logic: If field #16 **Substance Abuse** of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload field #17 **Substance Abuse Discharge Date** must be populated the date that the member was discharged from the substance abuse inpatient stay. The submission must be a valid date and must conform to the date format listed above. If field #16 **Substance Abuse** of the Billing Support Upload file contains a value of 'N' or

'U', then field this field should be blank and the system will ignore any values submitted in field #17 **Substance Abuse Discharge Date.**

SUD Active Use/Functional Impairment **↓BD ↑BU**

Field Length: 1

Format: Alpha (Y/N)

Description: Providers use this field to indicate if a member suffers from a substance abuse related functional impairment or has a problematic substance abuse issue based on the criteria listed below.

Editing Logic: This field should be populated with a value of 'Y' for a member with at least one *Indicator A* value **AND** at least one *Indicator B* value. This field should be populated with a value of 'N' for members that do not meet the criteria. If a member has 2 *Indicator B* values, but does not have an *Indicator A* value, then the member does not meet the criteria and this field must be populated with a value of 'N'.

Indicator A	AND	Indicator B
• Positive Lab test **OR** • other documentation of substance use **OR** • LDSS positive screening for referral to SUD service **OR** • Referral for SUD service from parole/probation within last 30 days		• Documentation from family and/or criminal courts that indicates domestic violence and/or child welfare within the last 60 days **OR** • Documentation from Drug court within the last 60 days **OR** • Police report alleging SUD involvement including, but not limited to, operating a vehicle under the influence, harassment, disorderly conduct, and/or public lewdness within the last 60 days.

Appendix B: File Error Reason Codes

Error Code	Error Code Message
INVALID_LENGTH	Record rejected for an invalid length of characters~~Invalid line length~~
INVALID_RECIP_ID	Record rejected for an invalid CIN.~~Member ID not on file~~
INVALID_PEND_CODE	Record rejected for an invalid Pend Code.~~Invalid Pend reason code.~~
MEMBER_NOT_IN_PLAN	Record rejected because at the time of the upload, the member included in the line is not enrolled with the Plan.~~As of (DATE) the member is not enrolled in the Managed Care Plan.~~
INVALID_COV_CODE	Record rejected because at the time of the upload, the member has an invalid coverage code.~~The member's Coverage Code < Code/Description > is not compatible with the Health Home Program.~~
INVALID_RE_CODE	Record rejected because at the time of the upload, the member has an invalid R/E code.~~The member's R/E Code < Code/Description > is not compatible with the Health Home Program.~~
INVALID_HEALTH_HOME_ID	Record rejected for an invalid Health Home MMIS ID.~~Invalid Health Home MMIS Provider ID~~
NO_RELATIONSHIP	Record rejected because the~~The~~ Health Home is not contracted with the Managed Care Plan.
EXISTING_SEGMENT	Record rejected for an existing segment.~~Overlapping Outreach/Enrollment Segment on file with < HH >, <Segment Type, Start Date - End Date>.~~
INVALID_DATA_COMBO	Record rejected because ~~O~~only Health Home MMIS Provider ID or Pend Reason Code are required. Both cannot be entered for the same member
DUPLICATE_ACTION	Record rejected because the user is attempting to take an action through the file that they have already done (the exception is a MCP user can pend a pended assignment)
INVALID_ADDRESS	Record rejected for an address that did not meet the system validations.
INVALID_PHONE	Record rejected for a phone that did not meet the system validations.
INVALID_STATUS	Invalid assignment status for operation.
INVALID _NPI_FORMAT	Record rejected for invalid NPI format. NPI field must contain 10 numeric characters.
INVALID _AGE	Members under 21 years of age must be referred into the Health Home program online via Children's Referral Portal
001	CIN Format is invalid CIN format is AA11111A~~The member ID (CIN) entered ( ) does not conform to the CIN format "A11111AA"~~
002	As of <MMDDYYYY> the member is not eligible for Medicaid~~As of (DATE), the member is not eligible for Medicaid~~
003	The DOB entered does not match the DOB in the Medicaid system~~The DOB entered ( ) does not match the member's DOB in the Medicaid system~~
004	The gender entered does not match the gender in the Medicaid system~~The gender entered ( ) does not match the member's gender in the Medicaid system~~
006	Member is not assigned to the provider~~As of (DATE), the member was not assigned to your Health Home. The member was assigned to ( ).~~
011	The Begin Date entered is not the 1st of the month~~The begin date entered ( ) is not the 1st of the month. The begin date must be the 1st of the month.~~
012	The end date entered is not the last day of the month~~The end date entered ( ) is not the last day of the month. The end date must be the last day of the month.~~
013	The end date entered is prior to the segment begin date <MMDDYYYY>~~The end date entered ( ) is prior to the segment begin date ( ).~~

Error Code	Error Code Message
014	The Outreach Enrollment code entered must be O or EThe Outreach/Enrollment code entered ( ) is invalid. Valid codes are "O" or "E".
015	Valid gender codes are M or FThe value entered ( ) is an invalid gender code. Valid gender codes are "M" or "F".
016	Invalid Record TypeThe value entered ( ) is an invalid record type. Valid record types are "A", "C", "R" or "D"
017	Valid referral indicators are R NULL or TThe value entered ( ) is an invalid referral indicator. Valid referral indicators are "R","T", or NULL
021	The Care Management Agency MMIS ID entered <XXXXXXXX> is invalidThe Care Management Agency MMIS ID entered ( ) is invalid.
022	The Health Home MMIS ID entered <XXXXXXXX> is invalidThe Health Home MMIS ID entered ( ) is invalid.
025	Segment does not follow record type formatThe segment entered ( ) does not follow the file format associated with the segment record type ( ). File specifications can be found in the Health Home Tracking System Specifications Document.
026	Overlapping segment w HH MMIS ID <12345678> <MMDDYYYY> to <MMDDYYYY> Overlapping Outreach/Enrollment Segment on file with < HH >, <Segment Type, Start Date - End Date>.
0272728	Original record does not exist for Change or Delete operationInvalid format on line
029028	A member can only have 3 months of active outreach in 6 monthsNo matching segment. Unable to change/delete.
030029	The segment begin date cannot be prior to 01012012A member can only have 3-months of active outreach in 6-months.
030031	Segment begin dates cannot be in the futureThe begin date entered ( ) is prior to the Health Home project start date 1/1/2012.
031	The begin date entered ( ) is in the future. Begin dates cannot be in the future.
035033	Assignment must be pendingA member can only have 3-months of active outreach in 6-months.
036034	CIN has an open segmentMember is in a Pioneer ACO. The member should be referred to a Pioneer ACO Health Home.
037035	Invalid End Date Reason CodeThe assignment is not in a pending status. Unable to Accept or Reject an assignment that is not in a pending status.
038036	Invalid Rejection Reason Codethe member has an Outreach/Enrollment Segment on file with < HH >, <Segment Type, Start Date - End Date>. Unable to take action on an assignment for a member with an open outreach or enrollment segment.
039037	Invalid Coverage Code foundInvalid End Date Reason
040038	Invalid RE Code foundInvalid Rejection Reason
041039	Assignment does not follow record type formatThe member's Coverage Code < Code/Description > is not compatible with the Health Home Program.
042040	No relationship exists between HH and CMAThe member's R/E Code < Code/Description > is not compatible with the Health Home Program.
043041	Comments are requiredNo Relationship exists between the Health Home and Care Management Agency
044042	No Valid Record FoundInclude reason in Comments text box. Comments must be entered when selecting 'Other' as the reason
045043	Duplicate RecordUnable to pend the Outreach segment with a Pend start date of <DATE>. The member cannot have more than 3-months of active outreach in the 6-

Error Code	Error Code Message
	~~months prior to the date entered. Please wait to pend the segment until the Pend start date is no more then 1-month in the future.~~
N/A	MMDDYYYY Billing instance does not exist
N/A	MMDDYYYY Add only if service provided
N/A	DX exceeds 10 characters
N/A	Member qualifies for AH+ field required
N/A	Transitioned to community field req'd
N/A	Cont to qualify for AH+ field req'd
N/A	Interest in transitioning field is req'd
N/A	Incarceration field required
N/A	Release Date req'd if Incarceration is Y
N/A	CIN XXXXXXXX is not a valid CIN
N/A	No BI for XXXXXXXX as of MMDDYYYY (A)
N/A	No association with member (MMDDYYYY)
N/A	No billing instance to void (MMDDYYYY)
N/A	MMDDYYYY Duplicate billing instance
N/A	Service Date (MMDDYYYY) not 1st of month
N/A	DB can't be 'N' for non-converting CMA
N/A	Comment required with 'Other' submission
N/A	Chronic Condition(s) must be selected
N/A	HIV Status field required
N/A	Viral Load required if HIV Status is Y
N/A	T-Cell required if HIV Status is Y
N/A	Member Housing Status field required

Error Code	Error Code Message
N/A	HUD Category req'd for homeless member
N/A	Incarceration field required
N/A	Release Date req'd if Incarceration is Y
N/A	Mental Illness field required
N/A	Discharge Date req'd if Mental Illness=Y
N/A	Substance Abuse field required
N/A	Discharge Date req'd if Substnce Abuse=Y
N/A	SUD Active Use/Impairment req'd
N/A	AOT member field required
N/A	AOT minimum service provided field req'd
N/A	ACT member field required
N/A	ACT minimum service provided field req'd
N/A	Core Service Provided is required field
N/A	Member is not Medicaid eligible
N/A	Incorrect value provided for Viral Load
N/A	Incorrect value provided for TCell Count
N/A	Service Date Invalid Date Format
N/A	Incorrect values provided for Conditions

Appendix C: Segment Pend Reason Codes

The reason codes listed below explain why a user would pend a member's outreach or enrollment segment. These codes are used in the **Pend Reason Code** field on the Billing Support Download file, the **Pend Reason Code** field on the Tracking File Segment Records file, and the **Segment Pend Reason Code** field on the Enrollment Download File.

Code	Code Description
01	Patient of Inpatient Facility
02	Incarcerated
03	Hiatus
04	Other

Appendix D: Segment End Date Reason Codes

The reason codes listed below explain why a user would end a member's outreach or enrollment segment. These codes are used in the **Disenrollment Reason Code** field on the Enrollment Download file, the **End Date Reason** field on the My Members Download file, and the **Disenrollment Reason Code** field on the Tracking File Segment Records.

Code	Code Description	Outreach, Enrollment or Both
01	Transferred to another HH	Both
02	Member opted-out (pre-consent only)	Both
03	Transferred to another CMA	Both
04	Member deceased	Both
05	Member has a new CIN	Both
~~06~~07	Closed for ~~disruptive or uncooperative~~ behavior	Both
~~07~~08	Member moved out of service county	Both
~~08~~09	Member moved out of state	Both
~~09~~	~~Member not eligible~~	~~Both~~
~~10~~11	Member incarcerated	Both
12	Refused to sign or rescinded consent	Enrollment
~~11~~13	Patient of inpatient facility	Both
~~12~~14	Enrolled Health Home member lost to services	Enrollment
~~13~~15	Member dissatisfied with services	Both
~~14~~16	Inability to contact/locate member	Outreach
~~15~~17	Member found but not interested in enrolling in Health Home services	Outreach
~~16~~18	Member found and expressed interest in Health Home but at a future date	Outreach
~~17~~19	Member does not currently meet Health Home criteria	Both
~~18~~21	Member no longer requires Health Home services	Enrollment
~~19~~	~~Member transitioned to a FIDA Program~~	~~Both~~
23	Member disenrolled	Enrollment
~~20~~24	Member is no longer eligible for Medicaid	Both
~~21~~25	Member moved from Outreach to Enrollment Status	Outreach
~~22~~26	No resources that speak the member's primary language	Both
~~23~~32	Closure	Both
~~24~~33	Merger	Both
~~25~~34	Provider ID changed	Both
~~26~~	~~Change in functional eligibility~~	~~Both~~
27	Member not eligible for Health Home program	Both
~~28~~35	Member refused consent	Enrollment
29	Member withdrew consent	Enrollment
30	Hiatus to Closed	Outreach
31	Active to Hiatus	Outreach

98	Invalid end date reason ~~code~~ at conversion	Both
99	Other	Both

Appendix E: Assignment Rejection Reason Codes

The reason codes listed below explain why:

- HH would reject an assignment made to them by either DOH or by an MCP;
- CMA would reject an assignment made to them by a HH;
- HH would reject a referral made to their HH
- HH would reject a transfer made to their HH

These codes are used in the **Assignment Rejection Reason Code** field on the Past Assignments Download file and the **Rejection Reason** field on the Tracking File Assignment Records file.

Code	Code Description
01	Not a suitable assignment
02	Member moved out of service county
03	Member moved out of state
04	Member not eligible
05	Member incarcerated
06	Member deceased
07	Member inpatient
08	Referred to another Health Home
09	Other
10	At capacity
11	Appropriate provider linkages to best meet the member's needs not available
12	The member's address is outside of the service area
13	No resources that speak the member's primary language
14	Created in error
15	Referral Not Appropriate

Appendix F: Assignment Pend Reason Codes

The reason codes listed below explain why an MCP would pend a member's assignment or referral. These codes are used in the **Pend Reason Code** field on the Error Report: Managed Care Plan Final Health Home Assignment file and the **Pend Reason Code** field on the Managed Care Plan Final Health Home Assignment file.

Code	Code Description
01	The member is receiving care management services from the Managed Care Plan
02	The member is enrolled in a different program
03	Alternate Health Home needs to be identified
04	Awaiting contract with Health Home
05	Referral Not Appropriate
06	Other

Appendix G: Assignment End Reason Codes

The reason codes listed below explain why a HH would end a member's assignment to the HH or why a CMA would end a member's assignment with the CMA. These codes are used in the **Assignment End Date Reason Code** field on the Past Assignments Download file and the **End Date Reason** field on the Tracking File Assignment Records file.

Code	Accepted Language Values	Source	Comments
01	Created in error	Provider Input	
02	Member deceased	Provider Input	
03	Member has a new CIN	Provider Input	
04	Member moved out of service county	Provider Input	
05	Member moved out of state	Provider Input	
06	Member not eligible	Provider Input	
07	Member incarcerated	Provider Input	
08	Member inpatient	Provider Input	
09	Member does not currently meet HH criteria	Provider Input	
10	Member transitioned to a FIDA Program	Provider Input	
11	Member is no longer eligible for Medicaid	Provider Input	
12	Other	Provider Input	If this code is selected, explanation of "Other" reason is required
14	Changed HH	System generated	when system ends a HH Assignment because MCP/DOH created a new HH Assignment for a member that had an existing HH assignment
15	Changed CMA	System generated	when system ends a CMA Assignment because the Health Home created a new CMA Assignment for a member that had an existing CMA assignment
16	Moved from assignment to outreach with different CMA	System generated	when system ends a CMA Assignment because the Health Home created an outreach segment for member with a CMA that was different than the CMA that the HH assigned the member to.
17	Moved from assignment to enrollment with different CMA	System generated	when system ends a CMA Assignment because the Health Home created an enrollment segment for member with a CMA that was different than the CMA that the HH assigned the member to.
18	Outreach ended with no enrollment	System generated	when a HH/CMA assignment ends because the member cycled out of outreach/outreach hiatus without being enrolled
19	Enrollment ended	System generated	when a HH/CMA assignment ends because an enrolled member's segment ended with the HH/CMA.
20	No Medicaid Coverage	System generated	when MCP/HH/CMA assignment ends because the member is no longer Medicaid Eligible

Code	Accepted Language Values	Source	Comments
21	Invalid Coverage Code	System generated	when MCP/HH/CMA assignment ends because the member have a coverage code that is incompatible with the Health Home program (see Appendix H: Reference and Contacts for link to the HH Coverage Code Compatibility document on the HH website)
22	Invalid R/E Code	System generated	when MCP/HH/CMA assignment ends because the member has a recipient R/E code that is incompatible with the Health Home program (see Appendix H: Reference and Contacts for link to the HH Recipient R/E Compatibility document on the HH website)
23	TCM/HH – ACT Claim Exists	System generated	when MCP/HH/CMA assignment ends because of a recent TCM/HH/ACT claim in the system (this indicates that the member has a connection to a Health Home, even though the member is not yet in outreach or enrollment in the system)
24	Adult Home Member	System generated	when HH/CMA assignment ends because a member is an Adult Home member
25	Changed Recommended HH	System generated	when the DOH HH recommendation sent to a member's MCP by DOH is replaced with a new DOH HH recommendation
26	Member switched from Mainstream Managed Care to Fee-for-Service	System generated	when HH/CMA assignment ends because the member moved from MCP to FFS. Member's HH assignment switched to the HH that DOH assigned the member to based on member claims and encounters and HHs' Partner Network lists
27	Member switched from Non-Mainstream Managed Care to Fee-for-Service	System generated	when HH/CMA assignment ends because the member moved from MCP to FFS. Member's HH assignment switched to the HH that DOH assigned the member to based on member claims and encounters and HHs' Partner Network lists
28	Member switched Mainstream Managed Care Plans	System generated	when HH/CMA assignment ends because the member moved from one MCP to another MCP. Any assignments made while member was with the first MCP are ended and new MCP now responsible for assigning member to an HH.
31	Member switched from Non-Mainstream Managed Care to Mainstream Managed Care	System generated	when HH/CMA assignment ends because the member moved from to a Mainstream MCP. Any assignments made while member was with non-mainstream MCP are ended and new MCP now responsible for assigning member to an HH.
32	Member switched from Fee-for-Service to Mainstream Managed Care	System generated	when HH/CMA assignment ends because the member moved from FFS to MCP. Any assignments made while member was FFS are ended and new MCP now responsible for assigning member to an HH.

Code	Accepted Language Values	Source	Comments
35	Provider Changed ID	System generated	When an assignment is ended because a HH changed their MMIS Provider ID
99	Member has been removed from the assignment file	System generated	

Appendix H: High, Medium, Low (HML) Assessment Codes

For information on how the Health Home High, Medium, Low rates are determined, please see the **HH HML Rate Information** document available at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_hml_rate.pdf

The following codes are used in the Billing Support Upload file to respond to HML Assessment questions.

Field Description	Code	Code Description
HIV T-Cell Count	0	NA
HIV T-Cell Count	1	Unknown
HIV T-Cell Count	2	<200~~>350~~
HIV T-Cell Count	3	200-350
HIV T-Cell Count	4	>350~~<200~~
HIV Viral Load	0	NA
HIV Viral Load	1	Unknown
HIV Viral Load	2	<200
HIV Viral Load	3	200-400
HIV Viral Load	4	>400
HUD CODES	1	Meets HUD Category 1: Literally Homeless definition~~Meets HUD Category 2: Imminent Risk of Homelessness definition~~
HUD CODES	2	~~Meets HUD Category 1: Literally Homeless definition~~Meets HUD Category 2: Imminent Risk of Homelessness definition
Pre-Conditions of member	02	Mental Health
Pre-Conditions of member	04	Substance Abuse
Pre-Conditions of member	06	Asthma
Pre-Conditions of member	08	Diabetes
Pre-Conditions of member	10	Heart Disease
Pre-Conditions of member	12	Overweight
Pre-Conditions of member	14	HIV/AIDS
Pre-Conditions of member	16	Other

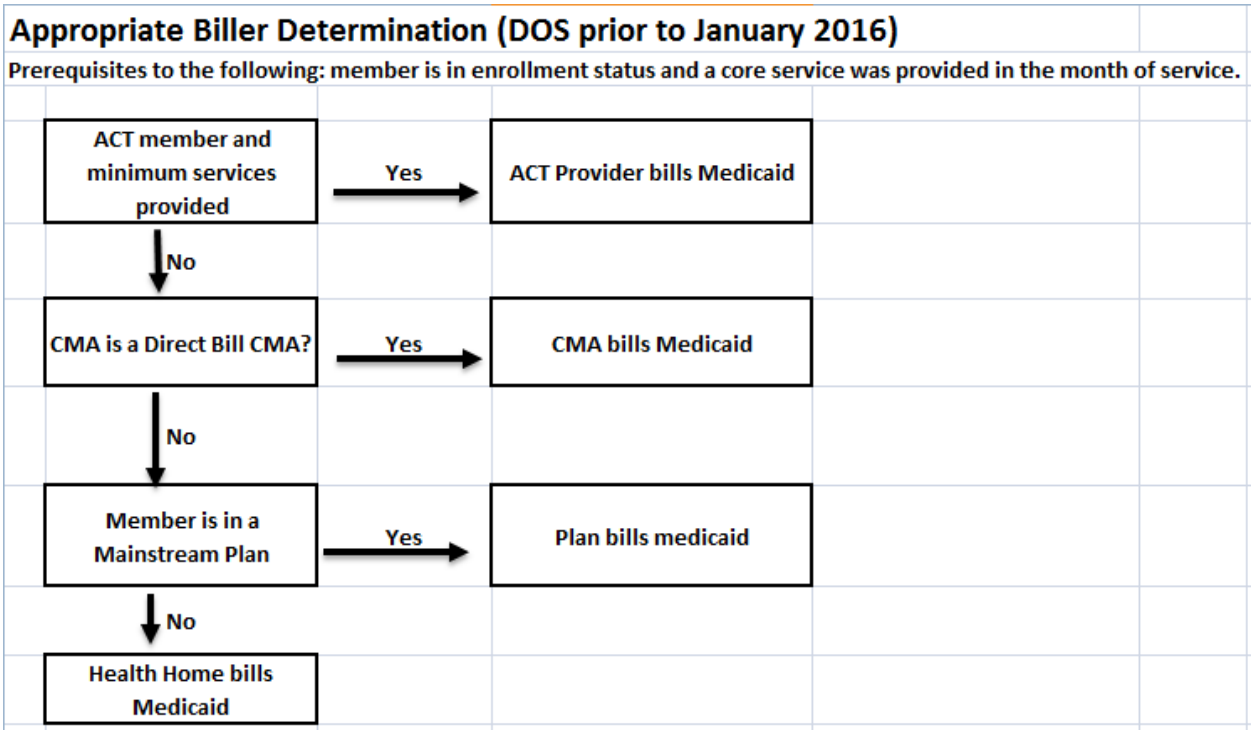
Appendix I: Record Type Codes

The record type codes listed below are submitted by either HHs or CMAs to indicate to the system the type of information that the user is submitting on the record. These codes also indicate to the system why type of format the system should expect for that record. For example, when a record is submitted with a value of 'D' in the **Record** Type field, the system knows to expect a delete record containing 17 characters.

These codes are used in the **Record Type** fields on the Tracking File Assignment Records, Tracking File Segments Record, Tracking File Delete Record, and the Tracking File Error Report files.

Code	Code Description	Record submitted by	Tracking File Segment Records	Tracking File Assignment Records	Tracking File Delete Record	Tracking File Error Report
S	Accept Assignment	HH/CMA		X		X
R	Reject Assignment	HH/CMA		X		X
E	End Assignment	HH/CMA		X		X
N	New Assignment	HH only		X		X
D	Delete Record	HH/CMA			X	X
C	Create Segment	HH/CMA	X			X
A	Accept Segment	HH only	X			X
M	Modify Segment	HH/CMA	X			X
P	Pend Segment	HH/CMA	X			X

Appendix J: Determining the Billing Entity Post 1/1/16



Appendix K: Plan Supplied Language Values

The following values are the only values that are accepted in the **Plan Provided Member Language** field on the MCP Final HH Assignment file.

Accepted Language Values
Arabic
Haitian-Creole
Polish
English
Cambodian (Khmer)
Vietnamese
Japanese
Russian
Navajo
Apache
Traditional Chinese
Simplified Chinese
Brazilian Portuguese
Korean
German
Tagalog
Other
Danish
Finnish
Irish
French
Spanish
Italian
American Sign
Lao
Cantonese

Appendix L: Reference and Contacts

The purpose of this appendix is to provide information on the NYS Medicaid program and to provide helpful links and contact information for Health Home providers.

1) If a member's personal information that is populated within this system by NYS Medicaid (e.g. date of birth, name, gender) is incorrect, then the member must correct that information directly with NYS Medicaid. Once this information is updated, it can take up to a week for that corrected information to be reflected within the MAPP HHTS. Depending on where the member's Medicaid case was opened, the member must either update this information through their local department of social services or through the Marketplace.
   a) If a member needs to update their information, a provider should view the member's County/District Code through MEVS to determine how the member should update their NYS Medicaid information.
      i) If the member's county code is 78, then that indicates that the member enrolled in NYS Medicaid through the Marketplace and that their case is open with the Marketplace. If a member with county code 78 needs to update personal information, the member can update it online themselves **OR** the member can call the Marketplace at 1-855-355-5777. Marketplace representative should be able to assist them and make any changes necessary.
      ii) If the member's County Code is not 78, then the member's case is open at their local department of Social Services. To correct personal information, the member can either call their local department of social services or walk in and speak to someone regarding correcting their personal information.
   b) The member may need to provide proof to either Social Services or the Marketplace (i.e., birth certificate, social security card, driver's license, etc.) to officially update their personal information with NYS Medicaid.
2) The Health Home website
   a) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
3) Health Homes Provider Manual: Billing Policy and Guidance
   a) https://www.emedny.org/ProviderManuals/HealthHomes/index.aspx
4) Health Home Program Email webform link (please select most appropriate subject when submitting an email)
   a) https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
5) Health Home Program Provider Policy line: **(518) 473-5569**
6) For additional information on how the Health Home High, Medium, Low rates are determined, please see the **HH HML Rate Information** document available at the link below
   a) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_hml_rate.pdf
7) Resources for determining if a member is eligible/appropriate for the Health Home Program:
   a) Eligibility Criteria for HH Services: Chronic Conditions
      i) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf
   b) Eligibility Requirements: Identifying Potential Members for HH Services
      i) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_hh_eligibility_policy.pdf
   c) Coverage Code Compatibility with HH Program
      i) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/coverage_codes_final_7.14.14.pdf
   d) Recipient R/E Compatibility with HH Program

i) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction-exception_codes_final_7.14.14.pdf

8) For questions about Health Home claims or issues with submitting Health Home claims:
   a) Information on working through denied Health Home claims
      i) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/information_on_denied_claims.pdf
   b) If the document above does not answer your question, call Computer Science Corporation (CSC) at: **1-800-343-9000**
   c) eMedNY **Provider Quick Reference Guide**
      i) https://www.emedny.org/contacts/telephone%20quick%20reference.pdf
   d) eMedNY **NYS Electronic Medicaid System Remittance Advice Guideline** document
      i) https://www.emedny.org/providermanuals/allproviders/general_remittance_guidelines.pdf
   e) eMedNY Payment cycle calendar
      i) https://www.emedny.org/hipaa/news/PDFS/CYCLE_CALENDAR.pdf