Medicaid Analytics Performance Portal Health Home Tracking System

File Specifications Document

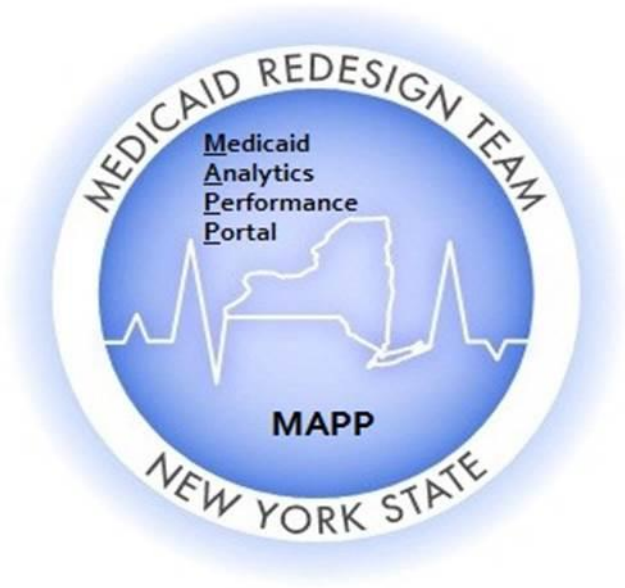

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Table of Contents

Introduction 7

Version Update 7

Purpose and Overview 7

MAPP HHTS Access 8

Additional Information 9

Brief Description of Files Available 9

Assignment Files 13

Managed Care Plan Assignment File 15

Description 15

Format 15

Editing Logic 20

Child Referral Download File 24

Description 24

Format 25

Editing Logic 26

Managed Care Plan Final Health Home Assignment File 27

Description 27

Format 27

Editing Logic 28

Error Report: Managed Care Plan Final Health Home Assignment File 30

Description 30

Format 30

Editing Logic 30

Health Home Assignment File 31

Description 31

Format 31

Editing Logic ..... 36~~35~~

Past Assignments 40

Description 40

Format ..... 41~~40~~

Editing Logic 41

Program Participation Files ..... 43~~42~~

Program Participation Upload File ..... 43~~42~~
Description ..... 43~~42~~
Format 43
Editing Logic 43
Program Participation Error Report 43
Description 43
Format ..... 44~~43~~
Editing Logic ..... 44~~43~~
Program Participation Download File 44
Description 44
Format 44
Editing Logic 44
Consent Files ..... 45~~44~~
Consent Upload File 45
Description 45
Format 45
Editing Logic 46
Consent Error File 47
Description ..... 48~~47~~
Format 48
Editing Logic 48
Consent Download File 48
Description 48
Format ..... 49~~48~~
Editing Logic 49
Tracking File Records 50
Tracking File Assignment Records 51
Description 51
Format 51
Editing Logic 52
Tracking File Segment Records 56
Description 56
Format 56

Editing Logic 57
Tracking File Delete Records 63
Description 63
Format 63
Editing Logic 64
Tracking File Error Report 64
Description 64
Format 64
Editing Logic 65
Member Downloads 65
Enrollment Download File 65
Description 65
Format 65
Editing Logic 67
My Members Download File 68
Description 68
Format 68
Editing Logic ..... 70~~69~~
Manage Assignments Download File 72
Description 72
Format 73
CIN Search Download File 73
Description 73
Format 73
Acuity Download File 76
Description 76
Format 77
Editing Logic 77
Billing Support 77
Billing Support Upload File 78
Description 78
Format 79
Editing Logic 80

Billing Support Error File 83
Description 83
Format 83
Billing Support Download File 83
Description 83
Format 86
Editing Logic ..... 90~~89~~
Partner Network Files 93
Partner Network File Upload 93
Description 93
Format 93
Partner Network File Error Report 94
Description 94
Format 94
Editing Logic 94
Partner Network File Download 95
Description 95
Format 95
Editing Logic 95
Assessment Files 96
Assessments Download File 96
Description 96
Format 96
Editing Logic 96
Appendix A: Field Descriptions 98
Appendix B: File Error Reason Codes 157
Appendix C: Segment Pend Reason Codes 165
Appendix D: Segment End Date Reason Codes 166
Appendix E: Assignment Rejection Codes ..... 167~~167~~
Appendix F: Assignment Pend Reason Codes 169
Appendix G: Assignment End Reason Codes 170
Appendix H: High, Medium, Low (HML) Assessment Codes 174
Appendix I: Tracking File Record Type Codes 177

Appendix J: Determining the Billing Entity 178
Appendix K: MCP Final HH Assignment File Accepted Values 179
Appendix L: Reference and Contacts ..... 182~~181~~
Appendix M: Consent File Codes ..... 184~~183~~
Appendix N: Program Participation File Codes ..... 185~~184~~

Introduction

Version Update

Version 3.0 and higher of the file Specifications removed references to historical use and changes of the MAPP HHTS file specifications and include the current functionality and usage of the specifications as of the most recent release date. Version logs and previous file specifications version are available in the archived section of the MAPP HHTS website for reference:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

Purpose and Overview

The purpose of the **Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) File Specifications Document** is to explain how 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 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, CMAs, and other organizations 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 <u>must</u> 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, <u>not to imply that a user can only use the file transfer method to perform the action within the system</u>. 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 learn how to navigate to the system and how to use all three methods during MAPP HHTS web based trainings. Please contact MAPP Customer Care Center (MAPP CCC – see Appendix L: Reference and Contacts) to request information on accessing existing training documents or web-based trainings.

This document includes the basic file formats that are listed on the Health Home website under Tracking System File Formats as "MAPP HHTS File Specifications v9.0":

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

The file format tables included in this document may contain two columns that do not appear on the file format excel spreadsheet.

The first one is the “Required” column containing values of ‘Y’ – yes, ‘N’-no, or ‘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 on an upload file; 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 may not be populated if the user who uploaded the file didn’t populate the field.
- A value of ‘C’ – conditional, means that the field is required, but only in certain situations (usually because a related field contains a value that requires additional information).

The second column not in the format tables is “Source”. This column indicates where data originated 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 the DOH Health Home Team or Managed Care Plans
User	Submitted by Managed Care Plans, Health Homes, Care Management Agencies, or other user

MAPP HHTS Access

The MAPP HHTS is a sub-section 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 DUA with DOH, and CMA that has a completed DOH approved BAA with a designated HH can access the system. LGU/SPOA and LDSS organizations also access the MAPP HHTS. Each provider ID 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 are responsible for setting up appropriate users from their organizations as MAPP HHTS users. All MCP, HH and CMA users must have an active HCS account and will be set up by their organization’s gatekeeper under one or more of the following user roles: worker, read only, gatekeeper, referrer 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. Referrer roles do not have access to view, upload or download files.

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

Additional Information

The files described in this document are organized into sub-sections based on the types of functions performed by each grouping of files. Each file in a sub-section contains a description, a file format table, 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 files, where applicable.

Lastly, all files can be uploaded into the system or downloaded from the system in either .csv or .txt (fixed length text file) format. When using fixed length text file format, special characters are disallowed in the file upload record. When using the comma delimited file format, a comma is necessary to represent the boundary between multiple fields but should not be used within a field. Additionally, all other special characters are disallowed in the file upload record.

However, error files will only be available in the format of the corresponding uploaded file (e.g. if you upload a .txt Billing Support Upload file, then your corresponding error file will be in .txt; if you upload a .csv tracking file, then your corresponding error file will be in .csv). Files uploaded into the system do not need a header row. We do, however, suggest you include header in .csv uploads to avoid file issues; if you include headers on a file upload, expect the first row containing the header information to be rejected.

Files can also be zipped prior to download. A zipped will be downloaded in either a .csv or .txt format.

File Changes have been archived on the website and this document reflects the system as it is currently implemented.

Brief Description of Files Available

File	Who Can Download	Who Can Upload	Description
Managed Care Plan Assignment File	MCP		This file is only accessible by MCP users 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.

File	Who Can Download	Who Can Upload	Description
Child Referral Download File	MCP, HH, CMA		This file contains information collected about a member that has an active, pending or pended assignment (no active segment) with the downloading provider that was entered into the MAPP HHTS through the Children's HH Referral Portal.
Managed Care Plan Final Health Home Assignment File		MCP	This file is only uploaded by MCP users and is used to assign a current plan member to a HH, to pend MCP Assignments, and to upload plan supplied member information such as language, updated demographic information, and optimization information.
Error Report: Managed Care Plan Final Health Home Assignment File	MCP		This file is created upon validating or processing an MCP Final HH Assignment file containing at least one error.
Health Home Assignment File	HH, CMA		This file is accessible by both HH and CMA users 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*. The Assignment file also contains information on pending and rejected transfers.
Past Assignments	MCP, HH, CMA		The Past Assignments file includes members who were assigned to the downloading user's organization but whose assignments with the user's organization were ended/rejected without resulting in segments within the last year.
Consent Upload File		HH, CMA	HH/CMA users upload this file to 'C' create, 'M' modify, and 'W' withdraw consent for all members, regardless of age. This file is also used to 'P' create Plan of Care records.
Consent Error File	HH, CMA		This file is created upon validating or processing a Consent Upload file containing at least one error.
Consent Download File	MCP, HH, CMA		This file contains all consent records and plan of care records with an active, withdrawn, or

File	Who Can Download	Who Can Upload	Description
			ended Consent Status for a provider's members.
Tracking File Assignment Records		HH, CMA	HHs use this file to accept, reject, and end member assignments; to create assignments for their CMAs; and to accept, reject, and end member assignments on behalf of their CMAs.
Tracking File Segment Records		HH, CMA	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. This file is also used to create and accept pending transfers.
Tracking File Delete Records		HH, CMA	The delete record is used to delete from the system an incorrectly entered outreach or enrollment segment and pending transfer requests.
Tracking File Error Report	HH, CMA		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.
Enrollment Download File	MCP, HH, CMA		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, canceled, hiatus, pended, pending active, pending closed, pending pended,* and *pending canceled.*
My Member Download File	MCP, HH, CMA		This file is downloaded from the ***My Members*** screen, which displays 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 with the user's provider.
Manage Assignments Download File	MCP, HH, CMA		This file is downloaded by a user from the online ***Manage Assignments*** screen, which displays the members that have a *pended or pending* assignment/ transfer with the user's organization.

File	Who Can Download	Who Can Upload	Description
CIN Search Download File	MCP, HH, CMA		This file is downloaded by a user from the ***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 a member's CIN.
Acuity Download File	MCP, HH, CMA		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 of outreach or enrollment while a member of the downloading MCP. Acuity has become obsolete for HH billing.
Billing Support Upload File		CMA, HH	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.
Billing Support Error File	HH, CMA		This file is created upon validating or processing a Billing Support Upload file containing at least one error.
Billing Support Download File	MCP, HH, CMA		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.
Partner Network File Upload		HHs	HHs use this file to submit to the system their network of providers.
Partner Network File Error Report	HHs		This file is created upon validating or processing a Partner Network File Upload file containing at least one error.
Partner Network File Download	MCP, HH, CMA		This file contains the information submitted into the system by an HH user 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.

File	Who Can Download	Who Can Upload	Description
Assessments Download File	MCP, HH, CMA		This file contains the children's HCBS assessment information and CANs-NY assessment information for assessments that have been signed and finalized in UAS.
Program Participation File		MCP, HH, CMA	Users upload this file to create, end, or cancel an opt-out record for a member for whom they have a signed opt out form. An MCP user can submit information for any member associated with the user's MCP. HH and CMA users can submit information for any member with a valid Medicaid ID regardless of the member's association with the uploading user's organization in MAPP HHTS.
Program Participation Error Report	MCP, HH, CMA		This file is created upon validating or processing a Program Participation file containing at least one error.
Program Participation Download File	MCP, HH, CMA		An MCP user will be able to view all members associated with the user's MCP in MDW when downloading this file. HH/CMA users will see members that have an HH/CMA assignment that overlaps the opt-out period as well as members that have had an opt-out record submitted from the downloading organization.

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 a straight referral is made (the referring provider does not put the member directly into an outreach or enrollment segment), which creates *pending* assignments/referrals with the members' MCPs (or HH for FFS members). An MCP can then either accept a member in a *pending* MCP assignment/referral

status, meaning that the plan agrees to assign the member to a HH, or the plan can pend the *pending* assignment/referral, meaning that the MCP is choosing not to act on the member's potential HH eligible status. An MCP would pend an assignment/referral 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/referral, the member's *pending* MCP assignment/referral moves to an *active* MCP assignment/referral status. An MCP can indicate that a *pending* MCP assignment/referral is accepted and move it to an active status by either accepting the *pending* assignment/referral or by the MCP assigning the member with a *pending* MCP assignment/referral directly to a HH, which automatically moves that member from a *pending* to an *active* MCP assignment/referral 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 members directly referred into the system and plan members assigned to the HH by the members' MCPs. The HH can either accept a *pending* HH assignment/referral, meaning that the HH agrees to assign the member to a CMA, or can reject the *pending* assignment/referral, 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/referral that is rejected by the HH is returned to DOH for reassignment. An HH can move a member from a *pending* HH assignment/referral to an *active* HH assignment/referral by either accepting the *pending* HH assignment/referral or by assigning a member with a *pending* HH assignment/referral to a CMA, which will automatically move the member to an *active* HH assignment/referral and create a *pending* assignment with the CMA. Additionally, when an HH creates a segment for a member with a *pending* HH assignment/referral, the system automatically moves the member's corresponding HH assignment status from *pending* to *active* and marks it as non-reportable (see last paragraph of this section for more information on non-reportable assignments).

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.* HHs are able to act on behalf of their CMAs.

While a member in an open outreach or enrollment segment 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. These "behind the scenes" assignments are called non-reportable and are not visible to users within the system. A member enrolled with a plan in outreach or enrollment will always have an *active* assignment with that MCP listed within the system. However, 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. This means that while an MCP member with an open segment will have an active MCP assignment within the system on the member's assignment tab, that member with the open segment will not be included on the MCP's assignment file.

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**.

As of ~~4/18/19~~11/~~14~~22/19 assignments that have been sitting with an MCP, HH or CMA for ~~an extended period of time~~90 days or longer will be ended and ~~these members~~ therefor removed from assignment files. Going forward,

any ~~adult~~ member that has had no assignment or segment action in the last ~~180~~ 90 days will be ended ~~and any child member that has had no assignment or segment action in the past year will be ended~~. This is a change from the previous purge logic, which removed an adult after 180 days and a child after 365 days. The purpose of this purge logic is to remove members that were ~~in the HH program but are no longer eligible or who have graduated~~known to the system but were not effectively connected to the program. Any member that has been removed from assignment files can be referred back into the program if appropriate. Members ~~that have been~~ with a *pended* ~~by the~~ MCP assignment follow special inactivity logic ~~time periods~~ that may differ from the usual 90 day~~s~~ purge logic. Please see *Appendix F: Assignment Pend Reason Codes* for a complete list of pend reasons and the system inactivity ~~timeframe for year~~logic for each MCP assignment pend reason. ~~for certain pend reasons will be excluded from this logic.~~

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 a member's demographic and contact information, last five unique providers that the member saw according to recent Medicaid claim and encounters data, 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.

As of 11/22/2019 fields that have become obsolete will remain on the file but will no longer contain data. These fields are indicated below with a "Null Value (blank)" value in the **Format** field,

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	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	M'caid	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	M'caid	Alpha

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
14	Medicaid Eligibility End Date	224	8	231	C	M'caid	MMDDYYYY, Numeric
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	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~~Blank	~~DOH~~N/A	Null Value (blank)
23	Acuity Score	382	7	388	Blank~~C~~	N/A~~DOH~~	Null Value (blank)~~00.0000, Numeric~~
24	Risk Score	389	6	394	Blank~~C~~	N/A~~DOH~~	Null Value (blank)~~Decimal, 999V99~~
25	Outpatient Rank	395	6	400	Blank~~C~~	N/A~~DOH~~	Null Value (blank)~~Decimal, 999V99~~
26	DOH Composite Score	401	6	406	Blank~~C~~	N/A~~DOH~~	Null Value (blank)~~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

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
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
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

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
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	Y	Gen	MMDDYYYY, Numeric
73	DOH Recommended Health Home MMIS ID	1410	8	1417	Blank~~C~~	N/A~~DOH~~	Null Value (blank)~~Numeric~~
74	DOH Recommended Health Home Name	1418	40	1457	Blank~~C~~	N/A~~M'caid~~	Null Value (blank)~~Alpha~~
75	HARP Flag	1458	1	1458	Y	M'caid	Alpha (E/Y/N) If eligible set to Y, if enrolled set to E
76	Managed Care Plan Assignment Status	1459	40	1498	Y	Gen	Alpha (Pending, Active, Pended)
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	M'caid	Alpha
81	CMA Assignment Status	1595	40	1634	C	HH/CMA	Alpha (Pending, Active, Rejected, Ended)
82	Assignment Source	1635	20	1654	Blank~~Y~~	N/A~~Gen~~	Null Value (blank)~~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 (see *Appendix K: ~~Plan Supplied Language Values)~~MCP Final HH Assignment File Accepted Values)*

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
91	CMA Assignment End Reason Code	1846	2	1847	C	CMA	Numeric (see Appendix G: Assignment End Reason Codes)
92	CMA Assignment End Reason Code Description	1848	40	1887	C	Gen	Alpha
93	CMA Assignment Record type	1888	10	1897	C	Gen	Alpha (Assignment, Referral, Transfer)
94	CMA Assignment Rejection Reason Code	1898	2	1899	C	CMA	Numeric (see Appendix E: Assignment Rejection Codes)
95	CMA Assignment Rejection Reason Code Description	1900	40	1939	C	Gen	Alpha
96	HH Assignment End Date	1940	8	1947	C	Gen	MMDDYYYY, Numeric
97	HH Assignment End Reason Code	1948	2	1949	C	HH	Numeric (see Appendix G: Assignment End Reason Codes)
98	HH Assignment End Reason Code Description	1950	40	1989	C	Gen	Alpha
99	HH Assignment Record type	1990	10	1999	C	Gen	Alpha (Assignment, Referral, Transfer)
100	HH Assignment Rejection Reason Code	2000	2	2001	C	HH	Numeric (see Appendix E: Assignment Rejection Codes)
101	HH Assignment Rejection Reason Code Description	2002	40	2041	C	HH	Alpha
102	HH Assignment Start Date	2042	8	2049	C	HH	MMDDYYYY, Numeric
103	MCP Assignment Record type	2050	10	2059	Y	Gen	Alpha (Assignment, Referral, Transfer)
104	End reason Comment	2060	300	2359	C	HH/CMA	Alphanumeric
105	Rejection reason Comment	2360	300	2659	C	HH/CMA	Alphanumeric
106	Pend Reason Code	2660	2	2661	C	MCP	Numeric
107	Pend Reason Code Comment	2662	300	2961	C	MCP	Alphanumeric
108	CMA Assignment Created Date	2962	8	2969	C	HH	MMDDYYYY, Numeric
109	CMA Assignment Start Date	2970	8	2977	C	CMA	MMDDYYYY, Numeric
110	CMA Assignment End Date	2978	8	2985	C	Gen	MMDDYYYY, Numeric
111	Referral Suggested Health Home Assignment	2986	8	2993	C	HH/CMA	Numeric
112	MCP Assignment Start Date	2994	8	3001	C	Gen	MMDDYYYY, Numeric
113	Outreach/Enrollment Code	3002	1	3002	C	Gen	Alpha (O, E)
114	Health Home MMIS ID	3003	8	3010	C	Gen	Numeric
115	Health Home Name	3011	40	3050	C	Gen	Alpha

Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
116	Segment End Date	3051	8	3058	C	HH/CMA	MMDDYYYY, Numeric
117	Segment End Date Reason Description	3059	40	3098	C	HH/CMA	Alpha
118	Segment End Date Reason Comments	3099	300	3398	C	HH/CMA	Alpha
119	Eligible for Outreach	3399	1	3399	C	Gen	Alpha (Y, N)
120	No of outreach mos within 12 mos	3400	2	3401	C	Gen	Numeric (01-12)
121	Child HCBS Flag	3402	1	3402	C	User	Alpha (O/N/H)
122	Suggested Health Home Name	3403	40	3442	C	User	Alpha
123	Suggested Health Home MMIS ID	3443	8	3450	C	User	Numeric
124	Suggested CMA Name	3451	40	3490	C	User	Alpha
125	Suggested CMA MMIS ID	3491	8	3498	C	User	Numeric
126	Engagement Optimization	3499	1	3499	C	User	Alpha
127	MCP Determined Eligibility	3500	23	3522	N	User	Numeric

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 a 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. **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 an encounter. This **excludes** claims and encounters for durable medical equipment, transportation, and pharmacy and **includes** physician, clinic, care management, inpatient, and emergency department claims and encounters.
    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 these criteria, these fields will be blank.
3. **HH Assignment Fields** (#77-78, #96-102 and #111)
    a. The **HH Assignment Status** (field #77) contains a value if the MCP assigned a member to a 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 reject the member's *pending* HH assignment. When the HH rejected the *pending* HH assignment created by the MCP, the system ended the member's pending assignment with that HH and kept the member's *active* MCP Assignment. The MCP should use **HH Assignment Rejection Reason Code** (field #100) and **HH Assignment Rejection Reason Code Description** (field #101) to further understand why the HH rejected the *pending* HH assignment and determine a more suitable HH to assign the member to. If an MCP user sees a value of 'Ended' in this field, then that user knows that the HH that the MCP assigned the member to ended the member's *active* HH assignment. When the HH ended the *active* HH assignment created by the MCP, the system ended

the member's assignment with that HH and kept the member's *active* MCP Assignment. In this case, it is possible that the HH had a segment with the member that ended and the HH decided to end the HH assignment when the segment ended or the HH may have accepted the HH assignment, never created a segment, then decided to end the HH assignment. The MCP should reassign a member with an 'ended´ value in the **HH Assignment Status** field to another HH, as appropriate. The MCP should look to **HH Assignment End Date** (field #96), **HH Assignment End Reason Code** (field #97) and **HH Assignment End Reason Code Description** (field #98) to further understand why the HH ended the *active* HH assignment and determine, when appropriate, a more suitable HH to assign the member to. The MCP should look at fields #117 and #118 to determine why a segment was ended (if any segment exists). These fields are populated with the member's most recent segment information and therefore could be populated with information from prior to the most recent ended HH assignment. By using fields #114 and #115 the MCP can determine when and by which HH the segment was ended.

b. Fields #96-98 and #100-101 will only be populated if the ended or rejected HH assignment (assignment must be reportable) overlaps at least one day with the period of time that the member has an assignment with the downloading MCP.
c. **HH Assignment Record Type** (field #99) is populated for any HH assignment (in either pending, active or ended status) that overlaps at least one day with the MCP assignment.
d. The **Suggested Alternative Health Home Assignment (**field #78) will only be populated if the HH suggested another HH to which the member should be assigned when rejecting the *pending* HH assignment or ending the *active* HH assignment. Members entered into the MAPP HHTS on or after December 1, 2016 that were under 21 when they were entered into the system **WILL NOT** contain a value in the **Suggested Alternative Health Home Assignment (field #78)** field.
e. **HH Assignment End Date** (field #96) and **HH Assignment Start Date** (field #102)
    I. **HH Assignment End Date** (field #96) is populated with the date that the assignment was ended by the HH and should always be populated if **Health Home Assignment Status** (field #77) is populated with a value of ended or rejected.
    II. **HH Assignment Start Date** (field #102) is populated with the start date of the HH assignment and should always be populated if **Health Home Assignment Status** (field #77) is populated with a value of ended or active.
f. **Referral Suggested Health Home Assignment** (field #111) is populated with the MMIS ID of the HH that a user suggests when the member has a Pending, Pended, or Active MCP assignment record with record type of referral. For example, a user from CMA A makes a referral for Lindsey Lou. While speaking with Lindsey, Lindsey asks to work with HH B, who is currently providing services for her friend. CMA A, therefore populated the HH dropdown in the adult referral wizard with HH B, which is now displayed for the MCP. The MCP should use this information when assigning Lindsey downstream. Referrers are not required to complete this field and therefore it may be blank.

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.

4. **CMA Assignment Fields** (# 79-81, # 91-95 and #108-110)
    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' or 'ended' in **CMA Assignment Status** (field #81) knows that the HH assigned the member to the CMA listed in fields #79 & #80 and that the CMA rejected/ended the

assignment. This tells the MCP that the HH that the MCP assigned the member to (fields #11-13) should reassign the member to another CMA.

b. Fields #91-95 provide additional information as to why a CMA may have ended an *active* CMA assignment or rejected a *pending* CMA assignment for any reportable CMA assignments that overlap with the MCP assignment for at least one day. This information is helpful and should be used to help inform the MCP when determining if a member needs to be reassigned to a different HH.

c. **CMA Assignment Record Type** (field #93) is populated for any CMA assignment (in either pending, active or ended status) that overlaps at least one day with the MCP assignment.

d. Depending on the member's status, fields #108-110 would also be populated as follows:

   I. When field #81 is populated with Pending, **CMA Assignment Created Date** (field #108) must be populated with the date that the reportable CMA assignment was created.

   II. When field #81 is populated with Active, **CMA Assignment Created Date** (field #108) must be populated with the date that the reportable CMA assignment was created and **CMA Assignment Start Date** (field #109) must be populated with the date that the CMA assignment moved from Pending to Active.

   III. When field 81 is populated with Ended or Rejected, **CMA Assignment Created Date** (field #108) must be populated with the date that the reportable CMA assignment was created, and **CMA Assignment Start Date** (field #109) must be populated with the date that the CMA assignment moved from Pending to Active, if applicable, and **CMA Assignment End Date** (field #110) must be populated with the date that the pending CMA assignment was rejected or the date that the Pending or Active CMA assignment was ended.

5. End Reason Comment and **Rejection Reason Comment** (field #104-105)

a. **End Reason Comment** (field #104) should only be populated with a comment associated with the ended CMA assignment if the member's HH assignment that overlaps with the CMA assignment is either Active or Null. If there is an ended HH assignment which overlaps with the MCP assignment the HH End Reason Comment will be populated. If no end reason comments were entered by the ending provider this field will be blank.

b. **Reject Reason Comment** (field #105) should only be populated with a comment associated with the Rejected CMA assignment if the member's HH assignment that overlaps with the CMA assignment is either Active or Null. If there is a rejected HH assignment which overlaps with the MCP assignment the HH Rejection Reason Comment will be populated. If no rejection reason comments were entered by the rejecting provider this field will be blank.

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. **MCP Assignment Record Type** (#103) and **MCP Assignment Start Date** (#112)

a. **MCP Assignment Record Type** (field #103) is the record type of the MCP assignment record. To determine the correct assignment record to use, the system will compare Create Date(s), if any, and Start Date(s), if any. The system will select the record type associated with the most recent of the compared dates.

b. **MCP Assignment Start Date** (field #112) reflects the most recent of the member's MCP Assignment start dates and displays it.

8. **Pend Reason** (#106-107)

a. **Pend Reason Code** (field #106) will only include data if the MCP assignment record is Pended. If the reason code is other, the comment entered by the pending provider will display in **Pend Reason Code Comment** (field #107).

9. **Medicaid Eligibility End Date** (field #14)
    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 MAPP HHTS does 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 #14).
10. **Fields Relating to Member's Most Recent Segment Information** (fields #113-118)
    a. The system will populate fields #113-118 with the most recent segment information (for any segment that is in a non-cancelled or non-hiatus status) for any member regardless of if the organization involved in the segment is associated with the downloading provider.
    b. **Outreach/Enrollment Code** (field #113) specifies if the most recent segment the member had was an outreach or an enrollment segment.
    c. **Health Home MMIS ID** (field #114) and **Health Home Name** (field #115) list the Health Home information associated with the member's most recent segment.
    d. **Segment End Date** (field #116)**, Segment End Date Reason Description** (field #117)**,** and **Segment End Date Reason Comments** (field #118) provide further information as to why the most recent segment ended.
        I. Providers are expected to use this information to determine if the member should be assigned downstream. For example, should an MCP see a member on this file with an **Active MCP Assignment** (field #76) but no **Health Home Assignment Status** (field #77) they should review fields #114-118 to determine if it makes sense to assign the member to a different Health Home or to pend the member.
            1. If they see that the member had a **Previous Enrollment Segment** (field #113) with a **Segment End Date Reason Description** (field #117) of 'Member no longer requires HH services' they would know that it is not appropriate to re-assign the member at this time and instead they would pend the member.
            2. If they see that the member had a **Previous Enrollment Segment** (field #113) with a segment end date reason description of (field #117) of 'Member moved out of service county' with a **Segment End Date Reason Comment** (field #118) of "mbr now living in Monroe county" the MCP would know that they should reassign the member to a Health Home that serves Monroe County.
11. **Fields Related to Outreach** (fields #119-120)
    a. **Eligible for Outreach** (field #119) will display a N if a member has 2 or more months of outreach in a status other than Cancelled or Hiatus within the last 12 months. If the member has 1 or less months of outreach in a status other than Cancelled or Hiatus in the last 12 months, the field will display a Y.
    b. **No of outreach mos within 12 mos** (field #120) displays a count of the number of months of outreach in a status other than Cancelled or Hiatus for the member within the last 12 months.
        I. Providers should use the data in these 2 fields as well as any new information that they have regarding a member to determine if it is appropriate to re-assign a member downstream.
        II. The 12-month periods are based on the date the file is downloaded. The month that the user is downloading the file is included in the 12-month count. For example, if a provider

downloads the file on 12/10/2017 the system will calculate the number of months of outreach the member had between 1/1/2017 and 12/31/2017.

16. Use the member's date of birth to determine if an assignment is for a child or an adult.

18.**Child HCBS Flag** (field #121) For children referred into the program on or after 1/10/19 this field will be populated based on the referral rationale selected during the referral process in the Children's Referral Portal (CRP). Children referred into the program prior to 1/10/19 will have a record with a blank value in this field. Adults will have a record with a blank value in this field both prior to and after 1/10/19.

i. The system will populate the field with "Y" if "HCBS Only" was selected for the member on the Referral Rationale Screen in the CRP.
ii. The system will populate the field with "H" if "Chronic Conditions and HCBS" was selected for the member on the Referral Rational Screen in the CRP.
iii. The system will populate the field with "N" if "Chronic Conditions Only" was selected for the member on the Referral Rationale Screen on the Referral Rational Screen in the CRP

19. **Fields Relating to Suggested Providers Selected during a Child Referral** (fields #122-125)

a. MAPP will populate these fields based on a referrer's responses when referring a child via the CRP.
b. If the member was not referred, was referred using the Adult Referral Wizard/File, was a child referred prior to 1/10/19, was entered directly into a segment, or the referrer did not select a suggested provider, these fields will be blank.
c. If the member has had multiple referrals where suggested providers were selected, the system will display the most recently suggested provider information.

20. **Engagement Optimization** (field #126-127)

a. Engagement Optimization (#126) is populated with A-C (now -excluding Y) or blank if indicated by the MCP upon file upload. These values represent different types of MCP initiated engagement plans. Value descriptions are listed in *Appendix K*: *MCP Final HH Assignment File Accepted Values*
b. MCP Determined Eligibility (#127) is populated with up to 8 two-digit eligibility codes that are deliminated with a space. These values and their definition can be found in *Appendix K: MCP Final HH Assignment File Accepted Values*.
c. Both of these fields are associated with the MCP that uploaded the file and it's downstream providers. If a member switches from MCP to FFS or switches MCPs these values will no longer display.

Child Referral Download File

Description

This file contains information collected about a member that was entered into the MAPP HHTS through the Children's HH Referral Portal.

MCP users can download the Child Referral Download file to view members under 21 years of age that have a *pending*, *pended*, or *active* (but no segments in a non-cancelled or non-closed status) assignment record associated with their organization. HH and CMA users can download the Child Referral Download file to view members under

21 years of age that have a reportable *pending or active* assignment record (but no segments in a non-cancelled or non-closed status) associated with their organization.

Format

Child Referral Download File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**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	DOB	69	8	76	Y	MMDDYYYY, Numeric
5	Referrer First Name	77	30	106	Y	Alpha
6	Referrer Last Name	107	30	136	Y	Alpha
7	Referrer Organization name	137	30	166	Y	Alpha
8	Referrer Organization ID	167	8	174	Y	Numeric
9	Consenting Individual to Refer	175	95	269	Y	Alpha
10	Consenter First Name	270	30	299	Y	Alpha
11	Consenter Last Name	300	30	329	Y	Alpha
12	Consenter Area Code	330	3	332	N	Numeric
13	Consenter Phone Number	333	7	339	N	Numeric
14	Consenter Preferred Communication	340	5	344	N	Alpha
15	Consenter Pref. Time of Day	345	9	353	N	Alpha
16	Consenter Email Address	354	40	393	N	Alpha
17	Additional Info on Chronic Conditions	394	300	693	N	Alpha
18	Comments Related to Referral	694	300	993	N	Alpha
19	Originating Referral Source Contact Name	994	60	1053	N	Alpha
20	Originating Referral Source Organization	1054	30	1083	C	Alphanumeric
21	Originating Referral Source Street 1	1084	30	1113	C	Alphanumeric
22	Originating Referral Source Street 2	1114	30	1143	N	Alphanumeric
23	Originating Referral Source City	1144	30	1173	C	Alpha
24	Originating Referral Source State	1174	2	1175	C	Alpha
25	Originating Referral Source Zip Code	1176	9	1184	C	Numeric
26	Originating Referral Source Area Code	1185	3	1187	C	Numeric
27	Originating Referral Source Phone Number	1188	7	1194	C	Numeric
28	Originating Referral Source Extension	1195	5	1199	C	Numeric
29	Originating Referral Source Phone Type	1200	4	1203	C	Alpha (Home, Cell, Work)
30	Comments	1204	300	1503	N	Alphanumeric
31	HCBS	1504	30	1533	C	Alpha (HCBS/None)

Child Referral Download File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Format**
32	Chronic Conditions	1534	100	1633	C	Alpha (Two or more chronic conditions, SED, Complex Trauma, HIV/AIDs, None)
33	Suggested Health Home Name	1634	40	1673	C	Alpha
34	Suggested Health Home MMIS ID	1674	8	1681	C	Numeric
35	Suggested CMA Name	1682	40	1721	C	Alpha
36	Suggested CMA MMIS ID	1722	8	1729	C	Numeric

Editing Logic

Fields #1-36 are populated for any member under 21 years of age submitted to the system through the Children's Referral Portal (CRP) with *pended*, *ending*, or *active* assignments and no segments as of the date the file is downloaded. If there is more than one referral per member, the most recent referral data is populated.

1. Data fields (#1-4) include the member's **Member ID** (field #1), **First Name** (field #2), **Last Name** (field #3), and **DOB** (field #4) information from the Medicaid Data Warehouse.
2. Data fields (#5-6) include the **Referrer First Name** (field #5) and **Referrer Last Name** (field #6) of the user (referrer) that submitted the most recent referral via the CRP.
3. **Referrer Organization Name** (field #7), is populated with the Managed Care Plan Name, Health Home Program Name, Care Management Agency Program Name, LGU Organization Name, LDSS Organization Name, or SPOA Organization Name, of the organization that submitted the most recent referral via the CRP. If DOH submitted the referral, the organization that DOH submitted on behalf of populates in this field.
4. **Referrer Organization ID** (field #8), is populated with the MMIS ID or HCS ID of the organization that submitted the most recent referral via the CRP. If DOH submitted the referral, the MMIS ID or HCS ID of the organization that DOH submitted on behalf of populates in this field.
5. **Consenting Individual to Refer** (field #9), includes the consenter's relationship with the member selected on the Consenter screen from the most recent referral via the CRP.
6. Data fields (#10-13) includes the **Consenter First Name** (field #10), **Last Name** (field #11), **Consenter Area Code** (field #12), and **Consenter Phone Number** (field #13). This information is retrieved from the most recent referral for the member that was submitted via the CRP.
7. Data fields (#14-16) include the consenter's contact details. The **Consenter Preferred Communication** (field #14), **Consenter Preferred Time of Day for Contact** (field #15), and **Consenter Email Address** (field #16). Information is retrieved from the most recent referral for the member that was submitted via the CRP.
8. Data fields (#17-18) include **Additional Info on Chronic Conditions** (field #17) which is any free text response entered under the chronic conditions page of the Children's Referral Portal and **Comments Related to Referral** (field #18) which is any free text response entered under the Consenter Contact information of the Children's Referral Portal.
9. Data fields (#19-30) are populated with information only if the provider entering a children's referral has indicated that someone outside of their organization provided them with the referral information outside of MAPP HHTS. The system then populates these fields with any information the MAPP HHTS user entered

related to the provider who originally identified the member as Health Home eligible and made the referral.

10. **Fields Pertaining to the HH Qualifying Conditions of the Member** (field #31-32)
    a. **HCBS** (field #31) indicates if the referrer felt that the member qualified for HH services based on being part of the HCBS identified population.
    b. **Chronic Conditions** (field #32) indicates what Chronic Conditions the member has that qualifies the member to be referred into the HH program.
    c. Should the member not have either HCBS or Chronic Conditions the respective field will indicate this by populating the response 'None'.

11. **Fields Relating to Suggested Providers** (fields #33-36)

    a. The system will populate these fields based on a referrer's responses when referring a child via the CRP.
    b. If the child was referred prior to 1/10/19 or the referrer did not select a suggested provider, these fields will be blank.

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, to pend MCP Assignments, and to upload plan supplied member contact, language, and optimization information into the system. The contact, language, and optimization fields 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 download files and may 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

Managed Care Plan Final Health Home Assignment File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
11	Plan Provided Member Language	180	30	209	C	Alpha
12	Engagement Optimization	210	1	210	N	Alpha
13	MCP Determined Eligibility	~~210~~211	~~1~~23	~~210~~233	~~C~~N	Numeric

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**.**
    a. Submit a record containing the member's CIN in **Member ID** (field #1) and the MMIS Provider ID of the HH that the MCP is assigning the member to in the **Health Home MMIS Provider ID** (field #2) field.
2. Reassign a member **with** an *active* or *pending* HH assignment, **NO** corresponding segments that are not closed or cancelled, **AND NO*** 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 (HH B) that the MCP would like to reassign the member to in **Health Home MMIS Provider ID** (field #2). 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. The HH assignment (HH A) will be ended once the MCP submits the MCP Final HH Assignment file reassigning the member to a new HH (HH B).
    c. This will not change the member's *active* MCP assignment status.

*If the member has a *pending* or *active* CMA Assignment, then the system will end date the *pending* or *active* CMA assignment.

3. Assign a member that does not have an active assignment in the system and is over 21 (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.
    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 **Health Home MMIS Provider ID** (field #2) or **Pend Reason Code** (field #3).
    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 the MCP is assigning the member to in **Health Home MMIS Provider ID** (field #2) field AND do not populate **Pend Reason Code** (field #3).
4. **Pend** the assignment for a member with an *active*, *pending* or a *pended* MCP assignment

a. To pend a member's MCP assignment, **Health Home MMIS Provider ID** (field #2) must be blank and **Pend Reason Code** (field #3) 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 #4-9) 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 #4) must contain at least 3 characters.
      ii. **Plan Provided Secondary Address – Zip** (field #9) must contain a valid zip code format. This 9-character field must contain either the five-digit zip code format (xxxxx) or the five-digit zip code plus four format (xxxxxxxxx).
      iii. **Plan Provided Secondary Address – City** (field #7) must contain letters only.
      iv. Values submitted to the system in field # 4-9 will be stored as Plan Supplied address evidence in the *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** (field #8) 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 phone number information into the system.
   a. **Plan Provided Member Phone Number** (field #10) is not required. However, when it is populated, it must contain a 10-digit number. If a record is submitted that doesn't meet these criteria the record will not be accepted.
7. Uploading MCP supplied language information into the system.
   a. **Plan Provided Member Language** (field #11) is not required. However, when it is populated, it must contain one of the languages listed in *Appendix K: MCP Final HH Assignment File Accepted Values*. If a record is submitted with a value in **Plan Provided Member Language** (field #11) that is not listed in *Appendix K,* the record will be accepted, but the unaccepted value listed in **Plan Provided Member Language** (field #11) will not be recorded within the system.
8. Uploading MCP Optimization and Eligibility information
   a. Member CIN (field #1) is required if a user submits an accepted value in either the **Engagement Optimization** (field #12) or **MCP Determined Eligibility** (#13) field. Please see *Appendix K: MCP Final HH Assignment File Accepted Values* for a list of accepted values.
   b. An MCP can submit acceptable values in one or both of these fields and also submit other information in any other fields (#2-11).
   c. Providers can submit a 'D' record to remove a value previously submitted in the **Engagement Optimization** field~~,~~. When submitted a 'D' record, all additional fields other than **Member CIN** (#1) must be blank. This will result in a blank value in the **Engagement Optimization** field in the Managed Care Plan Assignment download file and the Health Home Assignment download file.
   d. Providers can submit up to 8 of the 2-digit MCP Determined Eligibility codes (with a space deliminter) listed in Appendix K in the **MCP Determined Eligibility field**. If a value has already been submitted to this field, it can be rewritten by submitting another record with values in this field.

~~8.~~9. 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.

~~9.~~10. The MMIS Provider ID submitted in **Health Home MMIS Provider ID** (field #2) 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.

~~10.~~11. Members submitted in this file cannot have an outreach or enrollment segment in the system in any status except *Closed* or *Canceled*.

~~11.~~12. A record cannot contain a value in both **Health Home MMIS Provider ID** (field #2) and **Pend Reason Code** (field #3).

~~12.~~13. 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** (field #2), then the record will be rejected.

~~13.~~14. As of the file submission date, 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 #4) will be populated with a description of why the record was rejected. This 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*. It also contains information on members that have a pending or rejected transfer with the HH/CMA downloading the file.

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.

As of 11/22/2019 fields that have become obsolete will remain on the file but will no longer contain data. These fields. are indicated below with a 'Null Value (blank)" value in the **Format** field.

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	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	C	Gen	Numeric
12	Health Home NPI	174	10	183	C	M'caid	Numeric
13	Health Home Name	184	40	223	C	M'caid	Alpha
14	Medicaid Eligibility End Date	224	8	231	C	M'caid	MMDDYYYY, Numeric
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	C	M'caid	Alphanumeric
18	MDW Member City	313	40	352	Y	M'caid	Alpha

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
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~~	Blank~~DOH~~	~~MMDDYYYY, Numeric~~Null Value (blank)
23	Acuity Score	382	7	388	~~C~~	Blank~~DOH~~	Null Value (blank)~~00.0000, Numeric~~
24	Risk Score	389	6	394	~~C~~	Blank~~DOH~~	Null Value (blank)~~Decimal, 999V99~~
25	Outpatient Score	395	6	400	~~C~~	Blank~~DOH~~	Null Value (blank)~~Decimal, 999V99~~
26	DOH Composite Score	401	6	406	~~C~~	Blank~~DOH~~	Null Value (blank)~~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

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
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
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

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
72	HARP Flag	1402	1	1402	Y	DOH	Alpha (Y/N/E) If HARP eligible, set to Y; if enrolled set to E
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	C	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~~	Blank~~Gen~~	Null Value (blank)~~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
88	CMA Assignment End Reason	1790	2	1791	C	CMA	Numeric
89	CMA Assignment End Reason Code Description	1792	40	1831	C	Gen	Alpha
90	CMA Assignment Record type	1832	10	1841	C	Gen	Alpha (Assignment, Referral, Transfer)
91	CMA Assignment Rejection Reason Code	1842	2	1843	C	CMA	Numeric
92	CMA Assignment Rejection Reason Code Description	1844	40	1883	C	Gen	Alpha

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
93	HH Assignment Record type	1884	10	1893	C	Gen	Alpha (Assignment, Referral, Transfer)
94	HH Assignment Start Date	1894	8	1901	C	Gen	MMDDYYYY, Numeric
95	MCP Assignment Record type	1902	10	1911	C	Gen	Alpha (Assignment, Referral, Transfer)
96	MCP Type	1912	40	1951	C	Gen	Alpha
97	End reason Comment	1952	300	2251	C	CMA	Alphanumeric
98	Rejection reason Comment	2252	300	2551	C	CMA	Alphanumeric
99	CMA Assignment Created Date	2552	8	2559	C	CMA	MMDDYYYY, Numeric
100	CMA Assignment Start Date	2560	8	2567	C	CMA	MMDDYYYY, Numeric
101	CMA Assignment End Date	2568	8	2575	C	CMA	MMDDYYYY, Numeric
102	Rejected Assignment Suggested Alt Assignment	2576	8	2583	C	HH/CMA	Numeric
103	MCP Assignment Created Date	2584	8	2591	R	Gen	MMDDYYYY, Numeric
104	MCP Assignment Start Date	2592	8	2599	R	Gen	MMDDYYYY, Numeric
105	Outreach/Enrollment Code	2600	1	2600	C	Gen	Alpha (O, E)
106	Health Home MMIS ID	2601	8	2608	C	Gen	Numeric
107	Health Home Name	2609	40	2648	C	Gen	Alpha
108	Segment End Date	2649	8	2656	C	HH/CMA	MMDDYYYY, Numeric
109	Segment End Date Reason Description	2657	40	2696	C	HH/CMA	Alpha
110	Segment End Date Reason Comments	2697	300	2996	C	HH/CMA	Alpha
111	Eligible for Outreach	2997	1	2997	C	Gen	Alpha (Y, N)
112	No of outreach mos within 12 mos	2998	2	2999	C	Gen	Numeric (01-12)
113	Child HCBS Flag	3000	1	3000	C	Referrer	Alpha (O/N/H)
114	Suggested Health Home Name	3001	40	3040	C	Referrer	Alpha
115	Suggested Health Home MMIS ID	3041	8	3048	C	Referrer	Numeric
116	Suggested CMA Name	3049	40	3088	C	Referrer	Alpha
117	Suggested CMA MMIS ID	3089	8	3096	C	Referrer	Numeric
118	Engagement Optimization	3097	1	3097	C	MCP	Alpha
119	Transfer Initiator MMIS ID	3098	8	3105	C	HH/CMA	Numeric
120	Transfer Initiator Organization Name	3106	40	3145	C	HH/CMA	Alpha
121	Transfer Receiver MMIS ID	3146	8	3153	C	HH/CMA	Numeric

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
122	Transfer Receiver Organization Name	3154	40	3193	C	HH/CMA	Alpha
123	Transfer Create Date	3194	8	3201	C	HH/CMA	Date
124	Transfer Effective Date	3202	8	3209	C	HH/CMA	Date
125	Transfer Reason	3210	75	3284	C	HH/CMA	Alpha
126	Transfer Comment	3285	300	3584	C	HH/CMA	Alphanumeric
127	MCP Determined Eligibility	3585	23	3607	C	MCP	Numeric

Editing Logic

1. When an **HH user** accesses this file, it contains both managed care enrolled and fee for service members that have an *active* or *pending* assignment with the downloading provider. Members enrolled in in a managed care plan will have an *active* MCP assignment status. For fee for service members, **Managed Care Plan MMIS Provider ID** (field #9)**, Managed Care Plan Name** (field #10)**,** and the **Managed Care Plan Assignment Status (**field #73) will be blank.
    a. For members that have been assigned to a CMA, **CMA Assignment Status** (field #78) will contain one of four 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's assignment made to the CMA by the HH; *rejected* meaning that the HH assigned the member to a CMA, but that the CMA rejected the *pending* CMA assignment; or *ended* meaning that the HH assigned the member to a CMA, the CMA accepted that assignment, and then the CMA ended the *active* CMA assignment. If the member has not yet been assigned to a CMA, then **CMA Assignment Status** (field #78) will be blank.
    b. When **CMA assignment Status** (field #78) is populated the HH user can use the CMA fields (#88-92) to learn more about the CMA assignment. See number 8 for more information on CMA fields.
2. 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. It is possible for members enrolled in managed care working with a voluntary foster care agency (VFCA) CMA to have an *active* MCP assignment, no HH assignment, and then a *pending* or *active* CMA assignment status. Fee for service members will have an *active* HH assignment and **Managed Care Plan MMIS Provider ID** (field #9)**, Managed Care Plan Name** (field #10), and the **Managed Care Plan Assignment Status** (field #78) will be blank. In the case of a Voluntary Foster Care Agency (VFCA) it is possible to see a blank MCP assignment and a blank HH. In the **CMA Assignment Status** (field #78), 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.
3. 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. MAPP HHTS 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 **Medicaid Eligibility End Date** (field #14).
4. Fields #80-87, 118, and 127 will only be populated if the member's plan submitted information on the MCP Final HH Assignment file.

a. A list of accepted values and their definition for **Engagement Optimization** (field #118) and **MCP Determined Eligibility** (field #127) can be found in A*ppendix K: MCP Final HH Assignment File Accepted Values* and are meant to help the HH/CMA provider know that the MCP has already reviewed the members case and/or discussed the HH program with them.

~~4.~~5. 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 an encounter. This **excludes** claims and encounters for durable medical equipment, transportation, and pharmacy and **includes** physician, clinic, care management, inpatient, and emergency department claims and encounters.

b. For members that only have two claims within the system that match the criteria listed in 7a, 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 these criteria, these fields will be blank.

~~5.~~6. **CMA Assignment** (fields #76-78, #88-92 and #99-101)

a. These fields will only be populated when a HH downloads the file if the HH has assigned the member to a CMA. A HH user that sees a value of 'rejected' or 'ended' in **CMA Assignment Status** (field #78) knows that the HH assigned the member to the CMA and that the CMA rejected/ended the assignment. This tells the HH that they assigned the member to a **CMA** (fields #11-13) and now must reassign the member to another CMA. The HH should review for **ended CMA assignments (**fields #88-89) and for **rejected CMA Assignments** (fields #91-92) to aid in the reassignment process.

   i. These fields are only populated when the user is downloading on behalf of a HH and a reportable assignment record is **Ended** (#88-89) or **Rejected** (#91-92) by the CMA and it overlaps for at least one day with the HH assignment record period.

   ii. These fields should never be populated when a CMA user is downloading the file.

b. **CMA Assignment Record Type** (field #90) and **CMA Assignment Status** (field #78) should always be populated when the file is downloaded by a HH user and when a reportable CMA Assignment overlaps for at least one day with the HH assignment record period. **CMA Assignment Record Type** (field #90) and **CMA Assignment Status** (field #78) should always be populated when the file is downloaded by a CMA user.

c. Depending on the member's status, fields #99 -101 must also be populated as follows:

   i. When field #78 is populated with 'Pending', **CMA Assignment Created Date** (field #99) will be populated with the date that the reportable CMA assignment was created.

   ii. When field #78 is populated with 'Active', **CMA Assignment Created Date** (field #99) will be populated with the date that the reportable CMA assignment was created and **CMA Assignment Start Date** (field #100) will be populated with the date that the CMA assignment moved from 'Pending' to 'Active'.

   iii. When field #78 is populated with 'Ended' or 'Rejected', **CMA Assignment Created Date** (field #99) will be populated with the date that the reportable CMA assignment was created, and **CMA Assignment Start Date** (field #100) with the date that the CMA assignment moved from 'Pending' to 'Active', if applicable, and **CMA Assignment End Date** (field #101) with the date that the pending CMA assignment was 'Rejected' or the date that the pending or active CMA assignment was 'Ended'.

~~6.~~7. **End Reason Comment** (field #97) and **Rejection Reason Comment** (field #98)

a. If the downloading provider is a HH, these fields will be populated with any comments provided if a CMA user ended or rejected the member's assignment and this overlapped at least one day with the downloading provider's HH assignment. If no comment was added when the CMA ended/rejected the assignment, or no assignment was ended/rejected, these fields will be blank.
b. If the downloading provider is a VFCA CMA these fields will be populated with any comments provided by a HH user who ended or rejected the member's assignment, and this overlapped at least one day with the downloading provider's CMA assignment. If no comment was added when the HH ended/rejected the assignment or no assignment was ended/rejected these fields will be blank.
c. If the downloading provider is a non-VFCA CMA these fields will be blank.

~~7.~~8. **Rejected Assignment Suggested Alternative Assignment** (field #102)
a. This field will only be populated when a HH user downloads the file and a CMA has rejected a pending assignment and suggested another CMA assignment and this rejection overlaps with the downloading providers HH assignment.

~~8.~~9. **HH Assignment Record Type** (field #93)
a. If the user is downloading on behalf of a HH, this field is always populated with the record type of the 'Pending' or 'Active' HH assignment record.
b. If the user is downloading on behalf of a VFCA CMA, this field will only populate when the member also has an 'Active' HH assignment with the record type of the active HH assignment record.
c. If the user is downloading on behalf of a non-VFCA CMA, this field will always be populated with the record type of the 'Active' HH assignment record.

~~9.~~10. **HH Assignment Start Date** (field #94) is always populated if the member has an 'Active' HH assignment record. If the member had a 'Pending' HH Assignment record, then this field will be blank.

~~10.~~11. MCP Assignment Fields
a. **MCP Assignment Record Type** (field #95) and **MCP Type** (field #96) are populated when a member has an 'Active' assignment record with an MCP.
b. **MCP Assignment Created Date** (field #103) is populated with the create date of the active MCP assignment, if the member has an MCP assignment.
c. **MCP Assignment Start Date** (field #104) is populated with the start date of the active MCP assignment, if the member has an MCP assignment.

~~14.~~15. **Fields Relating to Member's Most Recent Segment Information** (#105-110)
a. The system will populate fields #105-110 with the most recent segment information (for any segment that is in a non-cancelled or non-hiatus status) for any member regardless of if the organization involved in the segment is associated with the downloading provider.
b. **Outreach/Enrollment Code** (field #105) specifies If the most recent segment the member had was an outreach or an enrollment segment.
c. **Health Home MMIS ID** (field #106) and **Health Home Name** (field #107) list the Health Home information associated with the member's most recent segment.
d. **Segment End Date** (field #108)**, Segment End Date Reason Description** (field #109)**,** and **Segment End Date Reason Comments** (field #110) provide further information as to why the most recent segment ended.
    i. Providers are expected to use this information to determine if the member assignment should be accepted or rejected and/or if the member should be assigned downstream. For example, should a HH see a member on this file with a **Pending HH Assignment**

(field #74) they should review fields #105-110 to determine if they may work with this member

1. If they see that the member had a **Previous Enrollment Segment** (field #105) with a **Segment End Date Reason Description** of (field #109) 'Member interested in HH at a future date' and a **Segment End Date** (field #108) in the last 2 weeks they would know that it is not appropriate to accept the pending assignment for this member at this time and instead they would reject the member assignment.
2. If they see that the member had a **Previous Enrollment Segment** (field #105) with a **Segment End Date Reason Description** (field #109) of 'Member dissatisfied with services' with a segment end date reason comment (field #110) of "mbr requesting to work with a different HH" the HH would know that they should accept the assignment and assign to a downstream CMA.

~~15.~~16. **Eligible for Outreach** (field #111) and **No of Outreach Mos Within 12 months** (field #112) provide information as to whether or not a member meets the 2 in 12-month outreach threshold that was implemented in October of 2017.

a. **Eligible for Outreach** (field #111) will display a N if a member has 2 or more months of outreach in a status other than Cancelled or Hiatus within the last 12 months. If the member has 1 or less months of outreach in a status other than Cancelled or Hiatus the field will display a Y.
b. **No of Outreach Mos Within 12 mos** (field #112) displays a count of number of months of outreach in a status other than Cancelled or Hiatus for the member.
   i. The 12-month periods are based on the date the file is downloaded. The month that the user is downloading the file is included in the 12-month count. For example, if a provider downloads the file on 12/10/2017 the system will calculate the # of months of outreach the member had between 1/1/17 and 12/31/2017.
   ii. Providers should use the data in these 2 fields as well as any new information that they have regarding a member to determine if it is appropriate to outreach to this member at the time.

~~16.~~17. Use the **Member's Date of Birth** (field #4) to determine if an assignment is for a child or an adult.

~~17.~~18. **Child HCBS Flag** (field #113)

a. For children referred into the program on or after 1/10/19 this field is populated based on the referral rationale selected during the referral process in the CRP. Children referred into the program prior to 1/10/19 have a record with a blank value in this field. Adults have a record with a blank value in this field both prior to and after 1/10/19
   i. The system will populate the field with "Y" if "HCBS Only" was selected for the member on the Referral Rationale Screen in the CRP.
   ii. The system will populate the field with "H" if "Chronic Conditions and HCBS" was selected for the member on the Referral Rational Screen in the CRP.
   iii. The system will populate the field with "N" if "Chronic Conditions Only" was selected for the member on the Referral Rationale Screen on the Referral Rational Screen in the CRP

~~18.~~19. **Fields Relating to Suggested Providers Selected during a Child Referral** (fields #114-117)

a. The system will populate these fields based on a referrer's responses when referring a child via the CRP.

b. If the member was not referred, was referred using the Adult Referral Wizard/File, was a child referred prior to 1/10/19, was entered directly into a segment, or the referrer did not select a suggested provider, these fields will be blank.

~~19.~~20. If the member has had multiple referrals where suggested providers were selected the system will display the most recently suggested provider information.

~~20.~~21. **Fields Relating to Transfers (fields #119-126)** will be populated to either indicate that the downloading provider has to act on a transfer (*pending* value in assignment status field) or to notify the provider that a transfer that the downloading provider requested was rejected (*rejected* value in assignment status field).If a CMA is downloading the file, then the transfer related fields are populated only if there is a pending transfer for the CMA's member.

a. Please refer to the transfer guide titled "Transfer System Logic' and found under the Health Home Tracking System tab on the MAPP HHTS portion of the HH website found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

b. Thirty days after a pending transfer is rejected, the *rejected* transfer record will be canceled and will no longer appear on the initiating Health Home's assignment file.

Past Assignments

Description

The Past Assignments file includes members who were assigned to the downloading user's organization, but whose assignments with the user's organization were ended/rejected without resulting in segments. This file contains assignments with the downloading provider that have an end date 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 and is no longer included in the provider's assignment file. This file includes member assignments that were rejected by the provider, member assignments ended by the provider, member assignments that ended because something about the member changed, which triggered the member's removal from the provider's assignment file, and members that were purged from the system due to inactivity.

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 6/1/16. As a result, the system ends the existing reportable assignment to create the enrollment segment. Although John's assignment was ended with HH B on 5/31/16, John will not be included on HH B's Past Assignment file, because John's assignment with HH B ended because HH B created a segment, 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**. However, if John was assigned to HH A by MCP A and then HH B enrolled John on 1/1/17 using an R code, then John would appear in HH A's Past Assignment Download because HH A's assignment did not result in a segment with HH A. The Past Assignment file also includes members that were purged from a provider's assignment file due to inactivity. Although all members purged for

inactivity are purged while in an assignment status, they may have had a previous segment with the downloading provider and still appear on the Past Assignments Download file.

Format

Past Assignments Download File						
Field #	**Field**	**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	Y	MMDDYYYY, Numeric
13	Last Modified Date	193	8	200	Y	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 changed the member's assignment (
   - **a.** Member switched MCP status (see #6)
   - **b.** When MCP changes a plan enrolled member's HH assignment or when DOH changes the HH assignment for a fee for service member.
   - **c.** When the HH changes a member's CMA assignment.
3. Member's coverage code changed to a coverage code that is incompatible with the Health Home program (See *Appendix L: Reference and Contacts* for more information on incompatible coverage codes).
4. Recipient R/E code or principle provider code added to a member's file that is incompatible with the Health Home program (See *Appendix L: Reference and Contacts* for more information on incompatible coverage codes).
5. Member started outreach or enrollment with another organization (only applies to HHs/CMAs).
6. Member switched MCP. This covers a few different situations:
   - a. Member moves from FFS to MCP: Rachel is an FFS member that is assigned to HH B (Rachel does not have a segment in the system). On August 13, 2016, 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 8/21/16 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 3/5/16 MCP A assigns Robert to HH B and then on 3/20/16, HH B assigns Robert to CMA C. On 8/1/16, 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 8/21/16 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, 2016. On August 13, 2016, Amy leaves MCP F and becomes an 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 8/21/16 will see that Amy is included in the file download.

Additional file editing includes:

7. The export will not include members who are currently assigned or in an outreach or enrollment segment with a provider but had past assignments with the provider that did not result in segments.
    a. In June 2016, Larry was assigned to HH B by MCP A. In July 2016, 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.
8. The export will not include members' assignments that ended because the HH ended the member's HH assignment by responding 'Yes' to the "End HH Assignment?" question when end dating the member's outreach or enrollment segment.
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 and HH B accepted the assignment in June 2016. On July 10, 2016, HH B submitted an enrollment segment into the system for Rita. On July 12, 2016 HH B realized that Rita's enrollment segment was submitted in error, so HH B submitted a delete record using the Tracking File Delete Record file on July 15, 2016. 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.
    b. Rita's assignment with HH B would not appear in HH B's Past Assignment Download if HH A created a retroactive segment that completely overlapped HH B's assignment.
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.

Program Participation Files

Program Participation Files allow MCP, HH and CMA workers to collect and view information relating to a member's decision to opt out of the Health Home program. Information can be collected and stored for members currently in the MAPP HHTS as well as members with valid Medicaid IDs that have had no history in the MAPP HHTS.

Program Participation Upload File

Description

MCP, HH, and CMA workers have the capability to upload this file to create, end, or cancel an opt-out record for a member for whom they have a signed opt out form. MCPs can submit information for any member associated with their MCPs. HHs and CMAs can submit information for any member with a valid Medicaid ID regardless of their association with the uploading organization in MAPP HHTS.

Format

Program Participation File					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Record Type	1	1	1	Character (C/E/D)
2	Member ID	2	8	9	AA11111A, Alphanumeric
3	Opt-Out Signature Date	10	8	17	MMDDYYYY, Numeric
4	Opt-Out Reason	18	2	19	Numeric
5	Opt-Out Date	20	8	27	MMDDYYYY, Numeric

Editing Logic

1.When submitting a 'C' or create record in **Record Type** (field #1), fields 2-4 must also be populated.

a. A create record will only be accepted if the member does not have a segment that is currently active or if the member has a segment with an end date that is the same month as the Opt-out Signature Date month submitted on the file.

2. When submitting an 'E' or end record, the **Member ID** (field #2), **Opt-Out Signature Date** (field #3) that matches the original record, and the **Opt-Out End Date** (field #5) must also be populated.

3. When submitting a 'D' or delete record the **Member ID** (field #2) and the **Opt-Out Signature Date** (field #3) that matches the original record must be populated.

Program Participation Error Report

Description

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

Format

Program Participation Error Report					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Line Number	1	6	6	Numeric
2	Member ID	7	8	14	AA11111A, Alphanumeric
3	Error Reason	15	30	44	Alphanumeric

Editing Logic

This error report contains one Error Reason field. If a record fails multiple validations, it will display the first error for the record. For a complete list of the error codes and error code descriptions used in this file, please see *Appendix B: File Error Reason Codes.*

Program Participation Download File

Description

MCP, HH and CMA workers have the capability to download this file to view their members that have opt-out records. MCP will be able to view all members associated with their MCP in MDW when downloading this file. HH/CMAS will see members that have a HH/CMA assignment that overlaps the opt-out period as well as members that have had an opt-out record submitted from the downloading organization.

Format

Program Participation Download File					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Member ID	1	8	8	AA11111A, Alphanumeric
2	Opt-Out Signature Date	9	8	16	MMDDYYYY, Numeric
3	Opt-Out Submission Date	17	8	24	MMDDYYYY, Numeric
4	Opt-Out Start Date	25	8	32	MMDDYYYY, Numeric
5	Opt-Out End Date	33	8	40	MMDDYYYY, Numeric
6	Opt-Out Reason	41	2	42	Numeric
7	Opt-Out Reason Description	43	50	92	Alphanumeric
8	Opt-Out Submitted by Organization Name	93	40	132	Alphanumeric
9	Opt-Out Submitted by Organization MMISID	133	8	140	Alphanumeric

Editing Logic

1. **Member ID** (field #1), **Opt-Out Signature Date** (field #2), **Opt-out Reason** (field #6), and **Opt-out Reason Description** (field #7) are populated based on the information submitted in the Program Participation Upload file.

2. **Opt-out End Date** (field #5) will be populated based on the information submitted in the Program Participation Upload File. If the user does not populate an end date the system will stamp an end date on the opt-out record based on the Opt-out Reason (field #6) as follows:

a. “Member Not Interested: No-Follow-Up”: No end date

b. “Member Not Interested: Follow-up in Three Months”: start date + 90 days

c. “Member Not Interested: Follow-Up in Six Months”: start date + 180 days

2. **Opt-Out Submission Date** (field #3) is a system calculated date, based on the day the file was uploaded into the system.

3. The system will calculate **Opt-Out Start Date** (field #4), which is the first of the month following the **Opt-out Signature Date** (field #2).

Consent Files

Consent files allow users to create, modify, withdraw, and access consent information for all their members, regardless of age. Prior to submitting a Tracking File Segment Record to create an enrollment segment for an assigned member working with an HH serving children or a member younger than 18 that is working with an HH serving adults, a user **MUST FIRST** submit the Consent Upload File to establish consent to enroll for this member. The Consent Upload File is also used to submit consent for all other members, but consent does not have to be submitted to the system before creating a segment for members 21 and older or members 18 years and older who are being served by an adult HH. This file also contains plan of care dates.

Consent Upload File

Description

HHs/CMAs upload this file to ‘C’ create, ‘M’ modify, and ‘W’ withdraw consent for all members, regardless of age. MCPs cannot upload this file. Additionally, this file allows HH users to create and delete Plan of Care records for members. Please see *Appendix M: Consent File Codes* for the codes used in this file and for a link to additional information regarding consent rules for members under 21.

Format

Consent Upload						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Format**
1	Record Type	1	1	1	Y	Alpha (C, M, W, P,D)
2	Member ID	2	8	9	Y	AA11111A, Alphanumeric
3	Health Home MMIS Provider ID	10	8	17	Y	Numeric

4	Existing Start Date	18	8	25	C	MMDDYYYY, Numeric
5	New Start Date	26	8	33	C	MMDDYYYY, Numeric
6	End Date	34	8	41	C	MMDDYYYY, Numeric
7	Consenter	42	2	43	C	Numeric (01, 02, 03, 04, 05)
8	Existing Consent Type	44	2	45	C	Numeric (01, 02, 03)
9	New Consent Type	46	2	47	C	Numeric (01, 02, 03)
10	Plan of Care	48	8	55	C	MMDDYYYY, Numeric

Editing Logic

1) There is no hierarchy related to the processing of the Consent Upload File by Record Type ('C', 'M', 'W', 'P', 'D'). Records will be processed according to how they are entered into the file starting with the first record entered. Record Types C, M, and W pertain to consent information. Record Types P and D pertain to POC information. If a user would like to upload both consent information and plan of care information for the same member they must submit 2 records.
2) When Record Type is 'C (Create Consent)', the following fields are required:
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **HH MMIS ID** (field #3)
    d. **New Start Date** (field #5)
    e. **Consenter** (field #7)
    f. **New Consent Type** (field #9)
    g. For a provider to submit a 'C' record, the member must have an active or pending assignment with the uploading provider.
3) When Record Type is 'W' (withdraw Consent), the following fields are required:
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **HH MMIS ID** (field #3)
    d. **Existing Start Date** (field #4)
    e. **End Date** (field #6)
    f. **Existing Consent Type** (field #8)
    g. Member must have an existing corresponding consent record (see #9) in the system with the uploading provider.
4) When Record Type is 'M' (modify consent), the following fields are required:
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **HH MMIS ID** (field #3)
    d. **Existing Start Date** (field #4)

   e. **Existing Consent Type** (field #8)
   f. Member must have an existing corresponding consent record (see #9) in the system with the uploading provider.

5) When Record Type is 'P (Create Plan of Care)', the following fields are required:
   a. **Record Type** (field #1)
   b. **Member ID** (field #2)
   c. **Plan of Care Date** (field #10)
   d. User must be a Health Home user to enter POC information. The user should not enter **HH MMIS ID** (field #3), if they enter this information the record will error.

6) When Record Type is 'D' (Delete Plan of Care), the following fields are required:
   a. **Record Type** (field #1)
   b. **Member ID** (field #2)
   c. **Plan of Care Date** (field #10)
   d. HH uploading the file must have an existing Plan of Care date for the member.

User must be a Health Home user to delete POC information. The user should not enter **HH MMIS ID** (field #3), if they enter this information the record will error.

7) When the system processes the Consent Upload File record(s) to modify or withdraw consent, the system will use the data entered in the **Member ID** (field #2)**, Health Home MMIS Provider ID** (field #3)**, Existing Start Date** (field #4)**, and Existing Consent Type** (field #8) fields to determine the existing consent record's Consent ID.

8) Consent to Enroll is required when an enrollment segment exists:
   a. for a member < 18 year of age or
   b. between 18 and 21 years of age and served in an HH serving children. Consent to enroll is not required for members 18 and older in an HH serving adults.

9) A consent record cannot be modified/withdrawn if the modification will result in an enrollment segment that is not completely covered by a consent to enroll record for a member under 21 that is being served by an HH serving children or less than 18 and served by an HH serving adults. The following scenarios describe modifications that the system will not allow. When Record Type is 'M', Existing Consent Type is '01', and member is < 18 OR between 18 years of age and 21 years of age and being served by an HH serving children on the segment begin date:
   a. and value is entered in the Begin Date field in which the modification would make it so that no Consent to Enroll exists that would cover the enrollment segment period, the New Start Date cannot be after the last day of the month of the segment begin date.
   b. and value is entered in the End Date field in which the modification would make it so that no Consent to Enroll exists that would cover the enrollment segment period, the End Date cannot be prior to the first day of the month of the segment end date.
   c. and the modification would make it so that no Consent to Enroll exists that would cover the enrollment segment period, a value cannot be entered into the New Consent Type field when an overlapping consent exists with a start date after the last day of the month of the consent start date.

10) Consent dates entered on the Consent Upload file cannot be in the future.

Consent Error File

Description

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

Format

Consent Error File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y, N, C)**	**Format**
1	Record Type	1	1	1	Y	Alpha (C, M, W)
2	Member ID	2	8	9	Y	AA11111A, Alphanumeric
3	Health Home MMIS Provider ID	10	8	17	Y	Numeric
4	Existing Start Date	18	8	25	C	MMDDYYYY, Numeric
5	New Start Date	26	8	33	C	MMDDYYYY, Numeric
6	End Date	34	8	41	N	MMDDYYYY, Numeric
7	Consenter	42	2	43	Y	Numeric (01, 02, 03, 04, 05)
8	Existing Consent Type	44	2	45	C	Numeric (01, 02, 03)
9	New Consent Type	46	2	47	C	Numeric (01, 02, 03)
10	Error Reason	48	30	77	Y	Alphanumeric

Editing Logic

The **Error Reason** (field #10) 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 #10). This error file contains both file format errors and logic errors. For more information on Consent Upload file errors, please review the *Consent Upload File: Editing Logic* section and *Appendix B: File Error Reason Codes*.

Consent Download File

Description

This file contains all the consent records with an active, withdrawn, or ended **Consent Status** for a provider's members. The file also contains submitted Plan of Care records (excluding deleted Plan of Care records). For HH providers this is determined by the HH that uploaded the file. For CMA/MCP users the file will display any Plan of Care information where the Plan of Care date overlaps at least 1 day with the provider's assignment for the member. MCPs, HHs, and CMAs can all download this file.

Format

	Consent Download File						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required Consent Record (Y, N, C)**	**Required POC Record (Y, N, C)**	**Format**
1	Member ID	1	8	8	Y	Y	AA11111A, Alphanumeric
2	First Name	9	30	38	Y	Y	Alpha
3	Last Name	39	30	68	Y	Y	Alpha
4	Health Home MMIS Provider ID	69	8	76	Y	N	Numeric
5	Health Home Name	77	40	116	Y	N	Alpha
6	Start Date	117	8	124	Y	N	MMDDYYYY, Numeric
7	End Date	125	8	132	C	N	MMDDYYYY, Numeric
8	Consenter	133	2	134	Y	N	Numeric (01, 02, 03, 04, 05)
9	Consent Type	135	2	136	Y	N	Numeric (01, 02, 03)
10	Status	137	2	138	Y	N	Numeric (01, 02, 03)
11	Last Updated By	139	40	178	Y	Y	Alpha
12	Date	179	8	186	Y	Y	MMDDYYYY, Numeric
13	Time	187	8	194	Y	Y	HH:MM:SS, Numeric
14	Plan of Care Date	195	8	202	N	Y	MMDDYYY, Numeric
15	Plan of Care Create Date	203	8	210	N	Y	MMDDYY, Numeric
16	Plan of Care HH MMISS Provider ID	211	8	218	N	Y	Numeric
17	Plan of Care HH Name	219	40	258	N	Y	Alpha

Editing Logic

1) Members will have a unique record for each consent type or Plan of Care they have in the system:
    a. A member with two consents to enroll records, one consent to share protected information record and 1 plan of care date will have four records in the Consent Download file.
2) The system will populate **Last Updated By** (field #11) with the user name of the most recent logged in user that created or updated the consent.
    a. The system will populate **Last Updated By** (field #11) with a value of 'conversion' when the record existed prior to December 1, 2016 and has not been updated post December 1, 2016.
3) The system will populate **Date** (field #12) with the most recent date the consent record was created or updated.
4) The system will populate **Time** (field #13) with the most recent time the consent record was created or updated.

5) The Consent Download file will be sorted by alphabetical ascending order (A – Z) by member last name.
6) The system will populate Plan of Care fields (field #14-17) with the most recent plan of care information.
    a. If the member has member has multiple Plan of Care Date records for the same date, the system will display these as follows:
        i. For a HH downloading the file, the system will display the Plan of Care record associated with that HH.
        ii. For an MCP or CMA downloading the file, the system will display individual line items for all Plan of Care records that overlap with the provider's assignment with the member
        iii. For example, member AA12345A has a plan of care date with HH A of 1/1/19 and a Plan of care date with HH B of 1/1/2019. HH A downloads the consent file and sees only the 1/1/19 plan of care. A CMA with a segment with a member starting 11/1/18 to open downloads the file and see's 2 lines for the member – 1 with HH A and one with HH B.
7) Deleted plan of care records will not be included on the consent file; however, all added and deleted plan of care information will be recorded in the on the Plan of Care screen available in the Member's case.
8) On consent records, the Plans of Care fields (#14-17) will be blank.
9) On Plan of Care records, only the following fields will be populated (all other fields will be blank).
    a. Member ID (field #1)
    b. First Name (field #2)
    c. Last Name (field #3)
    d. Plan of Care Date (field # 14)
    e. Plan of Care Create Date (field # 15)
    f. Plan of Care HH MMIS Provider ID (field # 16)
    g. Plan of Care HH Name (field # 17)

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. (Please refer to *Appendix I: Tracking File Record Type Codes* for further information on Tracking File record types.) 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 Records. These three file formats can be included in one file uploaded to the system as a Tracking File upload file (some restrictions apply) or these three file formats can be separated out into different files uploaded to the system as Tracking File upload files.

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 August 2015. 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 made via straight referrals, either directly to the HH or via the MCP; 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. VFCA CMAs can also use this file to assign a Health Home. 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)

Tracking File Assignment Records						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C-conditional)**	**Format**
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)
10	HH Provider MMIS ID	111	8	118	C	Numeric

Editing Logic

1. For an 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' (Accept Assignment) and 'N' (New Assignment) will be ignored by the system
        i. **Rejection Reason** (field #3)
        ii. **Suggested Alternate Assignment** (field #4)
        iii. **Rejection Reason Comment** (field #5)
        iv. **End Date Reason** (field #7)
        v. **End Date Reason Com**ment (field #8)
    b. Values submitted in the fields below for record type 'R' (Reject Assignment) will be ignored by the system
        i. **End Date Reason** (field #7)
        ii. **End Date Reason Comment** (field #8)
    c. Values submitted in the fields below for record type 'E' (End Assignment) will be ignored by the system
        i. **Rejection Reason** (field #3)
        ii. **Suggested Alternate Assignment** (field #4)
        iii. **Rejection Reason Comment** (field #5)
3. **Record Type 'R' (Reject Assignment)** is used by HHs to reject *pending* assignments, 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** (field #3) and **End HH Assignment** (field #9) must be populated with an accepted value on all 'R' records or the record will be rejected.
        i. When an HH submits an 'R' record to reject an MCP or a DOH assignment, **End HH Assignment** (field #9) should be populated with a value of 'Y'.

ii. When an HH submits an 'R' record to reject a *pending* CMA assignment on behalf of the HH's CMA, **End HH Assignment** (field #9) should be populated with a value of 'N'.

iii. When a CMA submits an 'R' record, the **End HH Assignment** field must be populated with a value of 'N'. If **End HH Assignment** (field #9) 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 #3), and will record into the member's case the **Suggested Alternate Assignment** (field #4) value, if submitted. This information is available to the provider either on screen or via the MCP/HH assignment download.

i. Angela is enrolled in MCP A. The MCP identified Angela as a potentially HH eligible member on July 3, 2016. MCP A assigned Angela to HH B on July 15, 2016, who rejected her *pending* HH assignment on August 2, 2016 because Angela lives outside of HH B's service area and listed HH C (MMIS Provider ID: 01234567) as a suggested HH assignment. Listed below is how MCP A and HH B will see Angela on their assignment 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 '07152016' (7/15/16) in **HH Assignment Created Date** (field #8), a value of '07032016' (7/03/16) in **MCP Assignment Created Date** (field #72), a value of '01234567' in **Suggested Alternative Health Home Assignment** (field #78), and a value of 'Rejected' in **Health Home Assignment Status** (field #77). The HH Rejection Reason Code and Description will also be displayed.

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 '07152016' (7/15/16) in **Assignment Created Date** (field #12), a value of '08022016' (8/2/16) in the **Assignment Rejection Date (**field #9), a value of '02' in **Assignment Rejection Reason Code (**field #10), and a value of 'Member moved out of service county' in **Assignment Rejection Reason Code Description** (field #11). Please refer to *Appendix E: Assignment Rejection Reason Codes*. **Assignment Start Date** (field #5) will remain blank because the *pending* assignment never moved into the *active* status and therefore does not have a start date.

c. When an HH is rejecting an assignment, **CMA Provider MMIS ID** (field #6) 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, **CMA Provider MMIS ID** (field #6) must be populated with that CMAs MMIS Provider ID, 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, by HHs to end an *active* CMA assignment, and by CMAs to end an *active or pending* assignment made to the CMA by an HH.
    a. **End Date Reason** (field #7) and **End HH Assignment** (field #9) 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 *active* Health Home assignment, **End HH Assignment** (field #9) 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, **End HH Assignment** (field #9) must be populated with a value of 'N'.
        iii. When an HH submits an 'E' record to end a CMA assignment and would also like to end their *active* HH assignment with the member, **End HH Assignment** (field #9) must be populated with a value of 'Y'.
        iv. When a CMA submits an 'E' record, **End HH Assignment** (field #9) 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 an HH submits a record type of 'E' and **CMA Provider MMIS ID** (field #6) does not contain a value, then **End HH Assignment** (field #9) 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, **End HH Assignment** (field #9) must contain a value 'N'.
    e. When an HH is ending an assignment made to the HH the **CMA Provider MMIS ID** (field #6) <u>must be blank</u> and the member <u>must have an *active* HH assignment</u> status.
    f. When an HH is ending a CMA assignment that the HH made to the CMA, the **CMA Provider MMIS ID (**field #6) <u>must be populated with that CMAs MMIS Provider ID</u> and the member <u>must have an *active or pending* assignment with that CMA</u>.
5. **Record Type 'S' (Accept Assignment)** is used by HHs to accept a *pending* assignment made to the HH, 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 or used by VFCA CMAs to accept pending assignments made by LGU/SPOAs.
    a. **End Health Home Assignment** (field #9) 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 an 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 **End HH Assignment (**field #9) and the **Care Management Agency MMIS ID (**field #6) must be blank.
    d. For an 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 **Care Management Agency MMIS ID (**field #6) and **End HH Assignment (**field #9) 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 **End HH Assignment (**field #9) and the **Care Management Agency MMIS ID (**field #6) 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 by a VFCA CMA to assign a member to a HH
    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 adult 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. VFCA CMAs can create a new assignment using the 'N' record for members:
        i. That have an active or pending CMA assignment
        ii. That currently don't have a HH assignment or to re-assign to a new HH
    c. Only HHs and CMAs with a type of Foster Care can submit record type 'N'. If a non-foster care CMA submits a record type of 'N', the record will be rejected.
    d. **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 **Care Management Agency Provider MMIS ID (**field #6) (the HH and CMA must be listed within that system as having an active relationship as of the file submission date) and **End HH Assignment (**field #9) must be populated with a value of 'N'. This will create a *pending* assignment for the CMA listed in **Care Management Agency Provider MMIS ID (**field #6).
        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 <u>Managed Care Plan Assignment</u> file with the HH's MMIS Provider ID listed in **Suggested Alternative Health Home Assignment (**field #78), **OR**
            2. Call the MCP and ask that the MCP assign the MCP enrolled member to the HH.
        iv. If a HH submits an 'N' record for a child member that they don't currently have a relationship with in the system, then the system will reject the record. If the HH would like to work with Child Member they should either:
            1. Make a straight referral within the MAPP HHTS Children's Referral Portal and request that the MCP assign the child member to them **OR**
            2. Make an outreach or enrollment referral within the MAPP HHTS Children's Referral Portal with their HH.
    e. To reassign a member in either an *active* or a *pending* CMA assignment from one CMA to 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 #6). 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 #6).

f. 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 #6) and submit a value of 'N' in **End HH Assignment (**field #9). 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 active HH status.
g. The system will not allow a HH to assign a member to a CMA with which the member already has a *pending* or *active* CMA assignment.
h. If a 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 **Care Management Agency Provider MMIS ID (**field #6) with a create date of the date that the file was uploaded.

7. When an 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 or pending assignment with the HH) and the CMA and that the member has the appropriate status with the CMA ID listed in **Care Management Agency MMIS ID (**field #6) to perform the action.
   b. For example, if HH B submits an 'R' record with CMA C in **Care Management Agency MMIS ID (**field #6), 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** (field #4) is not a required field. However, when **Suggested Alternate Assignment** (field #4) contains a value, that value must be a valid MMIS provider ID set up within the system as either an HH or a CMA. If an HH user is uploading the file with record type 'R' and the **Care Management Agency MMIS ID** (field #6) is blank, any ID submitted in **Suggested Alternate Assignment** (field #4) must be associated with an HH in the system, or the record will be rejected. If an HH user is uploading the file with record type 'R' and the **Care Management Agency MMIS ID** (field #6) is populated, the ID submitted in **Suggested Alternate Assignment** (field #4) must be associated with an existing CMA 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. HHs and CMAs can use this file to accept or delete pending referrals for adult members. MCPs cannot upload this file. Please review the new logic listed in the *Editing Logic* section for system logic that only applies to members under 21.

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)

Tracking File Segment Records							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
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	Adult or Child Services Provided Indicator	53	1	53	C	HH/CMA	Alpha (A/C)
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
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 **Health Home MMIS ID** (field #8) must have an active relationship with the CMA listed in **Care Management Agency MMIS ID** (field #9) for the entire segment period.

   In the event that the HH and CMA listed in the segment have a relationship in the system for a portion of the segment duration (between the segment begin date and end date), either the segment begin date and/or end date must be adjusted so that the segment occurs within the time that the HH and CMA had a relationship, or the HH must work with DOH to modify the HH/CMA relationship begin and end dates prior to submitting the original segment begin/end dates.
2. The system will reject a record that is attempting to take an action that has already been processed by the system.
   a. To determine if an action has already occurred, the system will compare the submitted segment to all segments in *active, pended, pending active, pending pended, pending canceled, or pending closed*

status, retrieving an exact match based on the following fields: **Member ID** (field #2)**, Begin Date** (field #5)**, Outreach/Enrollment Code** (field #7)**, Health Home MMIS ID** (field #8)**,** and **Care Management Agency MMIS ID** (field #9)**.**

3. The system will ignore any values submitted on the Tracking File Segment Records file in **Direct Biller Indicator (**field #10).
4. The system will accept the **Member ID** (field #2) if populated with a valid CIN and:
    a. Medicaid eligible as of the record **Begin Date** (field #5)
    b. Does not have either a coverage code or a recipient R/E/PP code that is incompatible with the Health Home program, as of the record **Begin Date** (field #5)
    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 a 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.
        iv. When a 'C' record type is processed into the system by a VFCA CMA, the system will create an *active* segment with the identified HH on field #8 for the submitted record. The VFCA CMA must have an active relationship with HH for the segment period.
    b. If an HH uploads a 'C' record matching the **Member ID** (field #2)**, Begin Date** (field #5)**, Outreach/Enrollment Code** (field #7)**, Health Home MMIS ID** (field #8) of a *pending* transfer for the HH listed in **Health Home MMIS ID** (field #8), and 'T' listed in **Referral Code** (field # 13) the system will update the original (transferred out) enrollment segment to *closed* status with the appropriate end date and will create a new (transferred in) enrollment segment in active status with the HH and CMA submitted in the record.
    c. If a CMA uploads a 'C' record matching the **Member ID** (field #2)**, Begin Date** (field #5)**, Outreach/Enrollment Code** (field #7)**, and Care Management Agency MMIS ID** (field #9) of a *pending* transfer for the CMA listed in **Care Management Agency MMIS ID** (field #9) and 'T' listed in the **Referral Code** (field #13), the system will update the original (transferred out) enrollment segment to *closed* status with the appropriate end date and will create a new (transferred in) enrollment segment in active or pending active status with the HH and CMA submitted in the record.
        i. Users may only respond to transfer records via file if the member is 18 or older and being served as an adult or 21 and older.
    ~~c.~~d. The system will automatically adjust the duration of an outreach segment, if an enrollment segment is submitted to ensure that an overlap does not occur.
        i. If a 'C' segment is submitted to create an enrollment segment that overlaps 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** (field #6) that is the day before the submitted enrollment segment begin date **and** will create a segment for the submitted enrollment record.

ii. If a 'C' segment is submitted to create an enrollment segment that 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.

~~d.~~e. End Health Home Assignment

i. When creating an enrollment segment or outreach segment with a begin date that is prior to 10/1/17 without an end date, this field must be blank.

ii. When creating 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 ends 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 ends.

iii. When submitting an outreach segment with a begin date on or after 10/1/17 this field must be answered even if no end date is submitted.

~~e.~~f. **Referral Code** (field #13) Editing Logic: the referral code must be populated with an 'R' when the provider does not have a previous assignment with the member for the segment period. The referral code is only accepted for members that are 21 and older. If a member is under 21, then a provider cannot create a segment for that member unless the member has either an *active* or a *pending* assignment with the Health Home at the time of the segment begin date.

i. HH A submits a segment for HH A and CMA B. Member is not assigned to HH A or CMA B and is 21 years old or older.

1. **Referral Code** (field #13) must contain a value of 'R', or the record will be rejected
2. Once the segment is created, the member will have a hidden "behind the scenes" active referral assignment record type with HH A and CMA B, where the start and end dates will equal the segment start and end dates, but no reportable, visible assignments with HH A and CMA B exist.

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 and the member is any age.

1. Referral Code must be blank, or the record will be rejected
2. Once the segment is created, the member will have a hidden "behind the scenes" active assignment record type assignment with HH A and CMA B, where the start and end dates will equal the segment start and end dates. And a reportable, visible HH A assignment with an end date one day prior to the segment start date exists.

iii. HH A submits a segment for HH A and CMA B on 8/5/15 with an 8/1/15 begin date. Member is assigned to HH A and has a pending assignment with CMA C (CMA assignment creation date = 7/18/15) and member is any age.

1. Referral Code must be blank, or the record will be rejected
2. Once the segment is created, the member will have a hidden "behind the scenes" active assignment record type with HH A, where the start and end dates will equal the segment start and end dates and a reportable HH A assignment with a 7/31/15 end date.
3. CMA B assignment has a hidden "behind the scenes" assignment creation date of 8/1/15. CMA C assignment has a reportable assignment with a 7/31/15 end date and no start date (as it was never accepted).

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 (member is assigned to HH C) 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 and member is over 21.
    1. Referral Code must contain a value of 'R'
    2. Once the segment is created, member will have a hidden "behind the scenes" active referral record type assignment with HH A with a creation date of 8/5/15 and a start date of 8/1/15.
    3. Once the segment is created, the CMA B assignment will be partitioned into two parts: the first reportable, visible assignment is an ended assignment with a create date of 7/18/15 and a start date of 7/25/15 with an end date one day prior to the segment start date (7/31/15), and the second non-reportable assignment will equal the start date (8/1/15) and end date (currently open-ended) of the segment.
    4. Once the segment is created, the HH C assignment will be ended with an end date one day prior to the segment start date.

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 and is any age.
    1. Referral Code must be blank, or the record will be rejected
    2. Once the segment is created, the member will have hidden "behind the scenes" active assignment record type with HH A and CMA B, where the start and end dates will equal the segment start and end dates.

vi. CMA B submits a segment for HH A and CMA B. Member is not assigned to HH A or CMA B and is over 21.
    1. Referral Code must contain a value of 'R', or the record will be rejected
    2. Once the segment is created, the member will have a hidden "behind the scenes" active referral record type assignment with HH A and CMA B, where the start and end dates will equal the segment start and end dates. No reportable assignment will exist.
    3. If CMA B does not have auto approval the segment will have a pending active status HH A accepts the segment creation.

vii. 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) and member is over 21.
    1. Referral code must contain a value of 'R'
    2. Once the segment is created, the member will have a hidden "behind the scenes" active assignment record type with HH A and a reportable, visible assignment with HH A that ended one day prior to the start of the segment (7/31/17). Member also has an active referral record type with CMA B, where the start and end dates will equal the segment start and end dates.
    3. CMA C assignment has a reportable, visible assignment creation date of 7/18/15, does not have an assignment start date, and has an assignment end date of 7/31/15.

viii. CMA B 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) and member is over 21.

1. Referral Code must be blank, or the record will be rejected
2. Once the segment is created, the member will have a hidden "behind the scenes" active referral record type with HH A with a creation date of 8/5/15 and a start date of 8/1/15.
3. Once the segment is created, CMA B will have a hidden "behind the scenes" active assignment record type with a creation and start date of 7/30/15
4. Once the segment is created, the member assignment with HH F will have a reportable, visible assignment creation date of 7/18/15, an assignment start date of 7/25/15, and an assignment end date of 7/31/15. 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 a status of *active, pended, pending active, pending pended, pending closed, pending canceled, closed, or 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** (field #2)**, Begin Date** (field #5)**, Outreach/Enrollment Code** (field #7)**, Health Home MMIS ID** (field #8)**,** and **Care Management Agency MMIS ID** (field #9).
      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 (puts the segment into canceled status) and resubmit the information (by creating a new segment), 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 a user would like to Modify a *pended* segment they can do so, but the system will not allow you to enter a **Pend Start Date** (field #18). If the **Pend Start Date** (field #18) needs to be modified the user must delete the originally pended segment and resubmit a pend record with the correct start date.
   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 **Segment End Date Reason Code** (field #14), the system will replace the current end date reason code with the one listed in the file.
   d. End Health Home Assignment (field #21)
      i. When a CMA submits a segment with an 'M' record type and end date is populated, **End Health Home Assignment** (field #21) must be populated with a value of 'N'.
      ii. When a HH submits an 'M' record to modify a segment without an **End Date** (field #6), this field must be blank, unless the modify record is an outreach segment that has a date of service on or after 10/1/17 (see iv).
      iii. When a HH submits an 'M' record to modify a segment with an **End Date** (field #6), 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.
      iv. For dates of service on or after 10/1/17, if an HH or CMA submits an 'M' record for an outreach segment they must enter a value in this field regardless of if the **End Date** (field #6) is populated.

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 the pending segment in the system that requires acceptance, the system will match the segments on the submitted record to the segments in the system using the following fields: **Member ID** (field #2)**, Begin Date** (field #5)**, Outreach/Enrollment Code** (field #7)**, Health Home MMIS ID** (field #8)**,** and **Care Management Agency MMIS ID** (field #9)**.** All other fields aside from **Record Type** (field #1) and **End Health Home Assignment** (field #21) 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, **End Health Home Assignment** (field #21) 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 **End Health Home Assignment** (field #21) to indicate to the system whether or not the active HH assignment with the member should end. The 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.
    c. Once this file is processed, the system will remove the word pending from the member's segment status: Pending active becomes active; pending pended becomes pended; pending closed becomes closed; pending canceled becomes canceled.
    d. If an 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, pended, or pending pended* status. The system allows providers the ability to pend a segment that already has a p*ended* or *pending pended* status. Follow the same guidance below to pend a segment with a *pended* or *pending pended* status.
    a. The following fields are required when pending a segment: **Record Type** (field #1), **Member ID** (field #2), **Date of Birth** (field #3)**, Gender** (field #4), **Begin Date** (field #5), **Outreach/Enrollment Code** (field #7), **Health Home MMIS ID** (field #8)**, Pend Start Date** (field #18)**, Pend Reason Code** (field #19)**,** and **Pend Reason Code Comment** (field #21) (if pend reason = 'Other').
        i. **Begin Date** (field #5) should be populated with the begin date of the segment that you are pending. When pending an *active* segment this would be the begin date of the active segment, when pending an already *pending* segment this would be the begin date of the pended segment.
        ii. **Pend Start Date** (field #18) should be populated with the date that you want the pended segment to start. The pend start date must be the first of a month.
    b. 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 a 'P' record to pend that segment.
    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** with an end date that is one day prior to the date listed in the **Begin Date** (field #5) of the newly submitted segment.
    d. To move a segment out of the pend status, end the member's CMA assignment and retain the member's HH assignment*,* submit an 'M' record with the date that the pend should end in the **End Date** (field #6), populate the **Segment End Date Reason Code** (field #14) appropriately, and populate

End Health Home Assignment (field #21) with a value of 'N'. This will create a subsequent assignment for the HH with the member with a start date of the new assignment one day following the end date of the segment (**Pend Start Date** (field #18) should be blank).

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 **End Date** (field 6), populate **Segment End Date Reason Code** (field #14) appropriately, and populate **End Health Home Assignment (**field #21) with a value of 'Y' (**Pend Start Date** (field #18) should be blank).

9. Prior to submitting a 'C' record to create an enrollment segment for a member under 21 that is being served as a child and there is an existing assignment with, a user must first successfully submit and process into the system a consent to enroll record using the Consent Upload file.
10. The **Adult or Child Services Provided Indicator** (field #11) is only a required field if the MMIS provider ID in **Health Home MMIS ID** (field #8) is identified in the system as serving both adults and children. If the MMIS provider ID in the **Health Home MMIS ID** (field #8) is identified in the system as serving adults only or children only, then this field is not required and will be ignored by the system.
    a. Health Home MMIS Provider IDs that serve both adults and children must submit a value of 'A' in **Adult or Child Services Provided Indicator** (field #11) when working with a member in their adult program. This will indicate to the system to create an Adult HML billing instance for the member.
    b. Health Home MMIS Provider IDs that serve both adults and children must submit a value of 'C' in **Adult or Child Services Provided Indicator** (field #11) when working with a member in their children's program. This will indicate to the system to look for CANS NY Assessment information and to create a children's questionnaire billing instance for the member.
11. When an outreach segment is created for a member under 21 by an HH that either only serves children or serves both children and adults, the system automatically assigns the member to the children's program regardless of the value that was submitted in **Adult or Child Services Provided Indicator** (field #11) by the submitting HH or CMA.

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. The Delete record is also utilized to reject a pending transfer for a member that is being served as an adult. Both HHs and CMAs use this file to act on incorrectly submitted segments associated with them or pending transfers that they need to act on (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** (field #2), the **Begin Date** (field #3), and the submitting provider for the delete record to be accepted.
    a. If the record is submitted by a HH, then the **Begin Date** (field #3) and HH uploading the file must match the Begin Date and Health Home MMIS Provider ID of a segment in the system 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** (field #3) and CMA uploading the file must match the Begin Date and Care Management Agency MMIS Provider ID of a segment in the system for 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.
3. When rejecting a *pending* transfer, the user must submit a file that contains the **Record Type** (field #1), **Member ID** (field #2) and **Begin Date** (field #3).
    ~~b.~~a. The **Begin Date** (field #3) should be populated with the effective date of the transfer.

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	C	HH/CMA	Alpha (C/A/M/P/D/S/R/E/N)
3	Member ID	8	8	15	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	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

Tracking File Error Report							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
12	Error Description1	55	70	124	Y	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, canceled, 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 overlaps 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.

When downloading the Enrollment Download File providers can select which segment statuses they would like included in their file. This allows providers to more readily access members associated with their organization that fit into specific categories. Providers can elect to download a file that contains all available statuses.

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	C	Alpha (Y/N/NULL)
8	Referral Code	43	1	43	C	Alpha

Enrollment Download File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
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, Canceled, 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	C	MMDDYYYY, Numeric
30	Adult or Child Services Provided Indicator	357	1	357	C	Alpha (A/C)
31	Current Managed Care Plan Name	358	40	397	C	Alpha
32	Current Managed Care Plan MMIS ID	398	8	405	C	Numeric
33	Pend Reason or Segment End Date Reason Comment	406	300	705	C	Alphanumeric
34	Child HCBS Flag	706	1	706	C	Alpha (Y/N)
35	Transfer Initiator MMIS ID	707	8	714	C	Numeric
36	Transfer Initiator Organization Name	715	40	754	C	Alpha
37	Transfer Receiver MMIS ID	755	8	762	C	Numeric
38	Transfer Receiver Organization Name	763	40	802	C	Alpha
39	Transfer Create Date	803	8	810	C	Date
40	Transfer Effective Date	811	8	818	C	Date
41	Transfer Reason	819	75	893	C	Alpha
42	Transfer Comment	894	300	1193	C	Alphanumeric

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 HH A 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 MAPP HHTS does 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 **Medicaid Eligibility End Date** (field #29).

8. Child HCBS Flag (field #34) This value will be populated based on RE codes relating to Children's HCBS waiver codes. If the member has an active RE code within the system as of the file download that corresponds to children's HCBS, the field will be populated with a 'Y', otherwise it will be set to 'N'.

8. **Transfer Information (field #35-42)** will be populated for providers' currently enrolled active or pending active members that also have a *pending* transfer record.
    a. HH A requests that HH B transfers a member to them. The member is currently in an active segment with HH B. When HH A downloads their enrollment file they will not see any information about the member. When HH B downloads the enrollment file, fields 35 – 42 will be populated on the member's active enrollment record with the member's pending transfer information.
    b. HH B then accepts the pending transfer. When HH B downloads the enrollment file again, HH B will see the closed enrollment segment, but no transfer information (fields 35-42 will be blank).
    c. Please refer to the transfer guide found under the Health Home Tracking System tab of the MAPP HHTS portion of the HH website found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm for more specific information.

Members Download File

Description

This file is downloaded from the ***My Members*** screen, which displays 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 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 select the *Download Search Results* button. This will prompt the system to create a file matching the file format below containing the member segments and assignment information that meet the criteria selected by the user. MCPs, HHs and CMAs can download this file.

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

My Members Download File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
15	Referral Health Home Name	258	40	297	C	Alpha
16	Segment 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
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	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	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	Rejected Assignment Suggested Alt Assignment	706	8	713	C	Numeric
43	Member Age (Years)	714	3	716	Y	Numeric
44	Assignment Start Date	717	8	724	C	MMDDYYYY, Numeric
45	Downloading Provider Assignment Start Date	725	8	732	C	MMDDYYYY, Numeric
46	Downloading Provider Assignment Status	733	40	772	C	Alpha (Pending, Pended, Active)
47	Referral Suggested Assignment	773	8	780	C	Numeric

Editing Logic

Since this file download may contain both segment and assignment information, based on the selection criteria on the ***My Members*** screen prior to file download, some of the fields above may or may not be populated based on the record source containing either segment information or assignment information. The table below describes how each field will be populated based on the record source (segment or assignment).

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 MAPP HHTS does 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 **Medicaid Eligibility End Date** (field #36).

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	• For Managed Care members, these fields will be populated with the MCP that the member is enrolled with as of the file download. • For fee for service members, these fields will be blank.	
Managed Care Plan Name		
Health Home MMIS Provider ID	• If a member has an 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 an 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 be populated with the date of the member's most recent assignment, based on the rules below**
Pending Referral	Will always be blank	Will always be populated
Referral Health Home MMIS Provider ID	• If a member has an 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 an HH with record type = referral, these fields will be blank. *	
Referral Health Home Name		
Segment 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 has an end date	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
Segment Pend Reason	Will only be populated if the segment is pended	Will always be blank

My Members Fields	Segment Record	Assignment Record
HARP	Will always be populated with either EL, EN, or Blank	
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 if the member has this field in the system	
City	Will always be populated	
State	Will always be populated	
Zip	Will always be populated	
Phone	Will always be populated if the member has this field in the system	
County of Fiscal Responsibility Code	Will always be populated	
County of Fiscal Responsibility Description	Will always be populated	
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 if the member has a Medicaid Eligibility End Date otherwise this will be blank	
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
Rejected Assignment 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
Member Age (Years)	Will be calculated based on the number of years from the Date of Birth to Today's Date.	
Assignment Start Date	Will always be blank	Will be populated with the start date of the member's most recent active or pended reportable assignment. *** This field will be blank if the assignment is pending. Populated August 1, 2017
Downloading Provider Assignment Start Date	Will always be blank	Will be populated with the start date of the downloading organization's most recent reportable assignment record if the user's provider's assignment is in the *active* or *pended* status. If the user's provider's assignment is not in the *active* or

My Members Fields	Segment Record	Assignment Record
		pended status, then this field will be blank. Populated August 1, 2017
Downloading Provider Assignment Status	Will always be blank	Will be populated with the status of the downloading organization's most recent reportable assignment record. Populated August 1, 2017
Referral Suggested Assignment	Will always be blank	Will be populated with the provider listed in the Suggested Alt Assignment field if the member has a Pending, Pended, or Active MCP assignment record with record type referral.

**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.*

***The logic below determines the most recent assignment that will populate **Assignment Created Date** (field #12):*

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

****Please use the logic below to determine the most recent assignment that will populate the **Assignment Start Date** (field #44):*

4. *Does the member have a reportable active CMA assignment?*
    a. Yes – CMA assignment start date displayed
    b. No – see #2
5. *Does the member have a reportable active HH assignment?*
    a. Yes – HH assignment start date displayed
    b. No – see #3
6. *Does the member have a reportable active MCP assignment and no segment?*
    a. Yes – MCP assignment start date displayed
    b. No – see #4
7. *Does the member have a reportable pended MCP assignment?*
    a. Yes – MCP assignment start date displayed
    b. No – field should be blank

Manage Assignments Download File

Description

This file is downloaded by a user from the online ***Manage Assignments*** screen, which displays the members that have a *pended or pending* assignment/referral 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 select 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.

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 file is downloaded by a user from the ***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 a 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 select 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.

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
2	DOB	9	8	16	Y	MMDDYYYY, Numeric
3	Gender	17	1	17	Y	Alpha (M/F)
4	Medicaid Effective Date	18	8	25	C	MMDDYYYY, Numeric
5	Medicaid End Date	26	8	33	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

CIN Search Download File						
Field #	Field	Start Pos.	Length	End Pos.	Required (Y/N/C-conditional)	Format
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
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

CIN Search Download File						
Field #	Field	Start Pos.	Length	End Pos.	Required (Y/N/C-conditional)	Format
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
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

CIN Search Download File						
Field #	Field	Start Pos.	Length	End Pos.	Required (Y/N/C-conditional)	Format
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
96	Member Age	2033	3	2035	Y	Numeric
97	First Name	2036	30	2065	Y	Alpha
98	Last Name	2066	30	2095	Y	Alpha
99	Program Participation	2096	7	2102	C	Alpha
100	Opt-Out Signature Date	2103	8	2110	C	MMDDYYYY, Numeric
101	Opt-Out Submission Date	2111	8	2118	C	MMDDYYYY, Numeric
102	Opt-Out Submitted by User	2119	40	2158	C	Alpha
103	Opt-Out Submitted by Organization Name	2159	40	2198	C	Alpha
104	Pending Transfer Initiator MMIS ID	2199	8	2206	C	Numeric
105	Pending Transfer Initiator Organization Name	2207	40	2246	C	Alpha
106	Pending Transfer Receiver MMIS ID	2247	8	2254	C	Numeric
107	Pending Transfer Receiver Organization Name	2255	40	2294	C	Alpha
108	Pending Transfer Create Date	2295	8	2302	C	Date
109	Pending Transfer Effective Date	2303	8	2310	C	Date
110	Pending Transfer Reason	2311	75	2385	C	Alpha
111~~0~~	Pending Transfer Comment	2386	300	2685	C	Alphanumeric
112	Medicaid Recipient Exemption Code 6 to 16	2686	32	2717	C	Alphanumeric (space deliminated)

Editing Logic

The first 5 RE codes associated with a member CIN will display in fields 85-94. Any additional RE codes, up to 16, will display under Medicaid Recipient Exemption Code 6 to 16 (field #112). Data in this field will include RE code only and be space deliminated.

Acuity Download File

Description

The Acuity Download file has become obsolete for service dates that are paid based on the HML methodology. 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 of outreach or enrollment while a member of the downloading MCP. For dates of service prior to 12/1/16 the adjusted acuity score is multiplied by the appropriate base rate to determine how much a 1386 or 1387 rate code claim will pay.

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 **End Date** (field #3) in the Acuity Download file. A member will not have an adjusted acuity score if the member is new to Medicaid or was not previously identified as Health Home eligible. Prior to December 1, 2016 service dates, DOH periodically identified members that did not have adjusted acuity scores and then load the average acuity score of 9.0744 for that member. For dates of service on or after 12/1/16 DOH no longer does this as the HML or children's questionnaire determines rates for these dates of service.

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.

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.

Billing instances are either potential, added, or voided. Potential billing instances are created by the system for all current and previous member months when a member is in a segment and a billable service could be performed. For example, if a member is in an active enrollment segment but loses Medicaid eligibility a potential billing instance will not display on the download file for the dates of service that co-inside with the time period in which the member does not have Medicaid eligibility. Billing instances are not created for future service dates.

For example, if a user downloads a Billing Support Download (BSD) file on July 31, 2016, the user will see billing instances for their members that meet the billing instance criteria through July 1, 2016. The user will not see billing instances for service dates after July 1, 2016, even for members that meet the billing instance criteria and do not have a segment end date. When the user downloads a BSD on August 1, 2016, the user will see billing instances for members that meet the billing instance criteria through August 1, 2016.

MCP capitated billing

Reimbursement for Health Home services is included in Mainstream MCP (HMO, PHSP, SNP, HARP) capitation rates. HHs bill eMEDny directly for FFS and non-mainstream MCP members but submit 837is for mainstream MCP members to the member's enrolled MCP as of the service date for payment.

Full and Limited HML billing

HML assessment questions are only required to be fully answered on a six-month basis. Once an HML is completed for month one, the member's HML responses are locked in for six months. During months two-six providers only need to respond to certain questions: attesting ~~to~~ if services were provided (e.g. Core Service, HH+ Minimum Services Provided), member population questions (AOT, ACT, AH, Exp HH+~~)~~ , the Chronic Condition/Pre-Condition question (Chronic Condition question required for DOS on or after 12/1/19). If there are significant changes to a member's level of Care Management need, a new HML should be completed prior to month seven. This will act as a new month one. An indicator on the download file informs the provider which month the completed HML represents. Responses to unrequired questions from month 1 will be brought forward and displayed in month 2-6 on the Billing Support Download file (effective 11/22/19).

Should the provider respond to the HML outside of chronological order, the system will not be able to calculate the month sequence and all questions must be answered. For example, a provider responds to all HML questions (fields #7-18, #20-34) on May 1st, 2018, this HML is now considered month 1. The provider then goes to complete the billing instance of July 1st, 2018 prior to completing the June 1st, 2018 billing instance. The provider will be required to answer all HML questions (fields #7-18, #20-34) for the July billing instance.

Should a provider void a previously submitted billing instance, all future completed HMLs within the six-month sequence will also be voided by the system. For example, today is 6/15/2018, a provider has already completed the 5/1/18 BI (month 1), and the 6/1/18 BI (month 2) if the provider now voids the 5/1/18 BI, the system will automatically delete the 6/1/18 BI as well.

Should an enrollment segment be ended for any reason and a new enrollment segment be created for the same member with the same HH and CMA, the start of the new enrollment segment will be considered month one and all HML questions will need to be submitted for that new enrollment segment. For example, HH A and CMA A have an enrollment segment with Member A from 5/1/18 to 7/31/18. Under this segment 5/1/18 is month 1, 6/1/18 is month 2, and 7/1/18 is month 3. On 8/1/18 HH A and CMA A create a new enrollment segment with member A starting 8/1/18. When completing the 8/1/18 BI HH A must answer all HML questions and this will be considered month 1.

Member's served as children have Children's Questionnaires that must be responded to in their entirety each month.

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 processed 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 April 1, 2016, 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.

Format

Billing Support Upload File					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Add/Void Indicator	1	1	1	Alpha (A/V)
2	Member ID	2	8	9	AA11111A, Alphanumeric
3	Service Date	10	8	17	MMDDYYYY, Numeric
4	Diagnosis Code	18	10	27	Alphanumeric
5	Pre-Conditions of member	28	16	43	Numeric (no commas)
6	Description of "Other" pre-condition	44	40	83	Alphanumeric
7	HIV Status	84	1	84	Alpha (Y/N)
8	HIV Viral Load	85	1	85	Numeric
9	HIV T-Cell Count	86	1	86	Numeric
10	Member Housing Status	87	1	87	Alpha (Y/N)
11	HUD Category	88	1	88	Numeric
12	Incarceration	89	1	89	Alpha (Y/N/U)
13	Incarceration Release Date	90	8	97	MMDDYYYY, Numeric
14	Mental Illness	98	1	98	Alpha (Y/N/U)
15	Mental Illness Discharge Date	99	8	106	MMDDYYYY, Numeric
16	Substance Abuse	107	1	107	Alpha (Y/N/U)
17	Substance Abuse Discharge Date	108	8	115	MMDDYYYY, Numeric
18	SUD Active Use/Functional Impairment	116	1	116	Alpha (Y/N)
19	Core Service Provided	117	1	117	Alpha (Y/N)
20	AOT Member	118	1	118	Alpha (Y/N)
21	AOT Minimum Services Provided	119	1	119	Alpha (Y/N)
22	ACT Member	120	1	120	Alpha (Y/N)
23	ACT Minimum Services Provided	121	1	121	Alpha (Y/N)
24	AH Member qualifies for Adult Home Plus Care Management	122	1	122	Alpha (Y/N)
25	AH Member transitioned to community	123	1	123	Alpha (Y/N)
26	AH Member continues to quality	124	1	124	Alpha (Y/N)

Billing Support Upload File					
Field #	Field	Start Pos	Length	End Pos	Format
27	AH Member interested in transitioning	125	1	125	Alpha (Y/N)
28	CMA Direct Biller Indicator	126	1	126	Alpha (Y/N)
29	Child in Foster Care	127	1	127	Alpha (Y/N)
30	HUD1 within past 6 months	128	1	128	Alpha (Y/N)
31	Member Housed	129	1	129	Alpha (Y/N)
32	Date Member Housed	130	8	137	MMDDYYYY, Numeric
33	Expanded HH+ population	138	1	138	Alpha (A-X)
34	HH+ Minimum Services Provided	139	1	139	Alpha (Y/N)
35	UAS Complexity Assessment	140	1	140	Alpha (Y/N/U)

- Please see appendix H for appropriate responses based on date of service.

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. Please see *Appendix H: High, Medium, Low (HML) Assessment Codes* for the codes used on the Billing Support Upload file.
2. Editing Logic for Enrollment Children's Questionnaire, HML Questionnaire and Outreach Questions can be found on the HH Website in the 2019 Quality Webinar – Billing Support files starting on slide 21: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/docs/mapp_hhts_webseries_billing_support_files.pdf
3. **Add/Void Indicator** (field #1)
    a. To indicate that a billable service was provided for a billing instance submit a record with a value of 'A' in **Add/Void Indicator** (field #1) and a value of 'Y' in **Core Service Provided (**field #19). Complete all other required and conditionally required fields.
    b. To indicate that a billable service was **NOT** provided for a billing instance submit a record with a value of 'A' in **Add/Void Indicator** (field #1) and a value of 'N' in **Core Service Provided (**field #19).
    c. To indicate that a record previously submitted with a value of 'A' in **Add/Void Indicator** (field #1) was submitted in error and should be voided, a record must be submitted containing an **Add/Void Indicator** (field #1) value of 'V' and **Member ID** (field #2) & **Service Date (**field #3) must match the values submitted in the original billing instance record that is being voided. The system will ignore fields #4-35 on the Billing Support Upload file (i.e. the system will not validate, or record values submitted in these fields) when the **Add/Void Indicator** contains a value of 'V'.
    d. Voiding an adult enrollment segment that was part of the six-month sequence will also void any subsequent billing instances in that six-month period that were already completed.
    e. The system will reject a record containing an **Add/Void Indicator** (field #1) value of 'A' submitted for a member and **Service Date** (field #3) with a current **Add/Void Indicator** (field #1) value of 'A'.
    f. The system will reject a record containing an **Add/Void Indicator** (field #1) value of 'V' for a member and **Service Date** (field #3) for which no add indicator was previously submitted or the current value is 'V'.

4. Attesting to **Core Service** (field #19) for Children
    a. If the user uploads a file with a record for an enrollment segment where the CANS NY Assessment result is Low or no CANS NY Assessment exists, populate **Core Service Provided** (field #19) with a value of 'Y' if at least one core Health Home service was provided during the service month.
    b. If the user uploads a file with a record for an enrollment segment where the CANS NY Assessment result is Medium or High, populate **Core Service Provided (**field #19) with a value of 'Y' if at least two Health Home services were provided, one of which must be a face-to-face encounter with the child.
5. Required fields for outreach
    a. When submitting a record for a billing instance that is associated with an outreach segment and the uploading provider is a Health Home that serves adults, serves both Adults and Children with members over 21, or is a CMA that is working with one of these Health Homes , the following fields are the only fields that are required to for adult records:
        i. **Add/Void Indicator** (field #1)
        ii. **Member ID** (field #2)
        iii. **Service Date** (field #3)
        iv. **Diagnosis Code** (field #4) (optional)
        v. **Core Service Provided** (field #19)
        vi. **ACT Member** (if Provider is Care Management Agency – ACT) (field #20)
    b. If a user uploads a file for a member that has an outreach segment with a value of 'C' in **Adult or Child Services Provided Indicator** (field #11) on their corresponding Outreach Segment, the following fields are required and the system will ignore all other fields:
        i. **Add/Void Indicator** (field #1)
        ii. **Member ID** (field #2)
        iii. **Service Date** (field #3)
        iv. **Diagnosis Code** (field #4) (optional)
        v. **Core Service Provided** (field #19)
        vi. **Child in Foster Care** (field #29)
        vii. **ACT member** (field #22) (only required if the CMA is identified as an ACT provider within the MAPP HHTS)
        viii. **AOT member** (field #20)
6. Required fields for a Children's questionnaire:
    a. If a user uploads a file for a member that has an enrollment segment with a value of 'C' in **Adult or Child Services Provided Indicator** (field #11) on their corresponding Enrollment Segment, the system will look to the following fields and will ignore all other fields:
        i. **Add/Void Indicator** (field #1)
        ii. **Member ID** (field #2)
        iii. **Service Date** (field #3)
        iv. **Diagnosis Code** (field #4) (optional)
        v. **Pre-Conditions of member** (field #5)
        vi. **Core Service Provided** (field #19)
        vii. **Child in Foster Care** (field #29)
7. The system will reject a record that is submitted for a member for a specific date of service if it does not meet certain requirements necessary to bill for Health Home services. In addition to the required field combinations outlined in the power point referenced in #2 above, this includes:

a. The system will reject a record submitted for a member that does not have an active outreach or enrollment segment with the uploading provider that would indicate that a billable service is possible for that service date.
    i. Example – HH A is providing Health Home services to member B starting Feb 1st, but submitted a segment for member Bwith a Jan 1st. When HH A attempts to upload a completed HML for Jan 1st the system will reject it.
b. The system will reject a record submitted for a member whose status within MAPP HHTS indicates that a billable service should not be provided for the member for the date of service, even if the member is associated with the provider within the system as of the service date.
    i. Example – A record submitted for a member with a pended enrollment with that provider 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.
    ii. Example – Tim is in an active enrollment segment with HH B as of 12/1/18, but on 1/10/19 Tim receives R/E code 81 as he now qualifies for the TBI waiver. For dates of service on or after 1/1/19 HH B is unable to upload a HML record for Tim.
        1. In some instances, the Billing instance may be able to be completed online only and not via file upload based on current HH policy. In most instances billing is also prohibited on screen.
        2. For example, member A is going to be released from a nursing home 5/15/18, but the NH code has yet to be ended. Per DOH policy the member can receive Health Home services for the month prior to and the month of discharge. The system will allow the completion of the billing instance online, but not via file upload.
c. The system will not accept an added enrollment billing instance for a member that is under 21, is being served as a child and does not have a valid CANS on file for the service date. This includes:
    i. Having no CANs-NY on file that corresponds to the 3rd month of an enrollment segment
    ii. Having the latest CANs-NY on file that is more than 6 months old (including the month the CANS NY Assessment was completed).

8. Updates to CANS-NY Person Records made within the UAS are reflected in the MAPP HHTS. When a CIN is added to the person record, all signed and finalized CANS-NY Assessments (that meet validations) are transferred to the new CIN. The previous calculated acuity is used to determine billing. If a CANS-NY Assessment Upon Enrollment is transferred, the Assessment Fee will only be tied to the original CIN, however, any new CINs will utilize the calculated acuity for billing.
   For example, Jane Doe is enrolled with HH A and CMA A starting on 12/1/17. Jane Doe's initial CANS-NY was completed on 12/16/17 and has a high acuity. On 3/10/18 Jane Doe is adopted. From 12/1/17 - 3/10/18 Jane Doe's CIN is AA12345A. From 3/11/18-current Jane Doe's CIN is BB12345B. Jane's Care manager is notified of Jane's new CIN on 3/25/18. HHCM enters the UAS and updates the person record to also include BB12345B. The care manager waits until the 1st of the following month to create a new enrollment segment with the new CIN in MAPP HHTS. Jane Doe now has:
   - A segment from 12/1/17-3/31/18 under CIN AA12345A
   - A segment from 4/1/18 – open under CIN BB12345B

   Within 15 minutes of creating the segment with CIN BB12345B, the high acuity from the initial CANs appears under the CIN BB12345B and is used for BIs from 4/1/18 forward. Should the care manager still

need to complete the BI from 3/1/18 under AA12345A they will get the high acuity. When HH A downloads the billing support download file they will see one Assessment Fee under CIN AA12345A.

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 #2) 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 **Error Reason** (field #2). 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*.

Error Files may be produced either when validating a file or when processing a file. Errors compare the values in the upload file to what has already been written to the system (already processed), therefore it is possible to see validation errors that would not result in processing errors.

Format

Billing Support Error File (.csv version of the Billing Support Error File includes BSU file upload fields in separate columns)						
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Required (Y/N/C – conditional)**	**Format**
1	Original Record from File	1	140	140	Y	Alphanumeric
2	Error Reason	141	40	180	Y	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, based on the criteria indicated when downloading the file.

When downloading the BSD file, the user must indicate a maximum of a six-month period that the billing support download should be downloaded for. Users have the option to either select a Date of Service range or a Last Transaction Date range when downloading the file. When selecting the Date of Service range, the BSD will include all known billing instances (potential, added and voided) for the date of services selected. For example, if a user downloads the BSD with a date of service range from 12/1/16-5/31/17 on 6/1/17, the file will contain all billing instances for 12/1/16, 1/1/17, 2/1/17, 3/1/17, 4/1/17, and 5/1/17 dates of service. If a member had a billing

instance added for a 12/1/16 date of service on 1/2/2017, this added billing instance will be included in the file. If this member's billing instance was later voided on 7/15/17, the voided billing instance would not be included on the file downloaded on 6/1/17. A new file with the most recent six months of service downloaded on 8/1/2017 would not show this voided billing instance as the search perimeters would only be from 2/1/17-7/31/17.

When selecting the Last Transaction Date range, the file will display any billing instances within the last transaction date range regardless of service date. The file will display all billing instances associated with a specific member's specific date of service that fall within the transaction date range. For example, if the same user downloaded the BSD with a last transaction date range from 2/1/17-7/31/2017 on 8/1/17 the user would see the voided BI for the member that was voided on 7/15/17, but not the added transaction from 1/2/2017. If the user had then gone in on 7/20/17 and re-added the billing instances both the voided BI from 7/15/17 and the re-added 7/20/17 billing instance would display.

As stated previously, there are three types of billing instances: potential, added, and voided. A **potential billing instance** is a service date that has a corresponding segment during the same time period 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 **Add/Void Indicator** (field #1). 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 **Add/Void Indicator** (field #1). 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 **Add/Void Indicator** (field #1)), 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 #1) for a previously added billing instance with the same billing instance service date).

Potential billing instances are identified within the Billing Support Download file with a blank value in **Add/Void Indicator** (field #1). Added billing instances are identified within the Billing Support Download file with a value of 'A' in **Add/Void Indicator** (field #1). Voided billing instances are identified within the Billing Support Download file with a value of 'V' in **Add/Void Indicator** (field #1).

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** (field #1) 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 (**field #1) 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 #1). 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, depending on how the provider downloads the file, 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** (field #1) value of 'V' does not delete the previously uploaded record with an **Add/Void Indicator** (field #1) 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 May 2016 Tina, a member of MCP A, is enrolled in the Health Home Program with HH B and CMA C with a begin date of 5/1/16. On June 3, 2016, a user from MCP A downloads the Billing Support Download file using the date of service range 5/1/16-6/30/16 and sees that Tina has two records within the file for service dates

5/1/16 and 6/1/16. Since neither of Tina's records in the Billing Support Download file have a value in **Add/Void Indicator** (field #1), 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 June 10, 2016, 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 **Add/Void Indicator** (field #1) and a value of 'Y' in **Core Service Provided** (field #19) for service dates 5/1/16 and 6/1/16. The MCP user downloads the Billing Support Download file on June 12, 2016 using the date of service range 5/1/16-6/30/16 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 **Add/Void Indicator** (field #1) a value of 'Y' in **Core Service Provided** (field #19), MCP A user knows that these billing instances were added and that services were provided. Therefore, the appropriate biller, in this case MCP A, submits claims to eMedNY (since this is prior to May 1st, 2018) for Tina for 5/1/16 and 6/1/16. On June 30, 2016, CMA C user realizes that Tina did not receive a billable service in June and that the 6/1/16 billing instance needs to be voided, so CMA C submits a Billing Support Upload file for Tina for service date 6/1/16 with a value of 'V' in **Add/Void Indicator (**field #1). On June 30, 2016, MCP A downloads the Billing Support Download file using the date of service range 5/1/16-6/30/16 and now sees **three** records for Tina:

1. service date 5/1/16; **Add/Void Indicator** 'A'; **Date HML Assessment Entered** 6/10/16
2. service date 6/1/16; **Add/Void Indicator** 'A'; **Date HML Assessment Entered** 6/10/16
3. service date 6/1/16; **Add/Void Indicator** 'V'; **Date HML Assessment Entered** 6/30/16

This indicates to the MCP A user that the billing instance added for service date 6/1/16 on 6/10/16 was added in error. Since MCP A already submitted to eMedNY a Health Home claim for Tina for 6/1/16, this indicates to the MCP A that the 6/1/16 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 6/1/16 and documentation to support why MCP A voided Tina's 6/1/16 claim.

Populating the Claims/Encounters Feedback Loop on the Billing Support Download File

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 and encounter information to identify specific paid, denied, or voided Health Home claims and paid or voided encounters (denied encounters are not reported to Medicaid) that are associated with a member's billing instance service date. Once a claim or encounter is submitted to eMedNY, it takes about a week or so for the system to access and pull that claim or encounter information into billing support.

While only one provider 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 or encounters in the system?
    a. Yes:
        i. The system will populate fields #57 - 66 based on the paid claim/encounter in the system for the member's billing instance service date.
        ii. The system will compare the expected **rate code** (field #54) to the rate code on the paid claim/encounter (**Paid Claim Rate Code** (field #66)). If the rate codes match, **Paid Claim Rate Code equals MAPP HML Rate Code** (field #68) will be populated with a value of 'Y'.

If the rate codes do not match, **Paid Claim Rate Code equals MAPP HML Rate Code** (field #68) will be populated with a value of 'N'.

iii. The system will compare the expected billing MMIS provider ID (**Billing Entity MMIS ID** (field #20)) to the MMIS provider ID on the paid claim/encounter (**Paid Claim Provider ID** (field #64)). If the MMIS provider IDs match, **Paid Claim Provider ID equals MAPP Billed Entity MMIS ID** (field #67) will be populated with a value of 'Y'. If the MMIS provider IDs do not match, **Paid Claim Provider ID equals MAPP Billed Entity MMIS ID** (field #67) will be populated with a value of 'N'

b. No – see #2

2. Are there any denied claims or voided claims/encounters in the system?
   a. Yes – see # 3
   b. No – fields #57-68 will be blank
3. Display information related to the most recent transaction for the member's billing instance service date.
   a. The system will populate fields #57 - 66 based on the most recent denied/voided claim/encounter.
   b. The system will compare the expected rate code (**Rate Code** (field #54)) to the rate code on the claim/encounter (**Paid Claim Rate Code** (field #66)). If the rate codes match, **Paid Claim Rate Code equals MAPP HML Rate Code** (field #68) will be populated with a value of 'Y'. If the rate codes do not match, **Paid Claim Rate Code equals MAPP HML Rate Code** (field #68) will be populated with a value of 'N'.
   c. The system will compare the expected billing MMIS provider ID (**Billing Entity MMIS ID** (field #20)) to the MMIS provider ID on the denied claim/encounter (**Paid Claim Provider ID** (field #64)). If the MMIS provider IDs match, **Paid Claim Provider ID equals MAPP Billed Entity MMIS ID** (field #67) will be populated with a value of 'Y'. If the MMIS provider IDs do not match, **Paid Claim Provider ID equals MAPP Billed Entity MMIS ID** (field #67) will be populated with a value of 'N'.

Format

Billing Support Download File							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
1	Add/Void Indicator	1	1	1	Y	HH/CMA	Alpha (A/V/Null)
2	Member ID	2	8	9	Y	HH/CMA	AA111111A, Alphanumeric
3	Service Date	10	8	17	Y	HH/CMA	MMDDYYYY, Numeric
4	Health Home MMIS ID	18	8	25	Y	HH/CMA	Numeric
5	Billing Instance Type	26	1	26	Y	HH/CMA	Alpha (O/E/F)
6	Member Fiscal County Code	27	2	28	Y	M'caid	Numeric
7	Managed Care Organization MMIS ID	29	8	36	C	M'caid	Numeric
8	Adjusted Acuity Score as of Service Date	37	7	43	C	M'caid	00.0000, Numeric
9	Diagnosis Code	44	10	53	N	HH/CMA	Alphanumeric

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

Billing Support Download File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
38	Incarceration Release Date	477	8	484	C	HH/CMA	MMDDYYYY, Numeric
39	Mental Illness	485	1	485	Y	HH/CMA	*Alpha
40	Mental Illness Stay Discharge Date	486	8	493	C	HH/CMA	MMDDYYYY, Numeric
41	Substance Abuse	494	1	494	Y	HH/CMA	Alpha (Y/N)
42	Substance Abuse Stay Discharge Date	495	8	502	C	HH/CMA	MMDDYYYY, Numeric
43	SUD Active Use/Functional Impairment	503	1	503	Y	HH/CMA	Alpha (Y/N)
44	Core Service Provided	504	1	504	Y	HH/CMA	Alpha (Y/N)
45	AOT Member	505	1	505	Y	HH/CMA	Alpha (Y/N)
46	AOT Minimum Services Provided	506	1	506	C	HH/CMA	Alpha (Y/N)
47	ACT Member	507	1	507	Y	HH/CMA	Alpha (Y/N)
48	ACT Services Provided	508	1	508	C	HH/CMA	Alpha (Y/N)
49	Impacted Adult Home Class Member	509	1	509	Y	M'caid	Alpha (Y/N)
50	AH Member qualifies for Adult Home Plus Care Management	510	1	510	C	HH/CMA	Alpha (Y/N)
51	AH Member transitioned to community	511	1	511	C	HH/CMA	Alpha (Y/N)
52	AH Member continues to quality	512	1	512	C	HH/CMA	Alpha (Y/N)
53	AH Member interested in transitioning	513	1	513	C	HH/CMA	Alpha (Y/N)
54	Rate Code	514	4	517	Y	Gen	Numeric
55	Rate Description	518	30	547	Y	Gen	Alphanumeric
56	Rate Amount	548	7	554	Y	Gen	Numeric, "0000.00"
57	Claim Status	555	1	555	C	M'caid	Alpha (P/D/Blank)
58	Date of Transaction	556	8	563	C	M'caid	MMDDYYYY, Numeric
59	Payment Cycle	564	4	567	C	M'caid	Numeric
60	Denial Reason Code	568	4	571	C	M'caid	Numeric
61	Denial Reason Code Description	572	25	596	C	M'caid	Alphanumeric
62	Denial Reason Code (2)	597	4	600	C	M'caid	Numeric
63	Denial Reason Code Description (2)	601	25	625	C	M'caid	Alphanumeric

Billing Support Download File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
64	Paid Claim Provider ID	626	8	633	C	M'caid	Numeric
65	Paid Claim Provider Name	634	40	673	C	M'caid	Alphanumeric
66	Paid Claim Rate Code	674	4	677	C	M'caid	Numeric
67	Paid Claim Provider ID equals MAPP Billed Entity MMIS ID	678	1	678	C	Gen	Alpha (Y/N)
68	Paid Claim Rate Code equals MAPP HML Rate Code	679	1	679	C	Gen	Alpha (Y/N)
69	Latest Transaction	680	1	680	Y	Gen	Alpha (Y/N)
70	Child in Foster Care	681	1	681	C	HH/CMA	Alpha (Y/N/Blank)
71	Last Transaction Date Time	682	16	697	Y	Gen	MMDDYYYYHH:MM:SS, Numeric
72	Insert Date	698	8	705	Y	Gen	MMDDYYYY, Numeric
73	CANS Completion Date	706	8	713	C	M'caid	MMDDYYYY, Numeric
74	Void Date	714	8	721	C	Gen	MMDDYYYY, Numeric
75	HUD1 Within Past 6 Months	722	1	722	C	Alpha (Y/N)	HUD1 Within Past 6 Months
76	Member Housed	723	1	723	C	Alpha (Y/N)	Member Housed
77	Date Member Housed	724	8	731	C	MMDDYYYY, Numeric	Date Member Housed
78	Expanded HH+ population	732	1	732	C	HH/CMA	Alpha*
79	HH+ minimum service provided	733	1	733	C	HH/CMA	Alpha (Y/N)
80	Provided Service Indicator	734	1	735	Y	HH/CMA	Alpha (A/C)
81	UAS Complexity Assessment	735	1	735	Y	HH/CMA	Alpha (Y/N/U)
82	Encounter Claim	736	1	736	C	Gen	Alpha (C/E/Blank)
83	Month Submitted	737	1	737	R	Gen	Alphanumeric

- Please refer to Appendix H for potential values of these fields based on the service dates

Editing Logic

1) **Medicaid Eligibility Status** (field #10) 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 January –February. Marco is enrolled in HH B in January and then enrolled in HH D in February. MCP A will see billing instance service dates for January and February in the Billing Support Download file. HH D will see billing instance service date 2/1/16 in the Billing Support Download file. HH B can will see billing instance service date 1/1/16 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 7/1/16. The 7/1/16 billing instance was never added. In July, the billing download file contains a record for John for a potential 7/1/16 billing instance with a blank in the A/V field. In August, John's 7/1/16 enrollment segment is deleted. The billing file downloaded in August does not contain a 7/1/16 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 7/1/16 and a billing instance was added in July. In July, the billing download file contains a record for Miriam's added 7/1/16 billing instance with an A in the A/V field. In August, Miriam's 7/1/16 enrollment segment is deleted. The billing file downloaded in August contains 2 records for Miriam:
         (1) 7/1/16 billing instance with value of 'A' **Add/Void Indicator** field
         (2) 7/1/16 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 7/1/16 and a billing instance was added in July. In July, the billing download file contains a record for Wayne's added 7/1/16 billing instance. In August, Wayne's 7/1/16 billing instance is voided. The billing file downloaded in August contains both an added and a voided record for Wayne's 7/1/16 billing instance. In September, Wayne's 7/1/16 enrollment segment is deleted. In September, the billing download file contains 2 records for Wayne:
         (1) 7/1/16 billing instance with value of 'A' Add/Void Indicator field
         (2) 7/1/16 billing instance with value of 'V' Add/Void Indicator field
   d) 3a-3c above only apply to billing instances with a value of 'O' or 'E' in **Billing Instance Type** (field #5). If the billing instance has a value of 'F' in **Billing Instance Type** (field #5), then nothing will happen to the billing instance when the segment is deleted.
4) The **Pend Reason Code** (field #11) and **Pend Reason Code Description** (field #12) will be blank for all billing instances that are not in Pend status on the billing instance service date.
5) When a provider submitts a month 2-6 HML responses, the system will populate the non-required fields on BSD for month 2-6 BIs with the values submitted on th corresponding month 1 BI. Users can use **Month Submitted** (field #83) to determine what month a service date is for a member. Children's Questionnaires and CANs-NY Assessment Fees will always be populated with a 1.
6) Conditionally Required Fields
   a) The following conditional fields are 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 in error, 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.

i) **HIV Viral Load** (field #33)
ii) **HIV T-Cell Count** (field #34)
iii) **HUD Category** (field #36)

b) The following fields 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.

i) **Incarceration Release Date** (field#38)
ii) **Mental Illness Stay Discharge Date** (field #40)
iii) **Substance Abuse Stay Discharge Date** (field #42)
iv) **AOT Minimum Services Provided** (field #46**)**
v) **ACT Services Provided** (field #48)
vi) **AH Member qualifies for Adult Home Plus Care Management** (field #50)
vii) **AH Member transitioned to community (**field #51)
viii) **AH Member continues to quality** (field #52)
ix) **AH Member interested in transitioning** (field #53)

7) **Latest Transaction** (field #69)

a) Used to indicate which Billing Instance for a member's service date is most recent, based on date and time of the Adult HML/Children's Questionnaire submission. Value of 'Y' means that the record is the most recent record.

8) For members under 21 that are being served by children's programs, the system will look to a data feed from the CANS NY Assessment tool to determine if a CANS NY Assessment has been completed for a member. If the information from that CANS NY Assessment feed passes the criteria below, then the system will create a CANS NY Assessment Fee billing instance.

a) The CIN from the feed is valid and exists in the system.
b) The HH MMIS ID from the feed exists in the system as a valid Health Home.
c) An Enrollment Segment exists in an Active, Closed or Pended status for the CIN and HH MMIS ID on the record with a begin date that is in the same month of the CANS Date of Completion or in the subsequent 6 months from the CANS Date of Completion.
d) The Assessment type selected when completing the CANS NY is 'Initial Upon Enrollment'
e) The Assessment Fee has not been written to a previous record due to a member CIN change

9) Users cannot add or void a CANS NY Assessment Fee billing instance. Only the system can add or void a CANS NY Assessment Fee billing instance.

10) Billing instances with a **Billing Instance Type** (field #5) value of 'F' will contain values in the following fields. All other fields will be blank**.**

a) **Add/Void Indicator** (field #1)
b) **Member ID** (field #2)
c) **Service Date** (field #3)
d) **Health Home MMIS ID** (field #4)
e) **Billing Instance Type** (field #5)
f) **Member Fiscal County Code** (field #6)
g) **Managed Care Organization MMIS ID** (field #7)
h) **Medicaid Eligibility Status** (field #10)

i) **Member Fiscal County Code Description** (field #13)
j) **Care Management Agency Name** (field #15)
k) **Care Management Agency ID** (field #16)
l) **Health Home Name** (field #18)
m) **Managed Care Plan Name** (field #19)
n) **Billing Entity MMIS ID** (field #20)
o) **Billing Entity Name** (field #21)
p) **Member Zip Code (**field #22)
q) **Member First Name** (field #23)
r) **Member Last Name** (field #24)
s) **Member DOB** (field #25)
t) **Member Gender** (field #26)
u) **Rate Code** (field #54)
v) **Rate Code Description** (field #55)
w) **Rate Amount** (field #56)
x) **Claim Status** (field #57)
y) **Date of Transaction** (field #58)
z) **Payment Cycle** (field #59)
aa) **Denial Reason Code (field #60)**
bb) **Denial Reason Code Description** (field #61)
cc) **Denial Reason Code (2)** (field #62)
dd) **Denial Reason Code Description (2)** (field #63)
ee) **Paid Claim Provider ID** (field #64)
ff) **Paid Claim Provider Name** (field #65)
gg) **Paid Claim Rate Code** (field #66)
hh) **Paid Claim Provider ID equals MAPP Billed Entity MMIS ID** (field #67)
ii) **Paid Claim Rate Code equals MAPP HML Rate Code** (field #68)
jj) **CANS Completion Date** (field #73)
kk) **Latest transaction** (field #69)
ll) **Last Transaction Date Time** (field #71)

11) For billing instances with a **Billing Instance Type** (field #5) value of 'O' or 'E', the system will populate the **CANS Completion Date** (field #73) with the signed and finalized date of the CANS NY Assessment that determined the rate amount for the billing instance was completed.
12) The **Direct Biller Indicator** (field #17): 'M' means that the MCP will bill; 'H' means that the HH will bill; and 'C' means that the CMA will bill. This field is obsolete.
13) The file will first display all records with a value of 'O' and 'E' in **Billing Instance Type** (field #5) and will then display all records with a value of 'F' in **Billing Instance Type** (field #5).
14) **Last Transaction Date Time** (field #71) is populated with the date and time that the record was last modified, regardless of the billing instance status.
15) **Insert Date** (field #72) is always populated with the date that the billing instance was first created. If a segment was created on 4/28/2017 at 11:07:23 AM with a begin date of 3/1/2017, then the system would create a potential billing instance for that member for service date 3/1/2017 with an insert date of 4/28/17 and a last transaction date/time of '0428201711:07:23'. If that billing instance was then added on 4/29/2017 at 10:07:23 AM, then the system would create a new added billing instance with an insert date of 4/28/17 and a last transaction date/time of '0429201710:07:23'. If that added billing instance was then voided on

4/29/2017 at 12:07:23 PM, then the system would create a new voided billing instance with an insert date of 4/28/17 and a last transaction date/time of '0429201712:07:23'.

16) **Void Date** (field #74) only displays for voided billing instances and will display the date the billing instance was voided.
17) **Provided Service Indicator** (field #80) will be populated with an "A" for Adult or "C" for Child based on the network type associated with the segment.
18) **UAS Complexity Assessment** (field #81) will be populated with a 'Y', 'N', or 'U'.
19) **Encounter Claim** (field #82) will be populated with a 'E', 'C', or be blank. This field indicates the type of payment (claim: FFS through Medicaid or encounter: paid for by plan) reported to Medicaid for the member for the given date of service and corresponds to the claims feedback loop data contained in fields 57-68.

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 of providers that are available to work with Health Home members.
2. DOH uses this network list to create adult 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. MCPs and CMAs do not have access to the HH provider network in MAPP HHTS. Updating this file in MAPP HHTS does not automatically update the list posted on the website.

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
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)

Partner Network File Upload						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
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 Partner Network File Upload 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 **Error** (field #3). 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

Is Partner NPI enrolled in NYS Medicaid? (field #2) and **Name associated with Partner NPI per NYS Medicaid** (field #3) are 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 field 2 will be N and field 3 will be blank.

Assessment Files

Assessments Download File

Description

This file can be downloaded by MCPs, HHs and CMAs. It contains the children's HCBS assessment information and CANs-NY assessment information for assessments that have been signed and finalized in UAS and processed by the MAPP HHTS. MCPs can see Assessment information for any member associated with their plan at the time the assessment was signed and finalized. HHs/CMAs can see any assessment information for a member that has an enrollment segment that either covers the period of time of the assessment or the subsequent 12 months after the assessment's signed and finalized date.

Format

Assessment Download File					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Member ID	1	8	8	Alphanumeric
2	Member First Name	9	30	38	Alpha
3	Member Last Name	39	30	68	Alpha
4	Assessment Type	69	1	69	Alpha (HCBS/CANs)
5	Assessment Outcome	70	1	70	Alpha (C/N/H/M/L)
6	Finalized Date	71	8	78	Numeric (MMDDYYY)
7	Assessor Organization Name	79	40	118	Alpha
8	Assessor Organization MMIS ID	119	8	126	Numeric
9	Health Home Name	127	40	166	Alpha
10	Health Home MMIS ID	167	8	174	Numeric
11	Target Population	175	1	175	Numeric (0/1/2/3)

Editing Logic

1) Member's identifiable information (#1-3)
   a) **Member ID** (field #1) is populated based on the data that is submitted in the person record in UAS
   b) The system uses the data populated in **Member ID** (field #1) to pull **Member First Name** (field #2) and **Member Last Name** (field # 3) from MDW
2) Fields displaying Assessment information (#4-8, 11)
   a) **Assessment Outcome** (field #5) displays the outcome of the Assessment
      i) For HCBS this includes either 'C' for LOC or 'N' for Not LOC
      ii) For CANs this includes 'H', 'M' or 'L' to indicate the acuity level
   b) **Target Population** (field #11) is only populated for HCBS assessment records. This is populated based on data submitted in UAS as follows:
      i) 0 – SED (Serious Emotional Disturbance)
      ii) 1 – MF (Medically Fragile)
      iii) 2 – DD-MF (Developmental Disability Medically Fragile)
      iv) 3 – DD-FC (Developmental Disability Foster Care)
3) Fields Displaying HH Data (#9-10)

a) If the record is a CANs-NY Assessment the information displayed in these fields will come from the values entered in UAS. If the record is a HCBS Assessment the information displayed comes from MAPP HHTS data as of the time the assessment was processed.

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	**MAD**	Manage Assignments Download
AD	Assessment Download	**MFA**	MCP Final HH Assignment
BSD	Billing Support Download	**MMD**	My Members Download
BSE	Billing Support Error	**PND**	Partner Network Download
BSU	Billing Support Upload	**PNE**	Partner Network Error
CD	CIN Search Download	**PNU**	Partner Network Upload
CRD	Child Referral Download	**PAD**	Past Assignments Download
CF	Consent Download	**PP**	Program Participation Download File
CE	Consent Error	**PU**	Program Participation Upload File
CU	Consent Upload	**PE**	Program Participation Error File
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
MA	Managed Care Plan Assignment	**TFD**	Tracking File Delete Record

↑ Files Uploaded to MAPP HHTS
↓ 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 an 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: https://www.omh.ny.gov/omhweb/act/

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 **↓BSD ↑BSU**

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 ACT (Assertive Community Treatment) members during the billing instance service month. This field remains on the BSU and BSD files although ACT members are no longer part of the HH program. For more information on ACT services, please visit the NYS Office of Mental Health Assertive Community Treatment website: https://www.omh.ny.gov/omhweb/act/.

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 **↓BSD ↑BSU**

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. This field remains on the BSU and BSD files although ACT members are no longer part of the HH program. For more information on ACT services, please visit the NYS Office of Mental Health Assertive Community Treatment website: https://www.omh.ny.gov/omhweb/act/

Editing Logic: If **ACT Member** (field #22) on the Billing Support Upload file contains a value of 'Y', then **ACT Minimum Services Provided** (field #23) 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 **ACT Member** (field #22) 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: The provider that needs to act on the pended or pending assignment.

Editing Logic: If a CMA user refers a mainstream~~n~~ MCP member into the Health Home program using the *Create Referral/Segment* link (the "adult referral wizard"), then that member's MCP will be listed in the **Actor** field on the MAD file when the MCP downloads the MAD file.

Additional Info on Chronic Conditions **↓CRD**

Field Length: 300

Format: Alpha

Description: This field includes any free text response entered under the chronic Conditions page of the Children's Referral Portal.

Editing Logic: This field is required when a value of 16: other is submitted in the **Pre-Conditions of member** field.

Add/Void Indicator **↓BSD ↑BSU**

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 **↓MMD↓BSD ↓HHA ↓MA↓A**

Field Length: 7

Format: 00.0000, Numeric

Description: ~~This is the member's 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 (same as **Acuity Score** from Managed Care Plan Assignment File and Health Home Assignment File).~~

~~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.~~ For service dates on or after 12/1/16 the adjusted acuity score is obsolete as billing is based on HML Responses or CANS acuity outcomes (same as **Acuity Score)**. This value is nulled out on the Health Home Assignment File and Managed Care Plan Assignment File.

AH Member continues to qualify **↓BSD ↑BSU**

Field Length: 1

Format: Alpha (Y/N)

Description: This field is required for impacted adult home class members that have transitioned or are interested in transitioning. If a member is not an impacted adult home class member, then this field will be ignored on the BSU and will be blank on the BSD. Please refer to the Adult Home Transition Guidance to determine if the member continues to qualify for the Adult Home Plus Care Management. If the member continues to qualify, submit a value of 'Y' on the BSU. If the member does not continue to qualify, submit a value of 'N' on the BSU.

AH Member interested in transitioning **↓BSD ↑BSU**

Field Length: 1

Format: Alpha (Y/N)

Description: This field is required on the BSU if the **AH Member transitioned to community** field is populated with a value of 'N'. If the **AH Member transitioned to community** field is populated with a value of 'Y' or is not required, then this field will be ignored on the BSU and will be blank on the BSD. If the member is interested in

transitioning out of the adult home, submit a value of 'Y' on the BSU. If the member is not interested in transitioning out of the adult home, submit a value of 'N' on the BSU.

AH Member qualifies for Adult Home Plus Care Management **↓BSD ↑BSU**

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

Description: This field is required for all impacted adult home class members. If a member is not an impacted adult home class member, then this field will be ignored on the BSU and will be blank on the BSD. Please refer to the Adult Home Plus Attestation and Guidance to determine is a member qualifies for adult home plus care management. If the member does qualify, submit a value of 'Y' on the BSU. If the member does not qualify, submit a value of 'N' on the BSU.

AH Member transitioned to community **↓BSD ↑BSU**

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

Description: This field is required for all impacted adult home class members. If a member is not an impacted adult home class member, then this field will be ignored on the BSU and will be blank on the BSD. If the member has not yet transitioned out of the adult home, submit a value of 'N' on the BSU. If the member has already transitioned out of the adult home, submit a value of 'Y' on the BSU.

AOT Member **↓BSD ↑BSU**

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: https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/

AOT Minimum Services Provided **↓BSD ↑BSU**

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: https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/

Editing Logic: If **AOT Member** (field #20) of the Billing Support Upload file contains a value of 'Y', then Billing Support Upload **AOT Minimum Services Provided** (field #21) must be populated with either a value of 'Y' or 'N'. If **AOT Member** (field #20) 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.

Assessment Outcome **↓AD**

Field Length: 1

Format: Alpha (C/N/H/M/L)

Description: This field indicates LOC/non-LOC for HCBS records and acuity for CANs-NY records

Assessment Type **↓AD**

Field Length: 1

Format: Alpha (C/H)

Description: This field indicates if the record is referring to a CANs-NY Assessment or a child HCBS Assessment

Editing Logic: If the record is referring to a CANs-NY assessment then this field will be populated with 'C', if the record is referring to a child HCBS assessment then this field will be populated with 'H'.

Assessor Organization MMIS ID **↓AD**

Field Length: 8

Format: Numeric

Description: This field indicates the organization MMIS ID of the assessor who completed the UAS assessment in the UAS.

Assessor Organization Name **↓AD**

Field Length: 40

Format: Alpha

Description: This field indicates the organization name the assessor who completed the UAS assessment is associated with in UAS.

Assigned Health Home MMIS Provider ID **↓CD**

Field Length: 8

Format: Numeric

Description: The MMIS ID of the Health Home that has an assignment with the member in MAPP HHTS.

Assigned Health Home Name **↓CD**

Field Length: 40

Format: Alpha

Description: The Health Home name associated with the **Assigned Health Home MMIS Provider ID** per NYS Medicaid data.

Assigned HH Assignment Status **↓CD**

Field Length: 40

Format: Alpha

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

Assignment Created Date **↓MMD ↓PAD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that a member assignment began in the *pending* status with a specific provider. See the ***My Members*** section for a description of how the system determines which provider's assignment created date to include on the file.

Assignment End Date **↓PAD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that an assignment ends.

Assignment End 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.

Assignment End Date Reason Description **↓PAD**

Field Length: 40
Format: Alpha

Description: The **Assignment End Date Reason Code's** corresponding description.

Assignment Rejection Date **↓PAD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that a user rejected a *pending* assignment (assignment, referral or transfer record type). If the *pending* assignment was rejected using a file upload, then 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 **Rejection Reason Code's** corresponding description**.**

Assignment Source **↓MA↓HHA↓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, Children's Referral Portal 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'. This value is nulled out on the Health Home Assignment File and Managed Care Plan Assignment File.

Assignment Start Date **↓MMD ↓PAD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that a member assignment began in the *active* status with a specific provider.

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

Field Length: 7

Format: 00.0000, Numeric

Description: The base acuity score has become obsolete.

Begin Date **↓A↓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.

Editing Logic: This field must contain a valid date. On the TFS file the begin date must be greater than or equal to the assignment date for the segment to be submitted without an 'R' **Referral Indicator** (adults only, children cannot be referred via files). 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; must fall within the HH and CMA's provider effective dates; and must fall within the HH/CMA relationship effective dates.

Billing Entity MMIS ID **↓BD**

Field Length: 8

Format: Numeric

Description: This field is calculated by the system.

Editing Logic: As of 12/1/16 this field is obsolete and should not be referenced.

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. As of 12/1/16 this field is obsolete and should not be referenced.

CANs Completion Date **↓BSD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date the CANs-NY assessment was signed and finalized in UAS.

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

Field Length: 8
Format: Numeric

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

Care Management Agency Name **↓HHA ↓MA ↓MMD ↓ED ↓BSD ↓CD**

Field Length: 40
Format: Alpha

Description: The name associated with the CMA MMIS provider ID in the NYS MDW (same as ***Assigned Care Management Agency Name)***.

Child HCBS Flag **↓HHA ↓MA**

Field Length: 1
Format: Alpha (O/N/H)

Description: Indicates if the child member was referred to the HH program for HCBS services.

Editing Logic: If the member was referred into the HH program for HCBS and does not have any other qualifying conditions for HHs (based on information provided during referral) this field will display O. If the member has both

HCBS and other qualifying conditions this field will display H. If the member has was not referred for HCBS eligibility but has other chronic conditions, it will display 'N'.

Child HCBS Flag **↓ED**

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

Description: Indicates if the child member has an active R/E code relating to HCBS services within the system as of the file download.

Child in Foster Care **↑BSU↓BSD**

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

Description: Indicates if a child is in foster care.

Chronic Conditions **↓CRD**

Field Length: 100
Format: Alpha

Description: Indicates if the child member was referred into the program for chronic conditions, and if so what chronic conditions.

City **↓ MMD ↓MA ↓HHA**

Field Length: 40
Format: Alphanumeric (MMD), Alpha (MA/HHA)

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 ***MDW Member City***).

Claim Status **↓BSD**

Field Length: 1
Format: Alpha (P/D/V/Blank)

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter 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. A value of 'V' means that the claim as voided. If an associated claim has not been submitted to NYS Medicaid, then this field will be blank.

CMA Assignment Created Date **↓HHA ↓MA ↓MMD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that a member's CMA assignment began in the *pending* status with a specific CMA. This field would be populated with information from the most recent CMA assignment record for a member.

CMA Assignment End Date **↓HHA ↓MA**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date the CMA assignment was ended.

CMA Assignment End Reason Code **↓HHA ↓MA**

Field Length: 2
Format: Numeric
Accepted Values: *See Appendix G: Assignment End Reason Codes*

Description: A code that corresponds to the reason that a member's CMA assignment ended. Depending on the action that triggered the ending of the CMA assignment, this code is either submitted into the system by a user or is generated by the system (same as **CMA Assignment End Reason)**.

CMA Assignment End Reason Code Description **↓HHA ↓MA**

Field Length: 40
Format: Alpha

Description: The **CMA Assignment End Reason Code's** corresponding description.

CMA Assignment Record Type **↓HHA ↓MA**

Field Length: 10
Format: Alpha (Assignment, Referral, Transfer)

Description: This field is utilized to identify the different types of CMA assignments in the system: Assignment, meaning the member was assigned to the CMA by a HH; Referral, which means that the member assignment resulted from a community referral; and Transfer, which means that the member's current HH is asking if the receiving provider will accept the member as a Transfer or another HH is asking for the current provider to transfer a member to them. This field is used to indicate the record's CMA assignment type.

CMA Assignment Rejection Reason Code **↓HHA ↓MA**

Field Length: 2
Format: Numeric
Accepted Values: *See Appendix E: Assignment Rejection Codes*

Description: A code that corresponds to the reason that a member's *pending* CMA assignment was rejected by the assigned CMA. Depending on the action that triggered the rejection of the CMA assignment, this code is either submitted into the system by a user or is generated by the system.

CMA Assignment Rejection Reason Code Description **↓HHA ↓MA**

Field Length: 40
Format: Alpha

Description: The **CMA Assignment Rejection Reason Code's** corresponding description

CMA Assignment Start Date **↓HHA ↓MA**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that a member's CMA assignment began in the *active* status with a specific CMA. This field would be populated with information from the most recent CMA assignment record for a member.

CMA Assignment Status **↓HHA ↓MA ↓CD**

Field Length: 40
Format: Alpha (Pending, Active, Rejected, Ended, or Blank)

Description: This field describes the status of a member's assignment with their CMA. *Pending* means the member was assigned to the CMA and that the CMA has not yet acted on that assignment. *Active* means that the CMA accepted the member's *pending* assignment. *Ended* means that the member's CMA assignment was ended and would only apply to MCP/HH downloading the file. The *Rejected* status only applies to HHs and MCPs. If an MCP or a HH sees that a member has a value of *rejected* in the **CMA Assignment Status** field, then the MCP or HH knows that the CMA that the HH assigned the member to reject that assignment (same as ***Assigned CMA Assignment Status.***)

CMA Direct Biller Indicator **↑BSU**

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

Description: For dates of service on or after 12/1/16 the CMA Direct Biller Indicator is obsolete as CMAs are no longer direct billers.

CMA Provider MMIS ID **↑TFA, ↓MA**

Field Length: 8
Format: Numeric

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

Comments **↓CRD**

Field Length: 300
Format: Alpha or Blank

Description: This field includes any free text response entered under the Originating Referral Source Contact information of the Children's Referral Portal.

Comments Related to Referral **↓CRD**

Field Length: 300
Format: Alpha or Blank

Description: This field includes any free text response entered under the Consenter Contact information of the Children's Referral Portal.

Community Services and Supports **↑PNU↓PND**

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

Description: Partners that provide community services, including but not limited to, food banks, religious organizations, community centers.

Consent Date **↓ED ↓MMD ↑TFS**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This field is no longer valid, and the Consent file should be used to view and capture consents.

Consenter **↑CU↓CF↓CE**

Field Length: 2
Format: Numeric
Accepted Values: *See Appendix M: Consent File Codes*

Description: This field indicates who signed the consent.

Consenter Area Code **↓CRD**

Field Length: 3
Format: Numeric

Description: The area code of the person that provided consent for the member to be referred to the HH Program. This information is retrieved from the most recent referral for the member that was submitted via the Children's Referral Portal.

Consenter Email Address **↓CRD**

Field Length: 40
Format: Alpha

Description: The identified email address of the person that provided consent for the member to be referred to the HH Program. This information is retrieved from the most recent referral for the member that was submitted via the Children's Referral Portal.

Consenter First Name **↓CRD**

Field Length: 30
Format: Alpha

Description: The first name of the person that provided consent for the member to be referred to the HH Program. This information is retrieved from the most recent referral for the member that was submitted via the Children's Referral Portal.

Consenter Last Name **↓CRD**

Field Length: 30
Format: Alpha

Description: The last name of the person that provided consent for the member to be referred to the HH Program. This information is retrieved from the most recent referral for the member that was submitted via the Children's Referral Portal.

Consenter Phone Number **↓CRD**

Field Length: 7
Format: Numeric

Description: The phone number of the person that provided consent for the member to be referred to the HH Program. This information is retrieved from the most recent referral for the member that was submitted via the Children's Referral Portal.

Consenter Preferred Communication **↓CRD**

Field Length: 5
Format: Alpha

Description: The identified preferred method of communication of the person that provided consent for the member to be referred to the HH Program. This information is retrieved from the most recent referral for the member that was submitted via the Children's Referral Portal.

Consenter Pref. Time of Day **↓CRD**

Field Length: 9
Format: Alpha

Description: The identified preferred time of day for communication with the person that provided consent for the member to be referred to the HH Program. This information is retrieved from the most recent referral for the member that was submitted via the Children's Referral Portal.

Consenting Individual to Refer **↓CRD**

Field Length: 95
Format: Alpha

Description: Includes the consenter's relationship with the member selected on the Consenter screen from the most recent referral via the Children's Referral Portal. The possible values are: *Parent, Guardian, Legally Authorized Representative, Member/Self Individual is 18 years old or older, Member/Self Individual is under 18 years old, but is a parent, or is pregnant, or is married.*

Consent Type **↑CU↓CD↓CE**

Field Length: 2
Format: Numeric (01, 02, 03)
Accepted Values: *See Appendix M: Consent File Codes*

Description: Populate this field with the type of consent that was signed (same as ***Existing Consent Type*** and ***New Consent Type***).

Core Service Provided **↓BSD ↑BSU**

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 receive 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 L*.

Corrections **↓PND ↑PNU**

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

Description: Partners that are associated with corrections and/or Office of Criminal Justice services.

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

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 ↓BSD**

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

Description: The provider that created the *pending* assignment listed on the MAD file.

Editing Logic: If a CMA user refers an MCP member into the Health Home program using the *Create Referral/Segment* link (the "referral wizard"), then that CMA will be listed in this field on the MAD file when the MCP downloads the MAD file.

Created Date **↓MAD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: Same as Assignment Created Date.

Current HARP Status **↓BSD**

Field Length: 2

Format: Alpha (Blank, EL, or EN)

Description: HARP stands for Health and Recovery Plans, which is a Managed Care Plan that covers certain Medicaid members that meet the HARP eligibility 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.

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/index.htm 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. HARP eligibility and enrollment is determined by RE codes and enrollment in a HARP MCP line of business.

Current Managed Care Plan MMIS ID **↓ED**

Field Length: 8

Format: Numeric

Description: This field displays the MMIS ID of the Managed Care Plan the member is associated with as of the date the Enrollment Download file is downloaded, which may be different from the Managed Care Plan the member was associated with during the segment period. This field will be blank for members that are currently fee for service. This field corresponds to the **Current MCP Name** field on the Enrollment Download file.

Current Managed Care Plan Name **↓ED**

Field Length: 40

Format: Alpha

Description: This field displays the name of the Managed Care Plan the member is associated with as of the date the Enrollment Download file is downloaded, which may be different from the Managed Care Plan the member was associated with during the segment period. This field will be blank for members that are currently fee for service.

Date **↓CF**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The most recent date the consent record was created or updated.

Date of Birth **↓BSD ↓CD ↓ED ↓MMD ↓HHA ↓MA ↓PAD ↑TFS↓CRD**

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 L: 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 ***DOB*** and ***Member DOB*)**.

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 HML Assessment Entered **↓BSD**

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 completed for the member's service date.

Date Member Housed **↓BSD ↑BSU**

Field Length: 8
Format: MMDDYYYY, Numeric

Description

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. Patient Acuity is obsolete. This field is nulled out on the Health Home Assignment File and Managed Care Plan Assignment File.

Date of Transaction **↓BSD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This field is populated with the date the claim or encounter was submitted to NYS Medicaid if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter that is associated with a member's service date.

DDSO **↓PND ↑PNU**

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

Description: Partners that are Developmental Disabilities Services Offices.

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

Field Length: 4
Format: Numeric

Description: This field is populated if the system determines that there is a denied NYS Medicaid claim or encounter 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 or encounter that is associated with a member's service date.

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

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

Field Length: 25
Format: Alphanumeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter that is associated with a member's service date.

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

Description of "Other" pre-condition **↓BSD ↑BSU**

Field Length: 40
Format: Alphanumeric

Description: If the **Pre-Conditions of member** (field #5) on the Billing Support Upload file contains code 16 'Other', then Billing Support Upload **Description of "Other" pre-condition** (field #6) 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 **Pre-Conditions of member** (field #5), then this field should be blank and the system will ignore any value populated in this field.

Please refer to the provider manual (see *Appendix L: Reference and Contacts* a link to the HH Program Manual).

Diagnosis Code **↓BSD ↑BSU**

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 or encounter. 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 or encounter 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 or encounter. 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, ICD-10, as of the record's service date.

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

Field Length: 1

Format: Alpha (M/H/C) (BSD), Alpha (Y/N) (CD, ED, TFS)

Description: This field is obsolete.

Disenrollment Reason Code **↓ED**

Field Length: 2

Format: Numeric

Accepted Values: Appendix D: Segment End Date Reason Codes

Description: The reason why the segment was ended.

Editing Logic: This field must contain an accepted value. This field is only required for segments with an end date.

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 Composite Score **↓ MMD ↓HHA ↓MA**

Field Length: 6

Format: Decimal, 999V99

Description: The field has become obsolete and is nulled out on the Health Home Assignment File and Managed Care Plan Assignment File.

DOH Recommended Health Home MMIS ID **↓ MA ↓ MMD**

Field Length: 8

Format: Numeric

Description: For each MCP member that DOH assigns to an MCP, DOH uses a member's Medicaid claims and encounters history and HHs' partner networks to populate this field with the Health Home that has the best connection with a member. If a member does not have claims and encounters in the system, or if this algorithm shows that a member is equally connected to multiple Health Homes, then the algorithm randomly assigns the member to a regional Health Home. MCPs can either assign their members to this HH or MCPs can assign

members to Health Homes using their own knowledge of the member (same as ***DOH Recommended HH***). This value is nulled out on the Managed Care Plan Assignment File.

DOH Recommended Health Home Name **↓MA**

Field Length: 40
Format: Alpha

Description: The name associated with a **DOH Recommended Health Home MMIS ID** within the NYS Medicaid MDW.

Downloading Provider Assignment Created Date **↓MMD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that the member's assignment began with the provider downloading the file.

Downloading Provider Assignment Start Date **↓MMD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This field is populated with the start date of the downloading provider's most recent reportable assignment that is in the *active* or *pended* status. This field is always blank for segment records.

Downloading Provider Assignment Status **↓MMD**

Field Length: 40
Format: Alpha (Pending, Pended, Active)

Description: This field is populated with the status (*pending, pended, active*) of the downloading provider's most recent reportable assignment record. This field is always blank for segment records.

Early Intervention Provider **↓PND↑PNU**

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

Description: Partners that provide early intervention services to children.

Eligible for Outreach **↓HHA↓MA**

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

Description: This field indicates whether or not a member has had 2 or more months of outreach in a status other than Cancelled within the last 12 months.

Encounter Claim **↓BSD**

Field Length: 1
Format: Alpha (C, E, or blank)

Description: Refers to the payment information contained in fields 57-68 of the Billing Support Download. C indicates that the Health Home was paid on a fee for service claim through eMedNY. E indicates that the Health

Home was paid by the member's Managed Care Plan. Plans are required to submit encounters to DOH to document what the Managed Care Plan paid a downstream provider. Generally, since encounters are reported to DOH by the Plans, it takes a little longer for encounters to be displayed on the Billing Support Download file than the claims.

End Date **↓A↓AD ↓CD ↓ED ↓MMD ↑TFS ↑CU↓CF↓CE**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The end date indicates when a value or a status becomes no longer effective.

Editing Logic: This field must contain a valid date. On the TFS file, the end date must always be the last day of the month. For example, if the services ended on May 10, 2016, the End Date must be 5/31/16. This date may not fall within an existing service segment.

The End Date indicates when the segment or consent ended. When a member dis-enrolls from Health Home services, the end date will indicate when Health Home services were discontinued. Unless a member is moving from outreach to enrollment or from pended to enrollment (with the same HH and CMA), an end date must be submitted using a modify record to indicate to DOH that a segment is ending. When a member is moving from outreach to enrollment or pended to enrollment, an end date is not needed to end date the outreach or pended segment. When a Create record for enrollment is submitted, the system will automatically end date any outreach or pended segments that are open as of the submitted end date.

Editing Logic: This date must be greater than the begin date and must always be the last day of the month. When a segment is ended, the segment must be ended using a modify record, never a delete record. The end date cannot cause the segment to overlap with another existing segment. For open segments, the end date field should be null.

End Date Reason/Assignment End Date Reason Description **↓HHA↑TFA↓MMD**

Field Length: 2 (reason code)/60 (description)

Format: See *Appendix G: Assignment End Reason Codes*

Description: Providers use acceptable codes to describe why they are ending the member's assignment.

End Date Reason Comment/Assignment End Date Reason Comment **↓HHA↓MA↑TFA**

Field Length: 40

Format: Alphanumeric

Description: When field **End Date Reason** is populated with code '12' indicating 'Other', this field must be populated with the reason that the provider ended the assignment. This field includes the corresponding comments to the **End Date Reason/Segment End Date Reason Description** (same as ***End Reason Comment*).**

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

Field Length: 1

Format: Alpha (Y/N)

Description: When a provider uses the TFS file to submit a record end dating a segment, a value of 'N' (No – don't end the HH assignment) in this field indicates to the system to add the member back to the Health Home's assignment file the day after the segment ends. A value of 'Y' (Yes –end the HH assignment) in this field indicates to the system NOT to add the member back to the Health Home's assignment file the day after the segment ends.

When a provider uses the TFA file to submit a record to end a CMA assignment, a value of 'N' (No – don't end the HH assignment) indicates that the system should just end the member's assignment with the CMA, but not the HH and a value of 'Y' means that the system should end the member's assignment with both the CMA and the HH.

End/Pend Reason Code **↑TFS**

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

Description: The reason why the segment is being end dated. This field should be left blank if the segment is open.

Editing Logic: This field must contain an accepted value. This field is only required for segments with an end date.

Engagement Optimization **↓MA↓HHA↑MFA**

Field Length: 1
Format: Alpha
Accepted Values: *Appendix K: MCP Final HH Assignment File Accepted Values*

Description: Indicates if a member is part of a MCP's engagement-optimization plan and describes how an MCP has engaged a member. This field is optional for MCPs.

Enrollment Care Management Agency MMIS Provider ID **↓CD**

Field Length: 8
Format: Numeric

Description: The MMIS ID of the CMA the member is enrolled with. If the member is not enrolled, this field will be blank

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Enrollment Care Management Agency Name **↓CD**

Field Length: 40
Format: Alpha

Description: The name in NYS Medicaid that corresponds to the **Enrollment Care Management Agency MMIS Provider ID.**

Error Field **↓CD**

Field Length: 40
Format: Alpha

Error Reason Code 1-5 **↓TFE**

Field Length: 8
Numeric: Numeric

Description: The code that corresponds to the **Error Reason Description**.

Error Reason/Error Reason Description 1-5 **↓BSE ↓TFE↓BE ↓EFA↓CE↓PNE↓PE**

Field Length: 30 (EFA,CE, PE); 40 (BE); 70 (TFE); 20 (PNE)
Format: Alphanumeric (EFA,CE, PE); 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 (same as ***Error)***.

Existing Start Date **↑CU↓CE**

Field Length: 8
Format: Numeric, MMDDYYYY

Description: The start date of the current consent data.

Expanded HH+ **↑BSU ↓BSD**

Field Length: 1
Format: Alpha
Accepted Values: *Appendix H: High Medium Low Assessment Codes*

Description: The **Expanded HH+** Field captures information regarding if a member is part of the Expanded HH+ population (same as ***Expanded HH+ Population***).

Finalized Date **↓AD**

Field Length: 8
Format: Numeric (MMDDYYY)

Description: This field is populated with the date the assessment was signed and finalized per UAS data.

First Name/Member First Name **↓AD↓BSD ↓ED ↓HHA ↓MAD ↓MA ↓MMD ↓PAD↓CD ↓CF↓CRD**

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 L: 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)

Description: This field indicates whether a provider/partner is associated with foster care services.

Gender/Member Gender **↓BSD ↓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 L: 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.

HARP, HARP Current, HARP Flag **↓HHA ↓MA ↓ED ↓BSD ↓MMD**

Field Length: 1 character (HHA, MA, ED); 2 characters (BSD, MMD)

Format: Alpha (Y/N/E - HHA, MA, ED); Alpha (EL/EN/Blank - BSD, MMD)

Description: **MAPP HHTS HARP Definitions (as of July 2016) ***

- A member that is enrolled in a HARP/SNP Managed Care Plan AND has an RE code of H1-H6 is considered HARP Enrolled in MAPP HHTS.
- A member that does not have an RE code of H1-H6 BUT has an RE code of H9 is considered HARP Eligible in MAPP HHTS.
- A member that does not have an RE code of H1-H9 is neither HARP eligible nor HARP enrolled

HARP flags within the system contain different values. Some spell out eligible/enrolled/blank and others use the logic below:

- HARP Y/N/E fields –Y: HARP eligible; E: HARP Enrolled; N: neither eligible nor enrolled.
- HARP El/En/Blank fields -El: HARP eligible; En: HARP Enrolled; Blank: neither HARP eligible nor HARP enrolled.

*As of service date for billing. Otherwise, as of transaction date

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HCBS **↓CRD**

Field Length: 30

Format: Alpha (HCBS/None)

Description: This field records if the referring provider indicated that the child record in the file was referred based on HCBS eligibility

Health Home Assignment Status **↓HHA ↓MA**

Field Length: 40

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

Description: This field describes the status of a member's assignment with their HH. *Pending* means member was assigned or referred to the HH and that the HH has not yet acted on that assignment. *Active* means that the HH either accepted the member's *pending* assignment/referral or that the HH member is back on the HH assignment file because the member had a segment that ended and the HH assignment was not ended with the segment. *Ended* means that the member's HH assignment was ended. The *Rejected* status only applies to MCPs. If an MCP sees that a member has a value of *rejected* in the **Health Home Assignment Status** field, then the MCP knows that the HH that the MCO assigned the member to reject that assignment (same as ***Assigned HH Assignment Status***).

Health Home (HH) MMIS ID **↓AD ↓BSD ↓CD ↓ED ↓EFA ↓HHA ↓MA ↑MFA ↓MMD ↓TFE↑TFS ↑CU ↓CF↓CE↑TFA**

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. For the Assessment Download File the **HH MMIS ID** is populated with the HH selected in the UAS for CANs-NY Assessments and the HH associated with the member at the time the assessment is processed for child HCBS members (same as ***Enrolled Health Home MMIS Provider ID***, ***Health Home MMIS Provider ID, HH Provider MMIS ID*** and ***Assigned Health Home ID***).

Health Home Name **↓AD ↓BSD ↓ED ↓HHA ↓MA ↓MMD↓CF**

Field Length: 40

Format: Alpha, Alphanumeric (BSD)

Description: The name associated with a Health Home MMIS Provider ID within the NYS Medicaid MDW. For the Assessment Download File, the **HH Name** is populated with the HH selected in the UAS for CANs-NY Assessments and the HH associated with the member at the time the assessment is processed for child HCBS members (same as ***Enrolled Health Home Name)***.

Health Home NPI **↓HHA ↓MA**

Field Length: 10

Format: Numeric

Description: The National Provider Identifier number that is associated with the Health Home's MMIS Provider ID.

HIV/AIDS Provider **↓PND ↑PNU**

Field Length: 1

Format: Alpha (Y/N)

Description: Partners that specialize in providing services to individuals with HIV/AIDS.

HIV Status **↓BSD ↑BSU**

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 **↓BSD ↑BSU**

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 acceptable codes. 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 **HIV Status** (field #7) in the Billing Support Upload file contains a value of 'Y', then Billing Support Upload **HIV T-Cell Count (**field #9) must be populated with one of the accepted values. If **HIV Status** (field #7) in 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. If this field was not required on the BSU, this field on the BSD will contain a value of '0'.

HIV Viral Load **↓BSD ↑BSU**

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 accepted codes. 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 **HIV Status** (field #7) in the Billing Support Upload file contains a value of 'Y', then Billing Support Upload **HIV Viral Load** (field #8) must be populated with one of the accepted values. If **HIV Status** (field #7) in 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. If this field was not required on the BSU, this field on the BSD will contain a value of '0'.

HH Assignment Created Date **↓HHA ↓MA**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that a member assignment began in the *pending* status with an HH.

HH Assignment End Date **↓MA**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date the HH ended the assignment.

HH Assignment End Reason Code **↓MA**

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

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

HH Assignment End Reason Code Description **↓MA**

Field Length: 40
Format: Alpha

Description: The description that corresponds to the **HH Assignment End Reason Code.**

HH Assignment Record Type **↓MA↓HHA**

Field Length: 10
Format: Alpha (Assignment, Referral, Transfer)

Description: This field is utilized to identify the different types of HH assignments in the system: Assignment, meaning the member was assigned to the HH by DOH or an MCP; Referral, which means that the member assignment resulted from a community referral; and Transfer, which means that the member's current HH is asking if the receiving provider will accept the member as a Transfer or another HH is asking for the current HH to transfer the member to them. This field is used to indicate the record's HH assignment type.

HH Assignment Rejection Reason Code **↓MA**

Field Length: 2
Format: Numeric
Accepted Values: Appendix E: Assignment Rejection Reason Codes

Description: A code that corresponds to the reason that a member's *pending* HH assignment was rejected by the assigned HH. Depending on the action that triggered the rejection of the HH assignment, this code is either submitted into the system by a user or is generated by the system .

HH Assignment Rejection Reason Code Description **↓MA**

Field Length: 40
Format: Alpha

Description: The description that corresponds with the **HH Assignment Rejection Reason Code.**

HH Assignment Start Date **↓MA↓HHA**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that a member's HH assignment began in the *active* status with a specific HH.

HH+ Minimum Services Provided **↓BSD ↑BSU**

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

Description: Indicates if HH+ level of services were provided for a HH+ member for a specific service date (same as ***HH+ service provided)***.

Hospital **↓PND ↑PNU**

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

Description: Partners that are Hospitals.

Housing **↓PND ↑PNU**

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

Description: Partners that provide housing services.

HUD Category **↓BSD ↑BSU**

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

Description: This field collects a member's HUD Category. 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 **Member Housing Status** (field #10) in the Billing Support Upload file contains a value of 'Y', then Billing Support Upload **HUD Category (**field #11) must be populated with one of the accepted values. If **Member Housing Status** (field #10) in 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 **HUD Category** (field #11)**.** If this field was not required on the BSU, this field on the BSD will contain a value of '0'.

HUD1 within Past 6 months **↑BSU**

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

Description: Indicates if the member meets the HUD 1 definition of homelessness in the past 6 months

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Impacted Adult Home Class Member/Impacted Adult Home Member **↓BSD ↓MMD**

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.

Editing Logic: Members with a value of 'Y' in this field must respond to the appropriate Adult Home questions on the Billing Support Upload file.

Incarceration **↓BSD ↑BSU**

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 **↓BSD ↑BSU**

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 **Incarceration** (field #12) in the Billing Support Upload file contains a value of 'Y', then Billing Support Upload **Incarceration Release Date (**field #13) 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 **Incarceration** (field #12) in 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 **↓BSD ↓ED**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: In the Enrollment Download File, this field signifies the first date that a record was submitted into the system. In the Billing Support Download File, this field is always populated with the date that a member's billing instance is first created. For example, if a segment was created on 4/28/2017 at 11:07:23 AM with a begin date of 3/1/2017, then the system would create a potential billing instance for that member for service date 3/1/2017 with an **insert date** of 4/28/17 and a **last transaction date/time** of '0428201711:07:23'. If that billing instance is then *added* on 4/29/2017 at 10:07:23 AM, then the system will create a new *added* billing instance with an **insert date** of 4/28/17 and a **last transaction date/time** of '0429201710:07:23'. If that added billing instance was then *voided* on 4/29/2017 at 12:07:23 PM, then the system would create a new *voided* billing instance with **insert date** of 4/28/17 and a **last transaction date/time** of '0429201712:07:23'. The **insert date** will help providers identify newly created billing instances, regardless of service date (e.g. if a provider submits a segment on August 2nd with a begin date of January 1, 2016, the **insert date** will allow the provider to look at all of the new August, billing instances and this new segment's January-August billing instances by filtering the **insert date** fields to dates on or before August 1st).

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

Field Length: 1

Format: Alpha (N/Y)

Description: Indicates if the Partner NPI is enrolled in NYS Medicaid: 'Y' means yes, and 'No' means no.

Latest Modified Date **↓PAD↓ED**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that the record was last modified.

Latest Transaction **↓BSD**

Field Length: 1

Format: Alpha (Y/N)

Description: Used to indicate which Billing Instance for a member's 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. A value of 'N' means that the record is not the most recent record. For each member service date, only one record will contain a value of 'Y'.

Last Name (Member Last Name)↓AD↓BSD ↓ED ↓HHA ↓MAD ↓MA ↓MMD ↓PAD↓CD↓CF↓CRD

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 L: 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.

Last Transaction Date Time **↓BSD**

Field Length: 16

Format: MMDDYYYY:MM:SS, Numeric

Description: This field is populated with the date and time that a member's record was last modified, regardless of the billing instance status. If a billing instance was added on 4/28/2017 11:07:23 AM then the Last Transaction Date/Time for that added billing instance would be '0428201711:07:23'.

Last Updated By **↓CF**

Field Length: 40

Format: Alpha

Description: This field is populated with the user name of the most recent user that created or updated the consent record.

Line Number **All Error Files except BSE**

Field Length: 6

Format: Numeric

Description: The line number on the submitted file that was rejected (same as ***Submitted Line)***.

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

Field Length: 1

Format: Alpha (Y/N)

Description: Partners that are Local Government Units and/or Single Point of Access providers.

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

Field Length: 40

Format: Alpha (Pending, Active, Pended)

Description: This field describes the status of a member's Health Home assignment with their MCP. *Pending* means that either DOH assigned a member to the MCP or a HH/CMA referred an MCP member into the Health Home program, and the MCP has not yet acted on that assignment. *Active* means that the MCP either accepted the member's *pending* assignment or that the MCP member is back on the MCP assignment file because the member had a segment that was end dated. *Pended* means that the MCP reviewed the member's *pending* assignment and determined that the member was not appropriate for the Health Home program at this time.

Managed Care Plan Enrollment Date **↓CD**

Field Length: 8

Format: MMDDYYYY, Numeric

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

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

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 MCP MMIS Provider ID, also referred to as the Plan ID, is the MMIS Provider ID associated with the member's Managed Care Plan (same as ***Managed Care Organization MMIS ID***).

Editing Logic: For fee for service members, this field will be blank. For all files, except for 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 **↓BSD ↓CD ↓HHA ↓MA ↓MMD**

Field Length: 40

Format: Alpha, Alphanumeric (BSD)

Description: The name associated with the **Managed Care Plan MMIS Provider ID** within NYS Medicaid MDW**.** For fee for service members, this field will be blank.

MCP Assignment Created Date **↓HHA ↓MA**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date that a member assignment began in the *pending* status with an MCP. If an MCP assignment started in the *active* status, the **MCP Assignment Created Date** will match the **MCP Assignment Start Date** (same as ***MCP Assignment Create Date*****).**

MCP Assignment Record Type **↓HHA ↓MA**

Field Length: 10
Format: Alpha (Assignment, Referral)

Description: This field is utilized to identify the different types of MCP assignments in the system: *Assignment*, meaning the member was assigned to the plan by DOH and, *Referral*, which means that the member assignment resulted from a community referral. This field is used to indicate the record's MCP assignment type.

MCP Assignment Start Date **↓MA↓HHA**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date the MCP Assignment was accepted.

MCP Determined Eligibility **↓HHA ↓MA ↑MFA**

Field Length: 23
Format: Numeric
Accepted Values *Appendix K: MCP Final HH Assignment File Accepted Values*

Description: Allows up to 8 2-digit coded eligibility reasons to be uploaded or displayed with a space delimiter.

MCP Type **↓HHA**

Field Length: 40
Format: Alpha

Description: This field indicates the provider type of the MCP as it is stored in the Provider Management section in the profile of the organization in the system. When there is more than one provider type listed for an MCP within the category of MCP, this field will be blank.

MDW Member 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 with NYS Medicaid.

For more information on how to change member Medicaid information, please see *Appendix L: Reference and Contacts* (same as ***DOH MDW Address 1/2*** and ***MDW Member Address Line 1/Line 2***).

Medicaid Coverage Code **↓CD**

Field Length: 2

Format: Alphanumeric

Description: A 2-digit code that describes what types of services a Medicaid member is eligible to receive. Please see the link below for additional information on coverage codes' compatibility with the Health Home program: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_coverage_codes.pdf

Medicaid Coverage Code Description **↓CD**

Field Length: 40

Format: Alpha

Description: Describes the 2-digit **Medicaid Coverage Code**.

Medicaid Effective Date **↓CD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The date that a member's most recent Medicaid eligibility became effective.

Medicaid Eligibility End Date/ Medicaid End Date **↓CD↓ED ↓HHA ↓MA ↓MMD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: Indicates when a member's Medicaid eligibility ends. This field is populated with a member's most current NYS Medicaid eligibility end date. If a member's **Medicaid Eligibility End Date** is in the past that indicates that the member was Medicaid eligible prior to that end date, but that the member is not currently eligible. If the member does not have a value in the **Medicaid Eligibility End Date** field that means that the member has a **Medicaid Eligibility End Date** of 12/31/9999 (the system will not display 12/31/9999 to indicate that a member is indefinitely eligible). **Please note**: it may take up to a week for information corrected or updated in NYS Medicaid's MDW to be listed within the MAPP HHTS.

Medicaid Eligibility Status **↓BSD**

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.

Medicaid Recipient Exemption Code 1-5 **↓CD**

Field Length: 2

Format: Alphanumeric

Description: Exception Codes are two-character codes that identify a member's Medicaid program exceptions or restrictions. Please see the link below for additional information on recipient exemption codes' compatibility with the Health Home program.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

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Medicaid Recipient Exemption Code 6 to 16 **↓CD**

Field Length: 32

Format: Alphanumeric (space deliminated)

Description: Up to 11 additional 2-digit RE codes will be displayed in this field with a space between each RE code. These are the 6th through 16th most recent RE codes based on start date in NYS Medicaid.

Medicaid Recipient Exemption Code Description 1-5 **↓CD**

Field Length: 40

Format: Alpha

Description: Describes the 2-digit

Medical Services Provider **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Description: Partners that provide medical care.

Medicare Indicator **↓HHA ↓MA**

Field Length: 1

Format: Alpha (N/Y)

Description: A value of 'Y' in this filed indicates that the member is enrolled in Medicare. A value of 'N' indicates that a member is not enrolled in Medicare.

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

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, then the member must update the information with NYS Medicaid. Please see *Appendix L: Reference and Contacts* for information on how a member can update this information with NYS Medicaid (same as ***DOH MDW Address 1***, ***DOH MDW Address 2***, ***MDW Member Address 1***, ***Address1/2*** and ***MDW Member Address 2***). **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 Age **↓CD ↓MMD**

Field Length: 3

Format: Numeric

Description: The age of the member in years.

Member City **↓HHA ↓MA ↓MMD**

Field Length: 40

Format: Alphanumeric

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix L: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. (same as ***MDW Member City*** and ***City***). **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 **↓BSD**

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 L: 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 **↓BSD**

Field Length: 40

Format: Alphanumeric

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

Member Housed **↑BSU**

Field Length: 1

Format: Alpha (Y/N)

Description: Currently this field should be left blank on the upload.

Member Housing Status/Member Living Status **↓BSD ↑BSU**

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 Phone **↓HHA ↓MA ↓MMD**

Field Length: 10

Format: Numeric

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix L: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. (same as ***MDW Member Phone*** and ***Phone***)

Member State **↓HHA ↓MA ↓MMD**

Field Length: 2

Format: Alpha

Description: The most recent member contact information from NYS Medicaid's MDW. If this information is incorrect, then the member must update the information with NYS Medicaid. Please see *Appendix L: Reference and Contacts* for information on how a member can update this information with NYS Medicaid. (same as ***MDW Member State*** and ***State***).

Member Zip Code **↓BSD ↓ 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 L: 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 **↓BSD ↑BSU**

Field Length: 1

Format: Alpha (Y/N/U/M/P/N/V)

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

Description: Indicates if a member has had an inpatient stay for either Mental Illness or Physical Health within the last year.

Mental Illness Stay Discharge Date **↓BSD ↑BSU**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This field must be populated if the **Mental Illness** indicated that the member had an inpatient stay for either mental health or physical health within the last year. 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 (same as ***Mental Illness Discharge Date).***

Editing Logic: If **Mental Illness (**field #14) of the Billing Support Upload file contains a value of that indicates that the member did have an inpatient stay for Mental or Physical Health then this field must be populated. If **Mental Illness (**field #14) 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 **Mental Illness Stay Discharge Date** (field #15)**.** If a provider knows that a member was recently discharged from an inpatient stay due to mental illness or physical health, but does not know the members' discharge date, then **Mental Illness (**field #14) must be populated with a value of 'U' or 'V' and **Mental Illness Stay Discharge Date** (field #15) should be blank.

Month Submitted **↓BSD**

Field Length: 1

Format: Alphanumeric

Description: This field represents the month of the HML, 1-6. A 1 will always be displayed for outreach segments, Children's Billing Questionnaires and CANs-NY Assessment Fees.

Name Associated with Partner NPI per NYS Medicaid **↓PND**

Field Length: 70

Format: Alpha

Description: The name that is associated with the NPI the Health Home uploaded on the Partner Network Upload File per NYS Medicaid.

New Start Date **↓CE ↑CU**

Field Length: 8

Format: Numeric, MMDDYYYY

Description: The start date of the newly uploaded consent record.

No of outreach mos within 12 mos **↓HHA ↓ MA**

Field Length: 2

Format: Numeric (01-12)

Description: This field displays the count of the number of months of outreach in a status other than Cancelled or Hiatus for a member within the last 12 months.

NYSID **↑TFS↓ED**

Field Length: 9

Format: Alphanumeric

Description: The New York State Identification Number is a unique identifier assigned to an individual by the New York State Division of Criminal Justice Services. This is an optional field.

OASAS Services **↓PND ↑PNU**

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

Description: Partners that provide Alcohol and/or Substance Abuse services and/or any other services regulated by the Office Alcohol and Substance Abuse.

OMH Services **↓PND ↑PNU**

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

Description: Partners that provide Mental Health/Behavior Health services and/or any other services regulated by the Office of Mental Health.

Opt-Out Effective Date **↓PP ↓CN↓PAD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This field is system populated with the date the opt-out is effective in the MAPP HHTS. This date is the first of the month following the **Opt-Out Signature Date.**

Opt-Out End Date **↓PAD ↓PP↑PU↓CN**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This field is populated with the date the member ends their opt out and is submitted by the user on the Program Participation upload file.

Opt-Out Reason **↓PP ↑PU**

Field Length: 2
Format: Numeric
Accepted Values: see Appendix N: Program Participation File Codes

Description: This field is populated with the reason code describing a members opt-out. This code is submitted by the provider who secured the opt-out signature.

Opt-Out Reason Description **↓PP**

Field Length: 50
Format: Alphanumeric

Description: The description of the **Opt-Out Reason**

Opt-Out Signature Date **↓PAD↓PP↑PU↓CD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This field is populated with the date the opt-out of Health Homes form is signed.

Opt-Out Submission Date **↓PP↓CD↓PAD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This field is system populated with the date the opt-out was submitted to the MAPP HHTS.

Opt-Out Submitted by Organization Name **↓PAD↓PP ↓CD**

Field Length: 40

Format: Alphanumeric, Alpha (CD)

Description: This field is system populated with the provider organization that submitted the opt-out information.

Opt-Out Submitted by User **↓CD**

Field Length: 40

Format: Alpha

Description: This field is system populated with the first and last name of the user who submitted opt-out information about the member.

OPWDD Services **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Description: Partners that provide services to People with Developmental Disabilities and/or any other services regulated by the Office for People with Developmental Disabilities.

Original Record from File **↓PNE↓BSE**

Field Length: 140 (BSE), 137 (PNE)

Format: Alphanumeric

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

Originating Referral Source Area Code **↓CRD**

Field Length: 3

Format: Numeric or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the first three digits of the phone number of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source City **↓CRD**

Field Length: 30
Format: Alpha or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the name of the city pertaining to the address of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Contact Name **↓CRD**

Field Length: 60
Format: Alpha or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the name of the provider who originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Extension **↓CRD**

Field Length: 5
Format: Alphanumeric or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field can include the extension number that accompanies a phone number of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Organization **↓CRD**

Field Length: 30
Format: Alphanumeric or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the name of the entity/organization of the provider who originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Phone Number **↓CRD**

Field Length: 7
Format: Numeric or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the seven digits (after the area code) of the phone number of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Phone Type **↓CRD**

Field Length: 3
Format: Alpha or Blank
Accepted values: Home, Cell, Work

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the type of phone the provider that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS is utilizing. This should describe the type of phone associated with the provided Originating Referral Source Phone Number.

Originating Referral Source State **↓CRD**

Field Length: 2
Format: Alpha or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the abbreviated name of the state pertaining to the address of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Street 1 **↓CRD**

Field Length: 30

Format: Alphanumeric or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the street address of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Street 2 **↓CRD**

Field Length: 30

Format: Alphanumeric or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the continuation of the street address of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Originating Referral Source Zip Code **↓CRD**

Field Length: 9

Format: Numeric or Blank

Editing Logic: This field will be populated with information only if the provider entering a children's referral through the CRP has indicated that someone outside of their organization provided them with the referral information outside of the MAPP HHTS. The system will populate this field with the information the MAPP HHTS user enters while completing the child referral for the originating referrer.

Description: This field includes the zip code number pertaining to the street address of the provider or the organization that originally identified the member as HH eligible and made the referral to the provider entering the referral into the MAPP HHTS.

Other **↓MAD**

Field Length: 60

Format: Alpha

Description: For MCP users, this field will be populated with the DOH recommended Heath Home assignment. For all other users, this field will be blank.

OT/PT/Speech **↓PND ↑PNU**

Field Length: 1

Format: Alpha (N/Y)

Description: Partners that provide OT (Occupational Therapy), PT (Physical Therapy), and/or Speech Therapy services.

Outpatient Score **↓HHA ↓MA**

Field Length: 6

Format: Decimal, 999V99

Description: This field is obsolete and has been nulled out on the Health Home Assignment File and Managed Care Plan Assignment File.

Outreach/Enrollment Code **↓BSD ↓ED ↓HHA ↓MA ↑TFS**

Field Length: 1

Format: Alpha (O/E/F)

Description: 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. On the Billing Support Download file only the **Billing Instance Type** may also include F to indicate that an initial CANs-NY Assessment Fee can be billed for the service date (same as ***Segment Type*** *and* ***Billing Instance Type)***.

Paid Claim Provider ID **↓BSD**

Field Length: 8

Format: Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter 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 or encounter 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, voided, or denied.

Please note: Encounters take longer to be submitted to DOH and therefore there can be a delay in this information populating in the MAPP HHTS system.

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

Field Length: 1

Format: Alpha (Y/N)

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter that is associated with a member's added billing instance service date.

If the MMIS Provider ID in the **Paid Claim Provider ID** (field #64) matches the MMIS Provider ID in the **Billing Entity MMIS ID** (field #20), then this field will be populated with a value of 'Y'. If the MMIS Provider ID in the **Paid Claim Provider ID** (field #64) does not match the MMIS Provider ID in the **Billing Entity MMIS ID** (field #20), 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 or encounter associated with the added billing instance service date, whether the claim or encounter was paid, voided, or denied.

Please note: Encounters take longer to be submitted to DOH and therefore there can be a delay in this information populating in the MAPP HHTS system.

Paid Claim Provider Name **↓BSD**

Field Length: 40
Format: Alphanumeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter 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 #64). Although this field name includes the word "Paid," this field will always be populated when there is a NYS Medicaid claim or encounter associated with the member's billing instance service date, whether the claim or encounter was paid or denied.

Please note: Encounters take longer to be submitted to DOH and therefore there can be a delay in this information populating in the MAPP HHTS system.

Paid Claim Rate Code **↓BSD**

Field Length: 4
Format: Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter 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 or encounter associated with the member's added billing instance service date, whether the claim or encounter was paid or denied.

Please note: Encounters take longer to be submitted to DOH and therefore there can be a delay in this information populating in the MAPP HHTS system.

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

Field Length: 1

Format: Alpha (Y/N)

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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 or encounter that is associated with a member's added billing instance service date.

If the rate code in the **Paid Claim Rate Code** (field #66) **matches** the rate code in the **Rate Code** (field #54), then this field will be populated with a value of 'Y'. If the rate code in the **Paid Claim Rate Code** (field #66) does not match the rate code in the **Rate Code** (field #54), 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 or encounter associated with the member's added billing instance service date, whether the that claim or encounter was paid or denied.

Please note: Encounters take longer to be submitted to DOH and therefore there can be a delay in this information populating in the MAPP HHTS system.

Partner NPI **↓PND ↑PNU**

Field Length: 10
Format: Numeric

Description: The NPI that is associated with the provider or provider group in MDW. The submitted NPI field must either contain 10 numeric characters or be null, otherwise the record will be rejected.

Payment Cycle **↓BSD**

Field Length: 4
Format: Numeric

Description: This field is populated if the system determines that there is a NYS Medicaid claim or encounter 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** (field #59) in the Billing Support Download file is a four-digit number that corresponds to a specific NYS Medicaid claims or encounter 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*.

Please note: Encounters take longer to be submitted to DOH and therefore there can be a delay in this information populating in the MAPP HHTS system.

Pediatric Provider **↓PND ↑PNU**

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

Description: Partners that provider services to children.

Pend/End Reason Comments **↓ED↑TFS**

Field Length: 300 (ED), 40 (TFS)
Format: Alphanumeric

Description: This field includes any comments associated with a pended or ended segment that the user provided when pending/ending the segment. If a segment contains both pend and end reason comments, the segment's end reason comment will be displayed in this field (same as ***Pend Reason Code Comment*** *and* ***Pend Reason or Segment End Date Reason Comments)***.

Pending Referral **↓MMD**

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

Description: This field will be populated with a Y if the member record is a pending referral.

Pend Reason Code Comment **↓HHA ↓MA**

Field Length: 300
Format: Alphanumeric

Description: The data in this field would be manually entered by an MCP provider to further describe the reason why an assignment was pended. This field is required if the Pend reason is "Other".

Pend Reason Code Description **↓BSD**

Field Length: 40
Format: Alphanumeric

Description: Describes the Pend reason that corresponds to the **Pend Reason Code.**

Pend Reason Code/Segment Pend Reason Code **↓BSD ↓HHA ↓MA ↓EFA ↑MFA ↑TFS ↓ED**

Field Length: 2
Format: Alphanumeric, Numeric (MA)
Accepted Values: *Appendix C* for pending a segment and *Appendix F* for pending an Assignment

Description: The value in the **Pend Reason Code** (field #3) on the MCP Final HH Assignment file and the Error Report: MCP Final HH Assignment, the Health Home Assignment and the Managed Care Plan Assignment files represents the reason that an MCP pended an assignment.

The value in the **Pend Reason Code** (field #11) on the Billing Support Download file and the Tracking File Segment Records and the **Segment Pend Reason Code** (field #18) on the Enrollment Download file represents the reason that HH or CMA pended an outreach of enrollment segment.

Pend Start Date **↑TFS**

Field Length: 8
Format: Numeric, MMDDYYYY
Description: The start date of the pended segment

Physician Indicator **↓PND ↑PNU**

Field Length: 1

Format: Alpha (Y/N)

Description: A value of Y indicates that the partner is an individual practitioner or a practitioner group. A value of N indicates that the partner is not an individual (the partner is a member of a facility).

Pioneer ACO **↓MMD**

Field Length: 1

Format: Alpha (Y/N)

Description: Indicates whether a member is part of the Pioneer ACO population.

Plan of Care Create Date

↓CDF

Field Length: 8

Format: MMDDYYYY, Numeric

Description: A system generated date that reflects when the plan of care date was submitted to the system.

Plan of Care Date

↑CU↓CFD

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This field contains the date that plan of care is signed as submitted to the system by the HH (same as ***Plan of Care)***/CMA..

Editing Logic: Only Health Homes can submit a Plan of Care Date.There is no logic built into the system at this time for this field.

Plan of Care HH MMIS Provider ID **↓CF**

Field Length: 8

Format: Numeric

Description: The HH MMIS ID that is associated with the Plan of Care information.

Plan of Care HH Name **↓CF**

Field Length: 40

Format: Alpha

Description: The HH name that is associated with the Plan of Care information.

Plan Provided Member Language **↓HHA ↓MA ↑MFA ↓MMD**

Field Length: 30; 40(MMD)

Format: Alpha

Description: Member information submitted to the system on the Managed Care Final HH Assignment file by the member's MCP. If the MCP did not submit this information into the system on the Managed Care Final HH Assignment file, then this field will be blank on the Managed Care Assignment file and the Health Home Assignment file (same as **Language**).

Plan Provided Member Phone Number **↓HHA ↓MA ↑MFA**

Field Length: 10
Format: Numeric

Description: Member information submitted to the system on the Managed Care Final HH Assignment file by the member's MCP. If the MCP did not submit this information into the system on the Managed Care Final HH Assignment file, then this field will be blank on the Managed Care Assignment file and the Health Home Assignment file.

Plan Provided Secondary Address – Apt/Suite **↓HHA ↓MA ↑MFA**

Field Length: 20
Format: Alphanumeric

Description: Member information submitted to the system on the Managed Care Final HH Assignment file by the member's MCP. If the MCP did not submit this information into the system on the Managed Care Final HH Assignment file, then this field will be blank on the Managed Care Assignment file and the Health Home Assignment file.

Plan Provided Secondary Address – City **↓HHA ↓MA ↑MFA**

Field Length: 40
Format: Alpha

Description: Member information submitted to the system on the Managed Care Final HH Assignment file by the member's MCP. If the MCP did not submit this information into the system on the Managed Care Final HH Assignment file, then this field will be blank on the Managed Care Assignment file and the Health Home Assignment file.

Plan Provided Secondary Address – State **↓HHA ↓MA ↑MFA**

Field Length: 2
Format: Alpha

Description: Member information submitted to the system on the Managed Care Final HH Assignment file by the member's MCP. If the MCP did not submit this information into the system on the Managed Care Final HH Assignment file, then this field will be blank on the Managed Care Assignment file and the Health Home Assignment file.

Plan Provided Secondary Address – Street 1 & Street 2 **↓HHA ↓MA ↑MFA**

Field Length: 40
Format: Alphanumeric

Description: Member information submitted to the system on the Managed Care Final HH Assignment file by the member's MCP. If the MCP did not submit this information into the system on the Managed Care Final HH Assignment file, then this field will be blank on the Managed Care Assignment file and the Health Home Assignment file.

Plan Provided Secondary Address – Zip **↓HHA ↓MA ↑MFA**

Field Length: 9
Format: Numeric

Description: Member information submitted to the system on the Managed Care Final HH Assignment file by the member's MCP. If the MCP did not submit this information into the system on the Managed Care Final HH Assignment file, then this field will be blank on the Managed Care Assignment file and the Health Home Assignment file.

Pre-Conditions of member **↓BSD ↑BSU**

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 the provider manual link available in *Appendix L*) 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 **Description of "Other" pre-condition** is required.

A member's pre-conditions(s) must be submitted on the Billing Support Upload file in **Pre-Conditions of member** (field # 5). This is a required field and must be populated for all service dates that correspond with an enrollment segment.

Program Participation **↓CD**

Field Length: 7
Format: Alpha

Description: This field is populated with opt-out if the member has an opt-out record with a start and end date that falls within the time period that the CIN Search file is downloaded.

Provided Service Indicator **↓ED↓BSD↑TSF**

Field Length: 1
Format: Alpha (A/C)

Description: This field is populated based on whether the member is in an Adult or Child HH network type on the associated segment (same as ***Adult or Child Services Provided Indicator)***.

Rate Amount **↓BSD**

Field Length: 7

Format: Numeric, "0000.00"

Description: This is the rate amount associated with the rate code for the billing instance service date. This field will only be populated when a billing questionnaire has been successfully submitted.

Rate Code **↓BSD**

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 may use the High, Medium, Low logic or CANS acuity as well as other system generated logic to determine the appropriate rate code for a member's billing instance service date.

Rate Code Description **↓BSD**

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 on or after 12/1/16, **this field describes the rate code that a member should be billed under for the billing instance service date**.

Recent Care Management Biller 1-6 Provider ID **↓CD**

Field Length: 8

Format: Numeric

Description: Based on Claims and Encounters data these fields are populated with the most recent paid claims or encounters information that have been submitted to NYS Medicaid.

Recent Care Management Biller 1-6 Service Date **↓CD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: Based on Claims and Encounters data these fields are populated with the most recent paid claims or encounters information that have been submitted to NYS Medicaid.

Recent Care Manager Biller 1-6 Provider Name **↓CD**

Field Length: 40

Format: Alpha

Description: Based on Claims and Encounters data these fields are populated with the most recent paid claims or encounters information that have been submitted to NYS Medicaid.

Record Type **↑TFS ↑TFE ↑TFD ↑TFA↓MAD↑PU↑CU↓CE**

Field Length: 1 (all files except MAD); 10 (MAD only)
Format: Alpha
Accepted Values: S, R, E, N, C, A, M, P, D (all except MAD); Assignment and Referral
Please also see Appendix I: Record Type Codes for more information

Description (all files except MAD): Defines the type of record that is being submitted to the system: Accept Assignment (S), Reject (R), End (E), New (N), Create (C), Accept Segment (A), Modify (M), Pend (P) and Delete (D). The system will process the record based on the layout defined for the record type.

Description (MAD Only): In the system, assignments have record types that are used to identify the different types of assignments: Assignment, meaning the member was assigned to a downstream provider; Referral, which means that the member assignment resulted from a community referral; and Transfer, which means that the member's current HH is asking if the receiving provider will accept the member as a Transfer or another HH is asking the current HH to transfer the member to them. The **Record Type** (field #4) on the on the Manage Assignments Download file is used to indicate the record's assignment type.

Referral Code **↓ED ↑TFS**

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

Description: The Referral Code indicates if a Medicaid member is a new referral 'R'. A 'T' can be used to accept a pending transfer for an adult (21 and over). If the member is not a new referral or transfer member the field should be blank.

Editing Logic: If the member is not a referral/transfer, then Health Home ID must match the assigned values for the Medicaid member. On the TFS, a provider can only use an 'R/T' code to create a segment for members that are 21 years or older. Child members must have a pending or active assignment with the uploading provider for a segment to be created via the file.

Referral Health Home MMIS Provider ID **↓MMD**

Field Length: 8
Format: Numeric

Description: The MMIS ID of the provider making the referral.

Referral Suggested Health Home Assignment/Referral Suggested Assignment **↓MA↓MMD**

Field Length: 8
Format: Numeric

Description: This field displays the MMIS ID of a Health Home if that Health Home is suggested during the referral process.

Referrer First Name **↓CRD**

Field Length: 30
Format: Alpha

Description: This field includes the first name of the user (referrer) that submitted the most recent referral for the member via the Children's Referral Portal.

Referrer Last Name **↓CRD**

Field Length: 30
Format: Alpha

Description: This field includes the last name of the user (referrer) that submitted the most recent referral for the member via the Children's Referral Portal.

Referrer Organization ID **↓CRD**

Field Length: 8
Format: Numeric

Description: This field includes the MMIS ID or HCS ID of the organization that submitted the most recent referral for the member via the Children's Referral Portal. If DOH submitted the referral, the MMIS ID or HCS ID of the organization that DOH submitted the referral on behalf of be included in this field.

Referrer Organization Name/ Referral Health Home Name **↓MMD ↓CRD**

Field Length: 30 (CRD), 40 (MMD)
Format: Alpha

Description: This field includes the MCP program name, HH program name, CMA program name, LGU Organization name, LDSS organization name, or SPOA organization name of the organization that submitted the most recent referral via the Children's Referral Portal/Adult Referral Wizard. If DOH submitted the referral, the name of the organization that DOH submitted the referral on behalf of be included in this field.

Rejected Assignment Suggested Alt Assignment **↓HHA↓MMD**

Field Length: 8
Format: Numeric (MMIS ID or blank)

Description: This field is used to indicate a suggested assignment when one is rejected.

Rejection Reason Code **↓HHA↓MA ↑TFA**

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

Description: This field is used to indicate why a provider is rejecting an assignment (same as ***Rejection Reason)***.

Rejection Reason Comment **↑TFA ↓MA↓HHA**

Field Length: 40 (TFA), 300 (MA)
Format: Alphanumeric

Description: This field is mandatory when a provider rejects an assignment using assignment rejection reason code 09: Other. When an assignment is rejected using rejection reason code 09, the provider must use this field to describe their reason for rejecting the assignment. A provider may submit a comment in this field if they select a different **Rejection Reason Code.**

Residence **↓PND ↑PNU**

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

Description: Partners that run residential programs.

Risk Score/Risk **↓BSD ↓HHA ↓MA**

Field Length: 6
Format: Decimal, 999V99

Description: This field is obsolete and has been nulled out on the Assignment Files. This value is nulled out on the Health Home Assignment File and Managed Care Plan Assignment File.

Segment End Date **↓HHA ↓MA**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The end date indicates when a value or a status becomes no longer effective.

Editing Logic: This field must contain a valid date. The end date must always be the last day of the month. For example, if the services ended on May 10, 2016, the End Date must be 5/31/16. This date may not fall within an existing service segment.

The Segment End Date indicates when the segment ended. When a member dis-enrolls from Health Home services, the end date will indicate when Health Home services were discontinued. When a member is moving from outreach and engagement to enrollment, an end date is not needed to end date the outreach segment. When a create record for enrollment is submitted to DOH, the system will automatically end date any outreach segments that are open under the primary key as of the submitted end date.

Segment End Date Description **↓ED ↓HHA ↓MA**

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. This field is blank if the segment is open (same as ***Segment End Date Reason Description***).

Segment End Date Reason Comment **↑TFS↓MA↓HHA**

Field Length: 300 (MA/HHA), 40 (TFS)
Format: Alpha/Alphanumeric

Description: A free text field to add or display the comment that is included when ending a segment (same as ***Segment End Date Reason Comments***).

Segment Pend Reason Description/Pend Reason **↓MMD↓ED**

Field Length: 40
Format: Alpha, Alphanumeric (MMD)
Accepted Values: See *Appendix C: Segment Pend Reason Codes*

Description: The reason why the segment is being pended. This field is left blank if the segment is in a status other than pended.

Segment Status **↓CD↓MMD**

Field Length: 40 (CD); 20 (MMD)
Format: Alpha

Description: The status of the segment that the member is in. If there is no segment this field will be blank.

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 **↓CD↓HHA ↓MA**

Field Length: 40
Format: Alphanumeric

Description: The contact information for the most recent service submitted to Medicaid for the Medicaid member (same as ***Provider 1-5 Address 1/Address 2)***.

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

Field Length: 40
Format: Alphanumeric, Alpha (CD)

Description: The contact information for the most recent service submitted to Medicaid for the Medicaid member (same as ***Provider I-5 City)***.

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

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date of the most recent service submitted to Medicaid for the Medicaid member (same as ***Provider 1-5 Service Date)***.

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

Field Length: 10
Format: Numeric

Description: The contact information for the most recent service submitted to Medicaid for the Medicaid member (Same as ***Provider 1-5 Phone)***.

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

Field Length: 40
Format: Alpha

Description: The contact information for the most recent service submitted to Medicaid for the Medicaid member (same as ***Provider 1-5 Provider Name)***.

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

Field Length: 10
Format: Numeric

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

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

Field Length: 2
Format: Alpha

Description: The contact information for the most recent service submitted to Medicaid for the Medicaid member (same as ***Provider 1-5 State)***.

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

Field Length: 9
Format: Numeric

Description: The contact information for the most recent service submitted to Medicaid for the Medicaid member (same as ***Provider 1-5 Zip)***.

Service Date **↓BSD ↑BSU**

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. Initial CANs NY Assessments Fees will display the date the CANs was signed and finalized on the Billing Support Download File and may not be the 1st of the month.

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

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

Description: Partners that are the local Social Service District Office.

Start Date **↑CU↓CD↓CE**

Field Length: 8
Format: MMDDYYY, Numeric

Description: Start Date (either existing or new) of a consent record.

Status **↓PAD↓ED↓CF**

Field Length: 2 (CD), 20 (ED)
Format: Numeric (01,02,03), Alpha

Description: This field indicates the status of the consent or the segment.

Status Start Date **↓ED**

Field Length: 8
Format: MMDDYYYY, Numeric
Description: The Start date of the most recent status.

Status End Date **↓ED**

Field Length: 8
Format: MMDDYYYY, Numeric
Description: The end date of the most recent status

Submitted Partner Name **↓PND ↑PNU**

Field Length: 100
Format: Alpha

Description: The name the Health Home would like to submit on their Partner Network Upload File to call a network partner by.

Substance Abuse **↓BSD ↑BSU**

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 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 **↓BSD ↑BSU**

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 **Substance Abuse (**field #16) in the Billing Support Upload file contains a value of 'Y', then Billing Support Upload **Substance Abuse Discharge Date (**field #17) must be populated with 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 **Substance Abuse (**field #16) in 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 **Substance Abuse Discharge Date** (field #17)**.**

SUD Active Use/Functional Impairment **↓BSD ↑BSU**

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, at least one *Indicator B* value, **AND** at least one *Indicator C* 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* or *C* 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	AND	Indicator C
• Positive Lab test for Opioids, Benzodiazepines, Cocaine, Amphetamines, or Barbiturates **OR** • Care manager observation (with supervisory sign-off) of continued use of drugs (including synthetic drugs) or alcohol **OR** • MCO report of continued use of drugs or alcohol		• Demonstration of a functional impairment including continued inability to maintain gainful employment **OR** • Continued inability to achieve success in school **OR** • Documentation from family and/or criminal courts that indicates domestic violence and/or child welfare involvement within the last 120 days **OR** • Documentation indicating active Drug court involvement		• The presence of 6 or more Criterion of substance use disorder under DSM-V which must also include pharmacological criteria of tolerance and/or withdrawal.

Suggested Alternate Assignment **↓HHA ↓MA ↓MMD ↑TFA**

Field Length: 8

Format: Numeric

Description: This field is optional. When a provider is rejecting an assignment, the provider can use this field to suggest another provider for the member (same as ***Suggested Alternative CMA Assignment***).

Suggested CMA MMIS ID **↓MFA ↓HHA↓CRD ↓MA**

Field Length: 8

Format: Numeric

Description: This field is associated with a Suggested CMA that the referring provider selected on the most recent child referral for the member.

Suggested CMA Name **↓MFA ↓HHA↓CRD↓MA**

Field Length: 40

Format: Alpha

Description: This field is associated with a Suggested CMA that the referring provider selected on the most recent child referral for the member.

Suggested Health Home MMIS ID **↓MFA ↓HHA↓CRD ↓MA**

Field Length: 8

Format: Numeric

Description: This field is associated with a Suggested HH that the referring provider selected on the most recent child referral for the member.

Suggested Health Home Name **↓MFA ↓HHA↓CRD ↓MA**

Field Length: 40

Format: Alpha

Description: This field is associated with a Suggested HH that the referring provider selected on the most recent child referral for the member.

Target Population **↓AD**

Field Length: 1

Format: Numeric

Description: Indicates the target population selected on the child HCBS assessment in UAS.

Time **↓CF**

Field Length: 8

Format: HH:MM:SS Numeric

Description: The most recent time that the consent record was created or updated.

Transfer Create Date **↓HHA↓ED↓CD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This date is associated with an assignment with a transfer record type. This date is the date that the transfer was created within the system (same as ***Pending Transfer Create Date)***.

Transfer Comment **↓HHA↓ED↓CD**

Field Length: 300
Format: Alphanumeric

Description: This is a text field for a comment, if necessary, about the transfer (same as ***Pending Transfer Comment)***.

Transfer Effective Date **↓MAD↓HHA ↓ED↓CD**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This date is associated with a pending assignment with a transfer record type. If an HH/CMA accepts a pending assignment with a transfer record type, the system will create a new enrollment segment with the appropriate HH/CMA with a begin date equal to the **Transfer Effective Date** (field #9) and will end date the original enrollment segment one day prior to the **Transfer Effective Date** (field #9) (same as ***Pending Transfer Effective Date).***

Transfer Initiator MMIS ID **↓HHA↓ED↓CD**

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 **Transfer Initiator MMIS ID** is populated with the MMIS ID for the organization that initiated the transfer (same as ***Pending Transfer Initiator MMIS ID)***.

Transfer Initiator Organization Name **↓HHA ↓ED↓CD**

Field Length: 40
Format: Alpha

Description: The **Transfer Initiator Organization Name** is populated with the name for the organization that initiated the transfer (same as ***Pending Transfer Initiator Organization Name).***

Transfer Reason **↓HHA↓ED↓CD**

Field Length: 75
Format: Alpha

Description: The **Transfer Reason** is a dropdown selection the initiating organization selects. The dropdown selected displays as text on the download files when a there is a pending transfer request (same as ***Pending Transfer Reason)***.

Transfer Receiver MMIS ID **↓HHA↓ED↓CD**

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 **Transfer Receiver MMIS ID** is populated with the MMIS ID for the organization that receives the member if the transfer is accepted (same as ***Pending Transfer Receiver MMIS ID).***

Transfer Receiver Organization Name **↓HHA↓ED↓CD**

Field Length: 40

Format: Alpha

Description: The **Transfer Receiver Organization Name** is populated with the name for the organization that receives the member if the transfer is accepted (same as ***Pending Transfer Receiver Organization Name).***

UAS Complexity Assessment **↑BSU ↓BSD**

Field Length: 1

Format: Alpha (Y/N/U)

Description: This field indicates if a UAS Complexity Assessment has been completed for an adult member.

Editing Logic: This is a required field on the HML for full HMLS, but does not affect HML rates.

Void Date **↓BSD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This field includes the date that a billing instance is voided. It is only populated on voided billing instances.

Appendix B: File Error Reason Codes

Error Name	Error Description
CIN XXXXXXXX is not a valid CIN	Invalid CIN Format
No association with member (MMDDYYYY)	Member not associated with user's organization
No BI for XXXXXXXX as of MMDDYYYY	No billable services
No BI for XXXXXXXX as of MMDDYYYY	Member status not billable
No billing instance to void (MMDDYYYY)	Nothing to void
MMDDYYYY Duplicate billing instance	Duplicate Billing Instance
Service Date (MMDDYYYY) not 1st of month	Date of Service not first of month
DB can't be 'N' for non-converting CMA **Note: this error message should read DB can't be 'Y' for non-converting CMA**	Direct Bill No to Yes
Comment required with 'Other' submission	Comments required when Other selected
Chronic Condition(s) must be selected	Chronic Conditions Required
HIV Status field required	Is the member HIV positive?
Viral Load required if HIV Status is Y	What is the member's viral load?
T-Cell required if HIV Status is Y	What is the member's T-Cell count?
Member Housing Status field required	Is the member homeless?
HUD Category req'd for homeless member	Does the member meet the HUD Category 1 or HUD Category 2 level of homelessness?
Incarceration field required	Was the member incarcerated within the past year?
Release Date req'd if Incarceration is Y	When was the member released (enter release date)?
Mental Illness field required	Did the member have a recent Inpatient Stay status for mental illness?
Discharge Date req'd if Mental Illness=Y	When was the member discharged from the inpatient stay for mental illness?
Substance Abuse field required	Did the member have a recent inpatient stay for substance abuse?

Error Name	Error Description
Discharge Date req'd if Substnce Abuse=Y	When was the member discharged from inpatient stay for substance abuse (enter the discharge date)?
SUD Active Use/Impairment req'd	SUD Active Use/Functional Impairment
AOT member field required	Is the member in AOT?
AOT minimum service provided field req'd	Were the minimum required AOT services provided and the caseload requirement met? For dates on or after the configurable date XX/XX/XXXX, the description will be: Were the minimum required AOT services provided and the caseload requirement met?
AOT minimum service provided field req'd	Were the minimum required AOT services provided?
ACT member field req'd if CMA is 'ACT'	Is the member in ACT?
ACT minimum service provided field req'd	Were the minimum required ACT services provided?
Member qualifies for AH+ field required	The member is an impacted adult home member on/after March 2014 and is a class member. Does the member qualify for Adult Home Plus Care Management (refer to Adult Home Plus Attestation)?
Transitioned to community field req'd	Has the Adult Home member transitioned to the community?
Cont to qualify for AH+ field req'd	Does the member continue to qualify for the Adult Home Plus Care Management?
Interest in transitioning field is req'd	Does the member continue to be interested in transitioning?
Core Service Provided is required field	Was a core Health Home service provided this month?
Invalid record type format	# of characters in fields exceeds limit
Incorrect value provided for field number <field #>	Invalid entry in field
Service Date entered is a future date	Service date in the future
R/E Code is not compatible	Member's R/E Code on the service date is not compatible on the service date

Error Name	Error Description
Missing a Completed CANS Assessment	CANS Assessment does not exist in Completed status for the member on the segment after the 2nd month of the Enrollment segment or the last CANS Completion Date is more than 6 months (including the month when the CANS was completed) in the past from the month of the segment
Member is not Medicaid eligible	Member is not Medicaid eligible on service date; Details
Child in Foster Care field is required	Has the child been in Foster Care at any time this month?
Core Service Provided is required field	If HH+ Minimum Services Provided = N, then Core Service Provided is required
HUD1 in 6mos req'd if Mbr Housing =N	If Member Housing Status = N, then HUD 1 within past 6 months is required
HUD1 in 6mos = blank if Mbr Housing=Y	If Member Housing Status = Y, then HUD 1 within past 6 months must be blank.
HUD1 in 6 mos = Y if prior HUD Cat = 1	If prior date of service HUD Category = 1, HUD 1 within past 6 months must be Y.
Date Mbr Housed req'd if HUD1 in 6 mos	If HUD 1 within past 6 months = Y, then Date Member Housed is required
Date Mbr Housed must be blank	If HUD1 within past 6 months = N, then Date Member Housed must be blank. If Member Housing Status = Y, then Date Member Housed must be blank.
Expanded HH+ Population is req'd field	Is the member in the expanded HH+ population?
HH+ Min Services req'd if HH+ pop = Y	If Expanded HH+ population = Y, then HH+ Minimum Services Provided is required (for dates of service prior to 5/1/19)
HH+ Min Services = blank if HH+ pop = N	If Expanded HH+ population = N, then HH+ Minimum Services Provided must be blank (for dates of service prior to 5/1/19
Pend Reasons 'Pended Due to Diligent Search' and 'Pend Reason Due to Continued Search Effort' are not valid pend reasons for outreach segments	Record rejected if the pend reason code '05 Pended Due to Diligent Search' or '06 Pend Reason Due to Continued Search Effort' is used to pend an outreach segment.
When performing the action to pend a pend, the former segment start date cannot equal the new segment start date	Record rejected if the start date of the new segment = the start date of the existing segment when attempting to pend a pended or pending pended segment
INVALID_LENGTH	Record rejected for an invalid length of characters in any field

Error Name	Error Description
INVALID_RECIP_ID	Record rejected for an invalid CIN. This could be a CIN that does not exist or the wrong format of a CIN.
INVALID_PEND_CODE	Record rejected for an invalid Pend Code. This would mean a user used a value that does not match any value in the code table.
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 in MDW.
INVALID_COV_CODE	Record rejected because at the time of the upload, the member has an invalid coverage code in MDW. This is applicable to new assignments for members who have participated in the Health Home program before or those that have a history, but are not actively participating in the Health Home program.
INVALID_RE_CODE	Record rejected because at the time of the upload, the member has an invalid R/E code in MDW. This is applicable to new assignments for members who have participated in the Health Home program before or those that have a history, but are not actively participating in the Health Home program.
INVALID_HEALTH_HOME_ID	Record rejected for an invalid Health Home MMIS ID. This could mean a MMIS ID was entered that does not exist, is in the wrong format, or the health home is suspended or closed.
NO_RELATIONSHIP	Record rejected because the Health Home is not contracted with the Managed Care Plan.
EXISTING_SEGMENT	Record rejected for an existing segment in the following statuses: Pending Active, Active, Pending Pended, Pended, Pending Closed, Pending Cancelled, or Hiatus.
DUPLICATE_ACTION	Record rejected because the user is attempting to assign a Health Home that has already been assigned. This would not include an MCP user that attempts to pend a pended assignment. Error also indicates that an opt-out record already exists within the same time period of the record attempting to be uploaded.
INVALID_ADDRESS	Record rejected for an address that did not meet the system validations.
Invalid_ Reason	Opt-out record was rejected du to non-conforming opt-out reasons.

Error Name	Error Description
INVALID_SEGMENT_END	Opt-out record was rejected due to the member having an enrollment in any status other then canceled that have effective dates that overlap the opt out signature date OR the member has an outreach segment in any status other then canceled that have effective dates that overlap the opt out signature date and does not have an end date in the month of opt out signature date.
INVALID_OPT-OUT_END	Record was rejected because an Opt-Out End Date is submitted for a member, and the member evidence record does not contain an Opt-Out Signature Date OR the Opt-Out End Date is prior to an Opt-Out Signature Date
SIGNATURE_DATE_REQUIRED	The Signature Date is required when: a C-record is submitted OR when a D-record is submitted.
END_DATE_REQUIRED	The Opt-Out End Date is required when a E-record is submitted. If an End Date is not submitted, the record will be rejected.
NO_RECORD_EXISTS	An existing record must exist in non-canceled status for the submission of a D-record. If a D-record is submitted, and a record does not exist for that member in the restriction table, then the submission will be rejected
INVALID_PHONE	Record rejected for a phone that did not meet the system validations.
INVALID_STATUS	Record rejected because the user is trying to perform an action that is not allowed on the due to the existing assignment's status. For example, a user cannot pend an active assignment.
INVALID_DATA_COMBO	Only Health Home MMIS Provider ID or Pend Reason Code are required. Both cannot be entered for the same member
MBR_UNDER_21	Members under 21 years of age must be referred into the Health Home program online via Children's Referral Portal
Invalid_Format	Record rejected for an invalid format in any field
INVALID_NPI_FORMAT	NPI must contain 10 numeric characters
INVALID_DATE_FORMAT	The date must be inputted as MMDDYYYY
Invalid Princ Prov code for service date	Principal Provider Code = AL and member not on Adult Home Class Member table and current billing status = Voided or In Progress
Invalid Princ Prov code for service date	Principal Provider Code = NH and current billing status = Voided or In Progress
HH+ Min Services req'd if HH+ pop does not = A	If Expanded HH+ population does not = A, then HH+ Minimum Services Provided is required

Error Name	Error Description
HH+ Min Services = blank if HH+ pop = A	If Expanded HH+ population = A, then HH+ Minimum Services Provided must be blank
POC Invalid Field	Record rejected because Record type is 'P', or 'D' and values were entered into fields other than Record Type, Member ID, and Plan of Care Date
POC Date Required	Record rejected because Record Type is 'P' or 'D' and Plan of Care Date not entered
Consent Record Not POC	Record rejected because Record type is 'C', 'W', or 'M' and a value was entered into the Plan of Care Date field.
001	CIN Format is invalid CIN format is AA11111A
002	As of <MMDDYYYY> the member is not eligible for Medicaid
003	The DOB entered does not match the DOB in the Medicaid system
004	The gender entered does not match the gender in the Medicaid system
006	Member is not assigned to the provider
011	The Begin Date entered is not the 1st of the month
012	The end date entered is not the last day of the month
013	The end date entered is prior to the segment begin date <MMDDYYYY>
014	The Outreach Enrollment code entered must be O or E
015	Valid gender codes are M or F
016	Invalid Record Type. Must be S, R, E, N for assign and C, A, M, P, D for seg recs
017	Valid referral indicators are R NULL or T
021	The Care Management Agency MMIS ID entered <XXXXXXXX> is invalid
022	The Health Home MMIS ID entered <XXXXXXXX> is invalid
025	Segment does not follow record type format
026	Overlapping segment w HH MMIS ID <12345678> <MMDDYYYY> to <MMDDYYYY>
028	Original record does not exist for Change or Delete operation
029	A member can only have 3 months of active outreach in 6 months
030	The segment begin date cannot be prior to 01012012
031	Segment begin dates cannot be in the future
034	Pioneer ACO member, refer to/contact the Pioneer ACO HH (BAHN)
035	Assignment must be pending

Error Name	Error Description
037	Invalid End Date Reason Code
038	Invalid Rejection Reason Code
039	Invalid Coverage Code found
040	Invalid RE Code found
042	No relationship exists between HH and CMA
044	No Valid Record Found
046	Pend Start Date is required
047	Segment Begin Date is required
049	Pend Start Date is before Segment Start Date
051	Invalid Date Format must be 'MMDDYYYY"
052	R code is required when segment start is prior to assignment
053	End Date Reason required when End Date populated
054	End HH Assignment required when End Date populated
055	Valid End HH Assignment values are Y N or NULL
056	End HH Assignment should not be populated unless end date is populated
057	End Date Reason should not be populated unless end date is populated
058	The segment falls outside of the HH's effective dates
059	The segment falls outside of the CMA's effective dates
060	Member has a pended assignment with <MCP>
061	The End Date entered is prior to the Pend Start Date
062	Invalid File Action
063	Adult / Child Services value is required for this member
064	The Provider Type for Suggested Alternate Assignment is invalid
064	Consent to Enroll is required for the full segment period
065	Suggested Alternate Assignment is required
065	Cannot Provide Child Services prior to Children's Program Start Date
065	Cannot Provide Child Services prior to Children's Program Start Date
066	Member under 21, use Child HH Referral Portal
067	Invalid Value for Adult or Child Services Provided Indicator

Error Name	Error Description
069	No relationship exists between HH and MCP
075	HH adult/child designated indicator does not match
076	Member is on the Exclusion Table
077	CMA Provider MMIS ID is required
078	Rejection Reason required
079	End Reason is required
080	HH Provider MMIS ID is required
081	End HH Assignment must contain Y/N
082	End HH must be Y for Record Type E and no CMA MMIS ID when HH user
083	End HH must be N for Record Type S when HH/CMA user
084	End HH must be N for Record Type N when HH or VFCA user
086	CMA is already assigned
087	HH is already assigned
088	Invalid Pend Date Reason Code
089	Record contains special characters which is not allowed
090	Record contains fewer fields than required
091	Record contains more fields than allowed
092	Only Active HH assignments can be Ended by a HH
093	Only Pending CMA assignment can be Ended by a HH
094	Only Active CMA assignment can be Ended by a CMA or HH
095	Only Pending or Active HH assignments can be Ended by a VFCA
096	Member ID required
097	User's organization must have a pending/active assignment
098	Invalid Record Type for non-VFCA CMA
100	Unable to Pend a segment in the current status
101	Comments are required when Reject or End Reason is Other

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.

Segment Pend Date Reason Codes and Descriptions valid for segments with a pend start date on or after 7/1/19

Code	Code Description
01	Pended due to Inpatient Stay
02	Pended due to Incarceration
03	Pended due to Hiatus
04	Pended due to Other
05	Pended due to Diligent Search Efforts

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.

For instance, the system **will allow** a segment with a start date of 5/1/2012 and an end date of 11/30/2018 to be closed using code 42: 'Program not compatible'. However, the system **will not allow** a segment with a start date of 5/1/2012 and an end date of 10/31/2018 to be closed using code 42: 'Program not compatible'.

Additional information regarding when it is appropriate to use each segment end date reason code can be found on the MAPP HHTS website:

i) https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/docs/mapp_segment_end_date_code_crosswalk.pdf
~~i)~~ii) https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/docs/mapp_segment_end_date_code_guidance.pdf

Segment End Date Reason Codes and Descriptions valid for segments with end dates on or after 10/31/2018

Code	Code Description	Outreach, Enrollment or Both
01	Transferred to another HH	Both
02	Individual opted-out (pre-consent only)	Outreach
03	Transferred to another CMA	Both
04	Individual deceased	Both
05	Individual has a new CIN	Both
07	Closed for Health, welfare and safety concerns for member and/or staff	Enrollment
09	Individual moved out of state	Both
11	Individual incarcerated	Both
13	Individual is in an inpatient facility	Both
14	Enrolled Health Home member disengaged from Care Management services	Enrollment
16	Inability to contact/locate individual	Outreach
18	Member interested in HH at a future date	Outreach
19	Individual doesn't meet HH eligibility/appropriateness criteria	Both
21	Member has graduated from HH program	Enrollment
24	Individual is not/no longer eligible for Medicaid	Both
25	Individual moved from Outreach to Enrollment	Outreach
28	Health Home change MMIS Provider ID	Both
29	Member withdrew consent to enroll	Enrollment

Code	Code Description	Outreach, Enrollment or Both
32	Provider closed	Both
33	Merger	Both
38	Active to Closed (system generated)	Outreach
41	Coverage not compatible	Both
42	Program not compatible	Both
43	Individual moved between HHSC and HHSA	Both
44	Segment Correction	Enrollment
45	Member Re-engaged	Enrollment*
98	Invalid end date reason at conversion (system generated)	Both

- *End reason code 45 is only valid for segments that have been pended for continued search or diligent search efforts

Appendix E: Assignment Rejection Codes

The reason codes listed below explain why a HH or CMA would reject an assignment, referral or transfer made to them. ÷

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	Provider linkages not available
12	Member's address outside of service area
13	No resources speak member language
14	Created in error
15	Referral Not Appropriate
16	Approved by the LDSS to change VFCA (effective on or after 12/1/16)
97	Assignment rejected in pre-MAPP HHTS

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.

Assignments that are pended by the MCP may or may not be eligible to be purged from the Assignment file based on inactivity. Included in the below table is a column that describes how long a member with a specific pended assignment must sit in activity before it is purged from the assignment file. The act of pending a member or change a pend reason is counted as an 'action' and restarts the inactivity clock.

Code	Code Description	Purge Inactivity Period
01	Receiving care management services	90 days
02	Member enrolled in different program	Never purged
03	Alternate HH needs to be identified	60 days
04	Awaiting contract with Health Home	60 days
05	Referral Not Appropriate	Never purged
06	Other	Never purged
07	Follow up 1 month	45 days
08	Follow up 3 months	90 days
09	Follow up 6 months	180 days

Appendix G: Assignment End Reason Codes

The reason codes listed below explain why an 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 meet HH criteria	Provider Input	
10	Member transitioned to a FIDA Program	Provider Input	
11	Member is no longer Medicaid eligible	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 an 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 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 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 an HH/CMA assignment ends because the member cycled out of outreach/outreach hiatus without being enrolled
19	Enrollment ended	System generated	when an HH/CMA assignment ends because an enrolled member's segment ended with the HH/CMA.

Code	Accepted Language Values	Source	Comments
20	No Medicaid Coverage	System generated	when MCP/HH/CMA assignment ends because the member is no longer Medicaid Eligible
21	Invalid Coverage Code	System generated	when MCP/HH/CMA assignment ends because the member has 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	Switched from Mainstream MCP to FFS	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	Switched from Non-Mainstream MCP to FFS	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	Switched Mainstream MCPs	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.
29	Switched Non-Mainstream MCPs	System generated	

Code	Accepted Language Values	Source	Comments
30	Switched Mainstream to N-Mainstream	System generated	
31	Switched Non-Mainstream to Mainstream	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	Switched from FFS to Mainstream MCP	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.
33	Switched from FFS to Non-Mainstream MCP	System generated	
34	Member switched from FFS to FFS	System generated	
35	Provider Changed ID	System generated	when an assignment is ended because an HH changed their MMIS Provider ID
36	Member deceased	System generated	If NYS Medicaid reports to the system that a member has a date of death according to NYS Medicaid, then the system end dates any assignments in the system with this reason code. If a member with a date of death from NYS Medicaid has a segment, the system does not end date the segment.
37	Segment Created	System generated	when the system ends an assignment due to the creation of a segment.
38	Pended by MCP	System generated	Effective on or after 12/1/16.
39	Not in HH eligible pop as of MM/DD/YYYY	System generated	When a member's MCP/HH/CMA assignment ends because they are no longer part of the HH eligible population when DOH updates the HH eligible population table as of a certain date.
40	Member No Longer Pioneer ACO	System generated	When a member's HH/CMA assignment ends because they are no longer part of the refreshed Pioneer ACO population table as of a certain date.
41	Pioneer ACO Member	System generated	When a member's HH/CMA assignment ends because they are now part of the refreshed Pioneer ACO population table as of a certain date.

Code	Accepted Language Values	Source	Comments
42	Risk Score below threshold	System generated	When a member's MCP/HH/CMA assignment ends because their risk score is below the DOH established threshold.
43	Member on Exclusion Table	System generated	When a member's MCP/HH/CMA assignment ends because they meet exclusionary criteria that is provided to DOH so that they are no longer prioritized for HH assignment.
44	Member case has been renewed per the assignment file	System generated	
45	Member is listed on the Adult Home Table	System generated	
46	Closure	System generated	When a HH/CMA assignment ends as a result of a HH/CMA provider being closed in the system.
47	Relationship with Member Ended	System generated	
48	Member Under 21	System generated	
49	Assignment Purged Due to Inactivity	System generated	
50	Assignment Ended due to Member Opt-out	System generated	
51	Child Re-Referred	System generated	
99	Member removed from assignment file	System generated	

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

The Billing Support Upload file accepts BIs for adults and children. Adult BIs ask a larger number of questions. Based on the member's population, level of services and responses to the questions the adult member receives a HH rate. A child's BI asks few questions and utilizes the Cans-NY assessment to determine the correct acuity level to bill at. For a current list of both adult and child rates please see: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/current_hh_rates.pdf

The following codes are used in the Billing Support Upload file. The majority of the below fields pertain only to adult HML assessments, although some questions, such as Pre-Conditions of member pertain to both adult and child questionnaires.

Field Description	Code	Code Description
HIV T-Cell Count	0	NA
HIV T-Cell Count	1	Unknown
HIV T-Cell Count	5	>200 (this code is only applicable to service dates on or after 12/1/16)
HIV T-Cell Count	6	<=200 (this code is only applicable to service dates on or after 12/1/16)
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
HUD CODES	2	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
Pre-Conditions of member	18	Complex Trauma (under 21 years of age)
Pre-Conditions of member	20	SED/SMI (this code is only applicable to service dates on or after 7/1/18)
Pre-Conditions of member	22	One or more DD conditions (this code is only applicable to service dates on or after 7/1/18)
Pre-Conditions of member	24	Children's HCBS only (this code is only applicable to service dates on or after 1/1/19)
Pre-Conditions of member	26	Children's HCBS and other conditions (this code is only applicable to service dates on or after 1/1/19)
Pre-Conditions of member	28	Adult HCBS and other conditions (this code is only applicable to service dates on or after 1/1/19)

Field Description	Code	Code Description
Billing Instance Type	O	Outreach
Billing Instance Type	E	Enrollment
Billing Instance Type	F	CANS NY Assessment Fee
Mental Illness	U	Member was discharged from a mental illness inpatient stay within the past year, but submitting provider does not know discharge date (this code is applicable to service dates before or after 5/1/18)
Mental Illness	M	Member was discharged from an inpatient stay due to **mental illness** within the past year (for service dates on or after 5/1/18)
Mental Illness	P	Member was discharged from an inpatient stay due to **physical health** within the past year (for service dates on or after 5/1/18)
Mental Illness	N	Member was not discharged from a mental illness **OR** physical health inpatient stay within the past year (for service dates on and after 5/1/18)
Mental Illness	V	Member was discharged from a **physical health** inpatient stay within the past year, but submitting provider does not know discharge date (for service dates on or after 5/1/18)
Expanded HH+ population	N	Member is not part of the expanded HH+ population
Expanded HH+ population	A	No (for service dates on or after 5/1/19)
Expanded HH+ population	B	Yes. HH+ HIV – Virally Unsuppressed (for service dates on or after 5/1/19)
Expanded HH+ population	C	Yes HH+ HIV – SMI and 3+ in-patient hospitalizations in the last year (for service dates on or after 5/1/19)
Expanded HH+ Population	D	Yes. HH+ HIV – SMI and 4+ ED visits in the last year (for service dates on or after 5/1/19)
Expanded HH+ Population	E	Yes. HH+ HIV – SMI and homelessness (HUD 1 definition) (for service dates on or after 5/1/19)
Expanded HH+ population	F	Yes. HH+ HIV – Injection Drug Use and 3+ in-patient hospitalizations within the last year (for service dates on or after 5/1/19)
Expanded HH+ population	G	Yes. HH+ HIV – Injection Drug Use and 4+ Ed visits within the last 12 months (for service dates on or after 5/1/19)
Expanded HH+ Population	H	Yes. HH+ HIV – Injection Drug use and homelessness (for service dates on or after 5/1/19)
Expanded HH+ population	I	Yes. HH+ HIV – Clinical Discretion MCP (for service dates on or after 5/1/19)
Expanded HH+ population	J	Yes. HH+ HIV Clinical Discretion Medical Providers (for service dates on or after 5/1/19)
Expanded HH+ Population	K	Yes. HH+ SMI – ACT step down (for service dates on or after 5/1/19)
Expanded HH+ population	L	Yes. HH+ SMI – Enhanced Service Package/Voluntary Agreement (for service dates on or after 5/1/19)
Expanded HH+ population	M	Yes. HH+ SMI – Expired AOT order within past year (for service dates on or after 5/1/19)
Expanded HH+ Population	N	Yes. HH+ SMI – Homelessness (HUD 1 definition) (for service dates on or after 5/1/19)
Expanded HH+ population	O	Yes. HH+ SMI – Criminal justice involvement (for service dates on or after 5/1/19)
Expanded HH+ population	P	Yes. HH+ SMI – Discharged from State PC (for service dates on or after 5/1/19)
Expanded HH+ Population	Q	Yes. HH+ SMI – CNYPC Release (for service dates on or after 5/1/19)
Expanded HH+ population	R	Yes. HH_ SMI – Ineffectively engaged in care (no outpatient 2/ 2+ psychiatric hospitalizations) (for service dates on or after 5/1/19)

Field Description	Code	Code Description
Expanded HH+ Population	S	Yes. HH+ SMI – Yes. HH+ SMI – ineffectively engaged in case (no outpatient w/ 3+ psychiatric ED visits) (for service dates on or after 5/1/19)
Expanded HH+ population	T	Yes. HH+ SMI – 3+ psychiatric inpatient hospitalizations in past year (for service dates on or after 5/1/19)
Expanded HH+ population	U	Yes. HH+ SMI – 4+ psychiatric ED visits in past year (for service dates on or after 5/1/19)
Expanded HH+ Population	V	Yes. HH+ SMI – 3+ medical inpatient hospitalizations in past year w/ dx of Schizophrenia or Bipolar (for service dates on or after 5/1/19)
Expanded HH+ Population	W	Yes. HH+ SMI – Clinical Discretion SPOA (for service dates on or after 5/1/19)
Expanded HH+ population	X	Yes. HH+ SMI – Clinical Discretion MCP (for service dates on or after 5/1/19)
UAS Complexity Assessment	N	UAS complexity Assessment has not been performed on the member (for DOS 1/1/19 and after)
UAS Complexity Assessment	Y	UAS complexity Assessment has been performed on the member (for DOS 1/1/19 and after)
UAS Complexity Assessment	U	Unknown if UAS complexity Assessment has been performed on the member (for DOS 1/1/19 and after)

Appendix I: Tracking File 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 what 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/Reject Transfer	HH/CMA			X	X
C	Create Segment/Accept Transfer	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

Effective 7/1/2018, Health Home services provided to members enrolled in mainstream (HMO, HARP, SNP, PHSP) managed care plans will be paid by the members' managed care plans. Health Homes will continue to bill NYS Medicaid directly for Health Home services provided to fee for services members and members enrolled in non-mainstream managed care plans (managed care plan product lines not listed above i.e., MLTC). For Health Home service dates on or after 12/1/2016 through 6/30/18, Health Homes bill Medicaid directly for all providers.

Appendix K: MCP Final HH Assignment File Accepted 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.~~ are accepted on the MCP Final Assignment File and display on the HH Assignment File.

Field Description	Code	Code Description
Plan Provided Member Language	NA	Arabic
Plan Provided Member Language	NA	Haitian-Creole
Plan Provided Member Language	NA	Polish
Plan Provided Member Language	NA	English
Plan Provided Member Language	NA	Cambodian (Khmer)
Plan Provided Member Language	NA	Vietnamese
Plan Provided Member Language	NA	Japanese
Plan Provided Member Language	NA	Russian
Plan Provided Member Language	NA	Navajo
Plan Provided Member Language	NA	Apache
Plan Provided Member Language	NA	Traditional Chinese
Plan Provided Member Language	NA	Simplified Chinese
Plan Provided Member Language	NA	Brazilian Portuguese
Plan Provided Member Language	NA	Korean
Plan Provided Member Language	NA	German
Plan Provided Member Language	NA	Tagalog
Plan Provided Member Language	NA	Other
Plan Provided Member Language	NA	Danish
Plan Provided Member Language	NA	Finnish
Plan Provided Member Language	NA	Irish
Plan Provided Member Language	NA	French

Field Description	Code	Code Description
Plan Provided Member Language	NA	Spanish
Plan Provided Member Language	NA	Italian
Plan Provided Member Language	NA	American Sign
Plan Provided Member Language	NA	Lao
Plan Provided Member Language	NA	Cantonese
Engagement-Optimization	A	Warm Hand-off
Engagement-Optimization	B	Direct Enrollment
Engagement-Optimization	C	Consent Signed
MCP Determined Eligibility	04	Substance Abuse
MCP Determined Eligibility	06	Asthma
MCP Determined Eligibility	08	Diabetes
MCP Determined Eligibility	10	Heart Disease
MCP Determined Eligibility	12	Overweight
MCP Determined Eligibility	14	HIV/AIDs
MCP Determined Eligibility	16	Other
MCP Determined Eligibility	18	Complex Trauma (under 21 years of age)
MCP Determined Eligibility	20	SED/SMI
MCP Determined Eligibility	22	One or more DD conditions
MCP Determined Eligibility	24	Children's HCBS only
MCP Determined Eligibility	26	Children's HCBS and other conditions
MCP Determined Eligibility	28	Adult HCBS and other conditions
MCP Determined Eligibility	30	Mental Health non-SMI/SED

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.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh_provider_manual_v2019-02.pdf
4) Health Home Program Policy and Standards Website
   a) https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm
5) 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
6) Health Home Serving Children email address: HHSC@health.ny.gov
7) Health Home Program Provider Policy line: **(518) 473-5569**
8) 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) https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_coverage_codes.pdf

d) Recipient R/E Compatibility with HH Program
   i) https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

9) 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
      ii) If the document above does not answer your question, call GDIT (General Dynamics Information Technology)at: **1-800-343-9000**
   b) eMedNY **Provider Quick Reference Guide**
      i) https://www.emedny.org/contacts/telephone%20quick%20reference.pdf
   c) eMedNY **NYS Electronic Medicaid System Remittance Advice Guideline** document
      i) https://www.emedny.org/providermanuals/allproviders/general_remittance_guidelines.pdf
   d) eMedNY Payment cycle calendar
      i) https://www.emedny.org/hipaa/news/PDFS/CYCLE_CALENDAR.pdf
10) Please contact MAPP Customer Care Center (email MAPPCustomerCareCenter@cma.com or phone (518) 649-4335) to request information on accessing existing MAPP HHTS training documents, web-based trainings, or to participate in an instructor led webinar based training.
11) UAS–NY Support Desk via email at uasny@health.ny.gov or by telephone at 518–408–1021
12) Managed Care Plan Contacts for Health Homes and Care Management Agencies https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care/mc_hh_contacts.htm

Appendix M: Consent File Codes

Listed below are the codes used within the Consent Files. Also, below is a link to the **Health Homes Serving Children Consent Process, Forms and Guidance** power point presentation that was presented on August 17, 2016.

Field Description	Code	Code Description
Record Type	C	Create Consent
Record Type	M	Modify Consent
Record Type	W	Withdraw Consent
Record Type	P	Create Plan of Care
Record Type	D	Delete Plan of Care
Consenter	01	Parent
Consenter	02	Guardian
Consenter	03	Legally Authorized Representative
Consenter	04	Member/Self – Individual is 18 years of age or older
Consenter	05	Individual is under 18 years old, but is a parent, or is pregnant, or is married
Consent Type	01	Consent to Enroll
Consent Type	02	Consent to Share Information
Consent Type	03	Consent to Share Information (Protected Services)
Status	01	Active
Status	02	Withdrawn
Status	03	Ended

Appendix N: Program Participation File Codes

Listed below are the codes used within the Program Participation Files.

Field Description	Code	Code Description
Record Type	C	Create
Record Type	E	End
Record Type	D	Delete
Opt-out Reason	01	Member not interested: No Follow-up
Opt-out Reason	02	Member not interested: follow-up in three months
Opt-out Reason	03	Member not interested: follow-up in six months

Appendix O: Transfer Reason Codes

Transfer Reason Codes are selected on the screen when creating a transfer request but can be viewed on the Health Home Assignment Download, CIN Search Download, and Enrollment File Download when providers utilize these files for certain members that have pending transfers.

Code	Code Description
1	Member moved out of service county
2	At Capacity
3	Appropriate provider linkages to best meet the member's needs not available
4	The member's address is outside of the service area
5	No resources that speak the member's primary language
6	Other
7	Member requested transfer