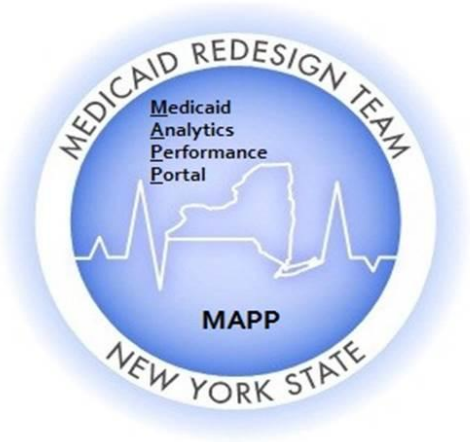
Medicaid Analytics Performance Portal
Health Home Tracking System

File Specifications Document version ~~4.9.4~~5.0.2

Commented [LM1]: Changed made from 5.0 to 5.0.1 and from 5.0.1 to 5.0.2 called out with comments.



~~February 12, 2026~~April 27, 2026

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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, the Medicaid Analytics Performance Portal Health Home Tracking System (MAPP HHTS) will be referred to as ***the system.*** Within this document *The New York State Department of Health*, *Managed Care Plan*, *Health Home*, and *Care Management Agency* will be referred to as ***DOH***, ***MCP***, ***HH***, and ***CMA*** respectively. Also, individuals associated with MCPs, HHs, CMAs, and other organizations accessing the MAPP HHTS will be referred to as ***users.***

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

- 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 Health Home website under *Tracking System Update and File Formats* in the **Updated File Specifications (XLS)** column:

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

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

The first one is the "Required" column containing values of 'Y' – yes, 'N'-no, or 'C'-conditional.

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 setup within the system with the gatekeeper (or admin) role. Individuals set up with the gatekeeper role within the system are responsible for setting up appropriate users from their organizations as MAPP HHTS users. All MCP, HH and CMA users must have an active HCS account and will be set up by their organization's gatekeeper under one or more of the following user roles: worker, read only, gatekeeper, referrer, or screener. Worker and read only users are able to download the files discussed within this manual, but only workers can upload files into the system. Referrer roles do not have access to view, upload or download files.

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

Additional Information

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

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

Each file downloaded from the system is a **"point in time" full file replacement** 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 not 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.

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

Brief Description of Files Available

File	Who Can Download	Who Can Upload	Description
Managed Care Plan Assignment File	MCP		This file is only accessible by MCP users and is comprised of plan enrolled members that do not have an open segment (not closed or canceled) that are currently assigned or referred to the user's MCP in either an *active*, *pending*, or *pended* MCP assignment status.
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.
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

File	Who Can Download	Who Can Upload	Description
			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.
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

File	Who Can Download	Who Can Upload	Description
			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.
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

File	Who Can Download	Who Can Upload	Description
			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 DOH 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 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 ~~*pending*~~ assignments/referrals with the members' MCPs (or HH for FFS members)~~. An MCP can then either accept a member in a *pending* MCP assignment/referral status, meaning that the plan agrees to assign the member to a HH, or the plan can pend the *pending* assignment/referral, meaning that the MCP is choosing not to act on the member's potential HH eligible status. An MCP would pend an assignment/referral when the MCP knows that the member is either not eligible or not appropriate for the Health Home program or if there is not an appropriate HH assignment currently available for the member. Once an MCP accepts a *pending* assignment/referral, the member's *pending* MCP assignment/referral moves to an *active* MCP assignment/referral status. An MCP can indicate that a *pending* MCP assignment/referral is accepted and move it to an active status by either accepting the *pending* assignment/referral or by the MCP assigning the member with a *pending* MCP assignment/referral directly to a HH, which automatically moves that member from a *pending* to an *active* MCP assignment/referral status~~ and the system creates a new *pending* HH assignment~~. status~~.

From there, HHs access their members with a *pending* HH assignment status, both fee for service members directly referred into the system and plan members assigned to the HH by ~~the members' MCPs~~ the 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 *pend*ing 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 therefor 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

Managed Care Plan Assignment File							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
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	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

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

Managed Care Plan Assignment File							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
63	Service 5: Last Service Date	1203	8	1210	C	M'caid	MMDDYYYY, Numeric
64	Service 5: Last Service Provider Name	1211	40	1250	C	M'caid	Alpha
65	Service 5: Last Service Provider NPI	1251	10	1260	C	M'caid	Numeric
66	Service 5: Last Service Address Line 1	1261	40	1300	C	M'caid	Alphanumeric
67	Service 5: Last Service Address Line 2	1301	40	1340	C	M'caid	Alphanumeric
68	Service 5: Last Service City	1341	40	1380	C	M'caid	Alpha
69	Service 5: Last Service State	1381	2	1382	C	M'caid	Alpha
70	Service 5: Last Service Zip Code	1383	9	1391	C	M'caid	Numeric
71	Service 5: Last Service Phone Number	1392	10	1401	C	M'caid	Numeric
72	MCP Assignment Created Date	1402	8	1409	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

Managed Care Plan Assignment File							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
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 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

Managed Care Plan Assignment File							
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Req'd**	**Source**	**Format**
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)
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, ~~to end~~ 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. ~~which is now displayed for the MCP. The MCP should use this information when assigning Lindsey downstream.~~ . Referrers are ~~not~~ required to complete this field when creating the referral ~~and therefore it may be blank~~ . 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

MCP Final HH Assignment File						
Field #	Field	Start Pos	Length	End Pos	Required (Y/N/C-conditional)	Format
11	Plan Provided Member Language	180	30	209	C	Alpha
12	Engagement Optimization	210	1	210	N	Alpha
13	MCP Determined Eligibility	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)

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

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
54	Service 4: Last Service Date	1004	8	1011	C	M'caid	MMDDYYYY, Numeric
55	Service 4: Last Service Provider Name	1012	40	1051	C	M'caid	Alpha
56	Service 4: Last Service Provider NPI	1052	10	1061	C	M'caid	Numeric
57	Service 4: Last Service Address Line 1	1062	40	1101	C	M'caid	Alphanumeric
58	Service 4: Last Service Address Line 2	1102	40	1141	C	M'caid	Alphanumeric
59	Service 4: Last Service City	1142	40	1181	C	M'caid	Alpha
60	Service 4: Last Service State	1182	2	1183	C	M'caid	Alpha
61	Service 4: Last Service Zip Code	1184	9	1192	C	M'caid	Numeric
62	Service 4: Last Service Phone Number	1193	10	1202	C	M'caid	Numeric
63	Service 5: Last Service Date	1203	8	1210	C	M'caid	MMDDYYYY, Numeric
64	Service 5: Last Service Provider Name	1211	40	1250	C	M'caid	Alpha
65	Service 5: Last Service Provider NPI	1251	10	1260	C	M'caid	Numeric
66	Service 5: Last Service Address Line 1	1261	40	1300	C	M'caid	Alphanumeric
67	Service 5: Last Service Address Line 2	1301	40	1340	C	M'caid	Alphanumeric
68	Service 5: Last Service City	1341	40	1380	C	M'caid	Alpha
69	Service 5: Last Service State	1381	2	1382	C	M'caid	Alpha
70	Service 5: Last Service Zip Code	1383	9	1391	C	M'caid	Numeric
71	Service 5: Last Service Phone Number	1392	10	1401	C	M'caid	Numeric
72	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)

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

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

Health Home Assignment File							
Field #	Field	Start Pos	Length	End Pos	Req'd	Source	Format
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 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 found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm
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
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 #~~6~~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

Child Referral Download File						
Field #	Field	Start Pos	Length	End Pos	Req'd	Format
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)
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:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm

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

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
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**: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm
b. **Health Home Email Webform (**select most appropriate subject): https://apps.health.ny.gov/pubpal/builder/email-health-homes

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

Plan of Care Error					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
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. 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. 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. 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. Also, if the file contains a DOB on file, it must match the DOB within HHTS for the Member ID	Invalid DOB	08

Name	Validation Criteria	Error Description	Error Reason Code
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	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
Responsible Signatory is Required	Responsible Signatory is required, AND If member >= 18, only 03 or 04 is allowed If member <18, then 01, 02, 03, 05 is allowed 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. 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. 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. 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.	P/G/LAR <> Phone Number is required	19

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 <> 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. Also, this field is required if 'P/G/LAR <> Address same as member?' = N 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. 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. 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 <> City	22
Invalid P/G/LAR <> State	If "P/G/LAR <> Address same as member?" = N, then the P/G/LAR <> State field is required. 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. 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

Name	Validation Criteria	Error Description	Error Reason Code
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
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 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. AND it must be in format MMDDYYYY	Invalid Interventions and Supports <n> Date	44

Name	Validation Criteria	Error Description	Error Reason Code
	For instance, "Interventions and Supports 3.3 Date" is required if "Interventions and Supports 3.3" is populated.		
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
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

Name	Validation Criteria	Error Description	Error Reason Code
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. May only be populated if P/G/LAR 2 Name is not null	Invalid P/G/LAR 2 Signature Date	62
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)*:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/docs/mapp_hhts_release_4.2_final.pdf

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 follow the link below to see the POC Upload File v10 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.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/docs/mapp_hhts_file_specifications_v10.xlsx

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, 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, and member program information (Early Intervention, High-Fidelity Wraparound, HCBS, and Medically Fragile) 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

Consent and Member Program Status Upload						
Field #	Field	Start Pos	Length	End Pos	Req'd	Format
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
You no longer submit consent to enroll and appropriateness criteria on the same record. Consent records are included in the Consent Download file.			
Member Program Information	A	U	R
*This record is used to upload into the system a member's connection to the Early Intervention (**Program Type**: '01'), the High Fidelity Wrap (**Program Type**: '02'), and Medically Fragile (**Program Type**: '06'). This information is included in the Member Program Status Download file, not the Consent Download file.*			
Continuing Eligibility Screening Tool Outcome	X	[redacted]	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	[redacted]	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, 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. **Record Types** C, M, and W pertain to consent
3. **Record Type** A, U and R pertain to provider supplied member program records (e.g. Early Intervention '01) & High-Fidelity Wraparound 02). This information is included in the Member Program Status Download file, not the Consent Download file.
4. **Record Type** N and E pertain to provider supplied member program records for Children's HCBS.
5. **Record Type** X, and Z pertain to Continuing Eligibility Screen Tool (CEST) related fields. This information is included in the Assessment Download file, not the Consent Download file.
6. **Record Type** S, T, and P pertain to Appropriateness records - both initial (adults and children) and yearly (children only). This information is included in the Assessment Download file, not the Consent Download file.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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

12. 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)
13. 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
14. 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)

15. 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)
16. 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)
17. 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)
18. 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)

19. 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)

20. 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.

~~21.~~ **CEST Outcome** submissions with a **CEST Start Date** that equals an existing **CEST Start Date** for the member will be rejected.

~~22.~~21.

22. 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 day
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

23. 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

24. 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**.

25. 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**.

26. 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).

27. 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'

Commented [LM2]: Addition: #26 was added to introduce the concept of a CEST due date being adjusted with a "buffer".

Commented [LM3]: Correction: deleted "CEST Outcome" and replaced it with "original segment's begin date"

Commented [LM4]: Addition: adding caveat that some CEST end dates may be adjusted.

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.

28. 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:

~~25.~~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'.

Commented [LM5]: Addition: adding caveat that some CEST end dates may be adjusted.

Commented [LM6]: Addition: #28 was added to explain how some newly created CEST due dates will be adjusted to add a "buffer" to give providers some time to complete required CEST after a segment transfer.

Commented [LM7]: Addition 5.0.2: added examples 28b & 28c

~~26.~~29. 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.~~30. If a closed segment forces a change to the **Appropriateness End Date** as described in #2~~0~~4 and then *the HH re-opens that closed segment*, 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.~~31. 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.~~32. Consent to Enroll is required to create an enrollment segment for all members.

~~30.~~33. 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.~~34. Consent dates entered on the Consent and Member Program Upload file cannot be in the future.

~~32.~~35. 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.~~36. 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.~~37. 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.~~38. 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: 1) 01 (EI) 2) 02 (HFW) 3) 05 (Children's HCBS) 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 MCP Assignment file with an *active* MCP assignment, a value of '07152016' (7/15/16) in **HH Assignment Created Date** (field #8), a value of '07032016' (7/03/16) in **MCP Assignment Created Date** (field #72), a value of '01234567' in **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 Health Home Assignment file since HH B no longer has an assignment with Angela. Angela will be listed on HH B's Past Assignment Download 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
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

- 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.

  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.

- The system will reject a record that is attempting to take an action that has already been processed by the system.
- 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)**.**
- The system will ignore any values submitted on the Tracking File Segment Records file in **Direct Biller Indicator (**field #10).
- The system will accept the **Member ID** (field #2) if populated with a valid CIN and:
- Medicaid eligible as of the record **Begin Date** (field #5)
- 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)
- 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.
- Does not have a *pended* MCP assignment
- **Record Type 'C' (Create Segment)** is used by HHs and CMAs to create an outreach or an enrollment segment.
- Segment status:
- When a 'C' record type is processed into the system **by a HH**, the system will create an *active* segment for the submitted record.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.

- 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.
- 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.
- End Health Home Assignment
- 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.
- 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.
- 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.
- **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.
- 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.
- **Referral Code** (field #13) must contain a value of 'R', or the record will be rejected
- 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.
- 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.
- Referral Code must be blank, or the record will be rejected
- 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.
- 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.
- Referral Code must be blank, or the record will be rejected
- 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.

- 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).
- 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.
- Referral Code must contain a value of ‘R’
- 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.
- 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.
- Once the segment is created, the HH C assignment will be ended with an end date one day prior to the segment start date.
- 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.
- Referral Code must be blank, or the record will be rejected
- 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.
- 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.
- Referral Code must contain a value of ‘R’, or the record will be rejected
- 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.
- If CMA B does not have auto approval the segment will have a pending active status HH A accepts the segment creation.
- 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.
- Referral code must contain a value of ‘R’
- 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.
- 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.
- 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.
- Referral Code must be blank, or the record will be rejected
- 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.

- 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
- 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.
- **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:
- '**Record Type** (field #1) = 'C'
- **Outreach/Enrollment Code** (field #7) = 'E'
- **Referral Code** (field #13) = 'R'
- **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.

- **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.*
- 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:
- **Member ID** (field #2)**, Begin Date** (field #5)**, Outreach/Enrollment Code** (field #7)**, HH MMIS ID** (field #8)**,** and **CMA MMIS ID** (field #9).
- If a provider would like to change any of the values previously submitted in the fields listed above, the provider must either:
- 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
- End the segment and then create a new segment with the new values.
- 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.
- 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.
- 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).
- 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.

- 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.
- 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.
- **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.

- **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.
- 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.
- End Health Home Assignment
- 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.
- 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.
- **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.
- 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').
- **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.
- **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.
- 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.
- 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.
- 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.
- 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.

- 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.
- 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.
- 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.

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. 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. 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
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

Enrollment Download File					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
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
68	Date Fair Hearing Scheduled	2052	8	2059	MMDDYYYY, Numeric

Editing Logic

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

- **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 found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm 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)
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

My Members Download						
Field #	Field	Start Pos	Length	End Pos	Always Populated(Y/N)	Format
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
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

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
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.	

My Members Fields	Segment Record	Assignment Record
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: • 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 • 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.	
Fair Hearing Program Type		
Fair Hearing Number		
Fair Hearing Start Date		
Fair Hearing End Date		
Fair Hearing Notice Type		
Fair Hearing Notice Type Start Date		
Date Fair Hearing Scheduled		

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
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

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

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

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

CIN Search Download						
Field #	Field	Start Pos.	Length	End Pos.	Required (Y/N/C-conditional)	Format
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)
131	MCP Type	2805	15	2819	C	Alphanumeric
132	DOD	2820	8	2827	C	MMDDYYYY, Numeric

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. MCPs can see Assessment information for any member associated with their plan at the time the assessment was signed and finalized. HHs/CMAs can see any assessment information for a member that has an enrollment segment that either covers the period of time of the assessment or the subsequent 12 months after the assessment's signed and finalized date.

Format

Assessment Download					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Member ID	1	8	8	Alphanumeric
2	Member First Name	9	30	38	Alpha
3	Member Last Name	39	30	68	Alpha
4	Assessment Type	69	1	69	Alpha (**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

Assessment Download					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
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
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

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 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

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 or outreach 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 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) Pended for Approved Fair Hearing
         (2) Pended for Denied Fair Hearing
         (3) Pended for Withdrawn Fair Hearing
         (4) Pended for FH Administrative Change
   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) <u>COS Enrollment Status:</u>

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**.
iii) This information will also be available at the provider level

j)

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
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. 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 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

HH Claim and Encounter Summary File Download					
Field #	Field Name	Start Pos	Length	End Pos	Format
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
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

Rate Codes to include in file	Long Description	Short Desc
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

Fair Hearings Download					
Field #	Field Name	Start Pos	Length	End Pos	Format
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
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 located here: https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/docs/special_population_and_hml_logic_flow.pdf. 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)

Billing Support Upload File					
Field #	Field	Start Pos	Length	End Pos	Format
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)
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)

Billing Support Upload File					
Field #	Field	Start Pos	Length	End Pos	Format
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 on the HH Website in the 2019 Quality Webinar – Billing Support files starting on slide 21: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/docs/mapp_hhts_webseries_billing_support_files.pdf
3) **Add/Void Indicator** (field #1)
   a) To indicate that a billable service was provided for a billing instance submit a record with a value of 'A' in **Add/Void Indicator** (field #1) and a value of 'Y' in **Core Service Provided (**field #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

~~f)~~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)

Billing Support Download File					
Field #	**Field Name**	**Start Pos**	**Length**	**End Pos**	**Format**
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)
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)

Billing Support Download File					
Field #	**Field Name**	**Start Pos**	**Length**	**End Pos**	**Format**
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
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)

Billing Support Download File					
Field #	Field Name	Start Pos	Length	End Pos	Format
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
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

Billing Support Download File					
Field #	**Field Name**	**Start Pos**	**Length**	**End Pos**	**Format**
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	Member MF	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
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.

Billing Support Download File					
Field #	Field Name	Start Pos	Length	End Pos	Format
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

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 ~~potential~~ billing instance (**Billing Instance Type** field #5 = 'FH') 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: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/cans-ny_launch_2.htm

10. Users cannot add ~~or void~~ a CANS NY Assessment Fee or an HCBS Assessment Fee billing instance (**Billing Instance Type** field #5 = 'F' or 'H'), ~~.~~ ~~O~~only the system can add ~~or void~~ 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.

~~10.~~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.

Commented [LC8]: Addition 5.0.2: Description of how CANS and HCBS added and voided BIs display on the Billing Support Download file.

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. <u>For HCBS assessment completion date from 4/1/21 – 12/31/23</u>: 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. <u>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:</u>

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 *(<u>this means re-assessments MUST be completed within a year OR providers WILL NOT BE ELIGIBLE FOR ASSESSMENT FEE)</u>*
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 **<u>will not</u>** 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 or 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 POC Upload File 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** and **Member MF**: the dates a member is identified as HFW/MF is submitted and maintained in the system by HHs using the Consent and Member Program Status Upload file. A member's detailed HFW/MF information 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. **Member MF** = 'Y' for the BI service date

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)
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
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

Provider Relationship Download File					
Field #	Field	Start Pos	Length	End Pos	Format
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
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
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
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

MCP HH Relationship Download					
Field #	Field	Start Pos	Length	End Pos	Format
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
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

HH CMA Relationship Download					
Field #	Field	Start Pos	Length	End Pos	Format
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
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

HH CMA Relationship Download					
Field #	Field	Start Pos	Length	End Pos	Format
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

Transfer Out File					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
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
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:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm 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? For dates on or after the configurable date XX/XX/XXXX, the description will be: Were the minimum required AOT services provided and the caseload requirement met?
AOT minimum service provided field req'd	Were the minimum required AOT services provided?
ACT member field req'd if CMA is 'ACT'	Is the member in ACT?
ACT minimum service provided field req'd	Were the minimum required ACT services provided?
Member qualifies for AH+ field required	The member is an impacted adult home member on/after March 2014 and is a class member. Does the member qualify for Adult Home Plus Care Management (refer to Adult Home Plus Attestation)?
Transitioned to community field req'd	Has the Adult Home member transitioned to the community?
Cont to qualify for AH+ field req'd	Does the member continue to qualify for the Adult Home Plus Care Management?
Interest in transitioning field is req'd	Does the member continue to be interested in transitioning?
Core Service Provided is required field	Was a core Health Home service provided this month?
Invalid record type format	# of characters in fields exceeds limit
Incorrect value provided for field number <field #>	Invalid entry in field
Service Date entered is a future date	Service date in the future
R/E Code is not compatible	Member's R/E Code on the service date is not compatible on the service date

Error Name	Error Description
Missing a Completed CANS Assessment	CANS Assessment does not exist in Completed status for the member on the segment after the 2nd month of the Enrollment segment or the last CANS Completion Date is more than 6 months (including the month when the CANS was completed) in the past from the month of the segment
Member is not Medicaid eligible	Member is not Medicaid eligible on service date; Details
Child in Foster Care field is required	Has the child been in Foster Care at any time this month?
Core Service Provided is required field	If HH+ Minimum Services Provided = N, then Core Service Provided is required
HUD1 in 6mos req'd if Mbr Housing =N	If Member Housing Status = N, then HUD 1 within past 6 months is required
HUD1 in 6mos = blank if Mbr Housing=Y	If Member Housing Status = Y, then HUD 1 within past 6 months must be blank.
HUD1 in 6 mos = Y if prior HUD Cat = 1	If prior date of service HUD Category = 1, HUD 1 within past 6 months must be Y.
Date Mbr Housed req'd if HUD1 in 6 mos	If HUD 1 within past 6 months = Y, then Date Member Housed is required
Date Mbr Housed must be blank	If HUD1 within past 6 months = N, then Date Member Housed must be blank. If Member Housing Status = Y, then Date Member Housed must be blank.
Expanded HH+ Population is req'd field	Is the member in the expanded HH+ population?
HH+ Min Services req'd if HH+ pop = Y	If Expanded HH+ population = Y, then HH+ Minimum Services Provided is required (for dates of service prior to 5/1/19)
HH+ Min Services = blank if HH+ pop = N	If Expanded HH+ population = N, then HH+ Minimum Services Provided must be blank (for dates of service prior to 5/1/19
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 Or 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 Or "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 Or 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: 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 Pended segment BI max number reached	When field #44 is populated with Y and #45 is not populated 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_SAME_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:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm (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 please see:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/current_hh_rates.pdf

The following codes are used in the Billing Support Upload file. The majority of the below fields pertain only to adult HML assessments, although some questions, such as Pre-Conditions of member pertain to both adult and child questionnaires.

Field Description	Code	Code Description
HIV T-Cell Count	0	NA
HIV T-Cell Count	1	Unknown
HIV T-Cell Count	5	>200 (this code is only applicable to service dates on or after 12/1/16)
HIV T-Cell Count	6	<=200 (this code is only applicable to service dates on or after 12/1/16)
HIV Viral Load	0	NA
HIV Viral Load	1	Unknown
HIV Viral Load	2	<200
HIV Viral Load	3	200-400
HIV Viral Load	4	>400
HUD CODES	1	Meets HUD Category 1: Literally Homeless definition
HUD CODES	2	Meets HUD Category 2: Imminent Risk of Homelessness definition
Pre-Conditions of member	02	Mental Health
Pre-Conditions of member	04	Substance Abuse
Pre-Conditions of member	06	Asthma
Pre-Conditions of member	08	Diabetes
Pre-Conditions of member	10	Heart Disease
Pre-Conditions of member	12	Overweight
Pre-Conditions of member	14	HIV/AIDS
Pre-Conditions of member	16	Other
Pre-Conditions of member	18	Complex Trauma (under 21 years of age)
Pre-Conditions of member	20	SED/SMI (this code is only applicable to service dates on or after 7/1/18)
Pre-Conditions of member	22	One or more DD conditions (this code is only applicable to service dates on or after 7/1/18)
Pre-Conditions of member	24	Children's HCBS only (this code is only applicable to service dates on or after 1/1/19)
Pre-Conditions of member	26	Children's HCBS and other conditions (this code is only applicable to service dates on or after 1/1/19)

Field Description	Code	Code Description
Pre-Conditions of member	28	Adult HCBS and other conditions (this code is only applicable to service dates on or after 1/1/19)
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)

Field Description	Code	Code Description
Expanded HH+ population	P	Yes. HH+ SMI – Discharged from State PC (for service dates on or after 5/1/19)
Expanded HH+ Population	Q	Yes. HH+ SMI – CNYPC Release (for service dates on or after 5/1/19)
Expanded HH+ population	R	Yes. HH_ SMI – Ineffectively engaged in care (no outpatient 2/ 2+ psychiatric hospitalizations) (for service dates on or after 5/1/19)
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
    - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
- Health Homes Provider Manual: Billing Policy and Guidance
    - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh_provider_manual_v2019-02.pdf
- Health Home Program Policy and Standards Website
    - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm
- Health Home Program Email webform link (please select most appropriate subject when submitting an email)
    - https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
- 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
        - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf
    - Eligibility Requirements: Identifying Potential Members for HH Services

        - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_hh_eligibility_policy.pdf
    - Coverage Code Compatibility with HH Program
        - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_coverage_codes.pdf
    - Recipient R/E Compatibility with HH Program
        - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf
- For questions about Health Home claims or issues with submitting Health Home claims:
    - Information on working through denied Health Home claims
        - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/information_on_denied_claims.pdf
        - If the document above does not answer your question, call GDIT (General Dynamics Information Technology) at: **1-800-343-9000**
    - eMedNY **Provider Quick Reference Guide**
        - https://www.emedny.org/contacts/telephone%20quick%20reference.pdf
    - eMedNY **NYS Electronic Medicaid System Remittance Advice Guideline** document
        - https://www.emedny.org/providermanuals/allproviders/general_remittance_guidelines.pdf
    - eMedNY Payment cycle calendar
        - https://www.emedny.org/hipaa/news/PDFS/CYCLE_CALENDAR.pdf
- 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
- Managed Care Plan Contacts for Health Homes and Care Management Agencies https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care/mc_hh_contacts.htm

Appendix M: Consent 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	~~High Fidelity Wraparound~~ 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

Commented [CL9]: Correction: clarification on description for this code, with the addition of other HFW Member Program Type codes.

Commented [CL10]: Addition: New codes to report on HFW eligibility and the reason for which the member is not receiving HFW services.

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
8	HH/CMA closure or merger
09	Transferred to CYES
10	Transferred from CYES

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: 1) POC submitted on POC Upload file is expired as of BI service date, **OR** 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	Warning: 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: 1) Member's submitted CEST Outcome expires the same month as the BI service date OR 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.

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

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.