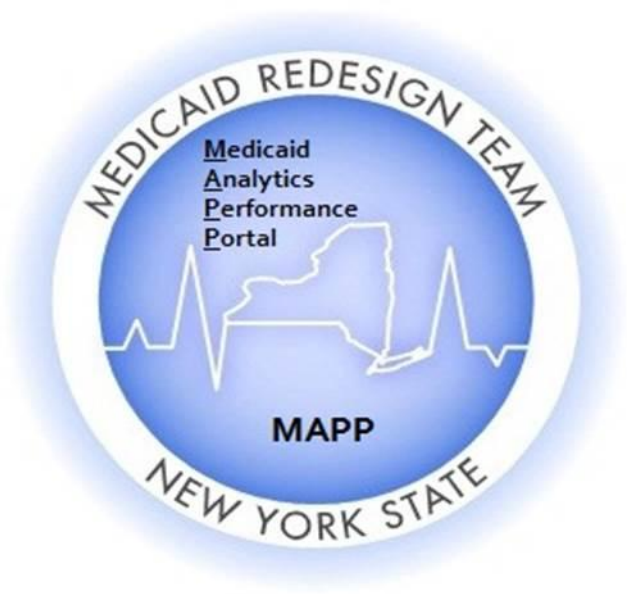
# DRAFT Medicaid Analytics Performance Portal Health Home Tracking System

*File Specifications Document version 5.1*



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# Introduction

## Purpose and Overview

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

Throughout this document:

1) Medicaid Analytics Performance Portal Health Home Tracking System (MAPP HHTS) will be referred to as ***the system.***
2) *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.
3) Individuals associated with MCPs, HHs, CMAs, and other organizations accessing the MAPP HHTS will be referred to as ***users.***
4) File names <u>will be underlined</u>
5) Field names **will be bolded**
6) The status of a segment, assignment, referral, transfer, and billing instance *will be italicized*
7) Values will be listed in 'single quotations'

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

- Individual online – performing actions for an individual member online one at a time.
- Bulk online - using online filters to define a group of members and performing an action on that group of defined members online.
- 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 this document does not address the other methods that can be used to perform actions within the system. While users can use a combination of methods when performing actions within the system, this document assumes that a user is only using the file upload method. For example, this document will state that a user *must* upload a specific file to complete a required action. Such a statement is meant to clarify to a user how a specific action is performed using the file transfer method, not to imply that a user can only use the file transfer method to perform the action within the system. This document does not explain how a user navigates to the MAPP HHTS nor how a user uploads a file to or downloads a file from the system. Users learn how to navigate to the system and how to use all three methods during MAPP HHTS web-based trainings and other training documents. 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 MAPP section of the Health Home website under *Tracking System Update and File Formats* in the **Updated File Specifications (XLS)** column:

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.

1) 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.
2) 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.
3) 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 set up 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 snapshot 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 uploading .csv or .txt file format, special characters are disallowed in the file upload record, other than the special characters listed below. When using the comma delimited file format, a comma is necessary to represent the boundary between multiple fields but cannot be used within a field.

**Allowed special characters:** @ * ( ) ! ~ ` / ? = + - _ $ : ; # % & ^ < > [ ] { }

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.

## 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. |
| 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. |

| File | Who Can Download | Who Can Upload | Description |
|---|---|---|---|
| MCP Final HH 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: MCP Final HH 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 Assignment Download | MCP, HH, CMA | | The Past Assignment Download 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 and Member Program 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' to create Plan of Care records and 'A' to add member program information. |
| Consent and Member Program Error File | HH, CMA | | This file is created upon validating or processing a Consent and Member Program Upload file containing at least one error. |
| Consent File Download | MCP, HH, CMA | | This file contains all consent records and plan of care records with an active, withdrawn, or 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. |

| File | Who Can Download | Who Can Upload | Description |
|---|---|---|---|
| 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 Members Download | 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 | 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. |
| CIN Search Download | 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. |

| File | Who Can Download | Who Can Upload | Description |
|---|---|---|---|
| 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 | HH, CMA | | This file contains the information submitted into the system by a 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. |
| 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 Upload | | 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. |

| File | Who Can Download | Who Can Upload | Description |
|---|---|---|---|
| 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 | 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 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. |
| Provider Relationship Download File | | MCP, HH, CMA | A MCP, HH, or CMA will be able to download this file and see all the provider relationships that they have presently or in the past. |
| Provider Active User Download | | MCP, HH, CMA | An MCP, HH or CMA user will be able to download this file and see all the active users associated with their organization. |
| R/E Code Download File | MCP, HH, CMA | | An MCP, HH or CMA user will be able to download this file and view the current and historical R/E code details for its members. |
| Enrolled Member Details Download | MCP, HH, CMA | | An MCP, HH or CMA user will be able to download this file and view select details about their members who are enrolled in a segment at the time of download. |
| Act on Transfer Out Upload | | HH | A HH will be able to upload this file to transfer out their members in enrollment segments to another HH or CMA. |
| Act on Received Transfers Upload | | HH | A HH will be able to upload this file to act on (accept or reject) transfers that it has received from other HHs. |
| Transfer Out Download | HH, CMA | | HHs and CMAs will be able to download this file to view members who are eligible to be transferred out of their organization. This file can be used as a |

| File | Who Can Download | Who Can Upload | Description |
|---|---|---|---|
| | | | prep file for the Act on Transfer Out Upload File. |
| Received Transfers Download | HH, CMA | | HHs and CMAs will be able to download this file to view members that it has received as pending transfers from other HHs. This file can be used as a prep file for the Act on Received Transfers Upload. |
| Health Home County Code Download File | MCP, HH, CMA | | MCPs, HHs, and CMAs will be able to download this file to view the counties that all active HHs are associated with in the system at the time of download. |
| HH CMA Relationship Download File | MCP, HH, CMA | | MCPs, HHs, and CMAs will be able to download this file and view all active HH CMA relationships at the time of download. |
| MCP HH Relationship Download | MCP, HH, CMA | | MCPs, HHs, and CMAs will be able to download this file and view all MCP HH relationships at the time of download. |
| HCBS Member Services Download File | MCP, HH, CMA | | MCPs, HHs, and CMAs will be able to download this file and view what type of HCBS services HCBS eligible members have recently received. |
| Member Program Status Download File | MCP, HH, CMA | | MCPs, HHs, and CMAs will be able to download this file and view the programs (e.g., OMH HH+ elig, AOT, ACT, AH) that their members are associated with. |
| Segments Potentially Incompatible with HH Services Download File | MCP, HH, CMA | | MCPs, HHs, and CMAs will be able to download this file and view segments that are potentially incompatible with health home services. Providers should use this file to determine if a member's segment should be end dated. |
| HH Claim and Encounter Detail File Download | MCP, HH, CMA | | This file contains the detail about member's Health Home claims and encounters within the last 45 months. |

| File | Who Can Download | Who Can Upload | Description |
|---|---|---|---|
| HH Claim and Encounter Summary File Download | MCP, HH, CMA | | This file contains one record per member and summarizes the member's Health Home claims and encounters within the last 45 months. |

## 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 active assignments/referrals with the members' MCPs (or HH for FFS members). and the system creates a new *pending* HH assignment.

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 system. 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 an FFS member assignment/referral that is rejected by the HH is returned to DOH for reassignment. A 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 a 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 11/22/19 assignments that have been sitting with an MCP, HH or CMA for 90 days or longer will be ended and therefore removed from assignment files. Going forward, any member that has had no assignment or segment action in the last 90 days 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 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 with a *pended* MCP assignment follow special inactivity logic that may differ from the usual 90-day purge logic. Please see *Appendix F: Assignment Pend Reason Codes* for a complete list of pend reasons and the system inactivity logic for each MCP assignment pend reason.

## 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**

| Managed Care Plan 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 Description | 79 | 30 | 108 | Y | M'caid | Alpha |
| 7 | Gender | 109 | 1 | 109 | Y | M'caid | Alpha (M/F/U/X) |
| 8 | HH Assignment Created Date | 110 | 8 | 117 | C | Gen | MMDDYYYY, Numeric |

| Managed Care Plan Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Source | Format |
| 9 | MCP MMIS Provider ID | 118 | 8 | 125 | Y | M'caid | Numeric |
| 10 | MCP Name | 126 | 40 | 165 | Y | M'caid | Alphanumeric |
| 11 | HH MMIS Provider ID | 166 | 8 | 173 | C | MCP | Numeric |
| 12 | HH NPI | 174 | 10 | 183 | C | M'caid | Numeric |
| 13 | HH Name | 184 | 40 | 223 | C | M'caid | Alphanumeric |
| 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 | Blank | N/A | Null Value (blank) |
| 23 | Acuity Score | 382 | 7 | 388 | Blank | N/A | Null Value (blank) |
| 24 | Risk Score | 389 | 6 | 394 | Blank | N/A | Null Value (blank) |
| 25 | Outpatient Rank | 395 | 6 | 400 | Blank | N/A | Null Value (blank) |
| 26 | DOH Composite Score | 401 | 6 | 406 | Blank | N/A | Null Value (blank) |
| 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 |

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

| Managed Care Plan Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Req'd** | **Source** | **Format** |
| 69 | Service 5: Last Service State | 1381 | 2 | 1382 | C | M'caid | Alpha |
| 70 | Service 5: Last Service Zip Code | 1383 | 9 | 1391 | C | M'caid | Numeric |
| 71 | Service 5: Last Service Phone Number | 1392 | 10 | 1401 | C | M'caid | Numeric |
| 72 | MCP Assignment Created Date | 1402 | 8 | 1409 | Y | Gen | MMDDYYYY, Numeric |
| 73 | DOH Recommended HH MMIS Provider ID | 1410 | 8 | 1417 | Blank | N/A | Null Value (blank) |
| 74 | DOH Recommended HH Name | 1418 | 40 | 1457 | Blank | N/A | Null Value (blank) |
| 75 | HARP | 1458 | 1 | 1458 | Y | M'caid | Alpha (E/Y/N) If eligible set to Y, if enrolled set to E, if neither set to N |
| 76 | MCP Assignment Status | 1459 | 40 | 1498 | Y | Gen | Alpha (Pending, Active, Pended) |
| 77 | HH Assignment Status | 1499 | 40 | 1538 | C | MCP/HH | Alpha (Pending, Active, Rejected, Ended) |
| 78 | Rejected Assignment Suggested HH Assignment | 1539 | 8 | 1546 | C | HH | Numeric |
| 79 | CMA MMIS Provider ID | 1547 | 8 | 1554 | C | HH | Numeric |
| 80 | CMA Name | 1555 | 40 | 1594 | C | M'caid | Alphanumeric |
| 81 | CMA Assignment Status | 1595 | 40 | 1634 | C | HH/CMA | Alpha (Pending, Active, Rejected, Ended) |
| 82 | Assignment Source | 1635 | 20 | 1654 | Blank | N/A | Null Value (blank) |
| 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: MCP Final HH |

| Managed Care Plan Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Source | Format |
| | | | | | | | Assignment File Accepted Values) |
| 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 | Alphanumeric |
| 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 HH 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) |

| Managed Care Plan Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Source | Format |
| 114 | Segment HH Provider ID | 3003 | 8 | 3010 | C | Gen | Numeric |
| 115 | Segment HH Name | 3011 | 40 | 3050 | C | Gen | Alphanumeric |
| 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 Comment | 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 HH Name | 3403 | 40 | 3442 | C | User | Alphanumeric |
| 123 | Suggested HH MMIS Provider ID | 3443 | 8 | 3450 | C | User | Numeric |
| 124 | Suggested CMA Name | 3451 | 40 | 3490 | C | User | Alphanumeric |
| 125 | Suggested CMA MMIS Provider 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 |
| 128 | Segment End Date Reason Category Code | 3523 | 2 | 3524 | C | HH/CMA | Alphanumeric |
| 129 | Segment End Date Reason Category Description | 3525 | 40 | 3564 | C | HH/CMA | Alphanumeric |
| 130 | OMH HH+ Eligible | 3565 | 1 | 3565 | Y | HH/CMA | Alpha (Y/N) |
| 131 | AOT Member | 3566 | 1 | 3566 | Y | HH/CMA | Alpha (Y/N) |
| 132 | ACT Member | 3567 | 1 | 3567 | Y | HH/CMA | Alpha (Y/N) |
| 133 | Impacted Adult Home Member | 3568 | 1 | 3568 | Y | HH/CMA | Alpha (Y/N) |
| 134 | EI Member | 3569 | 1 | 3569 | Y | HH/CMA | Alpha (Y/N) |
| 134 | HFW Member | 3570 | 1 | 3570 | Y | HH/CMA | Alpha (Y/N) |
| 135 | C-Yes Member | 3571 | 1 | 3571 | Y | HH/CMA | Alpha (Y/N) |
| 136 | MCP Type | 3572 | 15 | 3586 | Y | HH/CMA | Alpha |

**Editing Logic**

1) **Health Home assignment** (fields #8, #11-13)
   a) These fields will be blank until the MCP assigns a member to a HH using the MCP Final HH Assignment file or the system creates the referral through the referral portals. When the MCP submits a HH assignment, the **HH Assignment Created** will be populated with the date that either the system processed the referral, or the MCP 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 or the system 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 or system assigned the member to rejected the member's *pending* HH assignment. When the HH rejected the *pending* HH assignment created by the MCP or the system, 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 to the member, ended the member's *active* HH assignment. When the HH ended the *active* HH assignment created by the system or 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, to assign the member to a more suitable HH. 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 **Rejected Assignment Suggested HH 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 **Rejected Assignment Suggested HH 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 **HH 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 **HH Assignment Status** (field #77) is populated with a value of ended or active.

f) **Referral Suggested HH 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. The system will then create an active MCP assignment and a pending HH assignment with HH B. -. Referrers are required to complete this field when creating the referral -. When a member is with an MCP, the only HHs that are available to select in the referral drop-down are HHs that work with that MCP. If a member is FFS, all possible HHs will be available to select.

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(s) 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.
   b) **Pend Reason Code Comment** (field **# 107)** will be populated if a comment is entered when the assignment is *pended*, regardless of the **Pend Reason Code**. This field is required when **Pend Reason Code** (field #106) is populated with pend reason code 'Other'.

**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) **HH Provider ID** (field #114) and **HH 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)**, Segment End Date Reason Comment** (field #118), **Segment End Date Reason Category Code** (field #128), and **Segment End Date Reason Category Description** (field #129) 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 Status** (field #76), but no **HH 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 in 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 in field #113 with a **Segment End Date Reason Description** (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. Effective 7/1/20, outreach is no longer a Medicaid covered service.
    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.

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

13. **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.

1.1.1. The system will populate the field with "Y" if "HCBS Only" was selected for the member on the Referral Rationale Screen in the CRP.
1.1.2. 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.
1.1.3. 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)

- MAPP will populate these fields based on a referrer's responses when referring a child via the CRP.
- 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.
- 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)

1) 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*

2) 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*.
3) Both of these fields are associated with the MCP that uploaded the file and its downstream providers. If a member switches from MCP to FFS or switches MCPs these values will no longer display.

## MCP Final HH 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**

| MCP Final HH 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 | HH MMIS Provider ID | 9 | 8 | 16 | C | Numeric |
| 3 | Pend Reason Code | 17 | 2 | 18 | C | Alphanumeric |
| 4 | Plan Provided Secondary Address – Street 1 | 19 | 40 | 58 | C | Alphanumeric |
| 5 | Plan Provided Secondary Address – Street 2 | 59 | 40 | 98 | C | Alphanumeric |
| 6 | Plan Provided Secondary Address – Apt/Suite | 99 | 20 | 118 | C | Alphanumeric |
| 7 | Plan Provided Secondary Address – City | 119 | 40 | 158 | C | Alpha |
| 8 | Plan Provided Secondary Address – State | 159 | 2 | 160 | C | Alpha |
| 9 | Plan Provided Secondary Address – Zip | 161 | 9 | 169 | C | Numeric |
| 10 | Plan Provided Member Phone Number | 170 | 10 | 179 | C | Numeric |
| 11 | Plan Provided Member Language | 180 | 30 | 209 | C | Alpha |
| 12 | Engagement Optimization | 210 | 1 | 210 | N | Alpha |
| 13 | MCP Determined Eligibility | 211 | 23 | 233 | 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.

- Assign a member with an *active*, *pending*, or *pended* MCP assignment, **NO** corresponding segments that are not closed or cancelled**.**

    - 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 **HH MMIS Provider ID** (field #2) field.
- 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**.
    - 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 **HH 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).
    - 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).
    - 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.

- 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.
    - For example, an MCP user identifies a new plan member that is Health Home eligible and appropriate for the program.
    - To enter the member into the system and create an *active* MCP assignment (no HH assignment yet), the MCP user would:
        - Submit a record containing the member's CIN and do not include information in **HH MMIS Provider ID** (field #2) or **Pend Reason Code** (field #3).
    - To enter the member into the system to create an *active* MCP assignment and a *pending* HH assignment, the MCP user would:
        - 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 **HH MMIS Provider ID** (field #2) field AND do not populate **Pend Reason Code** (field #3).
- **Pend** the assignment for a member with an *active*, *pending* or a *pended* MCP assignment
    - To pend a member's MCP assignment, **HH 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.
- Uploading MCP supplied address information into the system.
    - 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.
        - **Plan Provided Secondary Address – Street 1** (field #4) must contain at least 3 characters.
        - **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).
        - **Plan Provided Secondary Address – City** (field #7) must contain letters only.

        - 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.
        - 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.
- Uploading MCP supplied phone number information into the system.
    - **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.
- Uploading MCP supplied language information into the system.
    - **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.
- Uploading MCP Optimization and Eligibility information
    - 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.
    - An MCP can submit acceptable values in one or both of these fields and also submit other information in any other fields (#2-11).
    - 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.
    - Providers can submit up to 8 of the 2-digit MCP Determined Eligibility codes (with a space delimiter) 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.

- 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.
- The MMIS Provider ID submitted in **HH 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.
- Members submitted in this file cannot have an outreach or enrollment segment in the system in any status except *Closed* or *Canceled*.
- A record cannot contain a value in both **HH MMIS Provider ID** (field #2) and **Pend Reason Code** (field #3).
- 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 **HH MMIS Provider ID** (field #2), then the record will be rejected.

- 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: MCP HH 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: MCP Final HH 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 | HH 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 *canceled*. 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 Description | 79 | 30 | 108 | Y | M'caid | Alpha |
| 7 | Gender | 109 | 1 | 109 | Y | M'caid | Alpha (M/F/U/X) |
| 8 | HH Assignment Created Date | 110 | 8 | 117 | C | Gen | MMDDYYYY, Numeric |
| 9 | MCP MMIS Provider ID | 118 | 8 | 125 | C | M'caid | Numeric |
| 10 | MCP Name | 126 | 40 | 165 | C | M'caid | Alphanumeric |
| 11 | HH MMIS Provider ID | 166 | 8 | 173 | C | Gen | Numeric |
| 12 | HH NPI | 174 | 10 | 183 | C | M'caid | Numeric |
| 13 | HH Name | 184 | 40 | 223 | C | M'caid | Alphanumeric |
| 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 | | Blank | Null Value (blank) |
| 23 | Acuity Score | 382 | 7 | 388 | | Blank | Null Value (blank) |
| 24 | Risk Score | 389 | 6 | 394 | | Blank | Null Value (blank) |
| 25 | Outpatient Score | 395 | 6 | 400 | | Blank | Null Value (blank) |
| 26 | DOH Composite Score | 401 | 6 | 406 | | Blank | Null Value (blank) |
| 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 |

| Health Home Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Source | Format |
| 33 | Service 1: Last Service State | 585 | 2 | 586 | C | M'caid | Alpha |
| 34 | Service 1: Last Service Zip Code | 587 | 9 | 595 | C | M'caid | Numeric |
| 35 | Service 1: Last Service Phone Number | 596 | 10 | 605 | C | M'caid | Numeric |
| 36 | Service 2: Last Service Date | 606 | 8 | 613 | C | M'caid | MMDDYYYY, Numeric |
| 37 | Service 2: Last Service Provider Name | 614 | 40 | 653 | C | M'caid | Alpha |
| 38 | Service 2: Last Service Provider NPI | 654 | 10 | 663 | C | M'caid | Numeric |
| 39 | Service 2: Last Service Address Line 1 | 664 | 40 | 703 | C | M'caid | Alphanumeric |
| 40 | Service 2: Last Service Address Line 2 | 704 | 40 | 743 | C | M'caid | Alphanumeric |
| 41 | Service 2: Last Service City | 744 | 40 | 783 | C | M'caid | Alpha |
| 42 | Service 2: Last Service State | 784 | 2 | 785 | C | M'caid | Alpha |
| 43 | Service 2: Last Service Zip Code | 786 | 9 | 794 | C | M'caid | Numeric |
| 44 | Service 2: Last Service Phone Number | 795 | 10 | 804 | C | M'caid | Numeric |
| 45 | Service 3: Last Service Date | 805 | 8 | 812 | C | M'caid | MMDDYYYY, Numeric |
| 46 | Service 3: Last Service Provider Name | 813 | 40 | 852 | C | M'caid | Alpha |
| 47 | Service 3: Last Service Provider NPI | 853 | 10 | 862 | C | M'caid | Numeric |
| 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 |

| Health Home Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Source | Format |
| 62 | Service 4: Last Service Phone Number | 1193 | 10 | 1202 | C | M'caid | Numeric |
| 63 | Service 5: Last Service Date | 1203 | 8 | 1210 | C | M'caid | MMDDYYYY, Numeric |
| 64 | Service 5: Last Service Provider Name | 1211 | 40 | 1250 | C | M'caid | Alpha |
| 65 | Service 5: Last Service Provider NPI | 1251 | 10 | 1260 | C | M'caid | Numeric |
| 66 | Service 5: Last Service Address Line 1 | 1261 | 40 | 1300 | C | M'caid | Alphanumeric |
| 67 | Service 5: Last Service Address Line 2 | 1301 | 40 | 1340 | C | M'caid | Alphanumeric |
| 68 | Service 5: Last Service City | 1341 | 40 | 1380 | C | M'caid | Alpha |
| 69 | Service 5: Last Service State | 1381 | 2 | 1382 | C | M'caid | Alpha |
| 70 | Service 5: Last Service Zip Code | 1383 | 9 | 1391 | C | M'caid | Numeric |
| 71 | Service 5: Last Service Phone Number | 1392 | 10 | 1401 | C | M'caid | Numeric |
| 72 | HARP Flag | 1402 | 1 | 1402 | Y | DOH | Alpha (Y/N/E) If HARP eligible, set to Y; if enrolled set to E; if neither set to N |
| 73 | MCP Assignment Status | 1403 | 40 | 1442 | C | MCP | Alpha (Pending, Active, Pended by MCP) |
| 74 | HH 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 | CMA MMIS Provider ID | 1491 | 8 | 1498 | C | HH | Numeric |
| 77 | CMA Name | 1499 | 40 | 1538 | C | M'caid | Alphanumeric |
| 78 | CMA Assignment Status | 1539 | 40 | 1578 | C | HH/CMA | Alpha (Pending, Active, Rejected, Ended) |
| 79 | Assignment Source | 1579 | 20 | 1598 | | Blank | Null Value (blank) |
| 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 |

| Health Home Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Source | Format |
| 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 |
| 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 | Segment HH MMIS Provider ID | 2601 | 8 | 2608 | C | Gen | Numeric |
| 107 | Segment HH Name | 2609 | 40 | 2648 | C | Gen | Alphanumeric |
| 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 |

| Health Home Assignment File | | | | | | | |
|---|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Source | Format |
| 110 | Segment End Date Reason Comment | 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 HH Name | 3001 | 40 | 3040 | C | Referrer | Alphanumeric |
| 115 | Suggested HH MMIS Provider ID | 3041 | 8 | 3048 | C | Referrer | Numeric |
| 116 | Suggested CMA Name | 3049 | 40 | 3088 | C | Referrer | Alphanumeric |
| 117 | Suggested CMA MMIS Provider 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 Provider ID | 3146 | 8 | 3153 | C | HH/CMA | Numeric |
| 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 |
| 128 | Segment End Date Reason Category Code | 3608 | 2 | 3609 | C | HH/CMA | Alphanumeric |
| 129 | Segment End Date Reason Category Description | 3610 | 40 | 3649 | C | HH/CMA | Alphanumeric |
| 130 | OMH HH+ Eligible | 3650 | 1 | 3650 | Y | M'caid | Alpha (Y, N) |
| 131 | AOT Member | 3651 | 1 | 3651 | Y | M'caid | Alpha (Y, N) |
| 132 | ACT Member | 3652 | 1 | 3652 | Y | M'caid | Alpha (Y, N) |
| 133 | Impacted Adult Home Member | 3653 | 1 | 3653 | Y | M'caid | Alpha (Y, N) |
| 134 | EI Member | 3654 | 1 | 3654 | Y | HH/CMA | Alpha (Y, N) |
| 135 | HFW Member | 3655 | 1 | 3655 | Y | HH/CMA | Alpha (Y, N) |
| 136 | C-YES Member | 3656 | 1 | 3656 | Y | M'caid | Alpha (Y, N) |

**Editing Logic**

1. When a 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, **MCP MMIS Provider ID** (field #9)**, MCP Name** (field #10)**,** and the **MCP 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 **MCP MMIS Provider ID** (field #9)**, MCP Name** (field #10), and the **Managed Care Plan Assignment Status** (field #73) 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.

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.

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.

1. 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.
2. 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:
1. 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.
2. 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'.
3. 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'.

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.

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.

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.

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.
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.
12. **Fields Relating to Member's Most Recent Segment Information** (#105-110)
    - 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.
    - **Outreach/Enrollment Code** (field #105) specifies If the most recent segment the member had was an outreach or an enrollment segment.
    - **HH MMIS ID** (field #106) and **HH Name** (field #107) list the Health Home information associated with the member's most recent segment.
    - **Segment End Date** (field #108)**, Segment End Date Reason Description** (field #109)**,** =**Segment End Date Reason Comments** (field #110), **Segment End Date Reason Category Code** (field #128), and **Segment End Date Reason Category Description** (field #129) provide further information as to why the most recent segment ended.
        - 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 Status** (field #74) they should review fields #105-110 to determine if they may work with this member
            - 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.
            - 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.
13. **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. Effective 7/1/20, outreach is no longer a Medicaid covered service.

1. **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.
2. **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.

1. 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.
2. 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.

14. Use the **Member's Date of Birth** (field #4) to determine if an assignment is for a child or an adult.
15. **Child HCBS Flag** (field #113)

1) 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
   - The system will populate the field with "Y" if "HCBS Only" was selected for the member on the Referral Rationale Screen in the CRP.
   - 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.
   - 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

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

1) The system will populate these fields based on a referrer's responses when referring a child via the CRP.
2) 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.

17. If the member has had multiple referrals where suggested providers were selected the system will display the most recently suggested provider's information.
18. Effective release 4.5 6/1/24, members transitioning from CYES to Health Home AND Health Home to CYES care management will be transferred to Health Homes through the MAPP HHTS. These transfers will be treated as any other transfer within the system and will be listed in the transfer fields below **(fields #119-126)** and will be handled within the transfer files (see Transfer Files section for more information). The MAPP HHTS Release 4.5 webinar will explain how to create/track CYES response *HH to CYES* transfers and how to review/accept/reject *CYES to HH* transfers within the system.
19. **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.

1) 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
2) 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 Assignment Download

**Description**

The Past Assignment Download 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 all 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 Download file, because John's assignment with HH B ended because HH B created a segment, which excludes him from being included on the Past Assignment Download 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 Download 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 Assignment Download file.

**Format**

| Past Assignment Download | | | | | | |
|---|---|---|---|---|---|---|
| **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 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 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 |
| 14 | Opt-Out Signature Date | 201 | 8 | 208 | C | MMDDYYYY, Numeric |
| 15 | Opt-Out Submission Date | 209 | 8 | 216 | C | MMDDYYYY, Numeric |

| Past Assignment Download | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Required (Y/N/C-conditional) | Format |
| 16 | Opt-Out Effective Date | 217 | 8 | 224 | C | MMDDYYYY, Numeric |
| 17 | Opt-Out End Date | 225 | 8 | 232 | C | MMDDYYYY, Numeric |
| 18 | Opt-Out Submitted by Organization Name | 233 | 40 | 272 | C | Alpha |
| 19 | Most Recent Record | 273 | 1 | 273 | Y | Alpha |

**Editing Logic**

1. A member can be removed from an assignment file for several reasons, including:
2. Member is no longer Medicaid eligible.
3. Assigning entity changed the member's assignment
   - **a.** Member switched MCP status (see #7)
   - **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.
4. 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).
5. Recipient R/E code or principal 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).
6. Member started outreach or enrollment with another organization (only applies to HHs/CMAs).
7. 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. A HH B user downloading the Past Assignment Download 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 Assignment Download 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 Assignment Download file on 8/21/16 will see that Amy is included in the file download.
8. Additional file editing includes:

a. 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.

b. 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 Download file.

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 Download 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 assignment for each member within the last year. Therefore, a member may appear on the file more than once if that member has had more than 1 ended/rejected assignment in the last year with the downloading provider. Field # 19 **(Member most recent record)** will be flagged with a Y for the most recent assignment for each member on the download file.

    a. If the file only contains one record for the member this field will be populated with a 'Y' for that member

    b. More historical assignments will have a blank value in field.

## 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 | Alphanumeric |
| 18 | Comments Related to Referral | 694 | 300 | 993 | N | Alphanumeric |
| 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 Referral Indicator | 1504 | 30 | 1533 | C | Alpha (HCBS/None) |
| 32 | Chronic Conditions | 1534 | 100 | 1633 | C | Alpha (Two or more chronic conditions, SED, Complex Trauma, HIV/AIDs, None) |

| Child Referral Download File | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Format |
| 33 | Suggested HH Name | 1634 | 40 | 1673 | C | Alpha |
| 34 | Suggested HH 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 |
| 37 | LDSS County | 1730 | 40 | 1769 | C | Alpha |
| 38 | LDSS Contact Name | 1770 | 40 | 1809 | C | Alpha |
| 39 | LDSS Phone Number | 1810 | 10 | 1819 | 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) 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)
    - 10.1. **HCBS Referral Indicator** (field #31) indicates if the referrer felt that the member qualified for HH services based on being part of the HCBS identified population.
    - 10.2. **Chronic Conditions** (field #32) indicates what Chronic Conditions the member has that qualifies the member to be referred into the HH program.
    - 10.3. 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)
    - 11.1. The system will populate these fields based on a referrer's responses when referring a child via the CRP.
    - 11.2. If the child was referred prior to 1/10/19 or the referrer did not select a suggested provider, these fields will be blank.

12. **Fields Relating to LDSS** (fields #37-39)
    - 12.1. These fields will only be populated when a child is identified as being in foster care and an outreach or enrollment segment is created.

## 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

**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 | | | | | |
|---|---|---|---|---|---|
| **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 End 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.
2. 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.
3. 
4. 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. 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

**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 | | | | | |
|---|---|---|---|---|---|
| **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 Effective 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).

## Plan of Care Files

Health Homes will be required to submit to the MAPP HHTS a complete Plan of Care (POC) for actively enrolled members using the Plan of Care Upload file specifications v15 described below. There will not be an associated screen within the tracking system to submit plan of care information. This requirement will be phased in throughout 2023 ending cumulating in the first quarter of 2024 when all enrolled members will need a comprehensive plan of care submitted to the tracking system in accordance with the ***Home Plan of Care Policy*** posted to the Health Home website

HH, CMA, MCP, and DOH users will be able to access submitted plans of care using either the Plan of Care Download file consisting of the plans of care for the downloading provider's members or the Plan of Care PDF,

which will contain a single member's complete plan of care in PDF format. These documents will contain the information submitted by Health Homes on the Plan of Care Upload file in addition to other member information housed within the tracking system, such as member segment information, the member's MCP affiliation, and HCBS provider/frequency/scope/duration information from the referral processed being built in IRAMS.

## Plan of Care Upload

**Description**

This file will be uploaded by Health Homes using the Plan of Care Upload file specifications linked below. The submitted **POC Effective Date** and **POC End Date** (defined in the *Editing Logic* section below) must overlap with the member's active segment dates with the uploading Health Home. As a reminder, this system update has been designed to support existing Plan of Care guidance and does not change existing DOH guidance regarding Plans of Care requirements.

Within the file specifications excel file posted to the HHTS website (linked below) is a column indicating if a field is required. The purpose of this indicator is to identify fields that are always required to be populated for the file to be accepted by the system, are conditionally required based on a value submitted in another file, fields not required, and fields that are required through policy in certain situations. However, that does not mean that the non-required fields are not essential elements in a complete plan of care. Health Homes must populate all fields in the file that are applicable to the member to ensure that the member's full plan of care is submitted to the system.

Additionally, HHs will also be able to use the update existing POC Type 'U' to update an existing POC (e.g. changing a care manager's name; updating a service provider), which does not affect the **POC End Date**. HHs will be able to add, delete, and modify POC they've submitted (defined in the *Editing Logic* section below).

**Format**

Due to the size of the POC Upload File, the file specifications will not be embedded into this document. Please follow the link below to see the POC Upload File v15 that is posted to the website (see *POC Upload* tab). This specifications document contains both system logic and requirements dictated by policy in addition to field definitions.

POC file specifications are housed in a separate excel document saved in the **Updated File Specifications (XLSX)** column in the ***MAPP Health Home Tracking System Release Information*** table that posted to the *Tracking System Updates and File Formats* section of the **Medicaid Analytics Performance Portal (MAPP)** website.

**Editing Logic**

This section only contains supplementary field definitions and editing logic, as needed. Please follow the link above for complete field definitions and system logic.

1. Plan of Care Upload records contain many fields resulting in very large files. To ensure the system can effectively process these complex records, Plan of Care uploads should be broken up into files no greater than 8MB. Files greater than 8MB will be rejected.
2. Below are the **Record Type** and **POC Type** combinations a provider must use when uploading plans of care into the system.

| Scenario | Record Type | POC Type |
|---|---|---|
| New POC to system | A | C |

| Scenario | Record Type | POC Type |
|---|---|---|
| Update information in POC already submitted to system | M | U |
| Deleting Submitted POC | D | |

3. **Determining if HH is authorized to submit POC for member**– for a HH to be able to submit a POC record, the CIN submitted in **Member ID** (field # 3) must have an *active* enrollment segment with the uploading HH **AND** the calculated POC date span must overlap at least one day with the member's active assignment with the uploading HH:
    a. A record's "POC date span" is the period between the **POC Effective Date** and the **POC End Date,** which are system derived and appear on the Plan of Care Download file (see POC Download/Editing Logic section for details on **POC End Date**).
    b. The **POC Effective Date** on the POC Download file will equal either the **Member Signature Date** (field #315) or the **P/G/LAR 1 Signature Date** (field #316), depending on the value in field #14.
4. If **Signature Date Comment Code** (field #319) contains '01', the **Comment Effective Date** is required and will be used by the system as the **POC Effective Date**. If **Signature Date Comment Code** (field #319) is blank, the **POC Effective Date** will be determined by:
    a. **Member Signature Date** (field #315) if the **Responsible Signatory** (field #14) contains '04' or '05'
    b. **P/G/LAR 1 Signature Date** (field #316) if the **Responsible Signatory** (field #14) contains '01', '02', or '03'
5. **Responsible Signatory** (field #14) This field identifies the person responsible to sign the plan of care. Acceptable values are listed below. If this field contains values '04' or '05', the effective date of the POC is equal to the date in **Member Signature Date** (field #315). If this field contains values '01', '02', or '03', the effective date of the POC is equal to the date in the **P/G/LAR 1 Signature Date** (field #316) **AND** the appropriate fields within the "P/G/LAR 1 field series" (fields 15-23) must also be populated *please note: in this situation, the* **Responsible Signatory** (field #14) contains the P/G/LAR 1 relationship information, negating the need for a "P/G/LAR 1 Relationship" field.
6. The system will use the member's DOB as of the POC Effective Date (*i.e. signature date of the responsible signatory*) to confirm that the appropriate **Responsible Signatory** (field #14) value is submitted as described below:
    a. If member >= 18, only 03 or 04 is allowed
    b. If member <18, then 01, 02, 03, 05 is allowed
7. Refer to Health Home policy documents, housed at the link below, for questions about what should be submitted within specific fields. If you have questions about what should be submitted in the field after reading the field definitions and reviewing existing policy guidance, submit your questions to the Health Home email webform, also linked below.
    a. **Health Home Policy and Standards**
    b. **Health Home Email Webform (**select most appropriate subject):
8. When submitting a POC for a member that is "New" (i.e. not updating an existing POC but creating a new date segmented POC) with a value of 'C' in the **POC Type** (field #2), all fields marked with 'Y' (and possibly 'Cs') are required AND you must submit 'A' in the **Record Type** (field #1).
9. When submitting an update to an existing POC for a member that has a POC submitted to the system that needs to be updated with a value of 'U' in the **POC Type** (field #2), all fields marked with 'Y' (and possibly 'Cs') are required AND the responsible signatory's signature date on the updated POC record must match

the **POC Effective Date** of the POC you're updating. In this situation you must also submit 'M' in **Record Type** (field #1).

10. To delete a POC submitted in error, submit 'D' in **Record Type** (field #1) AND make sure values in the **Responsible Signatory** (field #14) and **Member Signature Date** (field #315)/ **P/G/LAR 1 Signature Date** (field #316) matches the information on the POC you need to delete.
    a. For members in AOT who refuse to sign their Plan of Care, their uploaded POC does not contain a **Member Signature Date** or a **P/G/LAR 1 Signature Date** but does have a **Signature Date Comment Code** (field #319) containing '01' and a date in the **Comment Effective Date** (field #320). To delete a member's POC that was submitted in this manner, a delete record ('D') should be submitted on the Plan of Care Upload file using the record's corresponding **Comment Effective Date** (field #320).
11. Field #318 **Adult HCBS Services Identified**: this field is conditionally required through policy for adult Health Home enrolled members receiving HCBS services. Acceptable responses are:
    a. R: currently receiving adult HCBS
    b. I: interested in receiving adult HCBS
    c. C: currently receiving CORE services
    d. E: interested in receiving CORE services
    e. N: no
    f. [blank]
12. If field #318 **Adult HCBS Services Identified** is contains a null (blank) value on the uploaded, the Plan of Care Download file will contain a value of 'N" in this field.

## Plan of Care Error

A Plan of Care Error file will be created if there is at least one record on the upload file is rejected.

**Format**

| Plan of Care Error | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Line Number | 1 | 6 | 6 | Numeric |
| 2 | Record Type | 7 | 1 | 7 | Alpha (C, D) |
| 3 | Member ID | 8 | 8 | 15 | AA11111A, Alphanumeric |
| 4 | Date of Member Signature on POC | 16 | 8 | 23 | Date as MMDDYYYY |
| 5 | Date of PGLAR 1 Signature on POC | 24 | 8 | 31 | Date as MMDDYYYY |
| 6 | Date of PGLAR 2 Signature on POC | 32 | 8 | 39 | Date as MMDDYYYY |
| 7 | Error Reason Code 1 | 40 | 3 | 42 | Numeric |
| 8 | Error Reason Code 2 | 43 | 3 | 45 | Numeric |
| 9 | Error Reason Code 3 | 46 | 3 | 48 | Numeric |
| 10 | Error Reason Code 4 | 49 | 3 | 51 | Numeric |
| 11 | Error Reason Code 5 | 52 | 3 | 54 | Numeric |
| 12 | Error Description 1 | 55 | 70 | 124 | Alphanumeric |
| 13 | Error Description 2 | 125 | 70 | 194 | Alphanumeric |
| 14 | Error Description 3 | 195 | 70 | 264 | Alphanumeric |
| 15 | Error Description 4 | 265 | 70 | 334 | Alphanumeric |
| 16 | Error Description 5 | 335 | 70 | 404 | Alphanumeric |

**Editing Logic**

| Name | Validation Criteria | Error Description | Error Reason Code |
|---|---|---|---|
| Invalid Record Type | Record Type is required.<br>Also, if the file has a record type that is not A,M, or D then an error message will appear. | Invalid Rec Type Must be A or M or D | 01 |
| Record does not exist | If the file contains M or D for the record type and no record exists for the modify or cancel operation, then an error message will appear | Original record does not exist for Modify or Delete operation | 02 |
| Record contains too few or too many fields | If a record in the file contains too few or too many fields, an error message will appear | Invalid Record Length | 03 |
| Invalid POC Type | POC Type is required.<br>Also, if the file has a record type that is not C or U then an error message will appear. | Invalid POC Type Must be C or U | 04 |
| Invalid Member ID Format | If the file has CIN that does not meet the format requirements of 'AA11111A' then an error message will appear | Invalid Member ID Format Must be AA11111A | 05 |
| Invalid Member ID | CIN is required.<br>Also, if the file has CIN that is not known to the HHTS system then an error message will appear | Invalid Member ID | 06 |
| Segment Required | The member must have an active or pended segment with the submitting HH, AND the active segment period must overlap at least one day with the POC effective dates. | Segment required | 07 |
| Invalid DOB | DOB is required.<br>Also, if the file contains a DOB on file, it must match the DOB within HHTS for the Member ID | Invalid DOB | 08 |
| Invalid Date Format | If the file contains a date that is not in the correct format (must be 'MMDDYYYY') then an error message will appear<br>This message is applicable to all dates in the upload file. | Invalid Date Format Must be MMDDYYYY | 09 |
| Member's Phone Number is Required | Member's Phone Number is required as 10 numeric digit or 'NA' | Invalid Member Supplied Phone Number | 10 |
| Member Supplied Address 1 is Required | Member Supplied Address 1 is a required field | Invalid Member Supplied Address 1 | 11 |
| Member Supplied City is Required | Member Supplied City is a required field | Invalid Member Supplied City | 12 |
| Member Supplied State is Required | Member Supplied State is required in the following format: AA | Invalid Member Supplied State | 13 |
| Member Supplied Zip Code is Required | Member Supplied Zip Code is a required field, and must have a minimum of 5 characters | Invalid Member Supplied Zip Code | 14 |

| Name | Validation Criteria | Error Description | Error Reason Code |
|---|---|---|---|
| Responsible Signatory is Required | Responsible Signatory is required,<br>AND<br>If member >= 18, only 03 or 04 is allowed<br>If member <18, then 01, 02, 03, 05 is allowed<br><br>NOTE: the age calculation shall use the POC Effective Date instead of using the file's process date when verifying the member's DOB. | Invalid Responsible Signatory | 15 |
| P/G/LAR <> Name is required | If Responsible Signatory = 01, 02, OR 03, then the P/G/LAR <> Name field is required.<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | P/G/LAR <> Name is required | 16 |
| P/G/LAR <> Address same as member? Is required | If Responsible Signatory = 01, 02, OR 03, then the P/G/LAR <> same as member field is required.<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | P/G/LAR <> Address same as member is required | 17 |
| Invalid P/G/LAR <> Address same as member | The file must contain a value of Y or N AND Responsible Signatory = 01, 02, or 03, else an error message will appear.<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | Invalid P/G/LAR <> Address same as member | 18 |
| P/G/LAR <> Phone Number is required | If the answer to "P/G/LAR <> Address same as member?" = N, then the P/G/LAR Phone number field is required. Acceptable values are NA or 10-digit numeric values. Values not prescribed will result in error message.<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | P/G/LAR <> Phone Number is required | 19 |
| Invalid P/G/LAR <> email address | If the file contains a value in the "P/G/LAR <> email address" field, and the value does not contain an @ sign, then an error message will appear.<br>Also, this field is required if 'P/G/LAR <> Address same as member?' = N<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | Invalid P/G/LAR <> email address | 20 |
| Invalid P/G/LAR <> Address Line 1 | If "P/G/LAR <> Address same as member?" = N, then the P/G/LAR <> Address Line 1 field is required.<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | Invalid P/G/LAR <> Address Line 1 | 21 |
| Invalid P/G/LAR <> City | If "P/G/LAR <> Address same as member?" = N, then the P/G/LAR <> City field is required. | Invalid P/G/LAR <> City | 22 |

| Name | Validation Criteria | Error Description | Error Reason Code |
|---|---|---|---|
| | NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | | |
| Invalid P/G/LAR <> State | If "P/G/LAR <> Address same as member?" = N, then the P/G/LAR <> State field is required.<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | Invalid P/G/LAR <> State | 23 |
| Invalid P/G/LAR <> Zip Code | If "P/G/LAR <> Address same as member?" = N, then the P/G/LAR <> Zip Code field is required.<br>NOTE: The configurable field <> will allow this user message to be displayed for P/G/LAR 1 or P/G/LAR 2, or both (if necessary). | Invalid P/G/LAR <> Zip Code | 24 |
| Gender Identity is Required | Gender Identity is a required field | Invalid Gender Identity | 25 |
| Member's Pronouns is required | Member's Pronouns is a required field | Invalid Member's Pronouns | 26 |
| Primary Language is Required | Primary Language is a required field | Invalid Primary Language | 27 |
| Member Diagnoses is Required | Member Diagnoses is a required field | Invalid Member Diagnoses | 28 |
| Member Preferences and Strengths is Required | Member Preferences and Strengths is a required field | Invalid Member Preferences and Strengths | 29 |
| Barriers to achieving goals is Required | Barriers to achieving goals is a required field | Invalid Barriers to achieving goals | 30 |
| History and Risk Factors: Biological is Required | History and Risk Factors: Biological is a required field | Invalid History and Risk Factors: Biological | 31 |
| History and Risk Factors: Psychological is Required | History and Risk Factors: Psychological is a required field | Invalid History and Risk Factors: Psychological | 32 |
| History and Risk Factors: Family is Required | History and Risk Factors: Family is a required field | Invalid History and Risk Factors: Family | 33 |
| History and Risk Factors: Community is Required | History and Risk Factors: Community is a required field | Invalid History and Risk Factors: Community | 34 |
| History and Risk Factors: Cultural is Required | History and Risk Factors: Cultural is a required field | Invalid History and Risk Factors: Cultural | 35 |
| Care Manager Name is Required | Care Manager Name is a required field | Invalid Care Manager Name | 36 |

| Name | Validation Criteria | Error Description | Error Reason Code |
|---|---|---|---|
| Care Manager Email is Required | Care Manager Email is a required field, and must contain an @ sign, else an error message will appear. | Invalid Care Manager Email | 37 |
| Care Manager Phone Number is Required | Care Manager Phone Number is a required field | Invalid Care Manager Phone Number | 38 |
| Goals and Objectives 1 Required | Goals and Objectives 1 is a required field. | Invalid Goals and Objectives 1 | 40 |
| Interventions and Supports 1.1 is required | Interventions and Supports 1.1 is a required field | Invalid Interventions and Supports 1.1 | 41 |
| Interventions and Supports 1.1 Date is required | Interventions and Supports 1.1 Date is a required field, and must be in format MMDDYYYY | Invalid Interventions and Supports 1.1 Date | 42 |
| Interventions and Supports <n> is conditionally required | Interventions and Supports <n.1> is conditionally required if Goals and Objectives <n> is populated, where <n> are the values 1 through 8<br><br>For instance, “Interventions and Supports 2.1” is required if “Goals and Objectives 2” is populated. | Invalid Interventions and Supports <n> | 43 |
| Interventions and Supports <n> Date is conditionally required | Interventions and Supports <n> Date is conditionally required if Interventions and Supports <n> is populated, where <n> are the values 1.2 through 8.8.<br>AND it must be in format MMDDYYYY<br><br>For instance, “Interventions and Supports 3.3 Date” is required if “Interventions and Supports 3.3” is populated. | Invalid Interventions and Supports <n> Date | 44 |
| Invalid Caregiver/Family Advocacy and Support Services (CFASS) | If Caregiver/Family Advocacy and Support Services (CFASS) is populated, valid values are Y or N, else an error message will be displayed | Invalid Caregiver/Family Advocacy and Support Services (CFASS) | 45 |
| Invalid Community Habilitation (CH) | If Community Habilitation (CH) is populated, valid values are Y or N, else an error message will be displayed | Invalid Community Habilitation (CH) | 46 |
| Invalid Community Self Advocacy Training and Support (CSATS) | If Community Self Advocacy Training and Support (CSATS) is populated, valid values are Y or N, else an error message will be displayed | Invalid Community Self Advocacy Training and Support (CSATS) | 47 |
| Invalid Crisis Respite (CR) | If Crisis Respite (CR) is populated, valid values are Y or N, else an error message will be displayed | Invalid Crisis Respite (CR) | 48 |
| Invalid Day Habilitation (DH) | If Day Habilitation (DH) is populated, valid values are Y or N, else an error message will be displayed | Invalid Day Habilitation (DH) | 49 |

| Name | Validation Criteria | Error Description | Error Reason Code |
|---|---|---|---|
| Invalid Palliative Care - Counseling and Support Services (PCCSS) | If Palliative Care - Counseling and Support Services (PCCSS) is populated, valid values are Y or N, else an error message will be displayed | Invalid Palliative Care - Counseling and Support Services (PCCSS) | 50 |
| Invalid Palliative Care - Expressive Therapy (PCET) | If Palliative Care - Expressive Therapy (PCET) is populated, valid values are Y or N, else an error message will be displayed | Invalid Palliative Care - Expressive Therapy (PCET) | 51 |
| Invalid Palliative Care - Massage Therapy (PCMT) | If Palliative Care - Massage Therapy (PCMT) is populated, valid values are Y or N, else an error message will be displayed | Invalid Palliative Care - Massage Therapy (PCMT) | 52 |
| Invalid Palliative Care - Pain and Symptom Management (PCPSM) | If Palliative Care - Pain and Symptom Management (PCPSM) is populated, valid values are Y or N, else an error message will be displayed | Invalid Palliative Care - Pain and Symptom Management (PCPSM) | 53 |
| Invalid Planned Respite (PR) | If Planned Respite (PR) is populated, valid values are Y or N, else an error message will be displayed | Invalid Planned Respite (PR) | 54 |
| Invalid Prevocational Services (PS) | If Prevocational Services (PS) is populated, valid values are Y or N, else an error message will be displayed | Invalid Prevocational Services (PS) | 55 |
| Invalid Supported Employment (PE) | If Supported Employment (PE) is populated, valid values are Y or N, else an error message will be displayed | Invalid Supported Employment (PE) | 56 |
| Invalid Member residence a community based setting? | Member residence a community based setting? must be Y or N, else an error message will be displayed | Invalid Member residence a community based setting? | 57 |
| Invalid Does member want to live in this setting/at this address? | Does member want to live in this setting/at this address? must be Y or N, else an error message will be displayed | Invalid Does member want to live in this setting/at this address? | 58 |
| Invalid Are member's choices limited/restricted related to an identified risk? | Are member's choices limited/restricted related to an identified risk? must be Y or N, else an error message will be displayed | Invalid Are member's choices limited/restricted related to an identified risk? | 59 |
| Invalid Member Signature Date | Member Signature Date must be a valid date within the last 12 months, and is also required when Responsible Signatory = 04 or 05 | Invalid Member Signature Date | 60 |
| Invalid P/G/LAR 1 Signature Date | P/G/LAR 1 Signature Date must be a valid date within the last 12 months, and is also required when Responsible Signatory = 01, 02 or 03 | Invalid P/G/LAR 1 Signature Date | 61 |
| Invalid P/G/LAR 2 Signature Date | P/G/LAR 2 Signature Date must be a valid date within the last 12 months.<br>May only be populated if P/G/LAR 2 Name is not null | Invalid P/G/LAR 2 Signature Date | 62 |

| Name | Validation Criteria | Error Description | Error Reason Code |
|---|---|---|---|
| Interventions and Supports Interventions and Supports Interventions and Supports Interventions and Supports Plan of Care Date cannot be future date | If the user enters a start date that is in the future, then the system will display an error message. | Plan of Care Date cannot be future date | 63 |
| Record exists | If the user submits an A-record, where the POC Signature Date on the file = Existing System POC signature Date, then the system will display an error message. | POC Record exists | 64 |
| HH2 not permitted to delete HH1's POC | The HH deleting the record must equal the HH that created the record, else the system will display an error message. | Health Home not permitted to delete | 65 |
| Invalid HCBS Eligibility Assessment Result | HCBS Eligibility Assessment Result must be (R/I/C/E/N/blank or else an error message will be displayed | Invalid HCBS Eligibility Assessment Result | 66 |

## Plan of Care Download

**Description**

HH, CMA, and MCP can access submitted plans of care using either the Plan of Care Download file consisting of the plans of care for the downloading provider's members or the Plan of Care PDF, which will contain a single member's plan of care in PDF format. These documents will contain the information submitted by the HH on the Plan of Care Upload file in addition to other member information housed within the tracking system, such as member segment information, the member's MCP affiliation, and HCBS frequency/scope/duration information from the referral process within IRAMS. Please note that that children's HCBS frequency, scope, and duration information from IRAMS will not be populated within the POC download files until the fall release 4.4.

The Plan of Care PDF is housed within a member's page. For instruction on how to access this PDF, and how to filter the larger Plan of Care Download file, please see the 3/1/2023 MAPP HHTS Release 4.2 webinar (*expand MAPP Webinars/2023 section*).

When requesting the Plan of Care Download file from the system, providers will be able to use the following filters to dictate what plans of care will be included in the file:

- Only current POC (for members with active segment with provider) – this will return one POC record per member
- POC start date (range that user enters, similar to BSD, based on the **POC Effective Date**)
- POC updated date (range that user enters, similar to BSD, that filters records based on the **POC Submission Date** (field # 4)

**Format**

Due to the size of the POC Upload File, the file specifications will not be embedded into this document. Please see appropriate file posted in the *Updated File Specifications (XLSX)* column with the *Tracking System Updates and File Formats* section of the MAPP Section of the HH website (see *POC Upload* tab). This specifications document contains both system logic and requirements dictated by policy in addition to field definitions.

**Editing Logic**

1. File population – the logic listed below dictates the records that will be include in the Plan of Care Download file based on the requesting user type. The files described below can be filtered to smaller populations during the file download process as described above (e.g. requesting current POC only; POC submitted within a specific week)
    a. **HH and CMA users**:
        i. all plans of care submitted to the system for the members that have an active enrollment segment with the downloading provider. This file will include multiple records for members that have more than one POC submitted to the system (unless the provider selected 'Only current POC' when downloading the file, **AND**
        ii. For HH users, all POC submitted to the system by the downloading HH.
    b. **MCP users**: all plans of care submitted to the system for members currently enrolled in the downloading user's MCP MMIS ID.
2. **POC Effective Date** (field #2): if **Responsible Signatory** (field # 14) on the Plan of Care Upload file contains '01', '02', or '03', the **POC Effective Date** (field #2) will equal **Member Signature Date** (field #315 POC Upload), otherwise it will equal the **P/G/LAR 1 Signature Date** (field #316 POC Upload).
3. **POC End Date** (field # 3) – the end date is calculated by the system based on the **POC Type** (field 2, POC Upload) AND/OR the existence of another POC in the system for the member.
    a. When a **POC Type** (field #2 POC Upload) = 'C', the **POC End Date** (field # 3) equals (**POC Effective Date** + 365 days)
    b. If a new **POC Type** (field #2 POC Upload) = 'C' is uploaded to the system **AND** the member on that new POC record already has a 'C' POC in the system with a **POC End Date** (field # 3) that is greater than the new **POC Effective Date** (field #2), the system will automatically update the existing **POC End Date** (field # 3) record to equal the NEW **POC Effective Date** (field #2) minus one day.
    c. When a **POC Type** (field #2 POC Upload) = 'U', the **POC End Date** is not updated.

## Consent Files

Consent files allow users to create, modify, withdraw, and access consent, Plan of Care, appropriateness records, CEST outcomes, and member program 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 a HH serving children or a member younger than 18 that is working with a HH serving adults, a user MUST FIRST submit the Consent and Member Program Upload File to establish consent to enroll for this member. The Consent and Member Program Upload File is also used to update consent for all members.

### Consent and Member Program Status Upload File

**Description**

HHs/CMAs upload this file to create and update consent, appropriateness records, CEST Outcome, and member program information (Early Intervention, High-Fidelity Wraparound, and HCBS) for all members, regardless of age.

MCPs cannot upload this file. 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.

The Consent and Member Program Upload file can only be used to upload consent information for members that are already known to the system. When creating a new segment for members 21 and older, upload consent to enroll for that member using the Tracking File Segment Records file, not the Consent and Member Program Status upload file.

**Format**

| Consent and Member Program Status Upload | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Req'd | Format |
| 1 | Record Type | 1 | 1 | 1 | C | Alpha (C, M, W, A, U, R, N, E, X, Z) |
| 2 | Member ID | 2 | 8 | 9 | Y | AA11111A, Alphanumeric |
| 3 | HH MMIS Provider ID | 10 | 8 | 17 | C | 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, 06) |
| 8 | Existing Consent Type | 44 | 2 | 45 | C | Numeric (01, 04) |
| 9 | New Consent Type | 46 | 2 | 47 | C | Numeric (01, 04) |
| 10 | Member Program Type | 48 | 2 | 49 | C | Numeric (01, 02, 05, 06) |
| 11 | Member Program Start Date | 50 | 8 | 57 | C | MMDDYYYY, Numeric |
| 12 | Member Program End Date | 58 | 8 | 65 | C | MMDDYYYY, Numeric |
| 13 | CEST Outcome | 66 | 1 | 66 | C | Alphanumeric (C,E,M) |
| 14 | CEST Start Date | 67 | 8 | 74 | C | MMDDYYYY, Numeric |
| 15 | CEST End Date | 75 | 8 | 82 | C | MMDDYYYY, Numeric |
| 16 | Appropriateness Category | 83 | 2 | 84 | C | Alphanumeric |
| 17 | Appropriateness Detail | 85 | 250 | 334 | C | Alphanumeric |
| 18 | Appropriateness Start Date | 335 | 8 | 342 | C | MMDDYYYY, Numeric |

**Editing Logic**

The table below explains how and when to use each Record Type.

| Submitted Information | Add, Create | Modify | Delete, Withdraw, Cancel |
|---|---|---|---|
| **Consent to Enroll** | C | M | W |
| *Consent records are included in the Consent Download file. You no longer submit consent to enroll and appropriateness criteria on the same record.* | | | |
| **Member Program Information** | A | U | R |

| Submitted Information | Add, Create | Modify | Delete, Withdraw, Cancel |
|---|---|---|---|
| *This record is used to upload into the system a member's connection to the Early Intervention (, and the High Fidelity Wrap). This information is included in the Member Program Status Download file, not the Consent Download file. See Appendix M: Consent and Member Program Status File Codes* for **Program Type** codes | | | |
| **Continuing Eligibility Screening Tool Outcome** | X | | Z |
| *These record types are used to submit the Continuing Eligibility Screening Tool (CEST) Outcome. This information is included in the Assessment Download file, not the Consent Download file.* | | | |
| **Children's HCBS Status Update** | N | | E |
| *This record is used to upload into the system members that have an active K1 RE code that are no longer receiving HCBS services but are still enrolled in the Health Home program. This information is used by DOH to end date K1 RE codes. This information is not available on a download file. Submitted information is listed in the **Member Program Information** section of the **Personal Information** tab within the member's page in the tracking system.* | | | |
| **Appropriateness Record** | S | T | P |
| *This record is used to upload appropriateness for all members (IA and YA), regardless of age. Each appropriateness record submitted to the system will be distinctly documented within the system and will be in the Assessment Download file, not the Consent Download file.* | | | |

1. There is no hierarchy related to the processing of the Consent and Member Program upload file by **Record Type**. Records will be processed according to how they are entered into the file starting with the first record entered.
2. If a user would like to upload consent information, plan of care information, and member program information for the same member, they must submit 3 records. These three records can be on the same file or in separate files.
3. For **Record Type** '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.
4. For **Record Type** '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 #13) in the system with the uploading provider.

5. For **Record Type** '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 #13) in the system with the uploading provider.
6. For **Record Type** 'A' (Add a provider-supplied member program record) the following fields are utilized:
   a. **Record Type** (field #1)
   b. **Member ID** (field #2)
   c. **Member Program Type** (field #10)
   d. **Member Program Start Date** (field #11)
   e. **Member Program End Date** (field #12)- optional
7. For **Record Type** 'U' (Modify the end date of a provider-supplied member program record) the following fields are required:
   a. **Record Type** (field #1)
   b. **Member ID** (field #2)
   c. **Member Program Type** (field #10)
   d. **Member Program Start Date** (field #11)
   e. **Member Program End Date** (field #12)
8. For **Record Type** 'R' (Delete a provider supplied member program record) the following fields are utilized:
   a. **Record Type** (field #1)- required
   b. **Member ID** (field #2)- required
   c. **Member Program Type** (field #10)
   d. **Member Program Start Date** (field #11)
   e. **Member Program End Date** (field #12)- optional
9. For **Record Type** 'N' (Add New Children's HCBS Member Program Information Record) the following fields are utilized:
   a. **Record Type** (field #1)
   b. **Member ID** (field #2)
   c. **Member Program Type** (field #10)
   d. **Member Program End Date** (field #12)

10. For **Record Type** 'E' (Remove Existing Children's HCBS Member Program Information Record) the following fields are utilized:
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **Member Program Type** (field #10)
    d. **Member Program End Date** (field #12)
11. For **Record Type** 'X' (Adding CEST Information), and 'Z' (Deleting an CEST) the following fields are required:
    a. **Record Type** (field #1)

b. **Member ID** (field #2)
c. **HH MMIS ID** (field #3)
d. **CEST Outcome** (field #13)
e. **CEST Start Date** (field #14)

12. For **Record Type** 'S' (add appropriateness record) the following fields are utilized:
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **HH MMIS ID** (field #3)
    d. **Appropriateness Category** (field # 16)
    e. **Appropriateness Detail** *conditionally required based on appropriateness category* (field # 17)
    f. **Appropriateness Start Date** (field # 18)
13. For **Record Type** 'T' (modify existing appropriateness record) required:
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **HH MMIS ID** (field #3)
    d. **Appropriateness Category** *can be modified* (field # 16)
    e. **Appropriateness Detail** *can be modified and is conditionally required based on appropriateness category* (field # 17)
    f. **Appropriateness Start Date** *cannot* be modified (field # 18)
14. For **Record Type** 'P' (delete appropriateness record) required:
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **HH MMIS ID** (field #3)
    d. **Appropriateness Start Date** (field #18)

15. When creating an appropriateness record for a HHSC member (**?????** = 'C'), the system will calculate for the resulting IA/YA appropriateness record an **Appropriateness End Date** to indicate that the appropriateness record must be submitted yearly.
16. When creating an appropriateness record for a HHSA member (**?????** = 'C'), the resulting appropriateness record's **Appropriateness End Date** field will be blank to indicate that adult members are only required to submit IA, not YA.
17. When deleting an appropriateness record using the 'P' record, the system will set the appropriateness record to the *deleted* status, which will remove the record from the screen view, but display on the download file.
18. **CEST Outcome** submissions with a **CEST Start Date** that equals an existing **CEST Start Date** for the member will be rejected.
19. If the new record with **CEST Outcome** 'M' is submitted directly following an existing 'M' **CEST Outcome** (with existing 'M' End Date within 45 days of new 'M' CEST Start Date AND the HH is same), then the system will reject the new 'M' **CEST Outcome** record and the user can submit only 'E' or 'C'

    Example: Existing M record has Start Date: 1/1/2024; End Date: 3/01/2024

    1. New M submitted with Start Date: 5/1/2024: System will reject this because 5/1/2014 falls within 3/01/2024 + 45 days
    2. New M submitted with Start Date: 5/17/2024: System will accept because 5/17/2024 is after 3/01/2024 + 45 days

3. New E or C record submitted with Start Date: 5/1/2024: System will accept
4. New E or C record submitted with Start Date: 5/17/2024: System will accept

20. If the new record with CEST Outcome 'E' or 'M' is submitted directly following an existing 'E' CEST Outcome (with existing 'E' End Date within 45 days of new 'E' or 'M' CEST Start Date AND the HH is same), then the system will reject the new 'E' or 'M' CEST Outcome record and the user can submit only 'C'.

Example: Existing E record has Start Date: 1/1/2024; End Date: 3/01/2024

1. New E or M record submitted with Start Date: 5/1/2024: System will reject because 5/1/2014 falls within 3/01/2024 + 45 days
2. New E or M record submitted with Start Date: 5/17/2024: System will accept because 5/17/2024 is after 3/01/2024 + 45 days
3. New C record submitted with Start Date: 5/1/2024: System will accept
4. New C record submitted with Start Date: 5/17/2024: System will accept

21. If a member's segment is closed and there is a **CEST Outcome** for that member with a **CEST End Date** that is greater than the member's closed segment's **End Date**, the system will modify the member's **CEST End Date** so it equals the member's closed segment **End Date**.
22. If a closed segment forces a change to the **CEST End Date** as described in #24 and then *the HH re-opens that closed segment*, the system **WILL NOT** revert to the originally calculated **CEST End Date**. To get the original CEST End Date (CEST Start Date + 60/180 days *based on outcome*), use the 'Z' **Record Type** to delete the truncated CEST record and then use the 'X' **Record Type** to re-add the original **CEST Start Date**, which will trigger the system to recalculate the **CEST End Date** using the **CEST Outcome**.
23. When a member's segment is transferred using the system's transfer process, the system is programed to *maintain* the member's CEST due date from the original segment into the newly created segment (see number 27 below). In addition, under the new segment some CEST due dates will get modified to provide the new segment's providers a buffer to complete the CEST (see number 28 below).
24. The system achieves this in few different ways, depending on how long the member has been enrolled and the status of any submitted CEST records. Additionally, some CEST dues dates will be adjusted to allow the provider some additional time after the transfer occurs (see # 28 below). For the scenarios described below in 27a-27d, the member's pre-transfer segment is referred to as their *original segment*, is with HH1, and has an end date of 12/31/25. The member's new segment created as a result of the transfer is referred to as their *new segment*, is with HH2, and has a begin date of 1/1/26.
    a. Member enrolled for less than a year in original segment and did not need to submit CEST during original segment
        I. The system will create a new CEST outcome record for the member to maintain the member's CEST due date per the member's original segment's begin date.
        II. Upon acceptance of the member's transfer, the system will end date the original segment, will create the new segment, and will create a new CEST record for the member under the new HH.
        III. The new CEST record will:
            i. Be listed on the Assessment Download file as a single record (row)
            ii. **Assessment Outcome** field will be populated with 'T'
            iii. **CEST Start Date** field will be populated with new segment's begin date

iv. **CEST End Date** field will be populated with member's CEST due date per the member's original segment (see #28 for potential adjustment)

b. Member submitted CEST during original segment and that CEST outcome record's **CEST End Date** is greater than the original segment's end date

I. The system will create a new CEST outcome record for the member's new HH to maintain the member's CEST due date per the member's original segment

II. Upon acceptance of the member's transfer, the system will end date the original segment, will create the new segment, and will create a new CEST record for the member under the new HH.

III. The new CEST record will:

i. Be listed on the Assessment Download file as a single record (row)

ii. **Assessment Outcome** field will be populated with the appropriate value that corresponds with the member's **CEST Outcome** associated with the member's original segment

'L' - the CEST was transferred with the member and the original segment's CEST outcome was 'E'

2. 'P' - the CEST was transferred with the member and the original segment's CEST outcome was 'C'

3. 'N' - the CEST was transferred with the member and the original segment's CEST outcome was 'M'

iii. **CEST Start Date** field will be populated with new segment's begin date

iv. **CEST End Date** field will be populated with member's **CEST End Date** associated with the member's original segment (see #28 for potential adjustment).

c. Member enrolled for more than a year in original segment and provider did not submit CEST on time as required per the CEST policy

I. The system **will** not create a new CEST outcome record for the member

II. The system will block the provider from adding a billing instance for this member until a new CEST is submitted to the system by the member's new HH.

*i.* On the Billing Support Download file the **Validation Code** field will be populated with '1' *No CEST submitted after grace period for transferred member in the original segment*

d. Member submitted CEST during original segment and that CEST outcome record's **CEST End Date** is less than the original segment's end date (original HH allowed the member's CEST to expire and did not submit CEST as required per CEST policy)

I. The system **will** not create a new CEST outcome record for the member

II. The system will block the provider from adding a billing instance for this member until a new CEST is submitted to the system by the member's new HH.

*i.* On the Billing Support Download file the **Validation Code** field will be populated with the values below, based on the expired **CEST Outcome** associated with the original segment

1. '2' - CEST E expired for transferred member in the original segment

2. '3' - CEST C expired for transferred member in the original segment

3. '4' - CEST M expired for transferred member in the original segment

e. For 27c & 27d above, once a CEST outcome is submitted to the system by the new HH, billing blocks for services dates on/after the submitted **CEST Start Date** will go away and the new HH will be able to bill.

25. Once the system creates a new CEST Outcome for a transferred segment as described above, the system will further adjust some **CEST End Dates** to give providers a *buffer* for completing CEST due within the first two months of the new segment's begin date.
    a. Any CEST end date created as part of a transferred segment where the CEST end date would be greater than or equal to the new segment's begin date and less than the new segment's begin date plus 2 months, will be adjusted by the system to equal the last day of the second month of the segment (see examples below)
    b. Member transferred from HHA to HHB effective 4/1/26. Under HHA, member's initial CEST due 4/5/26:
        I. Upon acceptance of transfer, system will create for the member **CEST Outcome** of 'T' with an adjusted **CEST End Date** of '5/31/26'.
    c. Member transferred from HHA to HHB effective 4/1/26. Under HHA, member submitted CEST 'C' has **CEST End Date** 5/27/26:
        I. Upon acceptance of transfer, system will create for the member **CEST Outcome** of 'P' with an adjusted **CEST End Date** of '5/31/26'.
26. If a member's segment moves into the closed status and there is an appropriateness record for that member with an **Appropriateness End Date** that is greater than the member's closed segment's **End Date** OR if the appropriateness record does not have an **Appropriateness End Date**, the system will modify the member's appropriateness record so that the **Appropriateness End Date** equals the member's closed segment **End Date**.
    a. Please note, if the segment's end date is in the future (i.e. on 7/8/25 the segment is modified to add end date 7/31/25), the appropriateness record will not be immediately end dated. On the night of 7/31/25, the system will update the appropriateness record so the new **Appropriateness End Date** = '7/31/25'
27. If a closed segment forces a change to the **Appropriateness End Date** as described in #24 and then *the HH re-opens that closed segment or cancels a segment that modified the corresponding appropriateness record's* **Appropriateness End Date**, the system WILL NOT revert to the original **Appropriateness End Date**. To get the original **Appropriateness End Date**, use the 'P' **Record Type** to delete the record with the modified **Appropriateness End Date** and then use the 'S' **Record Type** to re-add the original appropriateness record, which will trigger the system to recalculate the **Appropriateness End Date**.
28. When the system processes the Consent and Member Program Upload File record(s) to modify or withdraw consent, the system will use the data entered in the **Member ID** (field #2)**, HH 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.
29. Consent to Enroll is required to create an enrollment segment for all members.
30. 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/adult consent date required record for all members. The following scenarios describe modifications that the system will not allow, when Record Type is 'M', Existing Consent Type is '01' or '04':
    a. and value is entered in the Begin Date field in which the modification would make it so that no Consent to Enroll/ Adult Consent Date Required 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/ Adult Consent Date Required 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/ Adult Consent Date Required 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.

31. Consent dates entered on the Consent and Member Program Upload file cannot be in the future.
32. Consenter '06' (System) is only valid with Consent Type '04' (Adult Consent Date Required). This is used by the system to ensure that all segments are covered by consent. These values are not available to providers
33. The system will ensure that Program Status for type '01' (EI) can only be added to a member record that is before the member's 4th birthday. If the member is already 4, then the record needs to have the Member Program End Date (field #12) on or before their 4th birthday. The system will ensure that Program Status for type '02' (HFW) can only be added to a member record that is before the member's 21st birthday. If the member is already 21, then the record needs to have the Member Program End Date (field #13) on or before their 21st birthday.
34. The system will ensure that if a provider attempts to submit a Member Program Status record for Program Type '05' (HCBS), the member must have a Member Program End Date between the start and end dates of a K1 R/E code. Additionally, the member must have an enrollment segment where the Member Program End Date is between the segment start date and end date.
35. The system must also capture the **Network Type** of the member's associated segment at the time of appropriateness record creation. This **Network Type** stamp will be displayed on corresponding download files (such as the Assessment Download file and the Billing Support Download file).

## Consent and Member Program Status Error File

**Description**

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

**Format**

| Consent and Member Program Status Error File | | | | | | |
|---|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Required (Y, N, C)** | **Format** |
| 1 | Line Number | 1 | 6 | 6 | Y | Numeric |
| 2 | Record Type | 7 | 1 | 7 | Y | Alpha (C, M, W, P, A, U, R, N, E, X, Z, S, T) |
| 3 | Member ID | 8 | 8 | 23 | Y | AA11111A, Alphanumeric |
| 4 | HH MMIS Provider ID | 16 | 8 | 23 | C | Numeric |
| 5 | Existing Start Date | 24 | 8 | 31 | C | MMDDYYYY, Numeric |
| 6 | New Start Date | 32 | 8 | 39 | C | MMDDYYYY, Numeric |
| 7 | End Date | 40 | 8 | 47 | N | MMDDYYYY, Numeric |
| 8 | Consenter | 48 | 2 | 49 | Y | Numeric (01, 02, 03, 04, 05, 06) |
| 9 | Existing Consent Type | 50 | 2 | 51 | C | Numeric (01, 04) |
| 10 | New Consent Type | 52 | 2 | 53 | C | Numeric (01, 04) |
| 11 | | ~~54~~ | ~~8~~ | ~~61~~ | ~~C~~ | (obsolete field) always blank |
| 12 | Member Program Type | 62 | 2 | 63 | C | Numeric Values include:<br>1) 01 (EI)<br>2) 02 (HFW)<br>3) 05 (Children's HCBS)<br>4) 06 (MF) |
| 13 | Member Program Start Date | 64 | 8 | 71 | C | MMDDYYYY, Numeric |
| 14 | Member Program End Date | 72 | 8 | 79 | C | MMDDYYYY, Numeric |
| 15 | CEST Outcome | 80 | 1 | 80 | C | Alphanumeric |
| 16 | CEST Start Date | 81 | 8 | 88 | C | MMDDYYYY, Numeric |
| 17 | CEST End Date | 89 | 8 | 96 | C | MMDDYYYY, Numeric |
| 18 | Appropriateness Category | 67 | 2 | 98 | C | Alphanumeric |
| 19 | Appropriateness Detail | 99 | 250 | 348 | C | Alphanumeric |
| 21 | Appropriateness Start Date | 349 | 8 | 356 | | |
| 22 | Error Reason | 357 | 30 | 386 | Y | Alphanumeric |

**Editing Logic**

The **Error Reason** (field #15) 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 #15). This error file contains both file format errors and logic errors. For more information on Consent and Member Program Status Upload file errors, please review the *Consent and Member Program Status Upload File: Editing Logic* section and *Appendix B: File Error Reason Codes*.

## Consent File Download

**Description**

This file contains all the consent records with an active, withdrawn, or ended **Consent Status** for a provider's members, regardless of how the consent was entered into the system (online, Consent and Member Program Upload File, or Tracking File Segments Record file). For HH providers this is determined by the HH that uploaded the file. For CMA/MCP users the file will display any consent information where the consent date overlaps at least 1 day with the provider's assignment for the member. MCPs, HHs, and CMAs can all download this file.

**Format**

| Field # | Field | Start Pos | Length | End Pos | Required Consent Record (Y, N, C) | 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 | HH MMIS Provider ID | 69 | 8 | 76 | Y | Numeric |
| 5 | HH Name | 77 | 40 | 116 | Y | Alphanumeric |
| 6 | Consent Start Date | 117 | 8 | 124 | Y | MMDDYYYY, Numeric |
| 7 | Consent End Date | 125 | 8 | 132 | C | MMDDYYYY, Numeric |
| 8 | Consenter | 133 | 2 | 134 | Y | Numeric (01, 02, 03, 04, 05, 06) |
| 9 | Consent Type | 135 | 2 | 136 | Y | Numeric (01, 02, 03, 04) |
| 10 | Status | 137 | 2 | 138 | Y | Numeric (01, 02, 03) |
| 11 | Last Updated By | 139 | 40 | 178 | Y | Alpha |
| 12 | Updated Date | 179 | 8 | 186 | Y | MMDDYYYY, Numeric |
| 13 | Updated Time | 187 | 8 | 194 | Y | HH:MM:SS, Numeric |

**Editing Logic**

1) Members will have a unique record for each consent type or they have in the system:
   a) A member with two consents to enroll records and one consent to share protected information record will have three records in the Consent File Download file.
2) The system will populate **Last Updated By** (field #11) with the username 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 File Download will be sorted by alphabetical ascending order (A – Z) by member last name.

## Tracking File Records

Tracking File Records are used to create, delete, pend, or modify segments and to create, reject, and accept . 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) |
| 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 MMIS Provider ID | 60 | 8 | 67 | C | Numeric |
| 7 | End Date Reason | 68 | 2 | 69 | C | Alphanumeric |
| 8 | End Date Reason Comment | 70 | 40 | 109 | C | Alphanumeric |
| 9 | End HH Assignment | 110 | 1 | 110 | Y | Alpha (Y/N) |
| 10 | HH Provider MMIS ID | 111 | 8 | 118 | C | Numeric |

**Editing Logic**

1. For a HH to submit this file on behalf of a CMA, the HH must have an active assignment with the member and must have an active relationship with the CMA as of the file submission date, or the records associated with the CMA in the file will be rejected.
2. Unless otherwise stated, if a record contains values in fields that do not apply to the submitted record type, the system will accept the record but will ignore the values in the fields that don't apply to the record type
    a. Values submitted in the fields below for record types 'S' (Accept Assignment) and 'N' (New Assignment) will be ignored by the system
        1. **Rejection Reason** (field #3)
        2. **Suggested Alternate Assignment** (field #4)
        3. **Rejection Reason Comment** (field #5)
        4. **End Date Reason** (field #7)
        5. **End Date Reason Comment** (field #8)
    b. Values submitted in the fields below for record type 'R' (Reject Assignment) will be ignored by the system
        1. **End Date Reason** (field #7)
        2. **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
        1. **Rejection Reason** (field #3)
        2. **Suggested Alternate Assignment** (field #4)
        3. **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 a 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.

1. When a 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'.
2. When a 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'.
3. 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.

1. 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 <u>MCP Assignment</u> 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 **Rejected Assignment Suggested HH 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 <u>Health Home Assignment</u> file since HH B no longer has an assignment with Angela. Angela will be listed on HH B's <u>Past Assignment Download</u> 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 a HH is rejecting an assignment, **CMA Provider 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 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 a 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.
    1. When a 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'.
    2. When a 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'.
    3. When a HH submits an 'E' record to end a CMA assignment and would also like to end their *active* HH assignment with the member, **End HH Assignment** (field #9) must be populated with a value of 'Y'.
    4. 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 a HH submits a record type of 'E' and **CMA Provider 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 a HH assignment. When a CMA submits an 'E' record type, **End HH Assignment** (field #9) must contain a value 'N'.
e. When a HH is ending an assignment made to the HH the **CMA Provider ID** (field #6) must be blank and the member must have an *active* HH assignment status.
f. When a HH is ending a CMA assignment that the HH made to the CMA, the **CMA Provider ID (**field #6) must be populated with that CMAs Provider ID and the member must have an *active or pending* assignment with that CMA.

5. **Record Type 'S' (Accept Assignment)** is used by HHs to accept a *pending* assignment made to the HH; 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 a HH or used by VFCA CMAs to accept pending assignments made by LGU/SPOAs.
    a. **End HH 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 a HH to accept a *pending* assignment made to the HH by an MCP or DOH, the HH must submit an 'S' record with a value of 'N' in **End HH Assignment (**field #9) and the **CMA Provider ID (**field #6) must be blank.
    d. For a HH to accept a *pending* CMA assignment made by the HH on behalf of that CMA, the HH must submit an 'S' record with the ID of the CMA that the HH is accepting the assignment on behalf of in **CMA Provider 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 **CMA Provider 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:
        1. That have an *active* HH assignment
        2. That have a *pending* HH assignment

3. FFS adult members that are not currently in the system with an assignment
4. 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:
   1. That have an active or pending CMA assignment
   2. 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 **CMA Provider 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 **CMA Provider ID (**field #6).
   1. If the member had an *active* HH assignment, then submitting this file will create a *pending* CMA assignment.
   2. If the member had a *pending* HH assignment, then submitting this file will create an *active* HH assignment and a *pending* CMA assignment.
   3. If a HH submits an 'N' record for a member that is enrolled in an MCP and does not yet have a HH assignment, then the system will reject the record. If a HH would like an MCP enrolled member to be assigned to their HH, then the HH should either:
      1. Refer the member to their Health Home in the system using the referral wizard (this action is only available online), which will create a *pending* referral for the member's MCP that will be included on the MCP's Managed Care Plan Assignment file with the HH's MMIS Provider ID listed in **Rejected Assignment Suggested HH Assignment (**field #78), **OR**
      2. Call the MCP and ask that the MCP assign the MCP enrolled member to the HH.
   4. If a HH submits an 'N' record for a child member that they don't currently have a relationship within 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 **CMA Provider 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 **CMA Provider 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 **CMA Provider 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 **CMA Provider ID (**field #6) with a create date of the date that the file was uploaded.

7. When a HH is acting on behalf of a CMA
   a. The system will validate that the HH uploading the file is appropriately associated with both the member (member has an active or pending assignment with the HH) and the CMA and that the member has the appropriate status with the CMA ID listed in **CMA Provider ID (**field #6) to perform the action.
   b. For example, if HH B submits an 'R' record with CMA C in **CMA Provider 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 a HH or a CMA. If a HH user is uploading the file with record type 'R' and the **CMA Provider ID** (field #6) is blank, any ID submitted in **Suggested Alternate Assignment** (field #4) must be associated with a HH in the system, or the record will be rejected. If a HH user is uploading the file with record type 'R' and the **CMA Provider 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) |
| 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/U/X) |
| 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 | HH MMIS Provider ID | 36 | 8 | 43 | Y | HH/CMA | Numeric |

| Tracking File Segment Records | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Req'd** | **Source** | **Format** |
| 9 | CMA MMIS Provider ID | 44 | 8 | 51 | Y | HH/CMA | Numeric |
| 10 | Direct Biller Indicator | 52 | 1 | 52 | N | HH/CMA | Field no longer used |
| 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/Pend 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 | Previous CIN | 165 | 8 | 172 | N | HH/CMA | AA11111A, Alphanumeric |
| 22 | New CIN | 173 | 8 | 180 | N | HH/CMA | AA11111A, Alphanumeric |

**Editing Logic**

1. The HH listed in **HH MMIS ID** (field #8) must have an active relationship with the CMA listed in **CMA MMIS ID** (field #9) for the entire segment period.
    a. 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)**, HH MMIS ID** (field #8)**,** and **CMA 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 a HH uploads a 'C' record matching the **Member ID** (field #2)**, Begin Date** (field #5)**, Outreach/Enrollment Code** (field #7)**, HH MMIS ID** (field #8) of a *pending* transfer for the HH listed in **HH 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 CMA MMIS ID** (field #9) of a *pending* transfer for the CMA listed in **CMA 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.
   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.
   **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.

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.

g. **Consent Date** (field #15)**:** When newly creating an enrollment segment for a member 21 or older, you must submit the date the member signed consent to enroll (DOH-5055) in the **Consent Date** field on the Billing Support Upload file. If the consent to enroll information isn't recorded on this file and doesn't already exist in the system, then the record will be rejected. When a record is adhering to the criteria below is created for a member 21 or older, the system will create a 'Consent to Enroll' record for the member with the Consent Start Date = date entered into the Consent Date field; Consent End Date= None; Consenter=Member/Self – Individual is 18 years of age or older:
   i. '**Record Type** (field #1) = 'C'
   ii. **Outreach/Enrollment Code** (field #7) = 'E'
   iii. **Referral Code** (field #13) = 'R'

h. **Previous CIN** (field #22) and **New CIN** (field #23): When creating a new segment, a provider can upload a Previous CIN or New CIN via file. The system will check to make sure that the CIN provided is not the same as the Member ID.

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)**, HH MMIS ID** (field #8)**,** and **CMA 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.
      i. 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).
      ii. 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.

iii. For dates of service on or after 10/1/17, if a 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.

d. Consent cannot be modified by using this file and Record Type 'M'. In order to modify a consent, a provider needs to do so via the Consent File.

e. **Previous CIN** (field #22) and **New CIN** (field #23): When modifying a segment, a provider can upload a Previous CIN or New CIN via file. The system will check to make sure that the CIN provided is not the same as the Member ID.

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)**, HH MMIS ID** (field #8)**,** and **CMA MMIS ID** (field #9)**.** All other fields aside from **Record Type** (field #1) will be ignored by the system.
   b. End Health Home Assignment
   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 a HH does not want to accept a *pending* segment, then the HH should work with the CMA to modify or delete the *pending* segment.
8. **Record Type 'P' (Pend Segment)** is used by HHs and CMAs to pend an outreach or enrollment segment in an *active, pending active, 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), **HH MMIS ID** (field #8)**, Pend Start Date** (field #18)**, Pend Reason Code** (field #19)**,** and **Pend Reason Code Comment** (field #20) (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.
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 and Member Program Upload file.

10. The **Adult or Child Services Provided Indicator** (field #11) is only a required field if the MMIS provider ID in **HH MMIS ID** (field #8) is identified in the system as serving both adults and children. If the MMIS provider ID in the **HH 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 a 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.
12. The system will not allow a provider to end date an existing active or pended segment for a member that has an open fair hearing request with the **Program Type = '**HCBS Children', **Aid to Continue =** 'Y', and **Program Type =** 'HCBS Children'. If you have questions about this policy, please contact the HH policy email webform.

## 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**

- Only segments in an *active, closed, pended, pending active, pending closed, or pending pended segment* status can be deleted.
- 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.

- 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.
- 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.

- 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).
  - 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 | HH MMIS Provider ID | 24 | 8 | 31 | C | HH/CMA | Numeric |
| 6 | CMA MMIS Provider 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 |
| 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.*

## MCP Comment File

**Description**

MCPs will use this file to upload into the system information about members in an outreach or enrollment segment. HH/CMA users cannot upload this file. Information submitted by MCPS on this file will be included in the Enrollment Download and My Members Download files; there is no *MCP Comment Download* file. Uploaded information will be included in files for 90 days (or until the **End Date** passes) and should be used by plans to alert HH/CMAs of member needs in real time.

**Format**

| MCP Comment File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Record Type | 1 | 1 | 1 | Alphanumeric (C,M,D) |
| 2 | Member ID | 2 | 8 | 9 | AA11111A, Alphanumeric |
| 3 | MCP Comment Code | 10 | 2 | 11 | Alphanumeric (A1/00) |
| 4 | MCP Comment | 12 | 300 | 311 | Alphanumeric |
| 5 | Effective Date | 312 | 8 | 319 | MMDDYYYY, Numeric |
| 6 | End Date | 320 | 8 | 327 | MMDDYYYY, Numeric |

**Editing Logic**

1. When submitting a create record (**Record Type** = 'C'), the following fields are required
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **MCP Comment Code** (field #3)
    d. ***MCP Comment** (field #4) is only required when **MCP Comment Code** (field #3) = '00'
    **Conditionally Required*
2. When submitting a modify record (**Record Type** = 'M'), the following fields are required
    a. **Record Type** (field #1)
    b. **Member ID** (field #2) *CIN must have existing MCP Comment in the system*
    c. **MCP Comment Code** (field #3) and **Effective Date** (field #5) *must match existing **MCP Comment Code** and **Effective Date** combination in the system*
    d. The system will use the values uploaded in **MCP Comment** (field #4) and **End Date** (field #6) to update the record
3. When submitting a delete record (**Record Type** = 'D'), the following fields are required
    a. **Record Type** (field #1)
    b. **Member ID** (field #2)
    c. **MCP Comment Code** (field #3) and **Effective Date** (field #5) *must match existing **MCP Comment Code** and **Effective Date** combination in the system*

d. Once a delete record is processed the status of the comment will be updated to *canceled*, the record will no longer be included in the download files, and it will only be visible by the MCP that submitted it through the member's personal page.

4. **Effective Date** (field # 5) is a system generated date and equals the date the comment was created in the system (either in through the Member's Page online or when the MCP Comment File was processed into the system).
5. **End Date** (field #8) is calculated by the system and equals **Effective Date** (field # 5) + 90 days. The MCP can upload a different value in the **End Date** (field #8) on either 'C' or 'M' record types, but the submitted value must be less than the system calculated end date, or it will be rejected.
6. Comments can overlap, but a member cannot have more than one unique comment code/effective date combination in the system at a time:
    a. A member has the following comment code in the system (**MCP Comment Code** (field #3) = 00, **Effective Date** (field #5) = 10/02/23) as of 10/15/23
    b. On 10/235/23, the provider
        i. **CAN SUBMIT**
            1. **MCP Comment Code** (field #3) = A1, **Effective Date** (field #5) = 10/14/23, *AND*
            2. **MCP Comment Code** (field #3) = 00, **Effective Date** (field #5) = 10/03/23,
        ii. **BUT CANNOT SUBMIT**
            1. **MCP Comment Code** (field #3) = 00, **Effective Date** (field #5) = 10/02/23
7. A complete list of **MCP Comment Code** values and descriptions of when to use them will be released soon.
    a. 00: MCP Comment Only
    b. A1: Disengaged from Services

## MCP Error Comment File

**Description**

This file is created upon validating or processing an MCP Comment File upload when at least one record was rejected by the system.

**Format**

| MCP Error Comment File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Line Number | 1 | 6 | 6 | Numeric |
| 2 | Record Type | 7 | 1 | 7 | Alphanumeric |
| 3 | Member ID | 8 | 8 | 15 | AA11111A, Alphanumeric |
| 4 | Effective Date | 16 | 8 | 23 | Date as MMDDYYYY |
| 5 | Error Reason Code 1 | 24 | 3 | 26 | Numeric |
| 6 | Error Reason Code 2 | 27 | 3 | 29 | Numeric |
| 7 | Error Reason Code 3 | 30 | 3 | 32 | Numeric |
| 8 | Error Reason Code 4 | 33 | 3 | 35 | Numeric |
| 9 | Error Reason Code 5 | 36 | 3 | 38 | Numeric |
| 10 | Error Description 1 | 39 | 70 | 108 | Alphanumeric |
| 11 | Error Description 2 | 109 | 70 | 178 | Alphanumeric |
| 12 | Error Description 3 | 179 | 70 | 248 | Alphanumeric |
| 13 | Error Description 4 | 249 | 70 | 318 | Alphanumeric |
| 14 | Error Description 5 | 319 | 70 | 388 | Alphanumeric |

**Editing Logic**

| Name | Validation Criteria | Message Text | Error Code |
|---|---|---|---|
| Invalid Record Type | Record Type is required.<br>Also, if the file has a record type that is not A,M, or D then an error message will appear. | Invalid Rec Type Must be C or M or D | 01 |
| Record does not exist | If the file contains M or D for the record type and no record exists for the modify or cancel operation, then an error message will appear | Original record does not exist for Modify or Delete operation | 02 |
| Record contains too few or too many fields | If a record in the file contains too few or too many fields, an error message will appear | Invalid Record Length | 03 |
| Invalid Member ID Format | If the file has CIN that does not meet the format requirements of 'AA11111A' then an error message will appear | Invalid Member ID Format Must be AA11111A | 04 |
| Invalid Member ID | CIN is required.<br>Also, if the file has CIN that is not known to the HHTS system then an error message will appear | Invalid Member ID | 05 |
| Invalid Date Format | If the file contains a date that is not in the correct format (must be 'MMDDYYYY') then an error message will appear This message is applicable to all dates in the upload file. | Invalid Date Format Must be MMDDYYYY | 06 |
| No Active MCP Assignment | If the file has CIN that has no Active MCP Assignment | Member does not have Active MCP Assignment | 07 |
| Invalid MCP Comment Code | If a record in the file contains in the MCP Comment Code field a value other than 00, A1 | Invalid MCP Comment Code | 08 |
| Record with Effective Date already exists | If the file contains a MCP comment record that matches with an existing record with same Comment code and same Effective Date for the uploading provider | Record with Effective Date already exists | 09 |
| MCP Comment Code is required | If a record in the file has MCP Comment Code field blank | MCP Comment Code is required | 10 |
| End Date Beyond Limit | If a record in the file has End Date populated but it is beyond <Configurable Days? From the date the file is processed. | End Date should be within <Configurable Days> limit. | 11 |
| End Date Before Effective Date | If a record in the file has End Date populated but it is prior to the date the file is processed. | End Date cannot be prior to Effective Date | 12 |

# 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 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.

Additionally, the Enrollment Download File can be filtered by a Latest Modified Date filter on the screen that allows the provider to narrow their search to a specific timeframe that the segment was last updated. For example, if the user performs a search using the Last Transaction Date filter where From Date = 11/02/2022 and To Date = 12/04/2022, the Enrollment Download file will include all instances that have Last Transaction Dates between and including 11/02/2022 to 12/04/2022.

**Format**

| Enrollment Download File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | Previous CIN | 9 | 8 | 16 | AA11111A, Alphanumeric |
| 3 | New CIN | 17 | 8 | 24 | AA11111A, Alphanumeric |
| 4 | First Name | 25 | 30 | 54 | Alpha |
| 5 | Last Name | 55 | 30 | 84 | Alpha |
| 6 | Gender | 85 | 1 | 85 | Alpha (M,F,U,X) |
| 7 | DOB | 86 | 8 | 93 | MMDDYYYY, Numeric |
| 8 | Date of Death | 94 | 8 | 101 | MMDDYYYY, Numeric |
| 9 | Medicaid Eligibility End Date | 102 | 8 | 109 | MMDDYYYY, Numeric |
| 10 | Member Fiscal County Code | 110 | 2 | 111 | Alphanumeric |
| 11 | Member Fiscal County Code Description | 112 | 40 | 151 | Alphanumeric |
| 12 | Begin Date | 152 | 8 | 159 | MMDDYYYY, Numeric |
| 13 | End Date | 160 | 8 | 167 | MMDDYYYY, Numeric |
| 14 | Outreach/Enrollment Code | 168 | 1 | 168 | |
| 15 | Adult or Child Services Provided Indicator | 169 | 1 | 169 | Alpha (A/C) |
| 16 | Status | 170 | 20 | 189 | Alpha (Active, Closed, Hiatus, Pended, Canceled, Pending Active, Pending Closed, Pending Pended, and Pending Canceled) |
| 17 | Referral Code | 190 | 1 | 190 | Alpha (R/Blank) |
| 18 | Segment End Date Reason Code | 191 | 2 | 192 | Numeric |
| 19 | Segment End Date Description | 193 | 40 | 232 | Alpha |
| 20 | Segment End Date Reason Category Code | 233 | 2 | 234 | Alphanumeric |
| 21 | Segment End Date Reason Category Description | 235 | 40 | 274 | Alphanumeric |
| 22 | Segment Pend Reason Code | 275 | 2 | 276 | Alphanumeric |
| 23 | Segment Pend Reason Description | 277 | 40 | 316 | Alpha |

| Enrollment Download File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 24 | Pend Reason or Segment End Date Reason Comment | 317 | 300 | 616 | Alphanumeric |
| 25 | Insert Date | 617 | 8 | 624 | MMDDYYYY, Numeric |
| 26 | Latest Modified Date | 625 | 8 | 632 | MMDDYYYY, Numeric |
| 27 | HH MMIS Provider ID | 633 | 8 | 640 | Numeric |
| 28 | HH Name | 641 | 40 | 680 | Alphanumeric |
| 29 | CMA MMIS Provider ID | 681 | 8 | 688 | Numeric |
| 30 | CMA Name | 689 | 40 | 728 | Alphanumeric |
| 31 | Current MCP MMIS Provider ID | 729 | 8 | 768 | Numeric |
| 32 | Current MCP Name | 769 | 40 | 776 | Alphanumeric |
| 33 | OMH HH+ Eligible | 777 | 1 | 777 | Alpha (Y/N) |
| 34 | AOT Member | 778 | 1 | 778 | Alpha (Y/N) |
| 35 | ACT Member | 779 | 1 | 779 | Alpha (Y/N) |
| 36 | Impacted Adult Home Member | 780 | 1 | 780 | Alpha (Y/N) |
| 37 | EI Member | 781 | 1 | 781 | Alpha (Y/N) |
| 38 | HFW Member | 782 | 1 | 782 | Alpha (Y/N) |
| 39 | Assessed by CYES | 783 | 1 | 783 | Alpha (Y/N) |
| 40 | HARP | 784 | 1 | 784 | Alpha (Y/N/E) If eligible Y, if enrolled E, if neither N |
| 41 | Child HCBS Flag Based on R/E Code | 785 | 1 | 785 | Alpha (Y/N) |
| 42 | Most Recent POC Signature Date | 786 | 8 | 793 | MMDDYYYY, Numeric |
| 43 | Most Recently Billed HH Rate Code | 794 | 4 | 797 | Numeric |
| 44 | Most Recently Billed DOS | 798 | 8 | 805 | MMDDYYYY, Numeric |
| 45 | Expanded HH+ Population Indicator | 806 | 1 | 806 | The Expanded HH+ population field captures information regarding if a member is part of the Expanded HH+ population |
| 46 | Expanded HH+ Population Description | 807 | 100 | 906 | Alphanumeric |
| 47 | Transfer Initiator MMIS Provider ID | 907 | 8 | 914 | Numeric |
| 48 | Transfer Initiator Organization Name | 915 | 40 | 954 | Alphanumeric |
| 49 | Transfer Receiver MMIS Provider ID | 955 | 8 | 962 | Numeric |
| 50 | Transfer Receiver Organization Name | 963 | 40 | 1002 | Alpha |
| 51 | Transfer Create Date | 1003 | 8 | 1010 | Date |
| 52 | Transfer Effective Date | 1011 | 8 | 1018 | MMDDYYYY, Numeric |
| 53 | Transfer Reason | 1019 | 75 | 1093 | Numeric |
| 54 | Transfer Comment | 1094 | 300 | 1393 | Alphanumeric |
| 55 | MCP Type | 1394 | 15 | 1408 | Alpha |
| 56 | MCP Comment Code | 1409 | 2 | 1410 | Alphanumeric |
| 57 | MCP Comment | 1411 | 300 | 1710 | Alphanumeric |
| 58 | MCP Comment Effective Date | 1711 | 8 | 1718 | MMDDYYYY, Numeric |
| 59 | Appropriateness Category | 1719 | 2 | 1720 | Alphanumeric |
| 60 | Appropriateness Detail | 1721 | 250 | 1970 | Alphanumeric |
| 61 | Appropriateness Start Date | 1971 | 8 | 1978 | MMDDYYYY, Numeric |
| 62 | Current Fair Hearing | 1979 | 1 | 1979 | Alpha |
| 63 | Fair Hearing Number | 1980 | 8 | 1987 | Alphanumeric |
| 64 | Fair Hearing Start Date | 1988 | 8 | 1995 | MMDDYYYY, Numeric |
| 65 | Fair Hearing End Date | 1996 | 8 | 2003 | MMDDYYYY, Numeric |
| 66 | Fair Hearing Notice Type | 2004 | 40 | 2043 | Alphanumeric |
| 67 | Fair Hearing Notice Type Start Date | 2044 | 8 | 2051 | MMDDYYYY, Numeric |

| Enrollment Download File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 68 | Date Fair Hearing Scheduled | 2052 | 8 | 2059 | MMDDYYYY, Numeric |
| 69 | Trans District Code | 2060 | 2 | 2061 | Alphanumeric |
| 70 | Trans District Description | 2062 | 60 | 2121 | 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.

- **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.
    - **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D
    - **Outreach/Enrollment Code:** E, **Begin Date**: 3/1/14, **End Date**: [blank], HH A, CMA D
- **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.
    - **Outreach/Enrollment Code:** O, **Begin Date**: 3/1/14, **End Date**: 3/31/14, HH B, CMA C
    - **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
    - **Outreach/Enrollment Code:** E, **Begin Date**: 9/1/14, **End Date**: [blank], HH B, CMA D
- **MCP A**
    - Juanita **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D
    - Juanita **Outreach/Enrollment Code:** E, **Begin Date**: 3/1/14, **End Date**: [blank], HH A, CMA D
    - Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
- **HH B**
    - Juanita **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D
    - Paul **Outreach/Enrollment Code:** O, **Begin Date**: 3/1/14, **End Date**: 3/31/14, HH B, CMA C
    - Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
    - Paul **Outreach/Enrollment Code:** E, **Begin Date**: 9/1/14, **End Date**: [blank], HH B, CMA D
- **CMA C**
    - Paul **Outreach/Enrollment Code:** O, **Begin Date**: 3/1/14, **End Date**: 3/31/14, HH B, CMA C
    - Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
- **CMA D**
    - Juanita **Outreach/Enrollment Code:** O, **Begin Date**: 1/1/14, **End Date**: 2/28/14, HH B, CMA D
    - Juanita **Outreach/Enrollment Code:** E, **Begin Date**: 3/1/14, **End Date**: [blank], HH A, CMA D
    - Paul **Outreach/Enrollment Code:** E, **Begin Date**: 9/1/14, **End Date**: [blank], HH B, CMA D
- **MCP F**
    - Paul **Outreach/Enrollment Code:** E, **Begin Date**: 4/1/14, **End Date**:8/31/15, HH B, CMA C
    - 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 #9).

- **Child HCBS Flag Based on R/E Code** (field #41) This value will be populated based on RE codes K1 relating to Children's HCBS waiver codes. If the member has an active K1 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'.

**9. Transfer Information (**field #47-54**)** will be populated for providers' currently enrolled active or pending active members that also have a *pending* transfer record. This field will also house CYES-HH and HH-CYES transfers. 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 47-54 will be populated on the member's active enrollment record with the member's pending transfer information.

1) 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 47-54 will be blank).
2) Please refer to the transfer guide found under the Health Home Tracking System tab of the MAPP HHTS portion of the HH website. for more specific information.

**10. Previous CIN** (field #2**) and New CIN** (field #3**)** are only visible to the HH and CMA that the member has a segment with when this information is supplied by the provider.

11. **The HH+ Expanded Population Indicator** (field #44) and the **Description of the HH+ Expanded Population** (field #45) are from the Billing Support Download File.

12. MCP Comment fields (# 56 – 58) will be blank unless the member is currently enrolled in an MCP and that MCP recently uploaded comments about the member into the tracking system.

13. Appropriateness information (fields 59-61) are required for new segments beginning on or after 2/1/2024 and describe why a member is appropriate for the Health Home program. Please see *Appendix Q: Appropriateness Criteria* the list of codes and code descriptions.

14 Fields # 62-68 will be populated using the following business logic:

If the most recent Fair Hearing Notice Type is 'disposition' AND the associated Notice Type End Date is 89 days or less of the file download, the record should be included in the file.

If the most recent Fair Hearing Notice Type is 'disposition' AND the associated Notice Type End Date is 90 days or more prior to file download, the FH fields should be blank

If Fair Hearing Notice Type is not null and does not equal 'disposition', display the FH information with the most recent Notice Type Start Date

## My Members Download

**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.

When an MCP user interacts with the ***My Members*** screen and requests a My Members Download file, the file will contain members that are currently enrolled in the user's plan that meet the criteria selected on the screen. When a non-MCP user selects an MCP ID on this screen requests a My Members Download file, the file will contain members that are currently enrolled in that plan. Prior to release 4.0, this file contained any member record that overlapped with a member's enrollment in the selected plan.

**Format**

| My Members Download | | | | | | |
|---|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Always Populated(Y/N)** | **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 | Gender | 77 | 1 | 77 | Y | Alpha (M,F, U,X) |
| 6 | Member Age | 78 | 3 | 80 | Y | Numeric |
| 7 | Date of Death | 81 | 8 | 88 | N | MMDDYYYY, Numeric |
| 8 | Medicaid Eligibility End Date | 89 | 8 | 96 | N | MMDDYYYY, Numeric |
| 9 | Address 1 | 97 | 40 | 136 | Y | Alphanumeric |
| 10 | Address 2 | 137 | 40 | 176 | N | Alphanumeric |
| 11 | City | 177 | 40 | 216 | Y | Alpha |
| 12 | State | 217 | 2 | 218 | Y | Alpha |
| 13 | Zip | 219 | 9 | 227 | Y | Numeric |
| 14 | Phone | 228 | 10 | 237 | Y | Numeric |
| 15 | County of Fiscal Responsibility Code | 238 | 2 | 239 | Y | Numeric |
| 16 | County of Fiscal Responsibility Description | 240 | 30 | 269 | Y | Alpha |
| 17 | Language | 270 | 40 | 309 | N | Alpha |
| 18 | HH Name | 310 | 40 | 349 | N | Alphanumeric |
| 19 | HH MMIS Provider ID | 350 | 8 | 357 | N | Numeric |
| 20 | CMA Name | 358 | 40 | 397 | N | Alphanumeric |
| 21 | CMA MMIS Provider ID | 398 | 8 | 405 | N | Numeric |
| 22 | MCP Name | 406 | 40 | 445 | N | Alphanumeric |
| 23 | MCP MMIS Provider ID | 446 | 8 | 453 | N | Numeric |
| 24 | Segment Type | 454 | 1 | 454 | N | Alpha (O,E,Blank) |

| My Members Download | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Always Populated(Y/N) | Format |
| 25 | Segment Status | 455 | 20 | 474 | N | Alpha (Active, Closed, Hiatus, Pended, Canceled, Pending Active, Pending Closed, Pending Pended, Pending Canceled) |
| 26 | Assignment Created Date | 475 | 8 | 482 | N | MMDDYYYY, Numeric |
| 27 | Consent Date | 483 | 8 | 490 | N | MMDDYYYY, Numeric |
| 28 | Begin Date | 491 | 8 | 498 | N | MMDDYYYY, Numeric |
| 29 | End Date | 499 | 8 | 506 | N | MMDDYYYY, Numeric |
| 30 | End Date Reason | 507 | 60 | 566 | N | Alphanumeric |
| 31 | Segment End Date Reason Category Description | 567 | 40 | 606 | N | Alphanumeric |
| 32 | Pend Reason Code Description | 607 | 40 | 646 | N | Alphanumeric |
| 33 | Most Recent HH Rate Code | 647 | 4 | 650 | N | Numeric |
| 34 | Most Recent HH Service Date | 651 | 8 | 658 | N | MMDDYYYY, Numeric |
| 35 | MCP Type | 659 | 10 | 668 | N | Alphanumeric |
| 36 | OMH HH+ Eligible | 669 | 1 | 669 | Y | Alpha (Y,N) |
| 37 | AOT Member | 670 | 1 | 670 | Y | Alpha (Y,N) |
| 38 | ACT Member | 671 | 1 | 671 | Y | Alpha (Y,N) |
| 39 | EI Member | 672 | 1 | 672 | Y | Alpha (Y,N) |
| 40 | C-YES Member | 673 | 1 | 673 | Y | Alpha (Y,N) |
| 41 | HFW Member | 674 | 1 | 674 | Y | Alpha (Y,N) |
| 42 | HARP | 675 | 2 | 676 | N | Alpha (Blank, EL, or EN) |
| 43 | Impacted Adult Home Member | 677 | 1 | 677 | Y | Alpha (Y,N) |
| 44 | Active K1 Code | 678 | 1 | 678 | Y | Alpha (Y,N) |
| 45 | Recent K1 Code | 679 | 1 | 679 | Y | Alpha (Y,N) |
| 46 | Recent Child HCBS Services | 680 | 1 | 680 | Y | Alpha (Y,N) |
| 47 | Recent Child HCBS Eligibility | 681 | 1 | 681 | Y | Alpha (Y,N) |
| 48 | Record Last Updated | 682 | 8 | 689 | Y | MMDDYYYY, Numeric |
| 49 | Most Recent POC Signature Date | 690 | 8 | 697 | N | MMDDYYYY, Numeric (from POC Upload File) |
| 50 | Expanded HH+ Population Indicator | 698 | 1 | 698 | Y | Alpha (A-X) |
| 51 | Expanded HH+ Population Description | 699 | 100 | 798 | C | Alpha |
| 52 | MCP Comment Code | 799 | 2 | 800 | N | Alpha |
| 53 | MCP Comment | 801 | 300 | 1100 | C | Alpha |
| 54 | MCP Comment Effective Date | 1101 | 8 | 1108 | C | Date |
| 55 | Current Fair Hearing | 1109 | 1 | 1109 | N | Alpha (Y/N) |
| 56 | Fair Hearing Program Type | 1110 | 15 | 1124 | C | Alphanumeric |
| 57 | Fair Hearing Number | 1125 | 8 | 1132 | C | Alphanumeric |
| 58 | Fair Hearing Start Date | 1133 | 8 | 1140 | C | Date |
| 59 | Fair Hearing End Date | 1141 | 8 | 1148 | C | Date |
| 60 | Fair Hearing Notice Type | 1149 | 40 | 1188 | C | Alphanumeric |
| 61 | Fair Hearing Notice Type Start Date | 1189 | 8 | 1196 | C | Date |

| My Members Download | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Always Populated(Y/N) | Format |
| 62 | Date Fair Hearing Scheduled | 1197 | 8 | 1204 | C | Date |
| 63 | Medically Fragile | 1205 | 1 | 1205 | C | Alpha (Y/N) |
| 64 | Consenter Type | 1206 | 150 | 1355 | C | Alphanumeric |
| 65 | Trans District Code | 1356 | 2 | 1357 | Y | Value from MDW |
| 66 | Trans District Description | 1358 | 60 | 1417 | Y | Value from MDW |

**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).

| 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 | |
| Gender | Will always be populated | |
| Member Age | Will be calculated based on the number of years from the Date of Birth to Today's Date. | |
| Date of Death | Will be populated if the member has a date of death in MDW | |
| Medicaid Eligibility End Date | *See note below on **Medicaid Eligibility End Date** | |
| Address 1 | Will always be populated | |
| Address 2 | Will only 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 only 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 only be populated if language information has been submitted into the system by an MCP user | |
| HH Name | If a member has a reportable HH assignment or a segment (excluding segments in the canceled status), then these fields will be populated with health home name and HH MMIS Provider ID. Otherwise, these fields will be blank. | |
| HH MMIS Provider ID | | |
| CMA Name | If a member has a reportable HH assignment or a segment (excluding segments in the canceled status), then these fields will be populated with health home name and HH MMIS Provider ID. Otherwise, these fields will be blank. | |
| CMA MMIS Provider ID | | |
| MCP Name | Will display plan information for members enrolled in an MCP. For fee for service members, these fields will be blank. | |
| MCP MMIS Provider ID | | |
| Segment Type | Will always be populated | Will always be blank |
| Segment Status | Will always be populated | Will always be blank |

| My Members Fields | Segment Record | Assignment Record |
|---|---|---|
| Assignment Created Date | Will always be blank | Will always be populated with the date that the member's most recent assignment was created |
| Consent Date | Will always be populated for enrollment segments. Will be blank for outreach segments | Will always be blank |
| Begin Date | Will always be populated | Will always be blank |
| End Date | Will be populated if the segment is closed, otherwise it will be blank | Will always be blank |
| End Date Reason | Will be populated if the segment is closed, otherwise it will be blank | Will always be blank |
| Segment End Date Reason Category Description | Will be populated if the segment is closed, otherwise it will be blank | Will always be blank |
| Pend Reason Code Description | Will only be populated if the segment is pended, otherwise it will be blank | Will always be blank |
| Most Recent HH Rate Code | Will be populated if the member has a claim/encounter with a DOS within the last 6 months, otherwise this field will be blank. | |
| Most Recent HH Service Date | Will be populated with DOS of most recent claim, if **Most Recent HH Rate Code** is populated. Otherwise, this field will be blank. | |
| MCP Type | The provider type of the MCP (field#21) as stored in Provider Management on the MCP record. For an FFS member, this field will be blank. | |
| OMH HH+ Eligible | Will always be populated | |
| AOT Member | Will always be populated | |
| ACT Member | Will always be populated | |
| EI Member | Will always be populated | |
| C-YES Member | Will always be populated | |
| HFW Member | Will always be populated | |
| HARP | Will always be populated | |
| Impacted Adult Home Member | Will always be populated | |
| Active K1 Code | Will always be populated | |
| Recent K1 Code | Will always be populated | |
| Recent Child HCBS Services | Will always be populated | |
| Recent Child HCBS Eligibility | Will always be populated | |
| Record Last Updated | Will always be populated | |
| Most Recent POC Signature Date | Will be populated if there is a plan of care corresponding to the segment uploaded on the POC Upload File. | Will be blank |
| Expanded HH+ Population Indicator | Will always be populated if member has been recently flagged on the BSU as HH+ | |
| Expanded HH+ Population Description | Will always be populated if member has been recently flagged on the BSU as HH+ | |
| MCP Comment Code | Will be populated if a member's current MCP recently submitted a comment, otherwise these fields will be blank. Will always be blank for fee for service members. | |
| MCP Comment | | |
| MCP Comment Effective Date | | |
| Current Fair Hearing | For the Fair Hearing related fields, the following business logic will determine the population of the fields:<br>• If the most recent Fair Hearing Notice Type is 'disposition' AND the associated Notice Type End Date is 89 days or less of the file download, the record should be included in the file. | |
| Fair Hearing Program Type | | |
| Fair Hearing Number | | |
| Fair Hearing Start Date | | |
| Fair Hearing End Date | | |
| Fair Hearing Notice Type | | |

| My Members Fields | Segment Record | Assignment Record |
|---|---|---|
| Fair Hearing Notice Type Start Date | • If the most recent Fair Hearing Notice Type is 'disposition' AND the associated Notice Type End Date is 90 days or more prior to file download, the FH fields should be blank<br>• If Fair Hearing Notice Type is not null and does not equal 'disposition', display the FH information with the most recent Notice Type Start Date<br>• If member has more than 1 active fair hearing, these fields will be populated with information associated with the member's most recently updated fair hearing notice type. | |
| Date Fair Hearing Scheduled | | |
| Medically Fragile | Will always be populated (if applicable) | |
| Consenter Type | Will always be populated (if applicable) | |
| Trans District Code | Will always be populated (if applicable) | |
| Trans District Description | Will always be populated (if applicable) | |

1) 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 #8).
2) MCP Comment fields (# 53 – 55) will be blank unless the member is currently enrolled in an MCP and that MCP recently uploaded comments about the member into the tracking system.

## Manage Assignments Download

**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 | | | | | | |
|---|---|---|---|---|---|---|
| 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 |

| Manage Assignments Download | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos. | Length | End Pos. | Required (Y/N/C-conditional) | Format |
| 11 | Other | 202 | 60 | 261 | C | Alpha |

## CIN Search Download

**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 | | | | | | |
|---|---|---|---|---|---|---|
| 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/U/X) |
| 4 | Medicaid Effective Date | 18 | 8 | 25 | C | MMDDYYYY, Numeric |
| 5 | Medicaid Eligibility 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 | MCP MMIS Provider ID | 76 | 8 | 83 | C | Numeric |
| 9 | MCP Name | 84 | 40 | 123 | C | Alphanumeric |
| 10 | MCP Enrollment Date | 124 | 8 | 131 | C | MMDDYYYY, Numeric |
| 11 | MCP Assignment Status | 132 | 40 | 171 | C | Alpha |
| 12 | Assigned HH MMIS Provider ID | 172 | 8 | 179 | C | Numeric |
| 13 | Assigned HH Name | 180 | 40 | 219 | C | Alphanumeric |
| 14 | Assigned HH Assignment Status | 220 | 40 | 259 | C | Alpha |
| 15 | Enrolled HH MMIS Provider ID | 260 | 8 | 267 | C | Numeric |
| 16 | Enrolled HH Name | 268 | 40 | 307 | C | Alphanumeric |
| 17 | Assigned CMA MMIS Provider ID | 308 | 8 | 315 | C | Numeric |
| 18 | Assigned CMA Name | 316 | 40 | 355 | C | Alphanumeric |
| 19 | Assigned CMA Assignment Status | 356 | 40 | 395 | C | Alpha |
| 20 | Enrolled CMA MMIS Provider ID | 396 | 8 | 403 | C | Numeric |
| 21 | Enrolled CMA Name | 404 | 40 | 443 | C | Alphanumeric |
| 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 |

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

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

| CIN Search Download | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos. | Length | End Pos. | Required (Y/N/C-conditional) | Format |
| 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 | MMDDYYYY, Numeric |
| 109 | Pending Transfer Effective Date | 2303 | 8 | 2310 | C | MMDDYYYY, Numeric |
| 110 | Pending Transfer Reason | 2311 | 75 | 2385 | C | Alpha |
| 111 | Pending Transfer Comment | 2386 | 300 | 2685 | C | Alphanumeric |
| 112 | Medicaid Recipient Exemption Code 6 to 16 | 2686 | 32 | 2717 | C | Alphanumeric (space deliminated) |
| 113 | ACT Member | 2718 | 1 | 2718 | C | Alpha (Y/N) |
| 114 | Medicaid Recipient Exemption Begin Date RE 1 | 2719 | 8 | 2726 | C | MMDDYYYY, Numeric |
| 115 | Medicaid Recipient Exemption End Date RE 1 | 2727 | 8 | 2734 | C | MMDDYYYY, Numeric |
| 116 | Medicaid Recipient Exemption Begin Date RE 2 | 2735 | 8 | 2742 | C | MMDDYYYY, Numeric |
| 117 | Medicaid Recipient Exemption End Date RE 2 | 2743 | 8 | 2750 | C | MMDDYYYY, Numeric |
| 118 | Medicaid Recipient Exemption Begin Date RE 3 | 2751 | 8 | 2758 | C | MMDDYYYY, Numeric |
| 119 | Medicaid Recipient Exemption End Date RE 3 | 2759 | 8 | 2766 | C | MMDDYYYY, Numeric |
| 120 | Medicaid Recipient Exemption Begin Date RE 4 | 2767 | 8 | 2774 | C | MMDDYYYY, Numeric |
| 121 | Medicaid Recipient Exemption End Date RE 4 | 2775 | 8 | 2782 | C | MMDDYYYY, Numeric |
| 122 | Medicaid Recipient Exemption Begin Date RE 5 | 2783 | 8 | 2790 | C | MMDDYYYY, Numeric |
| 123 | Medicaid Recipient Exemption End Date RE 5 | 2791 | 8 | 2798 | C | MMDDYYYY, Numeric |
| 124 | CYES Member | 2799 | 1 | 2799 | C | Alpha (Y/N) |
| 125 | OMH HH+ Eligible | 2800 | 1 | 2800 | C | Alpha (Y/N) |
| 126 | AOT Member | 2801 | 1 | 2801 | Y | Alpha (Y/N) |
| 127 | Impacted Adult Home Member | 2802 | 1 | 2802 | Y | Alpha (Y/N) |
| 128 | EI Member | 2803 | 1 | 2803 | C | Alpha (Y/N) |
| 129 | HFW Member | 2804 | 1 | 2804 | C | Alpha (Y/N) |
| 130 | MCP Type | 2805 | 15 | 2819 | C | Alphanumeric |
| 131 | DOD | 2820 | 8 | 2827 | C | MMDDYYYY, Numeric |
| 132 | Trans District Code | 2828 | 2 | 2829 | From MDW | Trans District Code |

| CIN Search Download | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos. | Length | End Pos. | Required (Y/N/C-conditional) | Format |
| 133 | Trans District Description | 2830 | 60 | 2889 | From MDW | Trans District Description |

**Editing Logic**

1. **Medicaid Recipient Exemption Code Fields** (field #s 84 – 94, 114-123) The fields show a member's recipient exemption codes and descriptions for the first 5 most recent active RE codes based on the RE code's begin date. An active RE code is defined as an RE code that either has no end date or has end date is in the future. Begin and End dates for these RE codes are captured in fields #114-123.

2. **Medicaid Recipient Exemption Code 6 to 16** (field # 112): This field contains any additional active RE codes, up to 16. An active RE code is defined as an RE code that either has no end date or has end date is in the future. Data in this field will include RE code only and be space deliminated.

3. **CYES Member** (field 124) - Will be populated with 'Y' if the member's most recent HCBS assessment was completed by the Independent Entity as part of the C-YES program. Others, this field will be populated with 'N'.

4. **OMH HH+ Eligible** (field 125) - Will be populated with 'Y' if the member is currently flagged as OMH HH+ eligible, per an OMH data feed that scrubs claims and encounters to identify members that are potentially OMH HH+ eligible.

## Assessment Download

**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. It also contains initial appropriateness, yearly appropriateness, and CEST outcome information submitted to the system by HH/CMA. MCPs can see this information for any member associated with their plan at the time the assessment was signed and finalized (for HCBS and CANS) and as of the record's start date for IA/YA/CEST. 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 and any IA/YA/CEST start date that overlaps with their enrollment segment with the member.

**Format**

| Assessment Download | | | | | |
|---|---|---|---|---|---|
| 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 |

| Assessment Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 4 | Assessment Type | 69 | 1 | 69 | Alpha (**H**CBS/**C**ANs/**E**ligibility/**A**ppropriateness) |
| 5 | Assessment Outcome | 70 | 1 | 70 | Alpha (C/N/H/M/L/I/S/E/T/P/N) |
| 6 | Finalized Date | 71 | 8 | 78 | MMDDYYYY, Numeric |
| 7 | Assessor Organization Name | 79 | 40 | 118 | Alpha |
| 8 | Assessor Organization MMIS ID | 119 | 8 | 126 | Numeric |
| 9 | HH Name | 127 | 40 | 166 | Alphanumeric |
| 10 | HH MMIS Provider ID | 167 | 8 | 174 | Numeric |
| 11 | Target Population | 175 | 1 | 175 | Numeric (0/1/2/3) |
| 12 | Most Recent Signed and Finalized Date for CANS or HCBS | 176 | 1 | 176 | Alpha (Y/Blank) |
| 13 | Primary Diagnosis | 177 | 2 | 178 | Numeric |
| 14 | Re-Transmission Indicator | 179 | 1 | 179 | Alpha (Y/Blank) |
| 15 | Re-Transmission Date | 180 | 8 | 187 | MMDDYYYY, Numeric |
| 16 | Type of Override | 188 | 1 | 188 | Numeric (0/1/Blank) |
| 17 | Continuation of Services | 189 | 1 | 189 | Numeric (0/1/2/Blank) |
| 18 | Override Decision | 190 | 1 | 190 | Numeric (0/1/Blank) |
| 19 | Date of Override Decision | 191 | 8 | 198 | MMDDYYYY, Numeric |
| 20 | Override Signature Date | 199 | 8 | 206 | MMDDYYYY, Numeric |
| 21 | CEST Start Date | 207 | 8 | 214 | MMDDYYYY, Numeric |
| 22 | CEST Create Date | 215 | 8 | 222 | MMDDYYYY, Numeric |
| 23 | CEST End Date | 223 | 8 | 230 | MMDDYYYY, Numeric |
| 24 | Transmitted Date Time | 231 | 16 | 246 | MMDDYYYYHH:MM:SS, Numeric |
| 25 | Received Date Time | 247 | 16 | 262 | MMDDYYYYHH:MM:SS, Numeric |
| 26 | Polled Date Time | 263 | 16 | 278 | MMDDYYYYHH:MM:SS, Numeric |
| 27 | Last Transaction Date | 279 | 16 | 294 | MMDDYYYYHH:MM:SS, Numeric |
| 28 | Appropriateness Create Date | 295 | 8 | 302 | MMDDYYYY, Numeric |
| 29 | Appropriateness Record Status | 303 | 10 | 312 | Alphanumeric |
| 30 | Appropriateness Sequence Number | 313 | 2 | 314 | Alphanumeric |
| 31 | Appropriateness Start Date | 315 | 8 | 322 | MMDDYYYY, Numeric |

| Assessment Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 32 | Appropriateness End Date | 323 | 8 | 330 | MMDDYYYY, Numeric |
| 33 | Appropriateness Category | 331 | 2 | 332 | Numeric |
| 34 | Appropriateness Detail | 333 | 250 | 582 | Alphanumeric |
| 35 | Associated Segment Network Type | 583 | 1 | 583 | Alphanumeric |
| 36 | Reactivation Date | 584 | 8 | 591 | MMDDYYYY, Numeric |
| 37 | Deactivation Date | 592 | 8 | 599 | MMDDYYYY, Numeric |
| 38 | Deactivation Rationale | 600 | 1 | 600 | Alphanumeric |
| 39 | Assessment GUID ID | 601 | 32 | 632 | Alphanumeric |
| 40 | MF Definition UAS | 633 | 1 | 633 | Alphanumeric |
| 41 | MF Definition Description UAS | 634 | 20 | 653 | Alphanumeric |
| 42 | MCCM Eligibility UAS | 654 | 1 | 654 | Alphanumeric |
| 43 | MCCM Eligibility Description UAS | 655 | 20 | 674 | Alphanumeric |
| 44 | HFW Eligibility UAS | 675 | 1 | 675 | Alphanumeric |
| 45 | HFW Eligibility Description UAS | 676 | 20 | 695 | Alphanumeric |

**Editing Logic**

1) Member's identifiable information (field #1-3)
2) **Member ID** (field #1) is populated based on the data that is submitted in the person record in UAS
3) The system uses data populated in **Member ID** (field #2) to pull **Member First Name** (field #2) and **Member Last Name** (field #3) from MDW
4) Fields displaying Assessment Information (fields #4-9, 11)
5) **Assessment Outcome** (field#5) displays the outcome of the Assessment
6) **Target Population** (field #11) is only populated for HCBS assessment records. This is populated based on data submitted in UAS as follows:
   a) 0-SED (Serious Emotional Disturbance
   b) 1- MF (Medically Fragile)
   c) 2- DD-MF (Developmental Disability Medically Fragile)
   d) 3- DD-FC (Developmental Disability Foster Care)
7) **Fields Displaying HH Data** (field #9-10)
8) 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.
9) **Primary Diagnosis** (field #13) is for HCBS is only. This is populated based on data submitted in UAS as follows:
   a) Null=no selection/not applicable
   b) 0=Schizophrenia Spectrum and Other Psychotic Disorders
   c) 1=Bipolar and Related Disorders
   d) 2=Depressive Disorders

e) 3=Anxiety Disorders
f) 4=Obsessive-Compulsive Related Disorders
g) 5=Trauma-and Stressor-Related Disorders
h) 6=Dissociative Disorders
i) 7=Somatic Symptoms and Eating Disorders
j) 8=Disruptive, Impulsive-Control, and Conduct Disorders
k) 9=Personality Disorders
l) 10=Paraphilic Disorders
m) 11=Gender Dysphoria
n) 12=Elimination Disorders
o) 13=Sleep-Wake Disorders
p) 14=Sexual Dysfunctions
q) 15=Medication-Induced Movement Disorders
r) 16=Attention Deficit/Hyperactivity Disorder
s) 17=Tic Disorders

10) Re-Transmission/Override Fields (fields #14-20) are only for HCBS assessments and are not required. They will only be populated when information is provided from the UAS system for these fields.
11) **Re-Transmission Indicator** (field #14) will be set to 'Y' if data is transmitted from UAS, if it isn't then the field will be blank.
12) **Re-Transmission Date** (field #15) will display the latest date that data was re-transmitted.
13) **Type of Override** (field #16) is based on data submitted in UAS as follows:
    a) 0=Fair Hearing
    b) 1=State Review
    c) 2=Blank (no selection)
14) **Continuation of Services** (field #17) is based on data submitted in UAS as follows:
    a) 0=No
    b) 1=Yes
    c) 2=Not Applicable/Not Currently Receiving Services
    d) Blank=No Selection
15) **Override Decision** (field #18) is based on data submitted in UAS as follows:
    a) 0=Denied
    b) 1=Approved
    c) Blank=No Selection
16) **CEST End Date** (field #23) – this field is calculated by the system based on the **CEST Start Date** and the **CEST Outcome:**

| CEST Outcome | Description | CEST End Date calculation logic |
|---|---|---|
| C | Continue enrollment | CEST Start Date + 180 |
| E | End enrollment | CEST Start Date + 60 |
| M | More information needed | CEST Start Date + 60 |

17) If a new **CEST Outcome** is submitted to the system with a **CEST Start Date** that that falls between an existing outcome's **CEST Start Date** and **CEST End Date**, the existing outcome's **CEST End Date** will be updated to equal new outcome's **CEST Start Date** minus one day:
    a) In the system as of 2/1/24:

i) Existing Record: **Assessment Outcome**: 'C'; **CEST Start Date**: 1/1/24; **CEST Submission Date**: 1/5/24 **CEST End Date**: 12/31/2024

b) New CEST outcome 'E' submitted to the system on 5/12/24, resulting records will be:

i) Existing Record - **Assessment Outcome**: 'C'; **CEST Start Date**: 1/1/24; **CEST Submission Date**: 1/5/24 **CEST End Date**: 5/9/24

ii) New Record - **Assessment Outcome**: 'E'; **CEST Start Date**: 5/10/24; **CEST Submission Date**: 5/12/24 **CEST End Date**: 6/9/24

18) Members' appropriateness records were removed from the Consent Download file and added to the Assessment Download file in release 4.8.2. While the Consent Download file only displayed the initial appropriateness submission date and the most recent appropriateness submission for a member in the pre-4.8.2 system, post 4.8.2 implementation the Assessment Download file will display all of a member's appropriateness records submitted to the system (both pre and post 4.8.2 implementation). Please see an example below of how pre-4.8.2 release appropriateness records were displayed in the Consent Download file pre-4.8.2 release and how those same records are displayed in the Assessment Download file post-4.8.2 implementation:

a) Scenario: a member has one segment in the tracking system and submitted three different appropriateness records to the pre-4.8.2 release system:

i) Code 10 on 5/5/25

ii) Code 11 on 6/6/25

iii) Code 12 on 7/7/25

b) Records on Consent Download file pre-release 4.8.2

| Example | Consent File Download Date | Appropriateness Submission Date | Appropriateness Category | Appropriateness Re-Submission Date |
|---|---|---|---|---|
| I | 5/15/2025 | 5/5/2025 | 10 | |
| ii | 6/8/2025 | 5/5/2025 | 11 | 6/6/2025 |
| iii | 7/7/2025 | 5/5/2025 | 12 | 7/7/2025 |

a) Records on Assessment Download file downloaded immediately after release 4.8.2 implementation

| Appropriateness Record Status | Appropriateness Sequence Number | Appropriateness Start Date | Appropriateness End Date | Appropriateness Category |
|---|---|---|---|---|
| Active | 1 | 5/5/2025 | 6/5/2025 | 10 |
| Active | 2 | 6/6/2025 | 7/6/2025 | 11 |
| Active | 3 | 7/7/2025 | If HHSA: null<br>If HHSC: 6/30/2026 | 12 |

19) Please see *Appendix R: Appropriateness Record Supplemental Documents* for descriptions of the supplemental documents posted to the website that further explain when appropriateness records are due to the system (both initial and yearly), how the **Appropriateness End Date** field is populated by the system, and how the **Appropriateness Sequence Number** field is populated by the system. **Associated Segment Network Type**

(field # 35) is populated with the value in the **Adult or Child Services Provided Indicator** field on the Enrollment Download file ('A' or 'C') in the system as of the moment the appropriateness record is created.

a) For the most part, this field will contain the same value as the **Adult or Child Services Provided Indicator** field, unless the system changed the segment's **Adult or Child Services Provided Indicator** value from 'C' to 'A' (because the member aged out of the HHSC program) AND the provider did not end date the segment when the member aged out.

20) The system will calculate the **Appropriateness End Date** field for the appropriateness record being created when an 'S' or 'T' **Record Type** (*create new* and *modify existing* appropriateness respectively) is submitted as follows:
    a) If a member is enrolled in a HHSA program (segment contains a value of 'A' in the **Associated Segment Network Type** field of the Assessment Download file) then the system *will not populate* the **Appropriateness End Date** field and it will be null, as the HHSA program does not require yearly appropriateness.
21) If a member is enrolled in a HHSC program (segment contains a value of 'C' in the **Associated Segment Network Type** field of the Assessment Download file) then the system *will populate* the **Appropriateness End Date** field with the last day of the 12th month (inclusive of the **Appropriateness Start Date** month), at which time a new appropriateness record is required. See *Appendix R: Appropriateness Record Supplemental Documents* for detailed examples of how the **Appropriateness End Date** field is populated. If a newly submitted/modified appropriateness record is submitted for a member that already has an appropriateness record in the system:
    a) The system will ensure that a member's appropriateness records do not overlap.
    b) If the creation of a new appropriateness record falls between the **Appropriateness Start Date** and **Appropriateness End Date** of an existing record for that member, the system will modify the existing record's **Appropriateness End Date** so it equals the day before the new record's **Appropriateness Start Date.**
    c) see *Appendix R: Appropriateness Record Supplemental Documents* for detailed examples.
22) When a member's segment moves to the closed status, the system will look for appropriateness records for that member where the **Appropriateness End Date** is greater than the member's segment end date and will modify that record's **Appropriateness End Date** so it equals the member's segment end date (see *Appendix R: Appropriateness Record Supplemental Documents* for detailed examples),
23) The **Appropriateness Sequence Number** is a numerical, chronological value assigned to each appropriateness record associated with a member's segment.
24) The **Appropriateness Record Status** field will contain a value of active for any appropriateness record submitted for a member, whether that record is still providing coverage for the member's segment or if the appropriateness record has expired and the **Appropriateness End Date** has passed. A value of 'canceled' means that the record was submitted into the system and then deleted by the provider.

## R/E Code Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs. The R/E Code Download will contain the current and historical R/E code details for members that have an association with the provider that is downloading the file at the time of the file download.

**Format**

| RE Code Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | First Name | 9 | 30 | 38 | Alpha |
| 3 | Last Name | 39 | 30 | 68 | Alpha |
| 4 | DOB | 69 | 8 | 76 | MMDDYYYY, Numeric |
| 5 | Medicaid Recipient Exemption Code | 77 | 2 | 78 | Alphanumeric |
| 6 | Medicaid Recipient Exemption Code Description | 79 | 40 | 118 | Alphanumeric |
| 7 | Medicaid Recipient Exemption Code Begin Date | 119 | 8 | 126 | MMDDYYYY, Numeric |
| 8 | Medicaid Recipient Exemption Code End Date | 127 | 8 | 134 | MMDDYYYY, Numeric |

**Editing Logic**

- The file will contain the current and historical R/E code details for current members of the downloading provider that have an active or pending active assignment or segment with the provider.
- Members may show up multiple times on this file. There will be one line for each RE code they have.

## Enrolled Member Details Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs. The Enrolled Members Detail Download File will contain the current and historical details for members that have an active segment with the provider that is downloading the file at the time of the file download.

**Format**

| Enrolled Member Details Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | Member First Name | 9 | 30 | 38 | Alpha |
| 3 | Member Last Name | 39 | 30 | 68 | Alpha |
| 4 | Member DOB | 69 | 8 | 76 | MMDDYYYY, Numeric |
| 5 | Enrollment / Outreach Code | 77 | 1 | 77 | Alpha (O/E) |
| 6 | Assessment Type | 78 | 1 | 78 | Alpha (H for HCBS/C for CANS) |
| 7 | K Code | 79 | 2 | 80 | Alphanumeric |
| 8 | K Code Start Date | 81 | 8 | 88 | MMDDYYYY, Numeric |
| 9 | K Code End Date | 89 | 8 | 96 | MMDDYYYY, Numeric |
| 10 | Current K Code | 97 | 1 | 97 | Alpha (Y/Blank) |
| 11 | CMA Name | 98 | 40 | 137 | Alphanumeric |
| 12 | A1 Start Date | 138 | 8 | 145 | MMDDYYYY, Numeric |
| 13 | A1 End Date | 146 | 8 | 153 | MMDDYYYY, Numeric |
| 14 | HH Name | 154 | 40 | 193 | Alphanumeric |
| 15 | A2 Start Date | 194 | 8 | 201 | MMDDYYYY, Numeric |

| Enrolled Member Details Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 16 | A2 End Date | 202 | 8 | 209 | MMDDYYYY, Numeric |
| 17 | Current MCP Name | 210 | 40 | 249 | Alphanumeric |
| 18 | Current MCP MMIS ID | 250 | 8 | 257 | Numeric |
| 19 | Assessment Outcome | 258 | 1 | 258 | Alpha (C/N/H/M/L) |
| 20 | Finalized Date | 259 | 8 | 266 | MMDDYYYY, Numeric |
| 21 | Most Recent Signed and Finalized Date for CANS or HCBS | 267 | 1 | 267 | Alpha (Y/Blank) |
| 22 | CMA MMIS ID | 268 | 8 | 275 | Numeric |
| 23 | HH MMIS ID | 276 | 8 | 283 | Numeric |
| 24 | EI Member | 284 | 1 | 284 | Alpha (Y/N) |
| 25 | HFW Member | 285 | 1 | 285 | Alpha (Y/N) |
| 26 | CYES Member | 286 | 1 | 286 | Alpha (Y/N) |
| 27 | OMH HH+ Eligible | 287 | 1 | 287 | Alpha (Y/N) |
| 28 | AOT Member | 288 | 1 | 288 | Alpha (Y/N) |
| 29 | ACT Member | 289 | 1 | 289 | Alpha (Y/N) |
| 30 | Impacted Adult Home Member | 290 | 1 | 290 | Alpha (Y/N) |
| 31 | HARP | 291 | 1 | 291 | Alpha (Y/N/E) If eligible Y, if enrolled E, if neither N |

**Editing Logic**

1. There will be one record for each K code and current K codes will be denoted by the **Current K Code Field** (Field #10).
2. There will be one record for each Children's HCBS Eligibility and/or CANS Assessment for the member.
3. Non-applicable columns will be left blank, when the record is for a K code, the assessments related columns will be left blank and vice-versa.
4. **CYES** (field 24) – Will be populated with 'Y' if the member's most recent HCBS assessment was completed by the Independent Entity as part of the C-YES program. Others, this field will be populated with 'N'.
5. **Early Intervention** (field 25) - Will be populated with 'Y' if the is currently flagged as receiving Early Intervention services. Otherwise, this field will be populated with 'N'.
6. **High Fidelity Wraparound** (field 26) - Will be populated with 'Y' if the is currently flagged as receiving High Fidelity Wraparound services. Otherwise, this field will be populated with 'N'.

## HCBS Member Services Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs. This file will contain members that have an active enrollment segment with a provider and either an A) Active K1 RE Code, OR B) An HCBS claim or encounter within the rolling 6 months period, OR C) Is HCBS eligible per HCBS feed from UAS. Each record will list a member and will summarize the types of HCBS services the member received within the past 6 months.

**Format**

| HCBS Member Services Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos. | Length | End Pos. | Format |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | First Name | 9 | 30 | 38 | Alpha |
| 3 | Last Name | 39 | 30 | 68 | Alpha |
| 4 | DOB | 69 | 8 | 76 | MMDDYYYY, Numeric |
| 5 | County of Fiscal Responsibility Code | 77 | 2 | 78 | Numeric |
| 6 | County of Fiscal Responsibility Description | 79 | 40 | 118 | Alphanumeric |
| 7 | K1 Status | 119 | 1 | 119 | Alpha |
| 8 | Child HCBS Eligibility Status | 120 | 1 | 120 | Alpha |
| 9 | HH Name | 121 | 40 | 160 | Alpha |
| 10 | HH MMIS Provider ID | 161 | 8 | 168 | Alpha |
| 11 | CMA Name | 169 | 40 | 208 | Alpha |
| 12 | CMA MMIS Provider ID | 209 | 8 | 216 | Alpha |
| 13 | Recent Child HCBS Service | 217 | 1 | 217 | Alpha |
| 14 | 8023: PLANNED RESPITE - INDIVIDUAL (UP TO 6 HOURS) | 218 | 1 | 218 | Alpha |
| 15 | 8003: CAREGIVER/FAMILY SUPPORTS AND SERVICES | 219 | 1 | 219 | Alpha |
| 16 | 8009: COMMUNITY ADVOCACY AND SUPPORT INDIV | 220 | 1 | 220 | Alpha |
| 17 | 8006: PREVOCATIONAL SERVICES | 221 | 1 | 221 | Alpha |
| 18 | 8024: PLANNED RESPITE - INDIVIDUAL (6-12 HOURS) | 222 | 1 | 222 | Alpha |
| 19 | 8012: COMMUNITY HCBS HAB | 223 | 1 | 223 | Alpha |
| 20 | 8015: SUPPORTED EMPLOYMENT | 224 | 1 | 224 | Alpha |
| 21 | 8010: COMMUNITY ADVOCACY AND SUPPORT GROUP OF 2 | 225 | 1 | 225 | Alpha |
| 22 | 8007: PRE-VOCATIONAL GROUP OF 2 | 226 | 1 | 226 | Alpha |
| 23 | 8008: PRE-VOCATIONAL GROUP OF 3 | 227 | 1 | 227 | Alpha |
| 24 | 8028: CRISIS RESPITE (UP TO 6 HOURS) | 228 | 1 | 228 | Alpha |
| 25 | 8025: PLANNED RESPITE - INDIVIDUAL (12-24 HOURS) | 229 | 1 | 229 | Alpha |
| 26 | 8027: PLANNED RESPITE - GROUP (UP TO 6 HOURS) | 230 | 1 | 230 | Alpha |
| 27 | 8005: CAREGIVER FAMILY SUPPORTS AND SERVICES GROUP OF 3 | 231 | 1 | 231 | Alpha |
| 28 | 8004: CAREGIVER FAMILY SUPPORTS AND SERVICES GROUP OF 2 | 232 | 1 | 232 | Alpha |
| 29 | 7933: DAY HABILITATION | 233 | 1 | 233 | Alpha |

| HCBS Member Services Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos. | Length | End Pos. | Format |
| 30 | 8011: COMMUNITY ADVOCACY AND SUPPORT GROUP OF 3 | 234 | 1 | 234 | Alpha |
| 31 | 8019: PALLIATIVE CARE - EXPRESSIVE THERAPY | 235 | 1 | 235 | Alpha |

**Editing Logic**

1. For **Fields #14 to #31**, the system will populate 'Y' if the member had at least one PAID claim or encounter within the last 6 months, otherwise the value populated will be 'N'.

## HCBS Member Billed Claims Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs. This file will contain basic information for clams and encounters paid for children's HCBS services for members of the downloading organization within the last 6 months.

**Format**

| HCBS Member Billed Claims Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | First Name | 9 | 30 | 38 | Alpha |
| 3 | Last Name | 39 | 30 | 68 | Alpha |
| 4 | DOB | 69 | 8 | 76 | MMDDYYYY, Numeric |
| 5 | County of Fiscal Responsibility Code | 77 | 2 | 78 | Numeric |
| 6 | County of Fiscal Responsibility Description | 79 | 30 | 108 | Alphanumeric |
| 7 | HH Name | 109 | 40 | 148 | Alpha |
| 8 | HH MMIS Provider ID | 149 | 8 | 156 | Alpha |
| 9 | CMA Name | 157 | 40 | 196 | Alphanumeric |
| 10 | CMA MMIS Provider ID | 197 | 8 | 204 | Numeric |
| 11 | MCP Name | 205 | 40 | 244 | Alphanumeric |
| 12 | MCP MMIS Provider ID | 245 | 8 | 252 | Numeric |
| 13 | Service Date | 253 | 8 | 260 | MMDDYYYY, Numeric |
| 14 | Rate Code | 261 | 4 | 264 | Numeric |
| 15 | Rate Code Description | 265 | 50 | 314 | Alphanumeric |
| 16 | Billed Provider Name | 315 | 40 | 354 | Alphanumeric |
| 17 | Billed Provider MMIS ID | 355 | 8 | 362 | Numeric |

**Editing Logic**

1) The download file is comprised of members for a rolling 6 month period, who have an enrollment segment in Active or Pending Active status with the downloading provider and an HCBS paid claim or encounter within the rolling 6 month period.

## Member Program Status Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs to view their Member Program Status data including AH, AOT, ACT, and OMH HH+ eligible status. This file will be populated with information with a start/end date period of that overlaps with the downloading provider's Active or Closed segments at least one-day **OR** the downloading organization submitted the information to the system.

**Format**

| Member Program Status Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos.** | **Length** | **End Pos.** | **Format** |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | First Name | 9 | 30 | 38 | Alpha |
| 3 | Last Name | 39 | 30 | 68 | Alpha |
| 4 | DOB | 69 | 8 | 76 | MMDDYYYY, Numeric |
| 5 | Program Type | 77 | 20 | 96 | Alpha |
| 6 | Program Type Begin Date | 97 | 8 | 104 | MMDDYYYY, Numeric |
| 7 | Program Type End Date | 105 | 8 | 112 | MMDDYYYY, Numeric |
| 8 | OMH HH+ Elig STATUS Desc | 113 | 20 | 132 | Alpha |
| 9 | ACT MMIS Provider ID | 133 | 8 | 140 | Alpha |
| 10 | AOT Type | 141 | 20 | 160 | Alpha |
| 11 | AOT Status indicator | 161 | 1 | 161 | Alpha |
| 12 | AH Name | 162 | 40 | 201 | Alpha |
| 13 | AH County | 202 | 20 | 221 | Alpha |
| 14 | Entered Date | 222 | 8 | 229 | MMDDYYYY, Numeric |

**Editing Logic**

1) The Program Type (field #5) describes the program that the member is currently enrolled in/associated with and includes the following values:
   a) Assisted Outpatient Treatment (AOT)
   b) Assertive Community Treatment (ACT)
   c) Adult Home
   d) OMH HH+ Eligible
      i) This value only flags members that were identified by OMH in PSYCKES as HH+ eligible at the time of file download. This value does not flag all OMH HH+ eligible members nor does it mean that a provider cannot provide HH+ services where appropriate and/or bill for those services. It also does not flag members that are HH+ eligible due to their HIV/AIDS status.
   e) CYES
   f) Early Intervention
   g) High Fidelity Wraparound
2) OMH HH+ Elig STATUS Desc (field #9) values will be the two or three-digit-codes concatenated separated by a space in ascending order. These codes are available in Appendix A.
3) Entered Date (field #17) and Updated Date (field 18) is the date on which the new feed is received from OMH/DOH.

## Segments Potentially Incompatible with HH Services Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs to view their members that have an attribute that potentially makes them incompatible with the Health Home program. Providers should review each member on this file to determine if the member's segment should be ended or if there is something about the member's status that needs to be updated.

**Format**

| Segments Potentially Incompatible with HH Services Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos. | Length | End Pos. | Format |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | First Name | 9 | 30 | 38 | Alpha |
| 3 | Last Name | 39 | 30 | 68 | Alpha |
| 4 | DOB | 69 | 8 | 76 | MMDDYYYY, Numeric |
| 5 | Date of Death | 77 | 8 | 84 | MMDDYYYY, Numeric |
| 6 | Segment Type | 85 | 1 | 85 | Alpha |
| 7 | Segment Status | 86 | 20 | 105 | Alpha |
| 8 | Begin Date | 106 | 8 | 113 | MMDDYYYY, Numeric |
| 9 | HH Name | 114 | 40 | 153 | Alpha |
| 10 | HH MMIS Provider ID | 154 | 8 | 161 | Alpha |
| 11 | CMA Name | 162 | 40 | 201 | Alpha |
| 12 | CMA MMIS Provider ID | 202 | 8 | 209 | Alpha |
| 13 | MCP Name | 210 | 40 | 249 | Alpha |
| 14 | MCP MMIS Provider ID | 250 | 8 | 257 | Alpha |
| 15 | MCP Type | 258 | 20 | 277 | Alpha |
| 16 | Mainstream v/s Non-Mainstream | 278 | 20 | 297 | Alpha |
| 17 | MCP Start Date | 298 | 8 | 305 | MMDDYYYY, Numeric |
| 18 | MCP End Date | 306 | 8 | 313 | MMDDYYYY, Numeric |
| 19 | MCP Incompatible | 314 | 1 | 314 | Alpha |
| 20 | Medicaid Coverage Code | 315 | 2 | 316 | Alpha |
| 21 | Medicaid Coverage Code Description | 317 | 40 | 356 | Alpha |
| 22 | Medicaid Effective Date | 357 | 8 | 364 | MMDDYYYY, Numeric |
| 23 | Medicaid Eligibility End Date | 365 | 8 | 372 | MMDDYYYY, Numeric |
| 24 | Medicaid Coverage Code Incompatible | 373 | 1 | 373 | Alpha |
| 25 | Medicaid Recipient Exemption Code Incompatible | 374 | 1 | 374 | Alpha |
| 26 | Incompatible Medicaid Recipient Exemption Code | 375 | 40 | 414 | Alpha |
| 27 | Medicaid Recipient Exemption Code Begin Date | 415 | 8 | 422 | MMDDYYYY, Numeric |
| 28 | Medicaid Recipient Exemption Code End Date | 423 | 8 | 430 | MMDDYYYY, Numeric |
| 29 | ACT Member | 431 | 1 | 431 | Alpha |
| 30 | Date Added to File | 432 | 8 | 439 | MMDDYYYY, Numeric |

| Segments Potentially Incompatible with HH Services Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos. | Length | End Pos. | Format |
| 31 | Pend Reason Code Description | 440 | 40 | 479 | Alpha |
| 32 | Extended Pended Segment | 480 | 40 | 519 | Alpha |
| 33 | Complete POC Missing | 520 | 1 | 520 | Alpha (Y/N) |
| 34 | Most Recent CEST is E or M | 521 | 1 | 521 | Alpha (Y/N) |
| 35 | Most Recent CEST Expired | 522 | 1 | 522 | Alpha (Y/N) |
| 36 | Most Recent CEST Outcome | 523 | 1 | 523 | Alpha (C/E/M) |
| 37 | Most Recent CEST End Date | 524 | 8 | 531 | MMDDYYYY, Numeric |
| 38 | Segment Creation Date | 532 | 8 | 539 | MMDDYYYY, Numeric |
| 39 | Pended Due to FH Outcome | 540 | 1 | 540 | Alpha |
| 40 | FH Start Date | 541 | 8 | 548 | MMDDYYYY, Numeric |
| 41 | FH End Date | 549 | 8 | 556 | MMDDYYYY, Numeric |
| 42 | COS Enrollment | 557 | 1 | 557 | Alpha |
| 43 | COS Enrollment Status Code | 558 | 2 | 559 | Alphanumeric |
| 44 | COS Enrollment Status Description | 560 | 40 | 599 | Alpha |
| 45 | Consent Date | 600 | 8 | 607 | MMDDYYYY, Numeric |
| 46 | IA Missing | 608 | 1 | 608 | Alpha |
| 47 | YA Missing | 609 | 1 | 609 | Alpha |
| 48 | YA Expired | 610 | 1 | 610 | Alpha |
| 49 | YA Start Date | 611 | 8 | 618 | MMDDYYYY, Numeric |
| 50 | YA End Date | 619 | 8 | 626 | MMDDYYYY, Numeric |
| 51 | HHSC w K1 and exp HCBS LOC | 627 | 1 | 627 | Alpha |

**Editing Logic**

1) This file is comprised of members currently associated with the downloading provider that also have an active, pended, pending active, pending closed, and pending pended enrollment segment and match one or more of the following criteria:
   a) Member Deceased
   b) Member enrolled in ACT at the time of file download
   c) Member's current MCP is incompatible with HH services
   d) Member has an R/E code that is incompatible with HH services
   e) Member's Coverage Code is incompatible with the HH program.
   f) Certain Pended Segments
      i) Segment is pended due to Diligent search over 3 months, OR
      ii) Segment is pended due to other pend reason (excluding the FH related pend reason codes) over 6 months, OR
      iii) Member's health home fair hearing has a disposition, and their segment is pended with one of the following reasons. When a member is pended with one of these pend reasons, the HH must immediately either re-enroll the member ('pended for approved fair hearing') or complete their disenrollment and end date the pended segment.
         (1) Ø 14: Pended for Approved Fair Hearing
         (2) Ø 15: Pended for Denied Fair Hearing
         (3) 16: Pended for Withdrawn Fair Hearing
         (4) 17: Pended for FH Administrative Change

(5) 18: Pended for FH Defaulted
(6) 18: Pended for Pre-Hearing Determination

g) Actively enrolled member does not have an active POC:
   i) for member enrolled in new segment, POC must be submitted within 56 days of EITHER the member's consent to enroll date **or** the member's segment begin date *whichever date is most recent.*
   ii) member has an expired POC and a new POC has not yet been submitted to the system.

h) CEST Outcome: if a member meets one of the CEST related criteria below, they will be included in this file:
   i) Member's current CEST outcome is 'M' or 'E'
   ii) Member is in an active enrollment segment and their most recent CEST Outcome has expired.

i) COS Enrollment Status:
   i) When the member's HH or CMA has a COS (Category of Service) Enrollment Status of '13' or '14'. This indicates that either the HH or the CMA must complete a Medicaid enrollment process and does not indicate that the member themselves are potentially incompatible with the health home program. Once the provider as completed their Medicaid enrollment duty (i.e. HH/CMA no longer have **COS Enrollment Status Code** '13', '14') the segments will be removed from the file.
   ii) If both the HH and the CMA have a **COS Enrollment Status Code** of '13' or '14' but they do not have the same code, the file will contain the HH's **COS Enrollment Status Code**.

j) This information will also be available at the provider level Expired Medicaid (member's Medicaid Eligibility End Date is in the past)

k) Members Medicaid will expire in next 3 months (based on member's Medicaid Eligibility End Date)

l) Members with missing initial appropriateness (IA) after the IA grace period

m) Members that are missing yearly appropriateness that have surpassed the point when it should have been submitted.

n) Members with expired HCBS LOC
   i) Members with active or pended HHSC enrollment segment **AND**
   ii) Open K1 RE code (date file downloaded falls between K1 start and end date) **AND**
   iii) Member's more recent HCBS assessment is expired

2) The **Medicaid Recipient Exemption Code Incompatible field** (field #25) will display a value of 'Y' if the member has an active RE code that is incompatible with HH services, otherwise 'N'.

3) The **Incompatible Medicaid Recipient Exemption Code field** (field #26) will list the member's RE code(s) that are incompatible with the HH program. If there are multiple RE codes, they will be displayed as list of values separated by a space.

4) **Date Added to File** (field 30) displays the date when the member is first added to this file. If there are more than one reasons for the member to be included on this file, the date corresponds with the first reason listed. Below are a few scenarios describing how this field is populated.
   a) Oliver, enrolled in HH1/MCP2, dies on 9/12/22. Oliver's death is reported to MDW/tracking system on 10/2/22.
      i) If HH 1 downloads this file on 9/25/22, Oliver will not be on the file.
      ii) If MCP 2 downloads the file on 10/3/22, Oliver will be on the file with '09122022' in field #5 **Date of Death** and 10/3/22 field # 30 **Date Added to File**.
      iii) If HH 1 downloads the file on 10/6/22, Oliver will be on the file with '09122022' in field #5 **Date of Death** and 10/6/22 field # 30 **Date Added to File**.
      iv) If HH 1 downloads the file again on 10/15/22, Oliver will be on the file with '09122022' in field #5 **Date of Death** and '10062022' field # 30 **Date Added to File**.

b) Liam is FFS and enrolled in HH 1 as of August 2022. On 9/12/22, an RE code that is incompatible with the Health Home program was activated for him and 10/1/22 he enrolled in a new MCP that is incompatible with the Health Home program.
   i) If HH 1 downloads this file on 9/15/22, Liam will be on the file with 'Y' in field #25 **Medicaid Recipient Exemption Code Incompatible,** fields 26-28 will be populated with the incompatible RE code information, and '09152022' will be in field # 30 **Date Added to File.**
   ii) If HH 1 downloads this file again on 10/15/22, Liam will be on the file with 'Y' in field #19 **MCP Incompatible**, 'Y' in field #25 **Medicaid Recipient Exemption Code Incompatible,** fields 26-28 will be populated with the incompatible RE code information, and '09152022' will be in field # 30 **Date Added to File.**

## HH Claim and Encounter Detail File Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs to view a provider's current members' past Health Home claims and encounters and the HH that have been submitted by the HH for members formally enrolled in their HH. For HH and CMAs, the file is comprised of members that currently have an *active* or *pended* enrollment segment with the downloading provider AND have at least one claim or encounter for Health Home services submitted to Medicaid (see rate codes listed in **Editing Logic** section) with service - dates within the last 45 months. Also, it includes information for any claim/encounter submitted by the HH within the last 45 months. For MCPs, this file will contain members currently enrolled in their plan, with an *active* or *pended* health home enrollment, and have at least one claim or encounter for Health Home services (see rate codes listed in **Editing Logic** section) submitted to Medicaid is a service date within the last 45 months.

**Format**

| HH Claim and Encounter Detail File Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | First Name | 9 | 30 | 38 | Alpha |
| 3 | Last Name | 39 | 30 | 68 | Alpha |
| 4 | Service Date | 69 | 8 | 76 | MMDDYYYY, Numeric |
| 5 | Payment Cycle | 77 | 4 | 80 | Numeric |
| 6 | Date of Transaction | 81 | 8 | 88 | MMDDYYYY, Numeric |
| 7 | Claim or Encounter | 89 | 1 | 89 | Alpha |
| 8 | Current MCP MMIS Provider ID | 90 | 8 | 97 | Numeric |
| 9 | Current MCP Name | 98 | 40 | 137 | Alphanumeric |
| 10 | MCP Type | 138 | 10 | 147 | Alphanumeric |
| 11 | HH MMIS Provider ID | 148 | 8 | 155 | Numeric |
| 12 | HH Name | 156 | 40 | 195 | Alphanumeric |
| 13 | CMA MMIS Provider ID | 196 | 8 | 203 | Numeric |
| 14 | CMA Name | 204 | 40 | 243 | Alphanumeric |

| HH Claim and Encounter Detail File Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field Name | Start Pos | Length | End Pos | Format |
| 15 | MCP MMIS Provider ID as of Service Date | 244 | 8 | 251 | Numeric |
| 16 | MCP Name as of Service Date | 252 | 40 | 291 | Alphanumeric |
| 17 | Billing Entity MMIS ID | 292 | 8 | 299 | Numeric |
| 18 | Billing Entity Name | 300 | 40 | 339 | Alphanumeric |
| 19 | Rate Code | 340 | 4 | 343 | Numeric |
| 20 | Rate Code Description | 344 | 30 | 373 | Alphanumeric |
| 21 | Amount Paid | 374 | 7 | 380 | Numeric, 0000.00/BLANK |
| 22 | Claim Supported By Added BI | 381 | 1 | 381 | Alpha |
| 23 | Expected Rate Code | 382 | 4 | 385 | Numeric |
| 24 | Expanded HH+ population | 386 | 1 | 386 | Alpha |
| 25 | HH+ Minimum Services Provided | 387 | 1 | 387 | Alpha |
| 26 | Rate Code Short Description | 388 | 10 | 397 | Alpha (see table below) |
| 27 | Expected Rate Code Description | 398 | 30 | 427 | Alphanumeric |
| 28 | Current Segment Status | 428 | 30 | 457 | Alpha |

**Editing Logic**

1. Rate codes included in the file:

| Rate Codes to include in file | Long Description | Short Desc |
|---|---|---|
| 1853 | Health Home Plus/Care Management | HH+ |
| 1860 | Health Home Services - Adult Home Transition | AH |
| 1864 | Health Home Services - Children (Low) | CL |
| 1865 | Health Home Services - Children (Med) | CM |
| 1866 | Health Home Services - Children (High) | CH |
| 1869 | Health Home Services - Children (Low) (Inc FFP) | CL:CT |
| 1870 | Health Home Services - Children (Med) (Inc FFP) | CM:CT |
| 1871 | Health Home Services - Children (High) (Inc FFP) | CH:CT |
| 1873 | Health Home Care Management | ACM |
| 1874 | Health Home High Risk/Need Care Management | AHRHN |

2. This file will contain a record for each claim and encounter submitted to Medicaid with service dates within the last 45 months for members with an *active* or *pended* enrollment segment with the HH OR for members who the HH submitted a claim or encounter for within the last 45

service months. For example, if a member has 12 fee for service claims and 10 encounters with service dates within the last 45 months, the member will have 22 records on the download file.

## HH Claim and Encounter Summary File Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs to view a summary of the provider's current members' Health Home claims and encounters submitted to Medicaid with a service date within the past 45 months. For HHs and CMAs, the file is comprised of members that currently have *active* or *pended* enrolled segments with the downloading provider. For MCPs, this file will contain members actively enrolled in their plan with an *active* or *pended* health home enrollment segment.

**Format**

| HH Claim and Encounter Summary File Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | First Name | 9 | 30 | 38 | Alpha |
| 3 | Last Name | 39 | 30 | 68 | Alpha |
| 4 | Total # C&E | 69 | 2 | 70 | Numeric |
| 5 | Total # C&E w current HH | 71 | 2 | 72 | Numeric |
| 6 | Total HH Enrolled Member Months | 73 | 2 | 74 | Numeric |
| 7 | Total HH Enrollment Months w Current HH | 75 | 2 | 76 | Numeric |
| 8 | Total Billable Pended MM | 77 | 2 | 78 | Numeric |
| 9 | Billable Pended MM w current HH | 79 | 2 | 80 | Numeric |
| 10 | Total Non-Billable Pended MM | 81 | 2 | 82 | Numeric |
| 11 | Non-Billable Pended MM w current HH | 83 | 2 | 84 | Numeric |
| 12 | HH+ Count | 85 | 2 | 86 | Numeric |
| 13 | AH Count | 87 | 2 | 88 | Numeric |
| 14 | CL Count | 89 | 2 | 90 | Numeric |
| 15 | CM Count | 91 | 2 | 92 | Numeric |
| 16 | CH Count | 93 | 2 | 94 | Numeric |
| 17 | CL:CT Count | 95 | 2 | 96 | Numeric |
| 18 | CM:CT Count | 97 | 2 | 98 | Numeric |
| 19 | CH:CT Count | 99 | 2 | 100 | Numeric |
| 20 | ACM Count | 101 | 2 | 102 | Numeric |
| 21 | AHRHN Count | 103 | 2 | 104 | Numeric |
| 22 | Date of Last HH+ C or E | 105 | 8 | 112 | MMDDYYYY, Numeric |
| 23 | Date of Last AH C or E | 113 | 8 | 120 | MMDDYYYY, Numeric |
| 24 | Date of Last CL C or E | 121 | 8 | 128 | MMDDYYYY, Numeric |
| 25 | Date of Last CM C or E | 129 | 8 | 136 | MMDDYYYY, Numeric |
| 26 | Date of Last CH C or E | 137 | 8 | 144 | MMDDYYYY, Numeric |

| HH Claim and Encounter Summary File Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field Name | Start Pos | Length | End Pos | Format |
| 27 | Date of Last CL:CT C or E | 145 | 8 | 152 | MMDDYYYY, Numeric |
| 28 | Date of Last CM:CT C or E | 153 | 8 | 160 | MMDDYYYY, Numeric |
| 29 | Date of Last CH:CT C or E | 161 | 8 | 168 | MMDDYYYY, Numeric |
| 30 | Date of Last ACM C or E | 169 | 8 | 176 | MMDDYYYY, Numeric |
| 31 | Date of Last AHRHN C or E | 177 | 8 | 184 | MMDDYYYY, Numeric |

**Editing Logic**

1. Rate codes included in the file:

| Rate Codes to include in file | Long Description | Short Desc |
|---|---|---|
| 1853 | Health Home Plus/Care Management | HH+ |
| 1860 | Health Home Services - Adult Home Transition | AH |
| 1864 | Health Home Services - Children (Low) | CL |
| 1865 | Health Home Services - Children (Med) | CM |
| 1866 | Health Home Services - Children (High) | CH |
| 1869 | Health Home Services - Children (Low) (Inc FFP) | CL:CT |
| 1870 | Health Home Services - Children (Med) (Inc FFP) | CM:CT |
| 1871 | Health Home Services - Children (High) (Inc FFP) | CH:CT |
| 1873 | Health Home Care Management | ACM |
| 1874 | Health Home High Risk/Need Care Management | AHRHN |

2. For field details see the **Field Description** field of the File Specifications Excel Document within the **Updated File Specifications (XLSX)**: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm
3. This file will contain one record for each member associated with the downloaded provider with an *active* or *pended* enrollment segment.
4. Fields # 12-21 contain the count of claims and encounter submitted to Medicaid with service dates within the past 45 months for the health home service listed in the field name (see #1 above for a crosswalk between rate code and field names)
5. Fields #22-23 contain the associated service date of the last claim or encounter submitted for the health home service listed in the field name (see #1 above for crosswalk between rate code and field names.

## Fair Hearing Download File

**Description**

This file contains fair hearing information available within the system for a provider's members. If the downloading user is HH or CMA, the file will contain records where the **Fair Hearing Start Date** and **Fair Hearing End Date** overlaps at least one day with the provider's enrollment segment start/end dates with the member in all statuses other than canceled. If the downloading user is MCP, the file will contain records where the **Fair Hearing Start Date** and **Fair Hearing End Date** overlaps at least one day within the member's enrollment dates with the MCP.

**Format**

| Fair Hearings Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Name per Fair Hearing | 1 | 100 | 100 | Alphanumeric |
| 2 | DOB per Fair Hearing | 101 | 8 | 108 | MMDDYYYY, Numeric |
| 3 | Member ID | 109 | 8 | 116 | Alphanumeric |
| 4 | First Name per MDW | 117 | 40 | 156 | Alphanumeric |
| 5 | Last Name per MDW | 157 | 40 | 196 | Alphanumeric |
| 6 | DOB per MDW | 197 | 8 | 204 | MMDDYYYY, Numeric |
| 7 | HH Name | 205 | 40 | 244 | Alphanumeric |
| 8 | HH MMIS Prov ID | 245 | 8 | 252 | Alphanumeric |
| 9 | CMA Name | 253 | 40 | 292 | Alphanumeric |
| 10 | CMA MMIS Prov ID | 293 | 8 | 300 | Alphanumeric |
| 11 | MCP Name | 301 | 40 | 340 | Alphanumeric |
| 12 | MCP MMIS Prov ID | 341 | 8 | 348 | Alphanumeric |
| 13 | Segment status | 349 | 30 | 378 | Alphanumeric |
| 14 | Segment Begin Date | 379 | 8 | 386 | MMDDYYYY, Numeric |
| 15 | Pend reason Code | 387 | 2 | 388 | Alphanumeric |
| 16 | Pend Reason Code Description | 389 | 40 | 428 | Alphanumeric |
| 17 | Member County Name | 429 | 40 | 468 | Alphanumeric |
| 18 | Member County Code | 469 | 2 | 470 | Alphanumeric |
| 19 | Created By | 471 | 40 | 510 | Alphanumeric |
| 20 | Fair Hearing Number | 511 | 8 | 518 | Alphanumeric |
| 21 | Fair Hearing Start Date | 519 | 8 | 526 | MMDDYYYY, Numeric |
| 22 | Fair Hearing End Date | 527 | 8 | 534 | MMDDYYYY, Numeric |
| 23 | FH Notice Type Start Date | 535 | 8 | 542 | MMDDYYYY, Numeric |
| 24 | FH Notice Type End Date | 543 | 8 | 550 | MMDDYYYY, Numeric |
| 25 | FH Notice Type Create Date and time | 551 | 16 | 566 | MMDDYYYYHH:MM:SS, Numeric |
| 26 | FH Notice Type Last Updated Date and time | 567 | 16 | 582 | MMDDYYYYHH:MM:SS, Numeric |
| 27 | Fair Hearing Aid to Continue | 583 | 1 | 583 | Alphanumeric |
| 28 | Fair Hearing Program Type | 584 | 60 | 643 | Alphanumeric |

| Fair Hearings Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field Name | Start Pos | Length | End Pos | Format |
| 29 | Fair Hearing Comments | 644 | 500 | 1143 | Alphanumeric |
| 30 | Fair Hearing Notice Type | 1144 | 30 | 1173 | Alphanumeric |
| 31 | Disposition of Fair Hearing | 1174 | 10 | 1183 | Alphanumeric |
| 32 | Date Fair Hearing Scheduled | 1184 | 8 | 1191 | MMDDYYYY, Numeric |
| 33 | Open Fair Hearing? | 1192 | 1 | 1192 | Alphanumeric (Y/N) |
| 34 | Most Recent FH Notice Type? | 1193 | 1 | 1193 | Alphanumeric (Y/N) |
| 35 | DOD | 1194 | 8 | 1201 | MMDDYYYY, Numeric |

**Editing Logic**

1) Fields 7-16 will be populated with the member's most recent segment information available within the system as of the file download.

## 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 an active or pended segment. 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**

Adult 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 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. If there are significant changes to a member's level of Care Management need, a complete HML should be completed. 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.

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.

Members 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 if a billable service was provided for a billing instance service date, 2) void a previously added billing instance submission, and 3) to submit member information needed to support a Health Home claim for members that received a billable service.

For additional information on the logic that the system uses to calculate rates, please refer to the 'Special Population Logic & HML Logic Flow' document posted under *Billing* in the *Health Home Tracking System Resources* subsection of the MAPP HHTS website. If any question that is not required per the flow is answered, the system will ignore the submitted value and display a blank field on the download.

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/W/U) |
| 2 | Member ID | 2 | 8 | 9 | AA11111A, Alphanumeric |
| 3 | Service Date | 10 | 8 | 17 | MMDDYYYY, Numeric |
| 4 | Diagnosis Code | 18 | 10 | 27 | Alphanumeric |
| 5 | HIV Status | 28 | 1 | 28 | Alpha (Y/N) |
| 6 | HIV Viral Load | 29 | 1 | 29 | Numeric |
| 7 | HIV T-Cell Count | 30 | 1 | 30 | Numeric |
| 8 | Member Housing Status | 31 | 1 | 31 | Alpha (Y/N) |
| 9 | HUD Category | 32 | 1 | 32 | Numeric |
| 10 | Incarceration | 33 | 1 | 33 | Alpha (Y/N/U) |
| 11 | Incarceration Release Date | 34 | 8 | 41 | MMDDYYYY, Numeric |
| 12 | Mental Illness or Physical Health Inpatient Stay | 42 | 1 | 42 | Alpha (M/P/N/U/V) |
| 13 | Mental Illness or Physical Health Inpatient Discharge Date | 43 | 8 | 50 | MMDDYYYY, Numeric |
| 14 | Substance Abuse Inpatient Stay | 51 | 1 | 51 | Alpha (Y/N/U) |
| 15 | Substance Abuse Inpatient Stay Discharge Date | 52 | 8 | 59 | MMDDYYYY, Numeric |
| 16 | SUD Active Use/Functional Impairment | 60 | 1 | 60 | Alpha (Y/N) |
| 17 | Core Service Provided | 61 | 1 | 61 | Alpha (Y/N) |
| 18 | Provider Supplied AOT Indicator | 62 | 1 | 62 | Alpha (Y/N) |
| 19 | AOT Minimum Services Provided | 63 | 1 | 63 | Alpha (Y/N) |
| 20 | AH Member qualifies for Adult Home Plus Care Management | 64 | 1 | 64 | Alpha (Y/N/U) |
| 21 | AH Member transitioned to community | 65 | 1 | 65 | Alpha (Y/N) |
| 22 | AH Member continues to qualify | 66 | 1 | 66 | Alpha (Y/N) |
| 23 | AH Member interested in transitioning | 67 | 1 | 67 | Alpha (Y/N) |
| 24 | Child in Foster Care | 68 | 1 | 68 | Alpha (Y/N) |
| 25 | HUD1 within past 6 months | 69 | 1 | 69 | Alpha (Y/N) |
| 26 | Date Member Housed | 70 | 8 | 77 | MMDDYYYY, Numeric |
| 27 | Expanded HH+ population | 78 | 1 | 78 | Alpha (A-X,1) |

| Billing Support Upload File | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 28 | HH+ Minimum Services Provided | 79 | 1 | 79 | Alpha (Y/N) |
| 29 | UAS Complexity Assessment | 80 | 1 | 80 | Alpha (Y/N/U) |
| 30 | SED/SMI | 81 | 1 | 81 | Alpha (Y/N) |
| 31 | HIV/AIDS | 82 | 1 | 82 | Alpha (Y/N) |
| 32 | Complex Trauma (under 21 years of age) | 83 | 1 | 83 | Alpha (Y/N) |
| 33 | Sickle Cell | 84 | 1 | 84 | Alpha (Y/N) |
| 34 | Children's HCBS Only | 85 | 1 | 85 | Alpha (Y/N) |
| 35 | Mental Health (excluding SMI/SED) | 86 | 1 | 86 | Alpha (Y/N) |
| 36 | Substance Abuse | 87 | 1 | 87 | Alpha (Y/N) |
| 37 | Asthma | 88 | 1 | 88 | Alpha (Y/N) |
| 38 | Diabetes | 89 | 1 | 89 | Alpha (Y/N) |
| 39 | Heart Disease | 90 | 1 | 90 | Alpha (Y/N) |
| 40 | Overweight | 91 | 1 | 91 | Alpha (Y/N) |
| 41 | One or More DD conditions | 92 | 1 | 92 | Alpha (Y/N) |
| 42 | Children's HCBS & Other conditions | 93 | 1 | 93 | Alpha (Y/N) |
| 43 | Adult HCBS and other conditions | 94 | 1 | 94 | Alpha (Y/N) |
| 44 | Other Qualifying Condition | 95 | 1 | 95 | Alpha (Y/N) |
| 45 | Description of "Other" Health Home Qualifying Conditions | 96 | 40 | 135 | Alphanumeric |
| 46 | In Person | 136 | 2 | 137 | Numeric |
| 47 | Telehealth | 138 | 2 | 139 | Numeric |
| 48 | Medically Fragile/Complex | 140 | 1 | 140 | Alpha (Y/N) |
| 49 | Assessment ID (GUID) | 141 | 32 | 172 | Alpha (W/U) |
| 50 | Assessment Type | 173 | 1 | 173 | Alpha (F/H)f |

*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 a link to the master file specifications excel document that contains 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 in the Best Practices and Quality Assurance Webinar Series: Billing Support Files (PDF) starting on slide 21.
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 #17). 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 #17).
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'.
g) Beginning with the 5/30/26 system release 5.0, the system will now accept void records for CANS Assessments and HCBS Assessments. This can be done on screen (from the Assessments Tab and the CANS/HCBS inner tab) and new Add/Void Indicator values have been created for the purpose of voiding CANS and HCBS Assessments via file upload. In the Add/Void Indicator field (field #1), a value of 'W' should be submitted for a record to void either a CANS or HCBS Assessment Fee BI and should accompany an Assessment Type (field #50) value of 'F' for CANS or 'H' for HCBS. A value of 'U' should be submitted for a record to unvoid either a CANS or HCBS Assessment Fee BI. The other required fields for submission
    i) When the Add/Void Indicator = 'W' or 'U', the following fields are required:
        (1) Member ID
        (2) Service Date
        (3) Assessment Type
        (4) Assessment ID
    ii) A voided assessment BI can be unvoided as long as the BI was not voided by the system or voided due to deactivation of the CANS or HCBS Assessment in the UAS.

4) Attesting to **Core Service Provided** (field #17) for Children (met member's CANS-NY acuity minimum requirements)
    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 #17) 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.
    c) For a member to be paid under the High-Fidelity Wraparound (HFW) rate, the following criteria must be met as of the billing instance service date (see HHSC HFW policy for more information).
        i) Member flagged as HFW within the MAPP HHTS (see Consent and Member Program Status Upload File section) AND billing instance service date falls between the member's HFW effective dates.
        ii) CMA has active HFW CMA indicator.

iii) If HFW minimum required services are providers to the member, submit 'Y' in ***Core Service Provided*** field. If HFW minimum required services not provided but lower acuity minimum required services provided, see 4d) below.

d) Attesting to **Core Service Provided** (field #17) for Children (didn't meet member's CANS-NY acuity minimum requirements but met lower CANS-NY acuity minimum requirements). *Please see the Health Home Service Children's policy regarding when to use the alternative values below within the* ***Core Service Provided*** *field (policy to be released)*.'H' (didn't meet HFW min req, but meets Complex min req) = 1866 Health Home Services - Children (High)

i) 'M' (didn't HFW or Complex min req, but meets Early Development/Intense min req) = 1865 Health Home Services - Children (Med)

ii) 'L' (didn't HFW, Complex, Early Development/Intense, but meets Low/Standard min req) 1864 Health Home Services - Children (Low)

iii) If a member did not receive any level of minimum required services in billing month, Core Service Provided = 'N'

5) 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) **Qualifying Conditions of Member** (field #30-45)

vi) **Core Service Provided** (field #17)

vii) **Child in Foster Care** (field #24)

6) 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 B with 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 an 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 12 months old (including the month the CANS NY Assessment was completed).

d) The system will reject a record submitted for a member with responses to the Adult Home (AH) questions when the member is not in AH. If the member is not in AH, the following fields need to blank:
   i) **AH Member qualifies for Adult Home Plus Care Management** (field #20)
   ii) **AH Member transitioned to community** (field #21)
   iii) **AH Member continues to qualify** (field #22)
   iv) **AH Member interested in transitioning** (field #23)

e) The system will not require and ignore the Core Service Provided (Field #17) when the user has responded 'Y' to AOT Minimum Services Provided (Field #19) or HH+ Minimum Services Provided (Field #28).

7) 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:

1. A segment from 12/1/17-3/31/18 under CIN AA12345A
2. 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.

8) Effective for service dates on or after 7/1/20, the Health Home program will no longer reimburse for outreach services provided to Medicaid members.

9) **HH Qualifying Conditions** (fields #30-44) require a response. A provider should respond 'Y' to all applicable qualifying conditions. If **Other Qualifying Condition** (field #44) has the response 'Y', then **Description of "Other" Health Home Qualifying Condition** (field #45) cannot be left blank.

10) If **fields #30-34** (representing single qualifying conditions) and **Other Qualifying Condition** (field #44) are all 'N', then at least two of **fields #35-43** must be populated with 'Y' identifying two chronic conditions that make a member eligible.

11) If fields #30-34 are all 'N' and only one field from 35-43 contain a 'Y', then the provider must populate field #44 with a 'Y' and list all remaining qualifying conditions in **Description of "Other" Health Home Qualifying Condition** (field #45) field.

12) If only field #44 contains 'Y', then the provider must list all qualifying conditions in **Description of "Other" Health Home Qualifying Condition** (field #45) field.
13) Billing instances that are more than 2 years old will not be accepted by MAPP HHTS.
14) The system will only allow up to 3 months of BIS to be created for segments "Pended due to diligent search". In the fourth month of a segment "Pended due to diligent search", the system will create a potential BI that cannot be added, as indicated in fields 81 and 82 **Validation Code/ Validation Code Description** on the BSD.
15) Fields 45 & 46 (**In Person** and **Telehealth**) collect the number of in person and telehealth interactions a member received within the billing instances service month. This field is required for members enrolled in a children's program and is optional for members enrolled in an adult program.
16) As part of the 6/1/24 system release 4.5, there are new billing criteria that require, in certain situations, initial appropriateness, CEST outcome, and a comprehensive plan of care be submitted to the system for providers to be able to bill for health home services. For more information about these requirements, please review the policy and system guidance documents described below. Billings instances that do not conform to the billing policy listed below will be rejected by the system. The **Validation Code** field on the Billing Support Download file will message to providers when a billing instances either cannot be added unless something changes about the member or warns the provider that a billing block is upcoming if something isn't submitted to the system.
    a) Health Home Policy Documents (*see* Policy and Standards *section of the Health Home website):*
        i) **Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016**
        ii) **Guide to Edits for the Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016**
    b) MAPP HHTS Documents (*expand the "Health Home Tracking System" subsection of the* Medicaid Analytics Performance Portal (MAPP) *section of the Health Home website)*
        i) **Initial Appropriateness in MAPP HHTS (PDF)**
        ii) **CEST Information in MAPP HHTS (PDF)**
        iii) **Plan of Care in MAPP HHTS (PDF)**
        iv) **Connection Between CEST and Billing Instances in MAPP HHTS (XLSX)**

## 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 #7) 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 #7). 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 | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Line Number | 1 | 6 | 6 | Numeric |
| 2 | Add/Void Indicator | 7 | 1 | 7 | Alpha (A/V) |
| 3 | Member ID | 8 | 8 | 15 | AA11111A, Alphanumeric |
| 4 | Service Date | 16 | 8 | 23 | MMDDYYYY, Numeric |
| 5 | Core Service Provided | 24 | 1 | 24 | Alpha (Y/N/Blank) |
| 6 | HH+ Minimum Services Provided | 25 | 1 | 25 | Alpha (Y/N/Blank) |
| 7 | Error Reason | 26 | 40 | 65 | Alphanumeric |

## 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 are associated with them in the MAPP HHTS. This file contains a combination of information that was submitted into the system by HHs/CMAs, supplied by NYS Medicaid, and system generated based on member information. 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. Beginning with release 4.8.2, the user has the ability to download a Billing Support Download File for a specified number of CINs, with a limit of 1,000.

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 Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Add/Void Indicator | 1 | 1 | 1 | Alpha (A/V/Blank) |
| 2 | Member ID | 2 | 8 | 9 | AA11111A, Alphanumeric |
| 3 | Service Date | 10 | 8 | 17 | MMDDYYYY, Numeric |
| 4 | HH MMIS Provider ID | 18 | 8 | 25 | Numeric |
| 5 | Billing Instance Type | 26 | 1 | 26 | Alpha |
| 6 | Member Fiscal County Code | 27 | 2 | 28 | Numeric |
| 7 | MCP MMIS Provider ID | 29 | 8 | 36 | Numeric/ Blank |
| 8 | Diagnosis Code | 37 | 10 | 46 | Alphanumeric/ Blank |
| 9 | Medicaid Eligibility Status | 47 | 1 | 47 | Alpha (Y/N) |
| 10 | Pend Reason Code | 48 | 2 | 49 | Alphanumeric/Blank |
| 11 | Pend Reason Code Description | 50 | 40 | 89 | Alphanumeric/Blank |
| 12 | Member Fiscal County Code Description | 90 | 40 | 129 | Alphanumeric |
| 13 | Date Assessment Entered | 130 | 8 | 137 | MMDDYYYY, Numeric/Blank |
| 14 | CMA Name | 138 | 40 | 177 | Alphanumeric |
| 15 | CMA MMIS Provider ID | 178 | 8 | 185 | Alphanumeric |
| 16 | Payor | 186 | 1 | 186 | Alpha (P/F/) |
| 17 | HH Name | 187 | 40 | 226 | Alphanumeric |
| 18 | MCP Name | 227 | 40 | 266 | Alphanumeric/Blank |
| 19 | Billing Entity MMIS ID | 267 | 8 | 274 | Numeric/Blank |
| 20 | Billing Entity Name | 275 | 40 | 314 | Alphanumeric/Blank |
| 21 | Member Zip Code | 315 | 9 | 323 | Numeric |
| 22 | Member First Name | 324 | 30 | 353 | Alpha |
| 23 | Member Last Name | 354 | 30 | 383 | Alpha |
| 24 | Member DOB | 384 | 8 | 391 | MMDDYYYY, Numeric |
| 25 | Gender | 392 | 1 | 392 | Alpha (M/F/U/X) |
| 26 | HARP | 393 | 2 | 394 | Alpha (Blank, EL, or EN) |
| 27 | HIV Status | 395 | 1 | 395 | Alpha (Y/N/Blank) |
| 28 | HIV Viral Load | 396 | 1 | 396 | Numeric/Blank |
| 29 | HIV T-Cell Count | 397 | 1 | 397 | Numeric/Blank |
| 30 | Member Living Status | 398 | 1 | 398 | Alpha (Y/N/Blank) |
| 31 | HUD Category | 399 | 1 | 399 | Numeric/Blank |
| 32 | Incarceration | 400 | 1 | 400 | Alpha (Y/N/Blank) |
| 33 | Incarceration Release Date | 401 | 8 | 408 | MMDDYYYY, Numeric/Blank |
| 34 | Mental Illness or Physical Health Inpatient Stay | 409 | 1 | 409 | Alpha (M/P/N/U/V/Blank) |

| Billing Support Download File | | | | | |
|---|---|---|---|---|---|
| Field # | Field Name | Start Pos | Length | End Pos | Format |
| 35 | Mental Illness or Physical Health Inpatient Discharge Date | 410 | 8 | 417 | MMDDYYYY, Numeric/Blank |
| 36 | Substance Abuse Inpatient Stay | 418 | 1 | 418 | Alpha (Y/N/Blank) |
| 37 | Substance Abuse Inpatient Stay Discharge Date | 419 | 8 | 426 | MMDDYYYY, Numeric/Blank |
| 38 | SUD Active Use/Functional Impairment | 427 | 1 | 427 | Alpha (Y/N/Blank) |
| 39 | Core Service Provided | 428 | 1 | 428 | Alpha (Y/N) |
| 40 | Provider Supplied AOT Indicator | 429 | 1 | 429 | Alpha (Y/N/Blank) |
| 41 | AOT Minimum Services Provided | 430 | 1 | 430 | Alpha (Y/N/Blank) |
| 42 | ACT Member | 431 | 1 | 431 | Alpha (Y/N/Blank) |
| 43 | Impacted Adult Home Class Member | 432 | 1 | 432 | Alpha (Y/N/Blank) |
| 44 | AH Member qualifies for Adult Home Plus Care Management | 433 | 1 | 433 | Alpha (Y/N/U/Blank) |
| 45 | AH Member transitioned to community | 434 | 1 | 434 | Alpha (Y/N/Blank) |
| 46 | AH Member continues to qualify | 435 | 1 | 435 | Alpha (Y/N/Blank) |
| 47 | AH Member interested in transitioning | 436 | 1 | 436 | Alpha (Y/N/Blank) |
| 48 | Rate Code | 437 | 4 | 440 | Numeric/Blank |
| 49 | Rate Code Description | 441 | 30 | 470 | Alphanumeric/Blank |
| 50 | Rate Amount | 471 | 7 | 477 | Numeric, “0000.00”/Blank |
| 51 | Claim Status | 478 | 1 | 478 | Alpha (P/D/V/Blank) |
| 52 | Date of Transaction | 479 | 8 | 486 | MMDDYYYY, Numeric/Blank |
| 53 | Payment Cycle | 487 | 4 | 490 | Numeric/Blank |
| 54 | Denial Reason Code | 491 | 4 | 494 | Numeric/Blank |
| 55 | Denial Reason Code Description | 495 | 25 | 519 | Alphanumeric/Blank |
| 56 | Denial Reason Code (2) | 520 | 4 | 523 | Numeric/Blank |
| 57 | Denial Reason Code Description (2) | 524 | 25 | 548 | Alphanumeric/Blank |
| 58 | Claim Provider ID | 549 | 8 | 556 | Numeric/Blank |
| 59 | Claim Provider Name | 557 | 40 | 596 | Alphanumeric/Blank |
| 60 | Claim Rate Code | 597 | 4 | 600 | Numeric/Blank |
| 61 | Claim Provider ID equals MAPP Billed Entity MMIS ID | 601 | 1 | 601 | Alpha (Y/N/Blank) |
| 62 | Claim Rate Code equals MAPP HML Rate Code | 602 | 1 | 602 | Alpha (Y/N/Blank) |
| 63 | Latest Transaction | 603 | 1 | 603 | Alpha (Y/N/Blank) |
| 64 | Child in Foster Care | 604 | 1 | 604 | Alpha (Y/N//U/Blank) |
| 65 | Last Transaction Date Time | 605 | 16 | 620 | MMDDYYYYHH:MM:SS, Numeric |
| 66 | Insert Date | 621 | 8 | 628 | MMDDYYYY, Numeric |
| 67 | Assessment Completion Date | 629 | 8 | 636 | MMDDYYYY, Numeric |

| Billing Support Download File | | | | | |
|---|---|---|---|---|---|
| Field # | Field Name | Start Pos | Length | End Pos | Format |
| 68 | Void Date | 637 | 8 | 644 | MMDDYYYY, Numeric |
| 69 | HUD1 within past 6 months | 645 | 1 | 645 | Alpha (Y/N) |
| 70 | Date Member Housed | 646 | 8 | 653 | MMDDYYYY, Numeric |
| 71 | Expanded HH+ population | 654 | 1 | 654 | Alpha (A-X,1) |
| 72 | HH+ Minimum Services Provided | 655 | 1 | 655 | Alpha (Y/N) |
| 73 | Provided Service Indicator | 656 | 1 | 656 | Alpha (A/C) |
| 74 | UAS Complexity Assessment | 657 | 1 | 657 | Alpha (Y/N/U) |
| 75 | Encounter Claim | 658 | 1 | 658 | Alpha (E/C/Blank) |
| 76 | Month Submitted | 659 | 1 | 659 | Alphanumeric |
| 77 | MCP Type | 660 | 10 | 669 | Alpha |
| 78 | Validation Code | 670 | 1 | 670 | Alpha (A/B/C/D/E/F/G/H/I/J) |
| 79 | Validation Code Description | 671 | 80 | 750 | Alphanumeric |
| 80 | Submitted POC Effective Date | 751 | 8 | 758 | MMDDYYYY, Numeric |
| 81 | CANS Acuity | 759 | 1 | 759 | Alphanumeric (L/M/H/Blank/C/I/S) |
| 82 | OMH HH+ Eligible | 760 | 1 | 760 | Alpha (Y/N/Blank) |
| 83 | OMH HH+ Elig STATUS Desc | 761 | 50 | 810 | Alphanumeric |
| 84 | SED/SMI | 811 | 1 | 811 | Alpha (Y/N) |
| 85 | HIV/AIDS | 812 | 1 | 812 | Alpha (Y/N) |
| 86 | Complex Trauma (under 21 years of age) | 813 | 1 | 813 | Alpha (Y/N) |
| 87 | Sickle Cell | 814 | 1 | 814 | Alpha (Y/N) |
| 88 | Children's HCBS Only | 815 | 1 | 815 | Alpha (Y/N) |
| 89 | Mental Health (excluding SMI/SED) | 816 | 1 | 816 | Alpha (Y/N) |
| 90 | Substance Abuse | 817 | 1 | 817 | Alpha (Y/N) |
| 91 | Asthma | 818 | 1 | 818 | Alpha (Y/N) |
| 92 | Diabetes | 819 | 1 | 819 | Alpha (Y/N) |
| 93 | Heart Disease | 820 | 1 | 820 | Alpha (Y/N) |
| 94 | Overweight | 821 | 1 | 821 | Alpha (Y/N) |
| 95 | One or More DD conditions | 822 | 1 | 822 | Alpha (Y/N) |
| 96 | Children's HCBS & Other conditions | 823 | 1 | 823 | Alpha (Y/N) |
| 97 | Adult HCBS and other conditions | 824 | 1 | 824 | Alpha (Y/N) |
| 98 | Other Qualifying Condition | 825 | 1 | 825 | Alpha (Y/N) |
| 99 | Description of "Other" Health Home Qualifying Conditions | 826 | 40 | 865 | Alpha/Blank |
| 100 | Most Recent HCBS Assessment Date | 866 | 8 | 873 | MMDDYYYY, Numeric |
| 101 | Expanded HH+ Population Description | 874 | 100 | 973 | Alphanumeric |
| 102 | In Person | 974 | 2 | 975 | Numeric |
| 103 | Telehealth | 976 | 2 | 977 | Numeric |

| Billing Support Download File | | | | | |
|---|---|---|---|---|---|
| Field # | Field Name | Start Pos | Length | End Pos | Format |
| 104 | Active K1 | 978 | 1 | 978 | Alpha Y/N |
| 105 | CEST Start Date | 979 | 8 | 986 | MMDDYYYY, Numeric/Blank |
| 106 | CEST Outcome | 987 | 1 | 987 | Alpha C/E/M |
| 107 | Consent to Enroll Date | 988 | 8 | 995 | MMDDYYYY, Numeric/Blank |
| 108 | Segment Begin Date | 996 | 8 | 1003 | MMDDYYYY, Numeric/Blank |
| 109 | Initial CEST Due Date | 1004 | 8 | 1011 | MMDDYYYY, Numeric/Blank |
| 110 | CEST End Date | 1012 | 8 | 1019 | MMDDYYYY, Numeric/Blank |
| 111 | Adult or Child Services Provided Indicator | 1020 | 1 | 1020 | Alpha A/C |
| 112 | Excluded from CEST Policy as Exp HH+ | 1021 | 1 | 1021 | Alpha Y/N |
| 113 | Last DOS with Exp HH+ | 1022 | 8 | 1029 | MMDDYYYY, Numeric/Blank |
| 114 | AOT Member per OMH | 1030 | 1 | 1030 | Alpha Y/N |
| 115 | CMA OMH HH+ | 1031 | 1 | 1031 | Alpha Y/N |
| 116 | CMA AI HH+ | 1032 | 1 | 1032 | Alpha Y/N |
| 117 | CMA HFW | 1033 | 1 | 1033 | Alpha Y/N |
| 118 | Member HFW | 1034 | 1 | 1034 | Alpha Y/N |
| 119 | CMA MF | 1035 | 1 | 1035 | Alpha Y/N |
| 120 | MF Per Provider | 1036 | 1 | 1036 | Alpha Y/N |
| 121 | Segment Created By Transfer | 1037 | 1 | 1037 | Alpha Y/Blank |
| 122 | Appropriateness Code at BI Submission | 1038 | 2 | 1039 | Alphanumeric |
| 123 | Appropriateness Start Date at BI Submission | 1040 | 8 | 1047 | MMDDYYYY, Numeric/Blank |
| 124 | Appropriateness End Date at BI Submission | 1048 | 8 | 1055 | MMDDYYYY, Numeric/Blank |
| 125 | Appropriateness Sequence Number at BI Submission | 1056 | 2 | 1057 | Alphanumeric |

| Billing Support Download File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 126 | Associated Segment Network Type at BI Submission | 1058 | 1 | 1058 | Alphanumeric |
| 127 | Medically fragile/Complex | 1059 | 1 | 1059 | Alpha (Y/N) |
| 128 | Assessment ID (GUID) | 1060 | 32 | 1091 | Alphanumeric unique identifier Populated for CANS/HCBS 1Assessment Fee BIs. Blank for others. |
| 129 | Most Recent Segment Appropriateness Code | 1092 | 2 | 1093 | Alphanumeric |
| 130 | Most Recent Segment Appropriateness Start Date | 1094 | 8 | 1101 | MMDDYYYY, Numeric/Blank |
| 131 | Most Recent Segment Appropriateness End Date | 1102 | 8 | 1109 | MMDDYYYY, Numeric/Blank |
| 132 | Most Recent Segment Appropriateness Sequence Number | 1110 | 2 | 1111 | Alphanumeric |
| 133 | Most Recent Associated Segment Network Type | 1112 | 1 | 1112 | Alphanumeric |
| 134 | MF Per UAS | 1113 | 1 | 1113 | Alphanumeric |

**Editing Logic**

1. **Medicaid Eligibility Status** (field #9) 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 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.
        1. 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.

1. 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.
    1. 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 #10) and **Pend Reason Code Description** (field #11) will be blank for all billing instances that are not in Pend status on the billing instance service date.
5. When a provider submits 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 the corresponding month 1 BI. Users can use **Month Submitted** (field #76) 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.
    1. **HIV Viral Load** (field #28)
    2. **HIV T-Cell Count** (field #29)
    3. **HUD Category** (field #31)

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.
    1. **Incarceration Release Date** (field#33)
    2. **Mental Illness or Physical Health Inpatient Discharge Date** (field #35)
    3. **Substance Abuse Inpatient Stay Discharge Date** (field #37)
    4. **AOT Minimum Services Provided** (field #41**)**
    5. **AH Member qualifies for Adult Home Plus Care Management** (field #44)
    6. **AH Member transitioned to community (**field #45)
    7. **AH Member continues to quality** (field #46)
    8. **AH Member interested in transitioning** (field #47)

7. **Latest Transaction** (field #65)
   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.** **CANS Assessment Fee Billing Instance:** 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 an added billing instance (**Billing Instance Type** field #5 = 'F') to signal that the provider is eligible to bill the CANS NY Assessment Fee.
   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. The CANS Acuity field will display CANS-NY acuity 1.0 or 2.0, depending on the values coming into the system from the UAS.

10. Users cannot add a CANS NY Assessment Fee or an HCBS Assessment Fee billing instance (**Billing Instance Type** field #5 = 'F' or 'H'), only the system can add an Assessment Fee billing instance. Beginning with the 5/30/26 system release 5.0, users now are able to void a CANS NY Assessment Fee billing instance or HCBS Assessment Fee billing instance. For more details on how to submit these records, see the Billing Support Upload File section on Add/Voids above.
    a. For CANS and HCBS assessment billing instances, any 'W'/Add records successfully uploaded on a Billing Support Upload file will display on the Billing Support Download file as an 'A' record and any 'U'/Unvoid records successfully uploaded on a Billing Support Upload file will display on the Billing Support Download file as a 'V' record.

11. Billing instances with a **Billing Instance Type** (field #5) value of 'F' or 'H' 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.** **HH MMIS ID** (field #4)
    **e.** **Billing Instance Type** (field #5)
    **f.** **Member Fiscal County Code** (field #6)
    **g.** **MCP MMIS ID** (field #7)
    **h.** **Medicaid Eligibility Status** (field #9)
    **i.** **Member Fiscal County Code Description** (field #12)
    **j.** **CMA Name** (field #14)
    **k.** **CMA MMIS Provider ID** (field #15)
    **l.** **HH Name** (field #17)
    **m.** **MCP Name** (field #18)
    **n.** **Billing Entity MMIS ID** (field #19)
    **o.** **Billing Entity Name** (field #20)
    **p.** **Member Zip Code (**field #21)
    **q.** **Member First Name** (field #22)

r. **Member Last Name** (field #23)
s. **Member DOB** (field #24)
t. **Gender** (field #25)
u. **Rate Code** (field #48)
v. **Rate Code Description** (field # 49)
w. **Rate Amount** (field #50)
x. **Claim Status** (field #51)
y. **Date of Transaction** (field #52)
z. **Payment Cycle** (field #53)
aa. **Denial Reason Code** (field #54)
bb. **Denial Reason Code Description** (field #55)
cc. **Denial Reason Code (2)** (field #56)
dd. **Denial Reason Code Description (2)** (field #57)
ee. **Claim Provider ID** (field #58)
ff. **Claim Provider Name** (field #59)
gg. **Claim Rate Code** (field #60)
hh. **Claim Provider ID equals MAPP Billed Entity MMIS ID** (field #61)
ii. **Claim Rate Code equals MAPP HML Rate Code** (field #62)
jj. **Assessment Completion Date** (field #67)
kk. **Latest transaction** (field #63)
ll. **Last Transaction Date Time** (field #65)

12. For billing instances with a **Billing Instance Type** (field #5) value of 'O' or 'E', the system will populate the **Assessment Completion Date** (field #67) with the signed and finalized date of the CANS NY Assessment that determined the rate amount for the billing instance was completed.
13. The **Payor** (field #16): 'P' for members enrolled in a mainstream plan or 'F' for members enrolled in a non-mainstream plan and fee for service members.
14. 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).
15. **Last Transaction Date Time** (field #65) is populated with the date and time that the record was last modified, regardless of the billing instance status.
16. **Insert Date** (field #66) 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'.
17. **Void Date** (field #68) only displays for voided billing instances and will display the date the billing instance was voided.
18. **Provided Service Indicator** (field #73) will be populated with an "A" for Adult or "C" for Child based on the network type associated with the segment.
19. **UAS Complexity Assessment** (field #81) will be populated with a 'Y', 'N', or 'U'.
20. **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.

21. **MCP Type** (field #75) will be populated with HMO, PHSP, SNP, HARP, FIDA, MLTC, MAP, OTHER, OR BLANK
22. **Validation Code** (field #78) and **Validation Code Description** (field #79): There are two types of validations displayed on the Billing Support Download file: billing blocks and warnings.
    a. Validation codes appear on the Billing Support Download file when a potential billing instance would be prevented from being added to the system (see *Appendix P: Billing Instance Validation Codes* for codes, validations, validation ordering), meaning that the member is not eligible for Health Home services that month. For example, if a member is not Medicaid eligible as of the BI **service date** the system will create a BI for that month with a value of 'E' in the **Validation Code** field and a value of 'Cannot create assessment for Medicaid Ineligible members' in the **Validation Code Description** field.
    b. If a potential billing instance fails, more than one validation the system will populate the first validation detected based on the processing order of operations outlined in Appendix P: Billing Instance Validation Codes. For example, if the member is Medicaid ineligible and does not have a valid Plan of Care, the validation code associated with that BI would be 'E' and not 'K'.
23. The file will display a validation code for members that have an HCBS Assessment AND the member's most recent HCBS Assessment is greater than one year from potential BI service date. This validation code will still allow the provider to add the billing instance, as the validation on the file is informational only to notify the provider of an overdue HCBS Assessment. **Plan of Care Date from Consent and Member Program File** (field #80) will be populated with the latest POC date that is earlier than the BI service date for the given period. This field will only be populated for Enrollment Segments.
24. The values in **OMH HH+ Eligible** (field #82) and **OMH HH+ Elig STATUS Desc**(field #83) are transmitted from OMH for informational purposes only and do not have bearing on rate calculation.
25. The value of **OMH HH+ Elig STATUS Desc**(field #83) will be the two or three-digit-codes concatenated separated by a space in ascending order. These codes are available in the .xlsx MAPP File Specifications document.
26. The values in **OMH HH+ Eligible** (field #82) and **OMH HH+ Elig STATUS Desc**(field #83) will begin to populate the file for BIs starting with the 12/1/2021 date of service. Beginning with files downloaded on or after 12/20/2021, these fields will appear on the file and will be populated for completed BIs that are submitted on or after 12/20/2021 and all potential BIs.
27. **HCBS Assessment Fee Billing Instance** - the system will create a potential billing instance with a **Billing Instance Type** (field #5) value of 'H' if the UAS feed indicates that an HCBS Assessment was completed for a member and the appropriate criteria is satisfied. The resulting BI indicates that the provider is eligible to receive reimbursement for the HCBS Assessment.
    a. For HCBS assessment completion date from 4/1/21 – 12/31/23: HCBS assessment fee billing instances will be created for the HH/CMA that a member was enrolled with as of the date the HCBS assessment was completed. These BIs will be created using the HCBS assessment dates emailed to Health Homes by the NYS DOH HHSC team via email in July 2024, which is based on information from the UAS.
    b. For HCBS assessment completion date on or after 1/1/24 an HCBS assessment fee BI will be created if the following conditions are met:
        1. The HCBS assessment finalized is within 45 days of the segment start date
        2. There is no other HCBS assessment fee BI for the member with the same finalized date
        3. No other HCBS assessment fee BI exists in past 300 days (10 months), from the new HCBS assessment finalized date

4. The new HCBS assessment finalized date is within 365 days from the finalized date of existing latest HCBS Assessment *(this means re-assessments MUST be completed within a year OR providers WILL NOT BE ELIGIBLE FOR ASSESSMENT FEE)*
5. The **Assessment Reason** from UAS is '0' *Initial Assessment* or '1' *Re-assessment*

c. Example
1. The system creates HCBS Assessment Fee BI for the 8/1/23 HCBS assessment.
2. If the provider completes another HCBS assessment on 8/2/24, the system will display that within the HHTS but **will not** create an HCBS Assessment Fee BI (**past 365 days**). The 8/2/24 HCBS assessment becomes the new "start date" to determine when the next HCBS Assessment Fee BI can be created.
3. If next HCBS assessment created 5/1/25, the system will display assessment within HHTS and system **will not** create an HCBS assessment Fee BI (**less than 300 days from 8/2/24**)
4. If next HCBS assessment created 6/1/25, the system will display assessment within HHTS and system **will** create an HCBS assessment BI (**Greater than 300 days from 8/2/24 and less than 365 days from 8/2/24**)
5. If next HCBS assessment created 8/13/25, the system would bring in the assessment but **will not** create an HCBS assessment BI (**Greater than 365 days from 8/2/24**)
6. **Note**: If a HCBS Assessment, upon Active or Pended Enrollment Segment was created on another CIN **for the same GUID Assessment ID**, then a HCBS Assessment Fee BI will not be created on the new CIN.

| Last HCBS Assessment Completed | Next HCBS Assessment completed Date | Assessment Fee BI Created? | Reason Assessment Fee BI is <u>or</u> is not Created |
|---|---|---|---|
| None | 8/1/2023 | Y | First assessment submitted |
| 8/1/2023 | 8/2/2024 | N | > 365 Days from 8/1/2023 date |
| 8/2/2024 | 5/1/2025 | N | < 300 days from 8/2/2024 date |
| 8/2/2024 | 6/1/2025 | Y | > 300 days and < 365 days from 8/2/24 date |
| 8/2/2024 | 8/13/2025 | N | > 365 Days from 8/1/2023 date |

28. The **Submitted POC Signature Date** field (field #80) will be populated with the signature date of the most recent Plan of Care submitted on the <u>POC Upload File</u> that overlaps with the member service date for that row on the download file.
29. Field #s 104 – 108 display member information with effective dates that cover the billing instance.
30. Field # 109 displays the month/year a member's initial CEST outcome is due to the system as outlined in the **Connection Between CEST and Billing Instances in MAPP HHTS** **v.3** file posted to the website. If the member is part of a population that is excluded from the CEST policy, this field will be blank.
31. Field #110 **CEST End Date** this field will be populated with member's current **CEST Start Date** as of the record's service date. If the member does not have a **CEST Outcome** in the system, or if the member's CEST Outcome submitted to the system is expired, this field will be blank.
32. Field #112 **Excluded from CEST Policy as Exp HH+** will be populated with 'Y' if the member is enrolled in a health home in the adult program and is excluded from the CEST billing policy that service month because they have a value other than 'A' in the **Expanded HH+ population** field within the past year.
    a. Example: For service date 08/01/2024, system will check if there is a non-A value in the Expanded HH+ population field in any of the BI of Service dates from 08/01/2023 to 08/01/2024.

If a non-A value is found in any of these 13 possible records, then the member is considered part of the Expanded HH+ Population and is therefore excluded from the CEST.

b. If the member is subject to the CEST policy and either does not have values in the **Expanded HH+ population** field in the past year or only has values of 'A' in the past year, this field will be populated with 'N'

33. If the system knows the member is part of a population excluded from the CEST submission requirement, this field will be blank. Field #113 **Last DOS with Exp HH+** will be populated with the service date of the last billing instances added to the tracking system where the member had a value other than 'A' in the **Expanded HH+ population**. If the member doesn't have a value other than 'A' in this field in the past 12 months, this field will be blank.

    a. Example: For service date 08/01/2024, if system finds a non-A value in the **Expanded HH+ Population** field in the member's previous billing instances and that record's service dates is 03/01/2024, and no other BI with a non-A value in the **Expanded HH+ Population** field after that, then this field will be populated with 03/01/2024. Otherwise, this field will be blank.

34. Field #111 **Adult or Child Services Provided Indicator** will be populated with the **Adult or Child Services Provided Indicator** value associated with the member segment that supports the billing instance service date.

35. Field numbers , 114-120 are descriptor fields that are populated with 'Y' if the member/CMA has the specific characteristic documented within the system as of the billing instance service date (if not, field will contain 'N').

    **a.** **AOT Member per OMH** a member's AOT status and AOT dates are provided to the system each weekend by OMH. If the member is identified as AOT per this feed as of the billing instance service date, this field will be populated with a 'Y'. The detailed AOT information from OMH is included in the **Member Program Status Download** file.

    **b.** **CMA OMH HH+/CMA HFW** and **CMA AI HH+:** these CMA flags are determined by OMH/Aids Institute. A HH can review this type of CMA information for their CMAs they are working with on the HH CMA Relationship Download file

    **c.** **CMA MF** is a CMA provider distinction that the DOH HHSC policy team maintains within the system.

    **d.** **Member HFW**: the dates a member is identified as HFW is submitted and maintained in the system by HHs using the Consent and Member Program Status Upload file. A member's detailed HFW status is available on the Member Program Status Download.

**36.** Beginning with release 4.8.2, members with segments created using the system's official transfer process will be excluded from the initial appropriateness policy requiring IA be submitted within the IA grace period and therefore are exempt from the IA billing block. The **Segment Created By Transfer** field was added to this file to identify billing instances that are associated with a segment that was created through the system's transfer process and therefore excluded from the IA billing block.

**37.** Yearly Appropriateness – beginning with release 4.8.2, will be required for members enrolled in the HHSC program as described by the HHSC appropriateness policy. Beginning 9/1/2026, the system will begin blocking billing for members that have been enrolled for over a year and do not have a yearly appropriateness record submitted to the system. To help providers keep track of member's appropriateness records, this file will display the member's appropriateness record information in the file in fields 121 – 125.

**38.** Field # 125 **Associated Segment Network Type** is populated with either A or C to indicate if the member's BIs is associated with an adult (A) or a children's (C) program segment.

39. Logic has been added to the system to accommodate the new Medically Fragile HHSC rate, which is awaiting approval. More information will be released about this rate by the DOH HHSC policy team. Once this rate is approved and turned on in the system, the following criteria must be met for a member to qualify for the new rate:
    a. **MF Per UAS** = 'Y' for the BI service date (value comes from UAS, not from HH submission to the system)
    **b.** **CMA MF** = 'Y' for the BI service date
    **c.** **Core Service Provided** = 'Y'
40. The added and voided billing instances the most recent appropriateness record before or equal to the service month that will allow the billing instance to pass the appropriateness validation(s) at the time of the billing instance submission.
    a. For example:

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| member's segment begin date is 1/1/25 | | | | | | | | | | | | |
| member appropriateness record start dates of: | | | | | | | | | | | | |
| 1. 2/10/25, submitted before 2/1 BI has been submitted | | | | | | | | | | | | |
| 2. 5/15/25, submitted before 5/1 BI has been submitted | | | | | | | | | | | | |
| 3. 7/20/25, submitted after 7/1 BI has been submitted | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| For completed BIs, Service Date: | 1/1 | 2/1 | 3/1 | 4/1 | 5/1 | 6/1 | 7/1 | 8/1 | 9/1 | 10/1 | 11/1 | 12/1 |
| "Appropriateness Start Date at BI Submission" will display as: | Blank | 2/10 | 2/10 | 2/10 | 5/15 | 5/15 | 5/15 | 7/20 | 7/20 | 7/20 | 7/20 | 7/20 |

    b. This rule is utilized in the population of the following fields:
        **1. Appropriateness Code at BI Submission**
        **2. Appropriateness Start Date at BI Submission**
        **3. Appropriateness End Date at BI Submission**
        **4. Appropriateness Sequence Number at BI Submission**

# Provider Files

## Provider Files

### HH 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:

- 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.
- 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.
- 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**

| HH 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) |
| 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) |

## HH Partner Network File Error Report

**Description**

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

**Format**

| HH 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) |

| Partner Network File Download | | | | | | |
|---|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Required (Y/N/C-conditional) | Format |
| 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.

## Provider Relationship Download File

**Description**

This file can be downloaded by MCPs, HHs and CMAs through the ***File Download*** screen. Based on a user's Provider ID and role, this file contains a provider's relationships (MCP to HH, HH to CMA) that are active, closed, and cancelled.

**Format**

| Provider Relationship Download File | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 1 | Managed Care Plan | 1 | 40 | 40 | Alpha |
| 2 | MCP MMIS ID | 41 | 8 | 48 | Numeric |
| 3 | Health Home | 49 | 40 | 88 | Alpha |
| 4 | HH MMIS ID | 89 | 8 | 96 | Numeric |
| 5 | Care Management Agency | 97 | 40 | 136 | Alpha |
| 6 | CMA MMIS ID | 137 | 8 | 144 | Numeric |
| 7 | Begin Date | 145 | 8 | 152 | MMDDYYYY, Numeric |
| 8 | End Date | 153 | 8 | 160 | MMDDYYYY, Numeric |
| 9 | Relationship Status | 161 | 8 | 168 | Alpha |
| 10 | Reason | 169 | 40 | 208 | Alphanumeric |
| 11 | Auto Approval | 209 | 3 | 211 | Alpha (Y/N) |
| 12 | Direct Bill Override | 212 | 3 | 214 | Alpha (Y/N) |
| 13 | OMH HH+ Flag | 215 | 3 | 217 | Alpha (Y/N) |
| 14 | OMH HH+ Flag Start Date | 218 | 8 | 225 | MMDDYYYY, Numeric |
| 15 | OMH HH+ Flag End Date | 226 | 8 | 233 | MMDDYYYY, Numeric |

| Provider Relationship Download File | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 16 | Active Enrollment | 234 | 6 | 239 | Numeric |
| 17 | Closed Enrollment | 240 | 6 | 245 | Numeric |
| 18 | Pended Enrollment | 246 | 6 | 251 | Numeric |
| 19 | Pending Canceled Enrollment | 252 | 6 | 257 | Numeric |
| 20 | Pending Pended Enrollment | 258 | 6 | 263 | Numeric |
| 21 | Pending Closed Enrollment | 264 | 6 | 269 | Numeric |
| 22 | Pending Active Enrollment | 270 | 6 | 275 | Numeric |
| 23 | CMA Active Enrollment | 276 | 6 | 281 | Numeric |
| 24 | MCP Gatekeeper Role | 282 | 3 | 284 | Numeric |
| 25 | MCP Worker Role | 285 | 3 | 287 | Numeric |
| 26 | HH Gatekeeper Role | 288 | 3 | 290 | Numeric |
| 27 | HH Worker Role | 291 | 3 | 293 | Numeric |
| 28 | CMA Gatekeeper Role | 294 | 3 | 296 | Numeric |
| 29 | CMA Worker Role | 297 | 3 | 299 | Numeric |
| 30 | MCP Merger Note | 300 | 200 | 499 | Alphanumeric |
| 31 | MCP Name Note | 500 | 200 | 699 | Alphanumeric |
| 32 | MCP MMIS ID Note | 700 | 200 | 899 | Alphanumeric |
| 33 | MCP Closure Note | 900 | 200 | 1099 | Alphanumeric |
| 34 | MCP Other Note | 1100 | 200 | 1299 | Alphanumeric |
| 35 | HH Merger Note | 1300 | 200 | 1499 | Alphanumeric |
| 36 | HH Name Note | 1500 | 200 | 1699 | Alphanumeric |
| 37 | HH MMIS ID Note | 1700 | 200 | 1899 | Alphanumeric |
| 38 | HH Closure Note | 1900 | 200 | 2099 | Alphanumeric |
| 39 | HH Other Note | 2100 | 200 | 2299 | Alphanumeric |
| 40 | HH EHR Note | 2300 | 30 | 2329 | Alphanumeric |
| 41 | CMA Merger Note | 2330 | 200 | 2529 | Alphanumeric |
| 42 | CMA Name Note | 2530 | 200 | 2729 | Alphanumeric |
| 43 | CMA MMIS ID Note | 27830 | 200 | 2929 | Alphanumeric |
| 44 | CMA Closure Note | 2930 | 200 | 3129 | Alphanumeric |
| 45 | CMA Other Note | 3130 | 200 | 3329 | Alphanumeric |
| 46 | AI HH+ Flag | 3330 | 3 | 3332 | Alphanumeric |
| 47 | AI HH+ Flag Start Date | 3333 | 8 | 3340 | MMDDYYYY, Numeric |
| 48 | AI HH+ Flag End Date | 3341 | 8 | 3348 | MMDDYYYY, Numeric |
| 49 | MCP Identifier | 3349 | 18 | 3366 | Alphanumeric |
| 50 | HH Identifier | 3367 | 18 | 3384 | Alphanumeric |
| 51 | CMA Identifier | 3385 | 18 | 3402 | Alphanumeric |

| Provider Relationship Download File | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 52 | HFW Flag | 3403 | 3 | 3405 | Alpha |
| 53 | HFW Flag Start Date | 3406 | 8 | 3413 | MMDDYYYY, Numeric |
| 54 | HFW Flag End Date | 3414 | 8 | 3421 | MMDDYYYY, Numeric |

**Editing Logic**

1) This file contains all relationships that have even been documented within the system. Field #s 7-10 contain the effective dates of the relationship, the relationship status, and why a closed relationship has ended.
2) **When an MCP user downloads this file,** the CMA fields (# 5 & 6) will be blank. The MCP fields (# 1 & 2) will be populated with the user's MCP's MMIS Provider ID. The HH fields (# 3 & 4) will be populated with the HHs that the MCP has ever had a relationship with.
3) **When a HH user downloads this file,** the CMA & MCP fields (#1,2,5,6) will be populated with the providers that the HH has ever had a relationship with. The HH fields (# 3 & 4) will be populated with the user's HH's MMIS Provider ID.
4) **When a CMA user downloads this file,** the MCP fields (# 1 & 2) will be blank. The HH fields (# 3 & 4) will be populated with the HHs that the CMA has ever had a relationship with. The CMA fields (# 5 & 6) will be populated with the user's CMA's MMIS Provider ID.
5) If an MMIS Provider ID is both a HH and a CMA, the ***Provider Relationship*** screen will show all relationships associated with that MMIS provider ID. However, Provider Relationship file will only contain the relationships associated with the user's provider ID and role. For example:
    a. MMIS Provider ID 01111111 is both a HH and a CMA. CMA 01111111 has a relationship associated with both HH 01111111 and HH 02222222 and HH 01111111 has a relationship with CMA 01111111, CMA 03333333, and MCP 04444444.
    b. The Provider Relationship file downloaded by a user with HH 01111111 will see the following relationships:
        i. HH 01111111 to CMA 01111111
        ii. HH 01111111 to CMA 03333333
    c. The Provider Relationship file downloaded by a user with HH 01111111 will see the following relationships:
        i. HH 01111111 to CMA 01111111
        ii. HH 02222222 to CMA 03333333
6) Fields (#67-22) are populated with the number of members with the listed enrollment segment status with the providers identified in the record.
    a. **When an MCP user downloads this file,** these fields will contain the count of members in the listed enrollment segment status with the HH listed in the record AND enrolled in the downloading MCP.
    b. **When a HH user downloads this file and the MCP fields are populated**, these fields will contain the count of members in the listed enrollment segment status with the HH listed in the record AND enrolled in the MCP listed in the file.

c. **When a HH user downloads this file and the CMA fields are populated**, these fields will contain the count of members in the listed enrollment segment status with both the HH and the CMA listed in the record.
d. **When a CMA user downloads this file,** these fields will contain the count of members in the listed enrollment segment status with both the HH and the CMA listed in the record.

7) CMA Active Enrollment (field #23) will populate with the number of all active enrollment segments for the CMA across all HHs and is not specific to the HH-CMA relationship pairing in the line item.
8) Fields # 49-51 will be blank unless DOH has assigned the provider ID/provider type an identifier.
9) This file includes the functionality to flag a CMA as a HFW provider to support the proposed Health Home Serving Children's HFW Rate. THIS NEW RATE HAS NOT YET BEEN APPROVED AND CMAs HAVE NOT YET BEEN IDENTIFIED IN THE SYSTEM AS HFW. More information will be released upon approval of this new rate.
10) Field # 52 **HFW Flag** will be blank if the provider is MCP, HH, or a CMA that has never been identified in the system as a High-Fidelity Wraparound (HFW) provider. If the CMA is currently a HFW provider, this field will = 'Yes'. If the CMA was identified as HFW in the past but is not currently a HFW provider, this field will = 'No'.
    a. If HFW = 'Yes', fields 53 & 54 will be populated with the CMA's current HFW effective dates.
    b. If HFW = 'Yes', fields 53 & 54 will be populated with the CMA's most recent HFW effective dates.

## Provider Contact Download

**Description**

This file can be downloaded by MCPs, HHs and CMAs through the ***File Download*** screen. This file contains all staff members that have been entered into the 'Provider members' inner tab (located within the relationships tab) by the MAPP Gatekeeper, for any assigned role in an active or canceled status.

**Format**

| Provider Contact Download | | | | |
|---|---|---|---|---|
| **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| Organization Name | 1 | 40 | 40 | Alphanumeric |
| Organization ID | 41 | 8 | 48 | Numeric |
| Program Name | 49 | 100 | 148 | Alphanumeric |
| Name | 149 | 40 | 188 | Alphanumeric |
| Email | 189 | 40 | 228 | Alphanumeric |
| Phone | 229 | 12 | 240 | Numeric |
| Fax Number | 241 | 12 | 252 | Numeric |
| Street 1 | 253 | 30 | 282 | Alphanumeric |
| Street 2 | 283 | 30 | 312 | Alphanumeric |
| Apt/Suite | 313 | 8 | 320 | Alphanumeric |
| City | 321 | 30 | 350 | Alphanumeric |
| State | 351 | 2 | 352 | Alphanumeric |
| Zip | 353 | 5 | 357 | Alphanumeric |
| From Date | 358 | 8 | 365 | MMDDYYYY, Numeric |
| To Date | 366 | 8 | 373 | MMDDYYYY, Numeric |

| Provider Contact Download | | | | |
|---|---|---|---|---|
| **Field Name** | **Start Pos** | **Length** | **End Pos** | **Format** |
| Role | 374 | 40 | 413 | Alpha |
| Title | 414 | 40 | 453 | Alphanumeric |
| Status | 454 | 10 | 463 | Alphanumeric |
| Last Updated By | 464 | 40 | 503 | Alphanumeric |
| Last Updated On | 504 | 8 | 511 | MMDDYYYY, Numeric |
| Position | 512 | 500 | 1011 | Alphanumeric |

**Editing Logic**

1. Field #3 contains the program name as reported by the provider. This will generally be populated if the program name is different from the name associated with the provider's MMIS ID in eMedNY. Field #3 will be blank if a program name has not been entered in the home tab of a provider's profile in MAPP HHTS.
2. All information contained in fields #3-17 is entered into the screen by the listed provider's gatekeeper(s). If information contained within this file is incorrect or outdated for your organization, please contact your organization's MAPP Gatekeeper(s) to update the information.
3. Field #14-15 contain the effective dates of positions assigned in the system after Release 4.4 implementation.
4. Field #21 contains the position that has been assigned to a provider's staff member. A staff member can have multiple positions such as 'Referral Contact' and 'HCS Contact'. The 'Role' will identify if the position is related to HHSA or HHSC for that organization.
5. Field #18 contains the status of the assigned position in the system. A user will have an active status if the end date is blank or in the future. The user will have a -closed status if the end date is in the past.
6. All information contained in this screen prior to Release 4.4 implementation will be purged. MAPP Gatekeepers will need to enter the organization's staff members and assign their Position(s) after 4.4 implementation, for this file to be populated.

## Provider Active User Download

**Description**

This file can be downloaded by MCPs, HHs and CMAs through the ***File Download*** screen. Based on a user's Provider ID and role, this file contains all the active users that are associated with the provider. It is the provider's responsibility to update this information in MAPP HHTS through the provider's gatekeeper(s).

**Format**

| Provider Active User Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Name | 1 | 40 | 40 | Alpha |
| 2 | Email Address | 41 | 40 | 80 | Alphanumeric |
| 3 | Area Code | 81 | 3 | 83 | Numeric |

| Provider Active User Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 4 | Phone Number | 84 | 10 | 93 | Numeric |
| 5 | Role | 94 | 4 | 97 | Alpha |
| 6 | Title | 98 | 40 | 137 | Alpha |
| 7 | From | 138 | 8 | 145 | MMDDYYYY, Numeric |
| 8 | To | 146 | 8 | 153 | MMDDYYYY, Numeric |
| 9 | Status | 154 | 8 | 161 | Alpha |
| 10 | Provider Name | 162 | 40 | 201 | Alpha |
| 11 | MMIS Provider ID | 202 | 8 | 209 | Numeric |
| 12 | Program Name | 210 | 100 | 309 | Alphanumeric |
| 13 | Position Type | 310 | 500 | 809 | Alpha |

**Editing Logic**

1) This file contains all active users with a MAPP role (Gatekeeper, Worker, Read Only, Screener, Dashboard Only) associated with a provider within the system. Field #s 7-8 contain the effective dates of user in the system. Field #9 contains the status of the user in the system.
2) When a provider downloads this file, Field #s 10-11 contain the provider's name and MMIS Provider ID.
3) All the information contained in this file was entered into the system by the provider's gatekeeper(s). If information contained within this file is incorrect or outdated, please contact you provider's gatekeeper to correct the information.
4) This file only contains active contacts.

## Health Home County Code Download File

**Description**

This file can be downloaded by MCPs, HHs, and CMAs. This file contains current and past information about the counties that active Health Homes are designated to serve.

**Format**

| Health Home County Code Download File | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 1 | HH MMIS Provider ID | 1 | 8 | 8 | Numeric |
| 2 | HH Name | 9 | 40 | 48 | Alpha |
| 3 | County Name | 49 | 40 | 88 | Alpha |
| 4 | County Code | 89 | 2 | 90 | Numeric |
| 5 | Region | 91 | 9 | 99 | Alphanumeric |
| 6 | HH Provider Type | 100 | 25 | 124 | Alphanumeric |
| 7 | From Date | 125 | 8 | 132 | MMDDYYYY, Numeric |
| 8 | To Date | 133 | 8 | 140 | MMDDYYYY, Numeric |
| 9 | Status | 141 | 8 | 148 | Alpha |

**Editing Logic**

1) There will be one row for each associated county code and provider type per active Health Home.

A single County Code may populate for a Health Home multiple times if it has From Date and To Date that make it a separate entry. Example: Health Home 'A' has County Code '01' with a From Date of 1/1/2012 and a To Date of 12/31/2012. Additionally, County Code '01' also exists for Health Home 'A' with a From Date of 1/1/2020 and a To Date of 12/31/2020. In this example, there would be a row for each of the From – To time periods for County Code '01' for Health Home 'A'.

2) A single County Code may populate for a Health Home multiple times if the provider services both adults and children.

Example: Health Home 'A' has Provider Types of both Health Home – Adult and Children's Health Home. Additionally, County Code '01' also exists for Health Home 'A'. In this example, there would be a row for each of the Provider Types for County Code '01' for Health Home 'A'.

## MCP HH Relationship Download

**Description**

This file can be downloaded by MCPs, HHs, and CMAs. The file will contain all active MCP-HH relationships.

**Format**

| MCP HH Relationship Download | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | MCP MMIS Provider ID | 1 | 8 | 8 | Numeric |
| 2 | MCP Name | 9 | 40 | 48 | Alphanumeric |
| 3 | MCP Type | 49 | 40 | 88 | Numeric |
| 4 | HH MMIS Provider ID | 89 | 8 | 96 | |
| 5 | HH Name | 97 | 40 | 136 | Alphanumeric |
| 6 | HH Provider Type | 137 | 40 | 176 | Alphanumeric |
| | | | | | |
| 7 | MCP-HH Relationship From Date | 177 | 8 | 184 | MMDDYYYY, Numeric |
| 8 | MCP Notes Acquisition or Merger | 185 | 200 | 384 | Alphanumeric |
| 9 | MCP Notes Estimated Closure Date | 385 | 200 | 584 | Alphanumeric |
| 10 | MCP Notes MMIS ID Change | 585 | 200 | 784 | Alphanumeric |
| 11 | MCP Notes Name Change | 785 | 200 | 984 | Alphanumeric |
| 12 | MCP Notes Other | 985 | 200 | 1184 | Alphanumeric |
| 13 | HH Notes Acquisition or Merger | 1185 | 200 | 1384 | Alphanumeric |
| 14 | HH Notes Estimated Closure Date | 1385 | 200 | 1584 | Alphanumeric |
| 15 | HH Notes MMIS ID Change | 1585 | 200 | 1784 | Alphanumeric |
| 16 | HH Notes Name Change | 1785 | 200 | 1984 | Alphanumeric |
| 17 | HH Notes Other | 1985 | 200 | 2184 | Alphanumeric |

| MCP HH Relationship Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 18 | MCP Identifier - Other | 2185 | 18 | 2202 | Alphanumeric |
| 19 | HH Identifier - Other | 2203 | 18 | 2220 | Alphanumeric |
| 20 | HH COS Status | 2221 | 2 | 2222 | Alphanumeric |
| 21 | HH COS Status Description | 2223 | 40 | 2262 | Alphanumeric |
| 22 | HH COS Begin Date | 2263 | 8 | 2270 | MMDDYYYY, Numeric |

**Editing Logic**

1) This file contains all MCP-HH relationships active as of the date the file is downloaded.

## HH CMA Relationship Download File

**Description**

This file can be downloaded by MCPs, HHs, and CMAs. The file will contain all active HH-CMA relationships.

**Format**

| HH CMA Relationship Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 1 | HH MMIS Provider ID | 1 | 8 | 8 | Numeric |
| 2 | HH Name | 9 | 40 | 48 | Alphanumeric |
| 3 | CMA MMIS Provider ID | 49 | 8 | 56 | Numeric |
| 4 | CMA Name | 57 | 40 | 96 | Alphanumeric |
| 5 | HH-CMA Relationship From Date | 97 | 8 | 104 | MMDDYYYY, Numeric |
| 6 | OMH HH+ Flag | 105 | 3 | 107 | Alpha |
| 7 | OMH HH+ Flag Start Date | 108 | 8 | 115 | MMDDYYYY, Numeric |
| 8 | OMH HH+ Flag End Date | 116 | 8 | 123 | MMDDYYYY, Numeric |
| 9 | HH Provider Type | 124 | 40 | 163 | Alphanumeric |
| 10 | CMA Provider Type | 164 | 225 | 388 | Alphanumeric |
| 11 | Active Enrollment | 389 | 6 | 394 | Numeric |
| 12 | Closed Enrollment | 295 | 6 | 400 | Numeric |
| 13 | Pended Enrollment | 401 | 6 | 406 | Numeric |
| 14 | Pending Canceled Enrollment | 407 | 6 | 412 | Numeric |
| 15 | Pending Pended Enrollment | 413 | 6 | 418 | Numeric |
| 16 | Pending Closed Enrollment | 419 | 6 | 424 | Numeric |
| 17 | Pending Active Enrollment | 425 | 6 | 430 | Numeric |
| 18 | CMA Active Enrollment | 431 | 6 | 436 | Numeric |
| 19 | HH Gatekeeper Role | 437 | 3 | 439 | Numeric |
| 20 | HH Worker Role | 440 | 3 | 442 | Numeric |
| 21 | CMA Gatekeeper Role | 443 | 3 | 445 | Numeric |
| 22 | CMA Worker Role | 446 | 3 | 448 | Numeric |
| 23 | AI HH+ Flag | 449 | 3 | 451 | Alpha |
| 24 | AI HH+ Flag Start Date | 452 | 8 | 459 | MMDDYYYY, Numeric |

| HH CMA Relationship Download | | | | | |
|---|---|---|---|---|---|
| Field # | Field | Start Pos | Length | End Pos | Format |
| 25 | AI HH+ Flag End Date | 460 | 8 | 467 | MMDDYYYY, Numeric |
| 26 | HH Notes Acquisition or Merger | 468 | 200 | 667 | Alphanumeric |
| 27 | HH Notes Estimated Closure Date | 668 | 200 | 867 | Alphanumeric |
| 28 | HH Notes MMIS ID Change | 868 | 200 | 1067 | Alphanumeric |
| 29 | HH Notes Name Change | 1068 | 200 | 1267 | Alphanumeric |
| 30 | HH Notes Other | 1268 | 200 | 1467 | Alphanumeric |
| 31 | CMA Notes Acquisition or Merger | 1468 | 200 | 1667 | Alphanumeric |
| 32 | CMA Notes Estimated Closure Date | 1668 | 200 | 1867 | Alphanumeric |
| 33 | CMA Notes MMIS ID Change | 1868 | 200 | 2067 | Alphanumeric |
| 34 | CMA Notes Name Change | 2068 | 200 | 2267 | Alphanumeric |
| 35 | CMA Notes Other | 2268 | 200 | 2467 | Alphanumeric |
| 36 | HH Identifier | 2468 | 18 | 2485 | Alphanumeric |
| 37 | CMA Identifier | 2486 | 18 | 2503 | Alphanumeric |
| 38 | HFW Flag | 2504 | 3 | 2506 | Alpha |
| 39 | HFW Flag Start Date | 2507 | 8 | 2514 | MMDDYYYY, Numeric |
| 40 | HFW Flag End Date | 2515 | 8 | 2522 | MMDDYYYY, Numeric |
| 41 | MF HH+ | 2523 | 1 | 2523 | Alpha (Y/N) |
| 42 | MF HH+ Start Date | 2524 | 8 | 2531 | MMDDYYYY, Numeric |
| 43 | MF HH+ End Date | 2532 | 8 | 2539 | MMDDYYYY, Numeric |
| 44 | Auto Approval | 2540 | 1 | 2540 | Alpha |
| 45 | HH COS Status | 2541 | 2 | 2542 | Alphanumeric |
| 46 | HH COS Status Description | 2543 | 40 | 2582 | Alphanumeric |
| 47 | HH COS Begin Date | 2583 | 8 | 2590 | MMDDYYYY, Numeric |
| 48 | CMA COS Status | 2591 | 2 | 2592 | Alphanumeric |
| 49 | CMA COS Status Description | 2593 | 40 | 2632 | Alphanumeric |
| 50 | CMA COS Begin Date | 2633 | 8 | 2640 | MMDDYYYY, Numeric |

**Editing Logic**

1) This file contains all active HH-CMA relationships as of the date the file is downloaded.
2) **OMH HH+ Flag and AI HH+ Flag End Date** (Field #8, Field 25) will be populated if the **HH+ Flag** (field #6, Field #23) is 'No' and an end date exists.
3) **Health Home Provider Type** (Field #9) if there are multiple provider types, they will be populated in the field separated by space until the maximum field length is reached.
4) **Care Management Agency Provider Type** (Field #10) if there are multiple provider types, they will be populated in the field separated by a space until the maximum field length is reached.
5) Fields (#11-17) are populated with the number of members with the listed enrollment segment status with the providers identified in the record.
6) CMA Active Enrollment (field #18) will populate with the number of all active enrollment segments for the CMA across all HHs and is not specific to the HH-CMA relationship pairing in the line item.

# Transfer Files

## Transfer Out Download

**Description**

The Transfer Out Download can be downloaded by HHs and CMAs. This file contains a record for every enrollment segment connected to the downloading provider in the system that is eligible to be transferred out by the downloading provider. This file is intended to be a 'prep' file for the *Act on Transfer Out Upload* file. This means that the file is the exact same format as the companion upload file. The first few fields in the file will be populated with member segment information and the remaining fields will be blank. The downloading provider can then remove the rows they will not use and then populate the appropriate fields to initiate the transfer of a member segment out of their organization. Using this file as a prep file is not required by the system but is meant to helpful where applicable.

**Format**

| Transfer Out File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Record Type | 1 | 1 | 1 | Alpha |
| 2 | Member ID | 2 | 8 | 9 | AA11111A, Alphanumeric |
| 3 | Transfer From HH MMISID | 10 | 8 | 17 | Numeric |
| 4 | Transfer From CMA MMISID | 18 | 8 | 25 | Numeric |
| 5 | Transfer to HH MMISID | 26 | 8 | 33 | Numeric |
| 6 | Transfer to CMA MMISID | 34 | 8 | 41 | Numeric |
| 7 | Effective Date of Transfer | 42 | 8 | 49 | MMDDYYYY, Numeric |
| 8 | Transfer Reason Code | 50 | 2 | 51 | Numeric |
| 9 | Transfer Reason Comment | 52 | 40 | 91 | Alphanumeric |

**Editing Logic**

a) The following fields are purposely blank. They are meant to be place holders for the fields required in the Act on Transfer Out Upload File:
   - **Transfer to HH MMISID** (field #5)
   - **Transfer to CMA MMISID** (field #6)
   - **Effective Date of Transfer** (field #7)
   - **Transfer Reason Code** (field #8)
   - **Transfer Reason Comment** (field #9)

## Act on Transfer Out Upload

**Description**

This file is uploaded by HHs only to submit transfers for enrollment segments. The transfer can either be from Health Home to Health Home or from CMA to CMA. MCPs and CMAs cannot upload this file into the system.

**Format**

| Act on Transfer Out Upload | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Record Type | 1 | 1 | 1 | Alpha |
| 2 | Member ID | 2 | 8 | 9 | AA11111A, Alphanumeric |

| Act on Transfer Out Upload | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 3 | Transfer From HH MMISID | 10 | 8 | 17 | Numeric |
| 4 | Transfer From CMA MMISID | 18 | 8 | 25 | Numeric |
| 5 | Transfer to HH MMISID | 26 | 8 | 33 | Numeric |
| 6 | Transfer to CMA MMISID | 34 | 8 | 41 | Numeric |
| 7 | Effective Date of Transfer | 42 | 8 | 49 | MMDDYYYY, Numeric |
| 8 | Transfer Reason Code | 50 | 2 | 51 | Numeric |
| 9 | Transfer Reason Comment | 52 | 40 | 91 | Alphanumeric |

**Editing Logic**

a) **Record Type** (field #1) should be populated with 'E' for Enrollment Record
b) When the transfer is from HH to HH it is necessary to complete fields #3 and #5, leaving fields #4 and #6 blank.
c) When the transfer is from CMA to CMA it is necessary to complete field #3, #4, and #6, leaving field #5 blank.
d) See *Appendix O: Transfer Reason Codes* for the list for acceptable **Transfer Reason Code** values

## Act on Transfer Out Error File

**Description**

This file is created upon validating or processing an Act on Transfer Out Upload file containing at least one error. An Act on Transfer Out Error File will not be created for an uploaded network file that does not contain rejected records. The Act on Transfer Out Error File will contain one record for each record in the uploaded Act on Transfer Out Upload that contains an error.

**Format**

| Act on Transfer Out Error File | | | | | |
|---|---|---|---|---|---|
| **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**

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 Act on Transfer Out Upload errors, please see *Appendix B: File Error Reason Codes*.

## Received Transfers Download

**Description**

The Received Transfers Download can be downloaded by HHs and CMAs. This file contains a record for every received transfer connected to the downloading provider in the system that is eligible to be accepted by the downloading provider. This file is intended to be a prep file for the Act on Received Transfers Upload file. This

means that the file is the exact same format as the companion upload file. The first few fields in the file will be populated with member segment information and the remaining fields will be blank. The downloading provider can then remove the rows they will not use and then populate the appropriate fields to initiate the transfer of a member segment out of their organization. Using this file as a prep file is not required by the system but is meant to helpful where applicable.

**Format**

| Received Transfers Download File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Record Type | 1 | 1 | 1 | Alpha |
| 2 | Member ID | 2 | 8 | 9 | AA11111A, Alphanumeric |
| 3 | Transfer to HH MMISID | 10 | 8 | 17 | Numeric |
| 4 | Transfer to CMA MMISID | 18 | 8 | 25 | Numeric |
| 5 | Start Date | 26 | 8 | 33 | MMDDYYYY, Numeric |
| 6 | Network Type | 34 | 1 | 34 | Alpha |
| 7 | Consent Type | 35 | 2 | 36 | Numeric |
| 8 | Consenter | 37 | 2 | 38 | Numeric |
| 9 | Consent Start Date | 39 | 8 | 46 | MMDDYYYY, Numeric |
| 10 | Transfer Reason Code | 47 | 2 | 48 | Numeric |
| 11 | Transfer Reason Comments | 49 | 40 | 88 | Alphanumeric |
| 12 | Reject Reason Code | 89 | 2 | 90 | Numeric |
| 13 | Reject Reason Comments | 91 | 40 | 130 | Alphanumeric |

**Editing Logic**

1) The following fields are purposely blank, they are meant to be place holders for the fields required in the Act on Received Transfers Upload file:
   a) **Record Type** (field #1)
   b) **Network Type** (field #6)
   c) **Consent Type** (field #7)
   d) **Consenter** (field #8)
   e) **Consent Start Date** (field #9)
   f) **Reject Reason Code** (field #12)
   g) **Reject Reason Comment** (field #13)
2) Transfer to HH MMISID (field #3) is populated based on the information entered on the creation of the transfer out transaction. If this is a CMA to CMA transaction, this field is blank.
3) Transfer to CMA MMISID (field #4) is populated based on the information entered on the creation of the transfer out transaction. If this is a HH to HH transaction, this field is blank.
4) Start Date (field #5) is entered by the provider that initiates the transfer.
5) Transfer Reason Code (field #10) and Transfer Reason Comments (field #11) are entered when the transfer is created.
6) Transfers from CYES to HH will be included in this file with a **Transfer Reason Code** = '10' *Transfer from CYES*.

## Act on Received Transfers 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 act on the transfers (HH to HH transfers or CMA to CMA transfers) that they have received from other Health Homes.

**Format**

| Act on Received Transfers Upload | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Record Type | 1 | 1 | 1 | Numeric |
| 2 | Member ID | 2 | 8 | 9 | MMDDYYYY, Numeric |
| 3 | Transfer to HH MMISID | 10 | 8 | 17 | Alpha |
| 4 | Transfer to CMA MMISID | 18 | 8 | 25 | Numeric |
| 5 | Start Date | 26 | 8 | 33 | Numeric |
| 6 | Network Type | 34 | 1 | 34 | Alpha A/C |
| 7 | Consent Type | 35 | 2 | 36 | Numeric |
| 8 | Consenter | 37 | 2 | 38 | Alphanumeric |
| 9 | Consent Start Date | 39 | 8 | 46 | Numeric |
| 10 | Transfer Reason Code | 47 | 2 | 48 | Alphanumeric |
| 11 | Transfer Reason Comments | 49 | 40 | 88 | Numeric |
| 12 | Reject Reason Code | 89 | 2 | 90 | MMDDYYYY, Numeric |
| 13 | Reject Reason Comments | 91 | 40 | 130 | Alpha |

**Editing Logic**

1. Record Type (field #1) values are either A (accept) or R (reject)
2. The following fields are populated from information that is captured in the system during the creation of the transfer. If this information is changed then the change will be ignored by the system. This information is found either on the screen or on the Received Transfers Download File:
    a. Transfer to HH MMISID (field #3)
    b. Transfer to CMA MMISID (field #4)
    c. Transfer Effective Date (field #5)
    d. Transfer Reason (field #10)
    e. Transfer Comments (field #11)
3. Reject Reason Comments (field #13) may be populated for any rejection reason but is required if a rejection reason of 'Other' is selected.

## Act on Received Transfers Error File

**Description**

This file is created upon validating or processing an Act on Received Transfers Upload file containing at least one error. An Act on Received Transfers Error File will not be created for an uploaded network file that does not contain rejected records. The Act on Received Transfers Error File will contain one record for each record in the uploaded Act on Received Transfers Out Upload File that contains an error.

**Format**

| Act on Received Transfers Error File | | | | | |
|---|---|---|---|---|---|
| **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**

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 Act on Received Transfers Upload errors, please see *Appendix B: File Error Reason Codes*.

# *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.

The most up to date information about field descriptions can be found within the most up to date **MAPP HHTS File Specifications (xlsx) Document** on the MAPP HHTS website

under the heading: *Tracking System Updates and File Formats* in the **Updated File Specifications (XLSX)** column.

# *Appendix B: File Error Reason Codes*

See Format within the **Plan of Care Error File** section of the website for Plan of Care 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 Substance 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?<br><br>For dates on or after the configurable date XX/XX/XXXX, the description will be:<br><br>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.<br>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 |
| Mbr D/C from ACT. ACT Mbr field must = N | ACT Member discharged within 6 months |
| 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<br>Or<br>Principal Provider Code = NH and current billing status = Voided or In Progress, or if the BI does not fall into the rule of the 1st month of NH |
| Cannot select HCBS only and HCBS other cannot both be indicated | "Children's HCBS Only" and "Children's HCBS and other conditions" cannot both be indicated |

| Error Name | Error Description |
|---|---|
| Cannot select HCBS only and another CC | "Children's HCBS Only" and "Children's HCBS and other conditions" |
| Cannot select only HCBS and other | "Children's HCBS and other conditions" has to be indicated with another Health Home Qualifying Condition |
| Cannot select Adult HCBS for child | "Adult HCBS and other conditions" can only be indicated for a member with Provided Service Type Indicator = Adult<br>Or<br>"Adult HCBS and other conditions" cannot be indicated for a member in HHSC |
| Cannot select child HCBS for adult | "Children's HCBS Only" cannot be indicated for a member in HHSA<br>Or<br>Children's HCBS and other conditions cannot be indicated for a member in HHSA |
| UAS Complexity field required | Did the member complete the UAS Complexity High Risk Assessment? |
| 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 |
| HH+ Min Services = blank if HH+ pop = A | If Expanded HH+ population = A, then HH+ Minimum Services Provided must be blank |
| Member does not have plan of care | Member must have Plan of Care after 56 number of days. |
| Release Date cannot be in future | Incarceration Release Date cannot be in the Future |
| Release Date cannot be prior to DOB | Incarceration Release Date cannot be prior to Member's Date of Birth |
| Release Date cannot be prior to 2012 | Incarceration Release Date cannot be prior to 1/1/2012 |
| Discharge Date cannot be in future | Mental Illness or Physical Health OR Substance Abuse Inpatient Stay Discharge Date cannot be in the Future |
| Discharge Date cannot be prior to DoB | Mental Illness or Physical Health OR Substance Abuse Inpatient Stay Discharge Date cannot be prior to Member's Date of Birth |
| Discharge Date cannot be prior to 2012 | Mental Illness or Physical Health OR Substance Abuse Inpatient Stay Discharge Date cannot be prior to 1/1/2012 |
| Date Member Housed cannot be in the Future | Date Mbr Housed cannot be in future |
| Date Mbr Housed cannot be prior to DoB | Date Member Housed cannot be prior to Member's Date of Birth |
| Date Mbr Housed cannot be prior to 2012 | Date Member Housed cannot be prior to 1/1/2012 |

| Error Name | Error Description |
|---|---|
| Member not AH null AH questions | When Member is not AH then AH questions should not be responded to. |
| BI for ACT Member | When a Member is enrolled in ACT |
| CANS outcome overwriting not allowed | When Core Service Provided = L, M, or H and the BI service date is outside the configurable range. |
| HH Qualifying Condition not yet approved | When a value '30' (Sickle Cell) is entered in Field#5, till the approval of HH Qualifying condition |
| Invalid value in Core Services field | When Core Services Provided field has value other than Y/N and Adult pre-designated alpha character/override code |
| 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 |
| 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. |

| Error Name | Error Description |
|---|---|
| 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 due to non-conforming opt-out reasons. |
| 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:<br>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. |

| Error Name | Error Description |
|---|---|
| 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 |
| 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. |
| Plan of Care may only be created by DOH and Health Homes | Record rejected because Record type is 'P' and organization is not DOH or a HH |
| TEMPORARY_CONSENT | Record rejected because the value '06' was entered into the New Consent Type field and the user is not DOH |
| SYSTEM_CONSENTER | Record rejected because the value '04' was entered into the Consenter field when the user is not DOH |
| MEMBER_AGE_CONSENTER | Record rejected because the value of '01', '02' or '05' was entered into the Consenter field when the member is not at least 18 years of age at any time during the month of the consent start date |
| Start Date cannot be prior to 1/1/2012 | Record rejected because the start date is prior to 1/1/2012, |
| Start Date cannot be >180 days in the Future | Record rejected because the start date is more than 180 days in the future. |
| End Date cannot be >180 days in the Future | Record rejected because the end date is more than 180 days in the future. |
| START_DATE_BEFORE_DOB | Record rejected because the start date cannot be before date of birth. |

| Error Name | Error Description |
|---|---|
| POC Start Date cannot be prior to the member DOB | Record rejected because the POC start date cannot be prior to date of birth. |
| POC Start Date cannot be prior to 1/1/2012 | Record rejected because the POC start date cannot be prior to 1/1/2012. |
| Pend Start Date cannot be >180 days in the Future | Record rejected because the pend start date cannot be greater than 180 days in the future. |
| Effective Date cannot be > 180 days in the future | Record rejected because the effective date cannot be greater than 180 days in the future. |
| SIGNATURE_DATE_BEFORE_DOB | Record rejected because the signature date is before date of birth. |
| SIGNATURE _DATE_BEFORE_1-1-2012 | Record rejected because the signature date is before 1/1/2012. |
| FUTURE_ SIGNATURE _DATE_>180 | Record rejected because signature date cannot be greater than 180 days in the future. |
| FUTURE_END_DATE_>180 | Record rejected because end date cannot be greater than 180 days in the future. |
| Start Date cannot be prior to Children's HH Program Start Date | Record rejected because the start date cannot be prior to the Children's HH Program start date. |
| From Date cannot be prior to 1/1/2012 | Record rejected because the from date cannot be prior to 1/1/2012. |
| From Date cannot be > 180 days in the future | Record rejected because the from date cannot be more than 180 days in the future. |
| To Date cannot be >180 days in the Future | Record rejected because the to date cannot be more than 180 days in the future. |
| The End Date Reason <xxx> is restricted to child-segment only | Record will be rejected because the end date reason that is restricted to a child segment only was used for an adult segment. |
| Service Date no longer available to add | When the BI Service Date is beyond the allowed range for the user to add BI |
| Service Date no longer available to void | When the BI Service Date is beyond the allowed range for the user to void the BI |
| 1 SQC/2 or more chronic conditions req'd | When fields 31-34,44 are all 'N', and at least two of fields 35-43 are not populated with a 'Y'. |
| HH Qual Condition Description required<br><br>Pended segment BI max number reached | When field #44 is populated with Y and #45 is not populated<br>When for enrollment segment with pend reason "Pended due to diligent search" BI creation maximum number reached |
| 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 |

| Error Name | Error Description |
|---|---|
| 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 |
| 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 |

| Error Name | Error Description |
|---|---|
| | |
| | |
| | |
| 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 |
| 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 |
| | |
| 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 |

| Error Name | Error Description |
|---|---|
| 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 |
| 102 | Pend Reason Codes 05 and 06 are not valid for outreach segments |
| 103 | Pended segments cannot be pended with same start date |
| 104 | The End Date Reason Code <xx> cannot be used after <mm/dd/yyyy> |
| 105 | Opt-out Signature must be Prior to Submission Date |
| 106 | End Reason 45 permitted for Diligent Search OR Continued Search Effort |
| 107 | The Pend Reason Code <xx> cannot be used after <mm/dd/yyyy> |
| 110 | Cannot create Pended Segment using M-record |
| 111 | Record exists in current status, no modification requested |
| 112 | Member enrolled in ACT, end date must be on or before xx/xx/xxxx |
| 113 | Member enrolled in ACT from xx/xx/xxxx to xx/xx/xxxx |
| 114 | Consent can only be created for Referrals |
| 115 | Consent cannot be modified via tracking file |
| Attempt to update a record with too large a value | Information submitted in Appropriateness Detail field is greater than the maximum allowed character count limit of 250 |

| Error Name | Error Description |
|---|---|
| <ADULT/CHILD> APPROPRIATENESS CATEGORY NOT WITHIN EFFECTIE PERIOD | Appropriateness category codes must be submitted within the proper effective period for the code |
| IA_CATEGORY_DISALLOWED_<10> MONTHS_AFTER_SEGMENT START | Appropriateness categories designated for IA use cannot be used beyond the first ten months of a member's segment. |
| YA_CATEGORY_ONLY ALLOWED_<10> MONTHS_AFTER_SEGMENT_START | Appropriateness categories designated for YA use cannot be used before the tenth month of a member's segment. |
| YA_CATEGORY_ONLY_ALLOWED_AFTER_ 1ST_SEQUENCE | YA category codes cannot be submitted for the first appropriateness record of a segment |
| EXISTING_APPROPRIATENESS_WITH_SA ME_START_DATE | Appropriateness records will be rejected if there exists an appropriateness record for the same member and start date. |

# *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 | Eligible for Billing? | Restrictions |
|---|---|---|---|
| 01 | Pended due to Inpatient Stay | Yes (per policy) | |
| 02 | Pended due to Incarceration | No | |
| 03 | Pended due to Hiatus | No | |
| 04 | Pended due to Other | No | |
| 05 | Pended due to Diligent Search Efforts | Yes (per policy) | |
| 07 | Pended due to Step Down to PCMH | Yes | |
| 08 | Pended due to Step Down to MCP Plan Care Management | Yes | |
| 10 | Pended due to Step Down | Yes | |
| 12 | Pended for HH Fair Hearing Aid Continuing | Yes | Only DOH can create/affect |
| 14 | Pended for Approved Fair Hearing | Yes | Only DOH can create but HH/CMA DOH can affect |
| 15 | Pended for Denied Fair Hearing | Yes | Only DOH can create but HH/CMA DOH can affect |
| 16 | Pended for Withdrawn Fair Hearing | Yes | Only DOH can create but HH/CMA DOH can affect |
| 17 | Pended for Administrative Change | Yes | Only DOH can create but HH/CMA DOH can affect |

# *Appendix D: Segment End Date Reason Codes & Categories*

The reason codes listed at the link 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.

The most up to date information about segment end date reason codes can be found within the **MAPP HHTS Segment End Date Category & Reason Codes Crosswalk and Guidance Chart** on the MAPP HHTS website:

(under the heading: Member Assignment and Enrollment)

# *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 |
| 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: MCP Final HH Assignment file and the **Pend Reason Code** field on the MCP Final HH 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 a HH would end a member's assignment to the HH or why a CMA would end a member's assignment with the CMA. These codes are used in the **Assignment End Date Reason Code** field on the Past Assignment 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 a HH Assignment because MCP/DOH created a new HH Assignment for a member that had an existing HH assignment |
| 15 | Changed CMA | System generated | when system ends a CMA Assignment because the Health Home created a new CMA Assignment for a member that had an existing CMA assignment |
| 16 | Moved 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 a HH/CMA assignment ends because the member cycled out of outreach/outreach hiatus without being enrolled |
| 19 | Enrollment ended | System generated | when a HH/CMA assignment ends because an enrolled member's segment ended with the HH/CMA. |
| 20 | No Medicaid Coverage | System generated | when MCP/HH/CMA assignment ends because the member is no longer Medicaid Eligible |

| Code | Accepted Language Values | Source | Comments |
|---|---|---|---|
| 21 | Invalid Coverage Code | System generated | when MCP/HH/CMA assignment ends because the member 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 a HH. |
| 29 | Switched Non-Mainstream MCPs | System generated | |
| 30 | Switched Mainstream to N-Mainstream | System generated | |

| Code | Accepted Language Values | Source | Comments |
|---|---|---|---|
| 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 a 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 a 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 a 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. |
| 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. |

| Code | Accepted Language Values | Source | Comments |
|---|---|---|---|
| 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

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 |
|---|---|---|
| Pre-Conditions of member | 30 | Sickle Cell (this code is only applicable to service dates on or after 3/1/2022) |
| Billing Instance Type | O | Outreach |
| Billing Instance Type | E | Enrollment |
| Billing Instance Type | F | CANS NY Assessment Fee |
| Billing Instance Type | H | HCBS 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 | 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) |

| Field Description | Code | Code Description |
|---|---|---|
| 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) |
| 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). As part of release 3.3, the **Payor** field was introduced to the Billing Support Download file to indicate the appropriate payor for a member month: 'P' for members enrolled in a mainstream plan or 'F' for members enrolled in a non-mainstream plan and fee for service members.

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 H Assignment File Accepted Values*

The following values are accepted on the MCP Final Assignment File and display on the HH Assignment File.

| Field Description | Code | Code Description |
|---|---|---|
| Plan Provided Member Language | | Arabic |
| Plan Provided Member Language | | Haitian-Creole |
| Plan Provided Member Language | | Polish |
| Plan Provided Member Language | | English |
| Plan Provided Member Language | | Cambodian (Khmer) |
| Plan Provided Member Language | | Vietnamese |
| Plan Provided Member Language | | Japanese |
| Plan Provided Member Language | | Russian |
| Plan Provided Member Language | | Navajo |
| Plan Provided Member Language | | Apache |
| Plan Provided Member Language | | Traditional Chinese |
| Plan Provided Member Language | | Simplified Chinese |
| Plan Provided Member Language | | Brazilian Portuguese |
| Plan Provided Member Language | | Korean |
| Plan Provided Member Language | | German |
| Plan Provided Member Language | | Tagalog |
| Plan Provided Member Language | | Other |
| Plan Provided Member Language | | Danish |
| Plan Provided Member Language | | Finnish |
| Plan Provided Member Language | | Irish |
| Plan Provided Member Language | | French |
| Plan Provided Member Language | | Spanish |
| Plan Provided Member Language | | Italian |

| Field Description | Code | Code Description |
|---|---|---|
| Plan Provided Member Language | | American Sign |
| Plan Provided Member Language | | Lao |
| Plan Provided Member Language | | 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.

- 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.
    - 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.
        - 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.
        - 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.
    - 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.
- The Health Home website
- Health Homes Provider Manual: Billing Policy and Guidance
- Health Home Program Email webform link (please select most appropriate subject when submitting an email)
- Health Home Program Provider Policy line: **(518) 473-5569**
- Resources for determining if a member is eligible/appropriate for the Health Home Program:
    - Eligibility Criteria for HH Services: Chronic Conditions
    - Eligibility Requirements: Identifying Potential Members for HH Services
    - Coverage Code Compatibility with HH Program
    - Recipient R/E Compatibility with HH Program
- For questions about Health Home claims or issues with submitting Health Home claims:
    - Information on working through denied Health Home claims
        - If the document above does not answer your question, call GDIT (General Dynamics Information Technology) at: **1-800-343-9000**
    - eMedNY Payment cycle calendar
- 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.

- UAS–NY Support Desk via email at uasny@health.ny.gov or by telephone at 518–408–1021

# *Appendix M: Consent and Member Program Status 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 |
| Record Type | A | Add a Member Program Record |
| Record Type | U | Modify the End Date of Member Program Record |
| Record Type | R | Delete a Member Program Record |
| Record Type | N | Add New Member Program Information Record |
| Record Type | E | Remove Existing Member Program Information Record |
| Record Type | X | Adding CEST Outcome Record |
| | | |
| Record Type | Z | Deleting CEST Outcome Record |
| 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, or homeless youth |
| Consenter | 06 | System (Not for use by HH or CMA) |
| Consent Type | 01 | Consent to Enroll |
| Consent Type | 02 | Consent to Share Information |
| Consent Type | 03 | Consent to Share Information (Protected Services) |
| Consent Type | 04 | Adult Consent Date Needed (Not for use by HH or CMA) |
| Status | 01 | Active |
| Status | 02 | Withdrawn |
| Status | 03 | Ended |
| Member Program Type | 01 | Early Intervention |
| Member Program Type | 02 | HFW eligible and receiving HFW services |
| Member Program Type | 05 | Children's Home & Community Based Services (HCBS) |
| Member Program Type | 10 | HFW eligible but not in HFW. Awaiting internal transfer to a HFW CMA |
| Member Program Type | 11 | HFW eligible but not in HFW. Awaiting external transfer to a HFW CMA |
| Member Program Type | 12 | HFW eligible but not in HFW. Awaiting HHSC transfer to HHSC with HFW CMA |

| | | |
|---|---|---|
| Member Program Type | 13 | HFW eligible but not in HFW. Family declined |
| Member Program Type | 14 | HFW eligible but not in HFW. Family did not want to switch CMA |
| Member Program Type | 15 | HFW eligible but not in HFW. Family did not want to switch HH |

# *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 |
|---|---|
| 01 | Member moved out of service county |
| 02 | At Capacity |
| 03 | Appropriate provider linkages to best meet the member's needs not available |
| 04 | The member's address is outside of the service area |
| 06 | Other |
| 07 | Member requested transfer |
| 08 | HH/CMA closure or merger |
| 09 | Transferred to CYES |
| 10 | Transferred from CYES |
| 18 | Transferred from a HHSC to a HHSA (transfer from 'C' network to 'A' network) |

# Appendix P: Billing Instance Validation Codes

Validation codes appear on the Billing Support Download File when a Potential Billing Instance would be prevented from being added to the system. If a Potential Billing Instance fails more than one validation, the system will populate the first validation detected based on the processing order of operations outlined below. For example, if the member is Medicaid ineligible and does not have a valid Plan of Care, the validation code associated with that Potential BI would be E and not J.

| Validation Code | Order of Operation | Validation Type | Validation Description | Validation logic |
|---|---|---|---|---|
| A | 1 | Billing Block | PR02: Pended due to Incarceration | Supporting segment is pended w code 02 |
| B | 2 | Billing Block | PR03: Pended due to Hiatus | Supporting segment is pended w code 03 |
| C | 3 | Billing Block | PR04: Pended due to Other | Supporting segment is pended w code 04 |
| D | 4 | Billing Block | PR06: Pended due to Continued Search Effort | Supporting segment is pended w code 06 |
| N | 5 | Billing Block | PR07: Pended due to Diligent search | Supporting segment has been pended w code 07 for more than three months |
| E | 6 | Billing Block | Cannot create assessment for Medicaid Ineligible members | Member Medicaid ineligible as of the BI service date |
| F | 7 | Billing Block | Invalid Coverage Code | Member's coverage code as of the BI service date not compatible with Health Home services |
| H | 8 | Billing Block | Adding a billing instance that has a Principal Provider Code = AL | Member has active PP code 'AL' as of BI service date |
| I | 9 | Billing Block | Adding a billing instance that is voided and has a Principal Provider Code = NH | Member has active PP code 'NH' as of BI service date |
| G | 10 | Billing Block | Member's R/E Code on the service date is not compatible | Member's R/E code(s) active as of the BI service date not compatible with Health Home services |
| X | 11 | Billing Block | HHSC member does not have Yearly Appropriateness submitted | |
| Q | 12 | Billing Block | Does not have Appropriateness Criteria submitted | Support segments begin date >= 6/1/2024 (created outside of system's transfer process) AND appropriateness criteria not submitted within 28 days of |

| Validation Code | Order of Operation | Validation Type | Validation Description | Validation logic |
|---|---|---|---|---|
| | | | within 28 days of Consent to Enroll | EITHER consent to enroll **or** segment begin date (*whichever is most recent)* |
| R | 13 | Billing Block | Does not have Comprehensive Plan of Care submitted within 56 days of Consent to Enroll | As of 6/1/24 BI service date active POC does not cover BI service date. Either:<br>1) POC submitted on POC Upload file is expired as of BI service date, **OR**<br>2) POC not submitted on POC Upload within 56 days of EITHER consent to enroll **or** segment begin date (*whichever is most recent)* |
| M | 14 | Billing Block | BI Date of Service no longer available to add or void | Submitted BI is over 2 years old |
| V | 15 | Warning | Warming: Member has an active K1 and most recent HCBS assessment is over a year old | Member has an active K1 and most recent children's HCBS assessment (per the UAS feed) is over a year old |
| O | 16 | Billing Block (not turned on) | Member has an active K1 and most recent HCBS assessment is over a year old | Member has an active K1 and most recent children's HCBS assessment (per the UAS feed) is over a year old |
| W | 17 | Warning | Warning: Last billable service month before POC expires | Member's POC submitted on POC Upload file expires the same month as the BI service date |
| Y | 18 | Warning | Warning: Last billable service month before Yearly Appropriateness expires | |
| U | 19 | Warning | Warning: Last billable service date without CEST outcome. | For members enrolled in adult program (excluding HH+ and Adult Home members) either:<br>1) Member's submitted CEST Outcome expires the same month as the BI service date OR<br>2) No CEST outcome has been submitted for member segment AND *Last month to bill w/o CEST outcome submission* = BI service date |
| S | 20 | Billing Block | CEST outcome required after the grace period | For members enrolled in adult program (excluding HH+ and Adult Home members), no CEST submitted for member segment and BI service date is the same month as CEST Billing Block |

| Validation Code | Order of Operation | Validation Type | Validation Description | Validation logic |
|---|---|---|---|---|
| | | | | month as determined by segment begin date |
| T | 21 | Billing Block | Existing CEST outcome for the Member has expired | For members enrolled in adult program (excluding HH+ and Adult Home members), submitted CEST outcome expired the month prior to the BI service date |
| 1 | 23 | | CEST outcome required for newly transferred segment | |
| 2 | 23 | | CEST E expired in the original segment | |
| 3 | 23 | | CEST C expired in the original segment | |
| 4 | 23 | | CEST M expired in the original segment | |

# *Appendix Q: Appropriateness Criteria*

Use the codes listed at the location below to indicate why a new member is appropriate for Health Home services in the **Appropriateness Category** field on the Consent and Member Status Upload file. The **Program** field indicates if the code is applicable to members enrolled in the Children's program, the Adult program, or to both programs. If a code contains a value of 'Y' in the **Comments Required (Y/N)?** field, the provider must provide details in the **Appropriateness Detail** (field #18) on the Consent and Member Status Upload file in addition to the **Appropriateness Category** code.

Acceptable appropriateness codes are listed within a document titled Appropriateness Criteria and Codes that is available in the *Policies and Resources* section of the **Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016** policy, posted to the ***Policy and Standards*** section of the Health Home website.

# *Appendix R: Appropriateness Record Supplemental Documents*

To clarify how the system will handle various appropriateness record submission scenarios, DOH has posted to the website three supplemental documents that describe in detail when initial and yearly appropriateness records are due to the system and how the **Appropriates End Date**/**Appropriateness Sequence** fields are populated by the system. These documents are linked in the *Health Home Tracking System Resources> IA, YA, CEST & POC* sub-section of the *Medicaid Analytics Performance Portal (MAPP)* section of the Health Home website.

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

**Appropriateness Billing Block Examples**

*Contains a multitude of examples of how billing is affected by appropriateness records, whether they are on-time, late, not present, or past their end date. The document is split into two tabs - one referencing scenarios applicable to HHSA and a second for scenarios applicable to HHSC (which includes Yearly Appropriateness records, per policy).*

**Appropriateness Sequence Examples**

*Intended to lend clarity to how the HHTS handles enrollment and the multiple appropriateness record(s) for each enrollment segment. With the implementation of Yearly Appropriateness for HHSC, the HHTS will support the history of all appropriateness records. The appropriateness records for each enrollment segment will be numbered sequentially and referred to as the 'Appropriateness Sequence Number'. This document provides examples of how multiple appropriateness records will be numbered, how the submission of a new appropriateness records affects the end dates of existing appropriateness records, and the impact of closing a segment on existing appropriateness records.*

**YA date calculator**

*Interactive Excel file, similar to the 'IA & POC Due Date Calculator,' which will accommodate input of a member's segment begin date and IA or YA start date. Automatically, the user will be provided with detail regarding the end date of the appropriateness record and dates of service that will be billable and those that will be blocked for that member.*

## *Appendix S: Assessment Download File Codes and Code Descriptions*

| Field | Code | Code Description | Assessment Type Code | Assessment Type |
|---|---|---|---|---|
| Assessment Outcome Description | C | LOC | H | HCBS |
| Assessment Outcome Description | C | Continue | E | CEST |
| Assessment Outcome Description | C | Complex CANS Acuity | C | CANS |
| Assessment Outcome Description | E | End | E | CEST |
| Assessment Outcome Description | H | High | C | CANS |
| Assessment Outcome Description | H | Transferred with an expired D | E | CEST |
| Assessment Outcome Description | I | Transferred with an active D | E | CEST |
| Assessment Outcome Description | I | Intensive CANS Acuity | C | CANS |
| Assessment Outcome Description | L | Low | C | CANS |
| Assessment Outcome Description | L | Transferred with an active E | E | CEST |
| Assessment Outcome Description | M | Medium | C | CANS |
| Assessment Outcome Description | M | More | E | CEST |
| Assessment Outcome Description | N | Not LOC | H | HCBS |
| Assessment Outcome Description | N | Transferred with an active M | E | CEST |
| Assessment Outcome Description | P | Transferred with an active C | E | CEST |
| Assessment Outcome Description | S | Standard CANS Acuity | C | CANS |
| Assessment Outcome Description | T | Transferred with no CEST in original segment and within grace period | E | CEST |
| Assessment Outcome Description | U | Unable to complete | H | HCBS |
| Assessment Outcome Description | W | Transferred with no CEST in original segment and outside grace period | E | CEST |
| Assessment Outcome Description | X | Transferred with an expired E | E | CEST |
| Assessment Outcome Description | Y | Transferred with an expired C | E | CEST |
| Assessment Outcome Description | Z | Transferred with an expired M | E | CEST |
| Continuation of Services | 0 | No | H | HCBS |
| Continuation of Services | 1 | Yes | H | HCBS |
| Continuation of Services | 2 | Not Applicable / Not Currently Receiving Services | H | HCBS |
| Continuation of Services | Blank | No Selection | H | HCBS |
| Override Decision | 0 | Denied | H | HCBS |
| Override Decision | 1 | Approved | H | HCBS |
| Override Decision | blank | No Selection | H | HCBS |
| Primary Diagnosis Code | 00 | Schizophrenia Spectrum and Other Psychotic Disorders | H | HCBS |

| Field | Code | Code Description | Assessment Type Code | Assessment Type |
|---|---|---|---|---|
| Primary Diagnosis Code | 01 | Bipolar and Related Disorders | H | HCBS |
| Primary Diagnosis Code | 02 | Depressive Disorders | H | HCBS |
| Primary Diagnosis Code | 03 | Anxiety Disorders | H | HCBS |
| Primary Diagnosis Code | 04 | Obsessive-Compulsive and Related | H | HCBS |
| Primary Diagnosis Code | 05 | Trauma and Stressor Related Disorders | H | HCBS |
| Primary Diagnosis Code | 06 | Dissociative Disorders | H | HCBS |
| Primary Diagnosis Code | 07 | Somatic Symptom and Eating Disorders | H | HCBS |
| Primary Diagnosis Code | 08 | Disruptive; Impulse Control; and Conduct Disorders | H | HCBS |
| Primary Diagnosis Code | 09 | Personality Disorders | H | HCBS |
| Primary Diagnosis Code | 10 | Paraphilic Disorders | H | HCBS |
| Primary Diagnosis Code | 11 | Gender Dysphoria | H | HCBS |
| Primary Diagnosis Code | 12 | Elimination Disorders | H | HCBS |
| Primary Diagnosis Code | 13 | Sleep-Wake Disorders | H | HCBS |
| Primary Diagnosis Code | 14 | Sexual Dysfunctions | H | HCBS |
| Primary Diagnosis Code | 15 | Medication-Induced Movement Disorders | H | HCBS |
| Primary Diagnosis Code | 16 | Attention Deficit/Hyperactivity Disorder | H | HCBS |
| Primary Diagnosis Code | 17 | Tic Disorders | H | HCBS |
| Primary Diagnosis Code | blank | No Selection/Not Applicable | H | HCBS |
| Re-Transmission Indicator | blank | No Selection | H | HCBS |
| Re-Transmission Indicator | Y | Assessment has been Re-Transmitted | H | HCBS |
| Target Population Code | 0 | SED Serious Emotional Disturbance | H | HCBS |
| Target Population Code | 1 | MF – Medically Fragile | H | HCBS |
| Target Population Code | 2 | DD-MF – Developmental Disability Medically Fragile | H | HCBS |
| Target Population Code | 3 | DD-FC – Developmental Disability Foster Care | H | HCBS |
| Type of Override | 0 | Fair Hearing | H | HCBS |
| Type of Override | 1 | State Review | H | HCBS |
| Type of Override | blank | No Selection | H | HCBS |