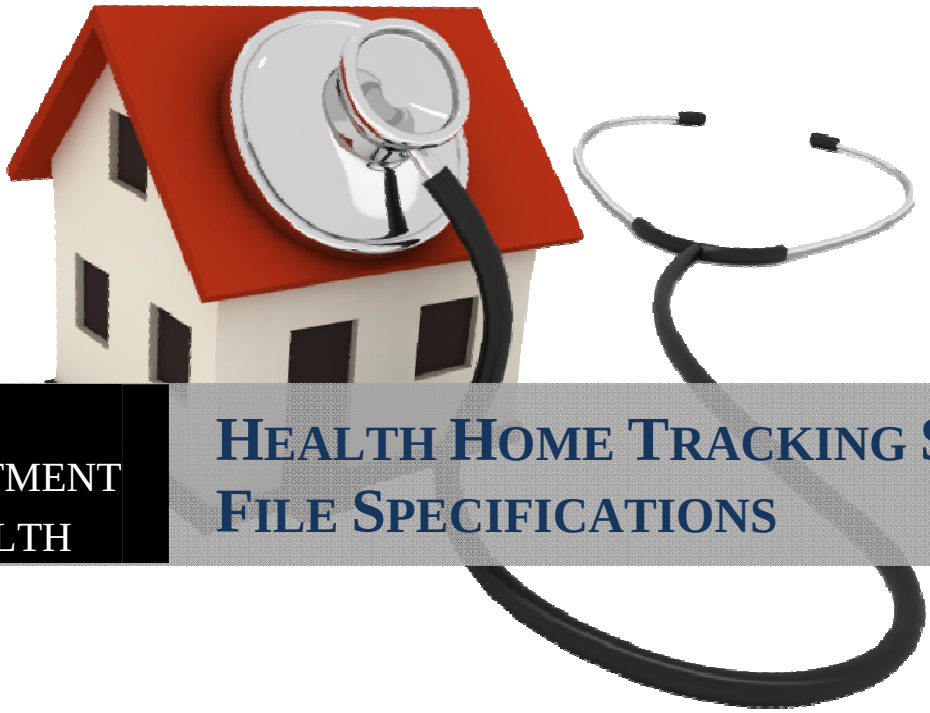

NYS DEPARTMENT OF HEALTH

HEALTH HOME TRACKING SYSTEM FILE SPECIFICATIONS

June 5, 2013

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Introduction

Purpose/Overview

The purpose of the *Health Home Member Tracking System* is to facilitate communication between the New York State Department of Health (DOH), Health Homes (HH), and Managed Care Plans (MCP) involved in providing Health Home services. The *Health Home Member Tracking System* resides in the *Health Commerce System*.

DOH will identify Medicaid members who are eligible for Health Home services and assign Fee-for-Service members to Health Homes. DOH will release, to each Managed Care Plan, assignment files containing Health Home eligible members with a suggested Health Home assignment. Managed Care Plans will then review the DOH proposed Health Home assignment and will submit a file back to DOH containing members' final Health Home assignments. Health Homes will then access one assignment file through the Portal that contains both Fee-for-Service and Managed Care enrolled Health Home eligible members.

Health Homes will assign members from the Health Home assignment files to downstream care management agencies, which will provide Health Home services. The Health Home then collects and compiles outreach and enrollment information from downstream providers for both Fee-for-Service and Managed Care members into a single file and submits that file to DOH through the Portal. These files should be processed before a claim is submitted to Medicaid; therefore, it is crucial that the data is submitted promptly and accurately. Claims without properly submitted Health Home tracking information may be denied for payment.

Only Health Homes will submit tracking system files to the *Health Home Member Tracking System Portal*. Managed Care Plans are only required to submit final Health Home assignment files to the Portal. Health Homes will be responsible for exchanging tracking files for both Fee-for-Service and Managed Care members with DOH.

For additional information regarding the Health Home program, please see the links below:

- Health Home website:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm
- Member Assignment, Tracking System, Billing and Rates section of the HH website:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm
- Health Home Medicaid Updates:
  http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/medicaid_updates.htm
- Health Home Provider Manual: COMING SOON
- Health Home contact information:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm
- Managed Care Plan Contact information (see Managed Care Information section):
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm
- Health Home MMIS Provider ID, NPI, Name crosswalk:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_name_pid_npi_information.xls

Health Home Member Tracking System Portal

The *Health Home Member Tracking System Portal* is an application housed in the *Health Commerce System* (HCS) that allows DOH, Health Homes and Managed Care Plans to download and upload fixed length text files in the formats outlined in this document.

Each Health Home and Managed Care Plan will assign two to three employees with Health Commerce System access as HCS contacts. These HCS contacts will be granted access to the Portal thus allowing them to download and upload fixed length text files through the Data Portal. Files that do not conform to the formatting and logic outlined in this document will not be accepted.

Instructions on how to access the Portal are available on the Health Home website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/Navigating_the_Online_Health_Home_Tracking_System.pdf

Files Available for Download through the Portal

The following section will provide a brief explanation of the file types available for download from the *Health Home Member Tracking System Portal*. Field descriptions and explanations of accepted values can be found in ***Appendix A: Field Descriptions*** at the end of this document.

Health Home Assignment Files

The Health Home Assignment files are used by DOH to communicate to Health Homes and Managed Care Plans the Medicaid members that have been pre-identified as eligible for Health Home services. Assignment files will contain members who are assigned to an entity and do not have an active Health Home segment in the Portal. Once the Health Home Member Tracking System specifications have been defined and implemented, DOH intends to update assignment files on a quarterly basis. The updated quarterly assignments files will be based on the Health Home eligible population for a more recent time period. DOH will notify Managed Care Plans and Health Homes when assignments based on the newly released population (the Health Home eligible population for a more recent time period) are available.

Managed Care Plans will download assignment files containing information about their Health Home eligible members in addition to proposed Health Home assignments. Managed Care Plans will review this information and use it to make a final Health Home assignment for their Health Home eligible members. Managed Care Plans will use the Managed Care Final Health Home Assignment file (discussed later) to submit to the Portal their members' final Health Home assignments.

The Portal will combine the final Managed Care Health Home Assignments submitted by Managed Care Plans with the Health Home Assignments for Fee-for-Service members. Health Homes will then be able to download their assignment file containing both Fee-for-Service and submitted Managed Care member assignments. Health Homes should use this assignment file to identify, locate, and provide outreach and enrollment services to Health Home eligible members. Once an assigned member begins an outreach or an enrollment segment in the tracking system, the member is removed from the assignment file. Also, if a member moves from FFS to Managed Care or from one Managed Care Plan to another, the member is removed from the original assignment file until the new plan assigns that

member to a Health Home. Finally, if an assigned member loses Medicaid eligibility, the member is removed from the assignment file.

Managed Care Plans and Health Homes have access to their assignment files around the clock. Health Homes will need to periodically download and check their assignment files for updates from Managed Care Plans as the plans submit their final Health Home assignments to the Portal. Additionally, since a member's eligibility and Managed Care status can change each month, Managed Care Plans and Health Homes are encouraged to download their assignment files on a regular basis.

Each new release of assignment files *replaces* previously released assignment files. Members that fall off of an assignment file from one assignment file to another are either no longer assigned to that Health Home or have since been enrolled in an active outreach or enrollment segment.

Health Homes and Managed Care Plans are not limited to only providing services to assigned members. Any Medicaid member that is eligible for Health Home services and is appropriate for this level of care management can be enrolled in the Health Home program as a referral. For information on Health Home referrals, please see the November 2012 Special Edition Medicaid Update.

Please note that there are two assignment file formats: one for the Health Homes and another for the Managed Care Plans. These two files are essentially the same except that the Managed Care file has two additional fields at the end of the file that contain DOH suggested Health Home assignment information. The assigned Health Home information listed in fields 11-13 on the Managed Care Assignment file will be blank until the Managed Care Plan submits the Managed Care Plan Final HH Assignment Submission file. Once the MCP final HH assignments have been submitted to the Portal, fields 11-13 will be populated with the plan's submitted HH assignment information.

Health Home Assignment File Format					
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	Date of Birth	69	8	76	MMDDYYYY, Numeric
5	County of Fiscal Responsibility Code	77	2	78	Numeric
6	County of Fiscal Responsibility Desc	79	30	108	Alpha
7	Gender	109	1	109	Character (M/F)
8	Assignment Date	110	8	117	MMDDYYYY, Numeric
9	Managed Care Plan MMIS ID	118	8	125	Numeric
10	Managed Care Plan Name	126	40	165	Alpha
11	Health Home MMIS ID	166	8	173	Numeric
12	Health Home NPI	174	10	183	Numeric
13	Health Home Name	184	40	223	Alpha
14	Medicaid Eligibility End Date	224	8	231	MMDDYYYY, Numeric
15	Medicare Indicator	232	1	232	Alpha (Y/N)
16	DOH Member Address Line 1	233	40	272	Alphanumeric
17	DOH Member Address Line 2	273	40	312	Alphanumeric
18	DOH Member City	313	40	352	Alphanumeric

19	DOH Member State	353	2	354	Alpha
20	DOH Member Zip Code	355	9	363	Numeric
21	DOH Member Phone	364	10	373	Numeric
22	Date of Patient Acuity	374	8	381	MMDDYYYY, Numeric
23	Acuity Score	382	7	388	Decimal, 99V9999
24	Risk Score	389	6	394	Decimal, 999V99
25	Outpatient Rank	395	6	400	Decimal, 999V99
26	DOH Composite Score	401	6	406	Decimal, 999V99
27	Service 1: Last Service Date	407	8	414	MMDDYYYY, Numeric
28	Service 1: Last Service Provider Name	415	40	454	Alphanumeric
29	Service 1: Last Service Provider NPI	455	10	464	Numeric
30	Service 1: Last Service Address Line 1	465	40	504	Alphanumeric
31	Service 1: Last Service Address Line 2	505	40	544	Alphanumeric
32	Service 1: Last Service City	545	40	584	Alphanumeric
33	Service 1: Last Service State	585	2	586	Alpha
34	Service 1: Last Service Zip Code	587	9	595	Numeric
35	Service 1: Last Service Phone Number	596	10	605	Numeric
36	Service 2: Last Service Date	606	8	613	MMDDYYYY, Numeric
37	Service 2: Last Service Provider Name	614	40	653	Alphanumeric
38	Service 2: Last Service Provider NPI	654	10	663	Numeric
39	Service 2: Last Service Address Line 1	664	40	703	Alphanumeric
40	Service 2: Last Service Address Line 2	704	40	743	Alphanumeric
41	Service 2: Last Service City	744	40	783	Alphanumeric
42	Service 2: Last Service State	784	2	785	Alpha
43	Service 2: Last Service Zip Code	786	9	794	Numeric
44	Service 2: Last Service Phone Number	795	10	804	Numeric
45	Service 3: Last Service Date	805	8	812	MMDDYYYY, Numeric
46	Service 3: Last Service Provider Name	813	40	852	Alphanumeric
47	Service 3: Last Service Provider NPI	853	10	862	Numeric
48	Service 3: Last Service Address Line 1	863	40	902	Alphanumeric
49	Service 3: Last Service Address Line 2	903	40	942	Alphanumeric
50	Service 3: Last Service City	943	40	982	Alphanumeric
51	Service 3: Last Service State	983	2	984	Alpha
52	Service 3: Last Service Zip Code	985	9	993	Numeric
53	Service 3: Last Service Phone Number	994	10	1003	Numeric
54	Service 4: Last Service Date	1004	8	1011	MMDDYYYY, Numeric
55	Service 4: Last Service Provider Name	1012	40	1051	Alphanumeric
56	Service 4: Last Service Provider NPI	1052	10	1061	Numeric
57	Service 4: Last Service Address Line 1	1062	40	1101	Alphanumeric
58	Service 4: Last Service Address Line 2	1102	40	1141	Alphanumeric
59	Service 4: Last Service City	1142	40	1181	Alphanumeric
60	Service 4: Last Service State	1182	2	1183	Alpha
61	Service 4: Last Service Zip Code	1184	9	1192	Numeric
62	Service 4: Last Service Phone Number	1193	10	1202	Numeric
63	Service 5: Last Service Date	1203	8	1210	MMDDYYYY, Numeric
64	Service 5: Last Service Provider Name	1211	40	1250	Alphanumeric
65	Service 5: Last Service Provider NPI	1251	10	1260	Numeric
66	Service 5: Last Service Address Line 1	1261	40	1300	Alphanumeric
67	Service 5: Last Service Address Line 2	1301	40	1340	Alphanumeric

68	Service 5: Last Service City	1341	40	1380	Alphanumeric
69	Service 5: Last Service State	1381	2	1382	Alpha
70	Service 5: Last Service Zip Code	1383	9	1391	Numeric
71	Service 5: Last Service Phone Number	1392	10	1401	Numeric

Managed Care Assignment File Format					
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	Date of Birth	69	8	76	MMDDYYYY, Numeric
5	County of Fiscal Responsibility Code	77	2	78	Numeric
6	County of Fiscal Responsibility Desc	79	30	108	Alpha
7	Gender	109	1	109	Character (M/F)
8	Assignment Date	110	8	117	MMDDYYYY, Numeric
9	Managed Care Plan MMIS ID	118	8	125	Numeric
10	Managed Care Plan Name	126	40	165	Alpha
11	Health Home MMIS ID	166	8	173	Numeric
12	Health Home NPI	174	10	183	Numeric
13	Health Home Name	184	40	223	Alpha
14	Medicaid Eligibility End Date	224	8	231	MMDDYYYY, Numeric
15	Medicare Indicator	232	1	232	Alpha (Y/N)
16	DOH Member Address Line 1	233	40	272	Alphanumeric
17	DOH Member Address Line 2	273	40	312	Alphanumeric
18	DOH Member City	313	40	352	Alphanumeric
19	DOH Member State	353	2	354	Alpha
20	DOH Member Zip Code	355	9	363	Numeric
21	DOH Member Phone	364	10	373	Numeric
22	Date of Patient Acuity	374	8	381	MMDDYYYY, Numeric
23	Acuity Score	382	7	388	Decimal, 99V9999
24	Risk Score	389	6	394	Decimal, 999V99
25	Outpatient Rank	395	6	400	Decimal, 999V99
26	DOH Composite Score	401	6	406	Decimal, 999V99
27	Service 1: Last Service Date	407	8	414	MMDDYYYY, Numeric
28	Service 1: Last Service Provider Name	415	40	454	Alphanumeric
29	Service 1: Last Service Provider NPI	455	10	464	Numeric
30	Service 1: Last Service Address Line 1	465	40	504	Alphanumeric
31	Service 1: Last Service Address Line 2	505	40	544	Alphanumeric
32	Service 1: Last Service City	545	40	584	Alphanumeric
33	Service 1: Last Service State	585	2	586	Alpha
34	Service 1: Last Service Zip Code	587	9	595	Numeric
35	Service 1: Last Service Phone Number	596	10	605	Numeric
36	Service 2: Last Service Date	606	8	613	MMDDYYYY, Numeric
37	Service 2: Last Service Provider Name	614	40	653	Alphanumeric
38	Service 2: Last Service Provider NPI	654	10	663	Numeric
39	Service 2: Last Service Address Line 1	664	40	703	Alphanumeric
40	Service 2: Last Service Address Line 2	704	40	743	Alphanumeric

41	Service 2: Last Service City	744	40	783	Alphanumeric
42	Service 2: Last Service State	784	2	785	Alpha
43	Service 2: Last Service Zip Code	786	9	794	Numeric
44	Service 2: Last Service Phone Number	795	10	804	Numeric
45	Service 3: Last Service Date	805	8	812	MMDDYYYY, Numeric
46	Service 3: Last Service Provider Name	813	40	852	Alphanumeric
47	Service 3: Last Service Provider NPI	853	10	862	Numeric
48	Service 3: Last Service Address Line 1	863	40	902	Alphanumeric
49	Service 3: Last Service Address Line 2	903	40	942	Alphanumeric
50	Service 3: Last Service City	943	40	982	Alphanumeric
51	Service 3: Last Service State	983	2	984	Alpha
52	Service 3: Last Service Zip Code	985	9	993	Numeric
53	Service 3: Last Service Phone Number	994	10	1003	Numeric
54	Service 4: Last Service Date	1004	8	1011	MMDDYYYY, Numeric
55	Service 4: Last Service Provider Name	1012	40	1051	Alphanumeric
56	Service 4: Last Service Provider NPI	1052	10	1061	Numeric
57	Service 4: Last Service Address Line 1	1062	40	1101	Alphanumeric
58	Service 4: Last Service Address Line 2	1102	40	1141	Alphanumeric
59	Service 4: Last Service City	1142	40	1181	Alphanumeric
60	Service 4: Last Service State	1182	2	1183	Alpha
61	Service 4: Last Service Zip Code	1184	9	1192	Numeric
62	Service 4: Last Service Phone Number	1193	10	1202	Numeric
63	Service 5: Last Service Date	1203	8	1210	MMDDYYYY, Numeric
64	Service 5: Last Service Provider Name	1211	40	1250	Alphanumeric
65	Service 5: Last Service Provider NPI	1251	10	1260	Numeric
66	Service 5: Last Service Address Line 1	1261	40	1300	Alphanumeric
67	Service 5: Last Service Address Line 2	1301	40	1340	Alphanumeric
68	Service 5: Last Service City	1341	40	1380	Alphanumeric
69	Service 5: Last Service State	1381	2	1382	Alpha
70	Service 5: Last Service Zip Code	1383	9	1391	Numeric
71	Service 5: Last Service Phone Number	1392	10	1401	Numeric
72	DOH Assignment Date	1402	8	1409	MMDDYYYY, Numeric
73	DOH Recommended Health Home MMIS ID	1410	8	1417	Numeric

Only applicable fields will contain data. Other fields will be populated with the appropriate number of blank spaces. For example, the Managed Care Plan MMIS ID field for a Fee-for-Service member would contain 8 blank spaces.

DOH Error Reports

There are three error reports in the tracking system: the Health Home Error Report, which provides information on records that are rejected from the Add/Change/Delete/Rejection records; the Health Home Billing Roster Rejection File, which provides information on records that are rejected from the Health Home Billing Roster Upload file; and the Managed Care Plan Assignment Error Report, which provides information on records that are rejected from the Managed Care Final Health Home Assignment File. The error reports are fixed length text files and the file formats for each error report are provided later in this section.

Once a tracking file is submitted to the Portal, several processes take place. Initially, a Health Home Error Report is generated to describe why rejected records were not accepted. Submitted files will be placed in one of three file statuses: Test, DOH Validated, and Final. There are two levels of editing: pre-processing and post processing (discussed later). Test and DOH Validated files are run through the pre-processing edits. The final files are run through the post-processing edits. As a result, when a file moves from DOH Validated to Final, the Health Home Error Report may be updated. The final Health Home Error Report is available once the submitted tracking file is in the Final status. If all records were accepted by the Portal, an error report will not be generated.

The DOH Error Report consists of a line number from the original submission, basic identification information, and up to five error codes indicating why the record was rejected. Descriptions of the error codes are listed in ***Appendix B: Error Reason Codes***.

Health Home Error Report File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Line Number	1	6	6	Numeric
2	Record Type	7	1	7	Character (A/C/D/R)
3	Member ID	8	8	15	AA11111A, Alphanumeric
4	Begin Date	16	8	23	MMDDYYYY, Numeric
5	Health Home MMIS ID	24	8	31	Numeric
6	Care Management Agency MMIS ID	32	8	39	Numeric
7	Error Reason Code 1	40	3	42	Numeric, Comma Delimited
8	Error Reason Code 2	43	3	45	Numeric, Comma Delimited
9	Error Reason Code 3	46	3	48	Numeric, Comma Delimited
10	Error Reason Code 4	49	3	51	Numeric, Comma Delimited
11	Error Reason Code 5	52	3	54	Numeric, Comma Delimited

Another error report that Health Homes will come across is the *Health Home Billing Roster Rejection* file. This file is returned when there are errors with a *Billing Roster Upload* file (discussed later). The Health Home Billing Roster Rejection file returns two fields, one containing a concatenation of the original record submitted and the second containing the reason that the record was rejected. To fix a record that was rejected from the Billing Roster, simply submit a Billing Roster Upload file containing the corrected record. An explanation of each reason can be found in ***Appendix E: Billing Roster Rejected Reasons***.

Health Home Billing Roster Rejection File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Original Record from File	1	20	20	Alphanumeric
2	Error Reason	21	40	60	Alpha

The last error report in the tracking system is the *Managed Care Plan Assignment Error Report*. This file is returned when there are errors with in the *Managed Care Plan Final Health Home Assignment File* (discussed later). This file returns four fields: the line number from the original submission, the member's ID, the submitted Health Home MMIS ID assignment, and the error reason indicating why the record was rejected. An explanation of each error reason can be found in ***Appendix F: Managed Care Final HH Assignment Error Reasons***.

Managed Care Final Assignment Error Report File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Line Number	1	6	6	Numeric
2	Member ID	7	8	14	AA11111A, Alphanumeric
3	Health Home MMIS ID	15	8	22	Numeric
4	Error Reason	23	30	52	Alphanumeric

Enrollment Download File

The Enrollment Download file, or "Data Dump," contains records that were successfully submitted and accepted into the Portal. As all downloaded files from the Portal, this file is dynamic and therefore is a snap shot of a member's Health Home status (outreach/enrollment) at a point in time. Every morning, files are updated to reflect the files submitted the previous day. The accuracy of this file is only valid up to the date it was downloaded and should not be used to verify members' Medicaid eligibility. Health Homes should break up this file and share it with their downstream providers as confirmation that submitted records were accepted into the Portal.

Enrollment Download File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Member ID	1	8	8	AA11111A, Alphanumeric
2	Begin Date	9	8	16	MMDDYYYY, Numeric
3	End Date	17	8	24	MMDDYYYY, Numeric
4	Outreach/Enrollment Code	25	1	25	Character (O/E)
5	Health Home MMIS ID	26	8	33	Numeric
6	Care Management Agency MMIS ID	34	8	41	Numeric
7	Direct Biller Indicator	42	1	42	Character (Y/N)
8	Referral Code	43	1	43	Character
9	Segment End Date Reason Code	44	2	45	Numeric
10	Consent Date	46	8	53	MMDDYYYY, Numeric
11	NYSID	54	9	62	Alphanumeric
12	Insert Date	63	8	70	MMDDYYYY, Numeric
13	Latest Modified Date	71	8	78	Alphanumeric

Acuity Download

The Acuity Download file contains members' Health Home acuity score history. Health Homes' Acuity Download files contain acuity information for the Health Homes' enrolled members and the Managed Care Plans' Acuity Download files will contain acuity information for the plans' enrolled members. A

member will be included on a Managed Care Plan's Acuity Download file as long as that member was enrolled with the plan for at least a month during the member's Health Home enrollment segment.

Acuity Download File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Member ID	1	8	8	AA11111A, Alphanumeric
2	Begin Date	9	8	16	MMDDYYYY, Numeric
3	End Date	17	8	24	MMDDYYYY, Numeric
4	Acuity Score	25	7	31	00.0000, Numeric

Health Home Billing Roster Download

This file is available for Health Homes to download upon successful upload of the *Billing Roster Upload* file. It is also the file that the Managed Care Plans download to verify billing. This file is created using the information submitted by the Health Homes on the Billing Roster File Upload (discussed later) and the Health Home enrollment information in the tracking system.

Health Home Billing Roster Download File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Add/Void Indicator	1	1	1	Character (A/V)
2	Member ID	2	8	9	AA11111A, Alphanumeric
3	Service Date	10	8	17	MMDDYYYY, Numeric
4	Health Home MMIS ID	18	8	25	Numeric
5	Outreach/Enrollment Code	26	1	26	Character (O/E)
6	Member Fiscal County Code	27	2	28	Numeric
7	Managed Care Organization MMIS ID	29	8	36	Numeric
8	Acuity Score as of Service Date	37	7	43	00.0000, Numeric

Files Submitted to the Portal

Files may be to the submitted to the Portal 24/7 and are processed **daily** at midnight. Once uploaded to the Portal, files will be placed in one of three file statuses: Test, DOH Validated, and Final. Test files are submitted to the Portal by selecting the *Test* box in the Portal prior to file upload. Test files will not be processed into the tracking system, so the corresponding error report will only contain records that failed pre-processing edits (see discussion below regarding edits). Only one file can be in the test status as a time. Any subsequent test files submitted to the Portal will overwrite the previously submitted test file.

Once a non-test file has been successfully uploaded to the Portal, it is listed as DOH Validated. DOH Validated means that the file was successfully uploaded to the Portal and that pre-processing edits have been applied, but that the file has not yet been processed into the tracking system. Pre-processing edits look at the file's format and basic content and rejects records that do not conform to the file formats outlined in this document, records containing invalid dates, records with invalid Medicaid Member IDs, and records with invalid MMIS IDs. At this time, an error report will be created if any records fail the pre-processing edits; if no records fail the pre-processing edits, an error report will not be created.

Files remain in the DOH Validated status until they are processed daily at midnight. Health Homes can only have one file in the DOH Validated status at a time. Any subsequent files submitted to the Portal will overwrite the file in the DOH Validated status. If a rejected record can be corrected and the submitted file is still in the DOH Validated status, a Health Home may make the necessary corrections to the submitted file and **resubmit the entire original file**, to include both previously accepted records and corrected records, to the Portal. Upon submission of this updated file, the new file will overwrite the existing file in the DOH Validated Status. If a file is already in the DOH Validated status and a Health Home would like to submit additional records, the Health Home must combine the new records with the submitted records and resubmit that merged file. This merged file will overwrite the file currently in the DOH Validated status.

Each day, submitted files are processed into the tracking system and run through post-processing edits at midnight. Once processed, submitted files move from the DOH Validated Files into the Final status. The Final status means that post-processing edits have been applied to the file and that the error report has been updated to reflect these edits. Once a file is in the Final status, the error report is also final. Post-processing edits compare the submitted records to records already accepted into the Tracking System, reject records that overlap with existing segments, and confirm member's Medicaid eligibility. Rejected records can be corrected and resubmitted as part of the Health Home's next file submission.

Users may log onto the Portal at any time to download the originally submitted file and the corresponding error report. Tracking Files/Error Reports may be in any of the following statuses:

File Status	Description
Uploaded	DOH received the file. Initial processing will begin immediately.
Test	The file was submitted to the Portal as a test, was run through the pre-processing edits, and **WILL NOT** be processed into the Portal. Health Homes may only submit one test file at a time. **All subsequent test files will overwrite the previously submitted test file**.
DOH Validated	The file has run through the first set of pre-processing edits. An error report outlining records that failed the pre-processing edits is available. Pre-processing edits reject records that contain invalid Member IDs, dates, and Provider IDs or files that do not conform to the specified file formats. **Only one file can be in this status at a time**.
Final	The file has run through all Health Home edits and the error report is now final. There is no limit on the number of files that can be in the Final status.

Managed Care Final Health Home Assignment File

This file is submitted to the Portal by Managed Care Plans. The purpose of this file is for the Managed Care Plans to submit to the Portal their enrolled plan members' Health Home assignments. Once this file is accepted by the Portal it is processed immediately and the submitted plan member assignments are incorporated into the Health Homes' Assignment Files the following day. There is no limit on how many Final Health Home Assignment files a Managed Care Plan can submit in one day. Managed Care Plans should notify the Health Homes they are working with once they submit Health Home assignments to the Portal using this file. Health Homes can access the submitted Managed Care Plan Health Home assignments by downloading the Health Home Assignment File.

Managed Care Plans need not submit Health Home Final Assignments for all Health Home eligible plan members. For example, if a Managed Care Plan has 100 members on their assignment file, their first Managed Care Final Health Home Assignment File may contain 60 members and their subsequent file may contain 40 members. If a subsequent file submission includes a new Health Home assignment for a member, then the new Health Home assignment will overwrite the Managed Care Plan's previous assignment. To void a previously submitted assignment, a Managed Care Plan should submit a record containing the member ID and a null value in the Health Home MMIS ID field. The Managed Care Plan Final Health Home Assignment File will be processed upon upload. The Managed Care Plan will have access to the Managed Care Plan Assignment Error Report shortly after the MCP Final Health Home Assignment File is processed and the Health Home will have access to their new assignments the following day.

Managed Care Final Health Home Assignment File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Member ID	1	8	8	AA11111A, Alphanumeric
2	Health Home MMIS ID	9	8	16	Numeric

Tracking File Record Types

Tracking File Add/Change Record

This record is used to submit new or updated information to the Health Home tracking system. To begin a service segment (to enroll a member outreach or enrollment) an Add record must be submitted to the Portal. To end a service segment, a Change record containing an end date must be submitted to the Portal. The only exception to this rule is when moving from outreach to enrollment (see below). All updates to a record must be submitted as a Change record and must contain all relevant information from the original record as well as the updated data element(s).

To update a client from outreach to enrollment, an Add record must be submitted to the Portal. This Add record starting an enrollment segment for a member in outreach will automatically trigger the Portal to end date the previously submitted outreach segment with the correct end date based on the enrollment segment's start date. When an outreach segment is submitted to the Portal, the system will automatically end date the outreach segment three months after the being date. To adjust the end date on an outreach segment, or to update a non-primary key field, you must submit a Change record. **Change records completely overwrite the existing record, so be sure to include all field values on a Change record including the referral code, the consent date, and the DOB/gender information**.

To reduce administrative burden, Health Homes, Managed Care Organizations, and Care Management Agencies exchanging tracking system information **MUST** use the DOH specified format listed in this document when exchanging Health Home tracking system information. Additional fields cannot be added to the any tracking system files.

Tracking File Add/Change Record					
Field	**Field**	**Start**	**Length**	**End**	**Format**

#		Pos		Pos	
1	Record Type	1	1	1	Character (A/C)
2	**Member ID**	**2**	**8**	**9**	**AA11111A, Alphanumeric**
3	Date of Birth	10	8	17	MMDDYYYY, Numeric
4	Gender	18	1	18	Character (M/F)
5	**Begin Date**	**19**	**8**	**26**	**MMDDYYYY, Numeric**
6	End Date	27	8	34	MMDDYYYY, Numeric
7	**Outreach/Enrollment Code**	**35**	**1**	**35**	**Character (O/E)**
8	**Health Home MMIS ID**	**36**	**8**	**43**	**Numeric**
9	**Care Management Agency MMIS ID**	**44**	**8**	**51**	**Numeric**
10	**Direct Biller Indicator**	**52**	**1**	**52**	**Character**
11	TBD 1	53	1	53	Character
12	TBD 2	54	1	54	Character
13	Referral Code	55	1	55	Character
14	Segment End Date Reason Code	56	2	57	Numeric
15	Consent Date	58	8	65	MMDDYYYY, Numeric
16	NYSID	66	9	74	Alphanumeric

Rules*:*

1. A service segment is the unique combination of the Medicaid member ID, Begin Date, Outreach/Enrollment Code, Health Home ID, Care Management ID, and Direct Biller Indicator field. This combination is the primary key of the record (shown in bold above).
2. The segment may not overlap with any existing segments.
3. Use a Change record to change a non-primary key field OR to end date a segment (except when moving from outreach to enrollment – see discussion above). When submitting a Change record, the values in the Change record must match the values in the existing segment exactly other than the field(s) that need to be changed.
4. To change a primary key field, the segment must first be end dated using a Change record and the new information must be added using an Add record. The Delete record is used to delete a record that is incorrect and should not have been submitted to the Portal.
5. A, C, D, and R records can be submitted in the same file submission.

Tracking File Delete Record

The delete record is used to remove an incorrectly entered outreach or enrollment event that never occurred. It should not be used to end date an existing segment. The Delete record permanently deletes a segment from the Portal.

Tracking File Delete Record					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Record Type	1	1	1	Character (D)
2	Member ID	2	8	9	AA11111A, Alphanumeric
3	Begin Date	10	8	17	MMDDYYYY, Numeric
4	Health Home MMIS ID	18	8	25	Numeric

Tracking File Rejection Record

The rejection record is used to reject a Health Home assignment. Providers should use this record to indicate that a member assignment is inappropriate and that a more suitable Health Home assignment is needed. Once rejected, the member will never be assigned to the rejecting Health Home again. Health Homes may use the suggested Health Home field to suggest a more appropriate assignment; however, the suggested Health Home field is not required and the member will not necessarily be assigned to the suggested Health Home. Currently, "Rejection Records" only apply to Fee For Service members; this functionality will be made available to Managed Care Plans in the near future. Until this functionality is built for Managed Care Plan members, Health Homes should notify the applicable Managed Care Plan when there is a concern regarding a MC plan member's Health Home Assignment.

The most effective way to refer a member to another Health Home is to contact that Health Home, send that Health Home the member's information, and for that Health Home to submit the member to the tracking system as a referral. Please familiarize yourself with the rules regarding sharing patient information prior to sharing any Health Home patient information.

Tracking File Rejection Record					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Record Type	1	1	1	Character (R)
2	Member ID	2	8	9	AA11111A, Alphanumeric
3	Rejection Reason	10	2	11	Numeric
4	Suggested Health Home	12	8	19	Numeric

Rules*:*

1. Rejection records can only be submitted for Medicaid members that did not begin an outreach/engagement or an enrollment segment.
2. Rejected members will not be reassigned to the rejecting Health Home again.
3. When the rejected record is processed daily at midnight, the member will be removed from the rejecting Health Home's assignment file.

Billing Roster File

The Billing Roster file is uploaded by the Health Homes to inform the Managed Care Plans that a Health Home enrolled member received a Health Home billable service for a specific date of service. This file includes the Member's ID, Service Date, and an Add/Void Indicator. The Add Indicator indicates that the Managed Care Plan should submit a claim for the member for the submitted date of service. The Void Indicator should be used to void a previously submitted record. For example, if a Health Home submits a record for John Smith with a service date of 1/1/12 on February 9 but then realizes on February 15 that a billable service was not provided in January, then the Health Home would submit a record with a Void indicator to delete the 1/1/12 record.

Since the purpose of the Billing Roster File is for the Health Homes to communicate to the Managed Care Plans which enrolled member the plan should bill for on a specific service date, only the Managed Care Plan members that have received a billable service for the service date AND are not receiving services from a converting provider should be included in the Billing Roster Upload file.

Upon submission, the Billing Roster file is processed. If a record is submitted in this file for a member that is not listed in the tracking system, the record will be rejected. If a record is submitted in this file for a member that has a value of "Y" in the Direct Biller Indicator field in the tracking system, the record will be rejected. Since there is minimal editing, Health Homes have access to both the Health Home Billing Roster Rejection file and the accepted Billing Roster file records (in the Health Home Billing Roster Download) as soon as the Billing Roster file is processed. Managed Care Plans also have access to the accepted Billing Roster file records (in the Health Home Billing Roster Download) as soon as the Billing Roster file is processed.

Billing Roster File Format					
Field #	**Field**	**Start Pos**	**Length**	**End Pos**	**Format**
1	Add/Void Indicator	1	1	1	Character (A/V)
2	Member ID	2	8	9	AA11111A, Alphanumeric
3	Service Date	10	8	17	MMDDYYYY, Numeric

Appendix A: Field Descriptions

Listed below are descriptions of the fields found in all of the file formats along with acceptable values, field formatting, and editing logic (if applicable).

This key is used on each field to show fields that are primary keys, the files that the field appears on, and which direction the field is transmitted.

🗝	Primary Key Field
AC	Add/Change Record
AD	Acuity Download
BR	Health Home Billing Roster Download
BRR	Health Home Billing Roster Rejected File
BU	Health Home Billing Roster Upload
D	Delete Record
E	Enrollment Download
HE	Health Home Error Report
HH	Health Home Assignment Record
MC	Managed Care Assignment Record
ME	Managed Care Plan Assignment Error Report
MF	Managed Care Final Health Home Assignment File
R	Rejection Record
↑	Records Uploaded to the Portal
↓	Records Downloaded from the Portal

Acuity Score **↓ AD ↓ BR ↓ HH ↓ MC**

Field Length: 7

Format: 99V9999, Decimal

Description: To calculate acuity scores, members are first grouped using the 3M Clinical Risk Group software. Each risk group is then assigned a raw acuity score based on the CRG resource use. These raw acuity scores are then adjusted for a predicted functional status factor (i.e., Mental Health, Substance Abuse and higher medical acuity groups are "up-weighted" until functional status data become available to more accurately adjust clinical acuity). Member specific adjusted acuity scores "predict" case management need based on a regression formula. These scores are multiplied by the appropriate base rate to calculate a member's PMPM claim payment. On the Health Home Billing Roster file, the acuity score listed is the member's acuity score as of the listed service date.

Add/Void Indicator **↓ BR ↑BU**

Field Length: 1

Format: Alpha

Description: The Add/Void Indicator is used in the Billing Roster function of the Tracking System. When submitted the *Health Home Billing Roster Upload* file, an Add/Void Indicator value of "A" indicates that

the record is a new submission to the Billing Roster function. A value of "V" indicates that the record is being submitted to void a previously submitted record.

Editing Logic: This field must contain a value of A or V.

Assignment Date **↓ HH ↓ MC**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The Assignment Date for fee for service members is the date that DOH assigned the member to the Health Home. The Assignment Date for managed care enrollees is the date that the enrollee's managed care plan submitted the Managed Care Final Health Home Assignment file containing the member's Health Home assignment to the Portal.

Begin Date **↓ E ↑ AC🗝 ↑D ↓ HE ↓AD**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The begin date indicates when the segment (the unique combination of the primary key fields) begins. On the Acuity Download file, this is the effective date of the acuity score.

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

For members enrolled in converting TCM/MATS/COBRA/CIDP programs, the begin date should coincide with the effective date of the program's conversion to Health Home services. If the member began services after the program's conversion to Health Home services, the begin data should coincide with the first of the month during which the member began to receive services.

Care Management Agency MMIS ID **↑ AC🗝 ↓ E ↓ HE**

Field Length: 8

Format: Numeric

Description: The field should be populated with the MMIS Provider ID of the Care Management Agency performing Health Home services. In some situations the Health Home is the Care Management Agency. In that situation, the Health Home's MMIS ID should be listed in both the Care Management Agency MMIS ID field and the Health Home MMIS ID field. If the Care Management Agency is not enrolled in Medicaid, then the Health Home's MMIS ID must be listed in the Care Management Agency MMIS ID field **(PLEASE SEE THE Billing Policy and Guidance for Health Homes Provider Manual ABOUT USING CARE MANAGEMENT AGENCIES THAT ARE NOT ENROLLED IN MEDICAID).**

Editing Logic: This field must contain a valid MMIS Provider ID.

Consent Date ↑ AC ↓ E

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This is the date that the member first signs the consent form with their Health Home. This date should not be updated as additional providers are added to page 3 of the consent form. For additional information on consent, please see the **Billing Policy and Guidance for Health Homes Provider Manual** and the *Forms & Templates* section of the Health Home website.

County of Fiscal Responsibility Code **↓ HH ↓ MC**

Field Length: 2

Format: Numeric

Description: The code designating the county that is fiscally responsible for the Medicaid member. This is the member's current county of residence per the member's official Medicaid file. If this information is incorrect, please work with the member to update their official address information with their local DSS office.

County of Fiscal Responsibility **↓ HH ↓ MC**

Field Length: 30

Format: Alpha

Description: The name of the county that is fiscally responsible for the Medicaid member. This is the member's current county of residence per the member's official Medicaid file. If this information is incorrect, please work with the member to update their official address information with their local DSS office.

Date of Birth **↑ AC ↓ HH ↓ MC**

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The member's date of birth that is on file with Medicaid. If this information is incorrect, please work with the member to update their official date of birth with their local DSS office.

Editing Logic: This field must contain a valid date and must match the date of birth that is on file for the member with Medicaid.

Date of Patient Acuity ↓ HH ↓ MC

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This is effective date of the listed acuity score.

Direct Biller Indicator ↑ AC ↓ E

Field Length: 1
Format: Numeric
Accepted Values: Y or N

Description: This field indicates that the member's Care Management Agency will bill Medicaid directly for all Health Home services provided. A value of "Y" indicates that the Care Management Agency is a direct biller and that the member's HH/MCP must not submit a claim to Medicaid for the member's Health Home services. A value of "N" indicates that the Care Management Agency is not a direct biller and that the member's HH/MCP must submit a claim to Medicaid for their member's Health Home services (Health Homes bill for FFS members and Managed Care Plans bill for their enrolled members).

Editing Logic: This field must contain a value of Y or N.

Segment End Date Reason Code ↑ AC ↓ E

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

Description: This code is used to describe the reason that for end dating a member's segment. Accepted values are listed in *Appendix C: Segment End Date Reason Codes.* This field must be left blank if the segment is open.

Editing Logic: This field must contain a value listed in *Appendix C: Segment End Date Reason Codes*. This field should only be populated with a Segment End Date Reason Code for segments with an end date. If there is no end date specified, this field should be filled with 2 blank spaces.

DOH Assignment Date ↓ MC

Field Length: 8
Format: MMDDYYYY, Numeric

Description: This is the date that DOH released a member's DOH suggested Health Home assignment to the member's managed care plan.

DOH Composite Score **↓ HH ↓ MC**

Field Length: 6

Format: 999V99, Decimal

Description: The Composite Score is the combination of the member's Risk Score and their Outpatient Rank. The composite score is used by DOH to prioritize members for Health Home assignment. Health Homes and Managed Care Plans should use the DOH Composite Score to prioritize Health Home assignments to members with the high DOH Composite Scores.

DOH Member Address Line 1 **↓ HH ↓ MC**

Field Length: 40

Format: Alphanumeric

Description: The member's most recent contact information from the Medicaid system. If incorrect, please work with the member to update their official contact information with their local DSS office.

DOH Member Address Line 2 **↓ HH ↓ MC**

Field Length: 40

Format: Alphanumeric

Description: The member's most recent contact information from the Medicaid system. If incorrect, please work with the member to update their official contact information with their local DSS office.

DOH Member City **↓ HH ↓ MC**

Field Length: 40

Format: Alphanumeric

Description: The member's most recent contact information from the Medicaid system. If incorrect, please work with the member to update their official contact information with their local DSS office.

DOH Member Phone **↓ HH ↓ MC**

Field Length: 10

Format: Numeric

Description: The member's most recent contact information from the Medicaid system. If incorrect, please work with the member to update their official contact information with their local DSS office.

DOH Member State **↓ HH ↓ MC**

Field Length: 2
Format: Alpha

Description: The member's most recent contact information from the Medicaid system. If incorrect, please work with the member to update their official contact information with their local DSS office.

DOH Member Zip Code **↓ HH ↓ MC**

Field Length: 9
Format: Numeric

Description: The member's most recent contact information from the Medicaid system. If incorrect, please work with the member to update their official contact information with their local DSS office.

DOH Recommended Health Home MMIS ID **↓ MC**

Field Length: 8
Format: Numeric

Description: This field contains the DOH suggested Health Home assignment for a member enrolled in managed care. This assignment is released to the member's managed care plan through the Managed Care Health Home Assignment file. Managed care plans may either assign their enrolled member to the DOH suggested Health Home or they may assign the member to another appropriate Health Home.

End Date **↑ AC ↓ AD ↓ E**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The End Date indicates when the service segment (the unique combination of the primary key fields) ends. On the Acuity Download file, the End Date indicates the last day that the listed acuity score is effective.

Editing Logic: This field must contain a valid date. The End Date must be greater than the segment's Begin Date. The End Date must always be the last day of the month. For example, if the member disenrolled from the Health Home on June 7, 2013, the End Date would be 6/30/13.

Error Reason **↓BRR ↓ME**

Field Length:

Managed Care Final Assignment Error Report	40
Health Home Billing Roster Rejected File	30

Format: Alpha
Accepted Values: See *Appendix F: Managed Care Final Health Home Assignment Submission Error Reasons* or *Appendix E: Health Home Billing Roster Error Reasons*

Description: This field explains why a record was rejected.

Error Reason Codes (1-5) **↓ H E**

Field Length: 3
Format: Numeric, Comma Delimited
Accepted Values: See *Appendix B: Error Reason Codes*

Description: The DOH error reports will list up to five Error Reason Codes for a record that was rejected. Valid Error Reason Codes are listed in *Appendix B: Error Reason Codes*.

First Name **↓ HH ↓ MC**

Field Length: 30
Format: Alpha

Description: The member's first name.

Gender **↑ AC ↓ HH ↓ MC**

Field Length: 1
Format: Alpha
Accepted Values: M, F

Description: The member's gender that is on file with Medicaid. If this information is incorrect, please work with the member to update their official gender with their local DSS office.

Editing Logic: This field must contain a value of either M or F and must match the member's gender that is on file with Medicaid.

Health Home MMIS ID **↑ AC🗝 ↑D ↓ E ↓ HE ↓ HH ↓ MC ↑ MF**

Field Length: 8
Format: Numeric

Description: This is the Health Home's MMIS Provider ID.

Editing Logic: This value must be a valid MMIS Provider ID. If a member has been assigned to a Health Home, the Health Home MMIS ID on a submitted record must match the Health Home that the member has been assigned to.

Health Home Name ↓ HH ↓ MC

Field Length: 40

Format: Alpha

Description: The name of the Health Home.

Health Home NPI ↓ HH ↓ MC

Field Length: 10

Format: Numeric

Description: The NPI of the Health Home.

Insert Date ↓ E

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This is the original date that the member first submitted into the Portal on an Add record.

Last Name ↓ HH ↓ MC

Field Length: 30

Format: Alpha

Description: The member's last name.

Latest Modified Date ↓ E

Field Length: 8

Format: MMDDYYYY, Numeric

Description: This reflects the date of the last adjustment to a record. For records that have not been changed since they were first submitted on the initial Add record, the Last Modified Date field will contain the same value as the Insert Date.

Line Number ↓ HE ↓ ME

Field Length: 6

Format: Numeric

Description: The Line Number is listed on the error repots to indicate which line on the input file failed the edit(s). For records with invalid formats, this may be the only way to identify which record from the input file is being rejected.

Managed Care Plan MMIS ID **↓ HH ↓ MC**

Field Length: 8
Format: Numeric

Description: The MMIS Provider ID of the member's Managed Care plan.

Managed Care Plan Name **↓ HH ↓ MC**

Field Length: 40
Format: Alpha

Description: The name of the member's Managed Care Plan.

Medicaid Eligibility End Date **↓ HH ↓ MC**

Field Length: 8
Format: MMDDYYYY, Numeric

Description: The date when the member's Medicaid eligibility expires. A value of 12/31/9999 indicates that the member's Medicaid eligibility will not expire. This field can be used to prioritize for enrollment members that are close to their Medicaid Eligibility End Date so that care managers can assist members in recertifying for Medicaid coverage.

Medicare Indicator **↓ HH ↓ MC**

Field Length: 1
Format: Alpha
Possible Values: Y, N

Description: Indicates whether a member is in Medicare as of the date of the file. This field is informational only.

Member ID **ALL 🗝 For AC**

Field Length: 8
Format: AA11111A, Alphanumeric

Description: This is a NYS Medicaid number used to identify Medicaid members.

Editing Logic: This field must be populated with a valid member ID. Health Home members must have current Medicaid eligibility to be accepted into the Portal. If the member is not a referral, the member must be assigned to the Health Home submitting the record.

NYSID ↑ AC ↓ E

Field Length: 9
Format: Alphanumeric

Description: A NYSID number is a unique identifier that is assigned to an individual by the New York State Division of Criminal Justice Services. If a Health Home knows a member's NYSID number, they should include it in the Add/Change record. This is not a required field, so if a Health Home does not know a member's NYSID number this field should be populated with 9 spaces.

Original Record from File ↓ BBR

Field Length: 20
Format: Alphanumeric

Description: This field contains a concatenation of the values submitted on the Billing Roster record that is being rejected.

Outpatient Rank ↓ HH ↓ MC

Field Length: 6
Format: Decimal, 999V99

Description: Ranks Health Home eligible members' utilization of outpatient services based on the members' overall outpatient use. Members without outpatient claims are assigned a value of 100. The remaining members receive a score based on how many services they received compared to the other members. Members with the most outpatient services receive low ranks (indicating that they have some sort of relationship with outpatient providers) and members with fewer outpatient services (indicating that they probably do not have a relationship with outpatient providers) receive higher scores. Possible values range from 0-100.

Outreach/Enrollment Code ↑ AC ↓ BR ↓ E

Field Length: 1
Format: Alpha
Accepted Values: O, E

Description: Specifies whether the segment is outreach (O) or enrollment (E). If a member begins a month in outreach but moves to enrollment by the end of that same month, only the enrollment segment should be submitted for the entire month. For example, if a member begins September in outreach and then enrolls in the program on September 29th, the Health Home would submit an Add record starting enrollment services with a begin date of September 1st.

To indicate that a member has moved from existing outreach and engagement segment to enrollment, the Health Home needs to submit an Add record beginning the new enrollment segment and the system will automatically end date the outreach segment.

Record Type ↑ AC ↑D ↓ HE ↑R

Field Length: 1
Format: Alpha
Accepted Values: A, C, D, R

Description: Defines the type of record that is being submitted to the system: Add (A), Change (C), Delete (D), or Rejection (R). The system will process the record based on the layout defined for each record type. Delete records will be processed first, Change records will be processed second, and Add records will be processed last. Rejection records will be used to influence Health Home assignment.

Editing Logic: This field must contain a value of A, C, D, or R.

Referral Code ↑ AC ↓E

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

Description: The Referral Code indicates if a member is a new referral ("R") or if they have been transferred ("T") from one Health Home to another Health Home. A new referral is any member that was referred to the Health Home as opposed to being assigned to that Health Home through the Portal. A value of "T" should only be used in this field when a Health Home is beginning a new segment for a member that was transferred **TO THAT HEALTH HOME** from another Health Home. If a Health Home wishes to transfer a member to another Health Home, the *Referral Code* indicator should be left blank and the *Segment End Date Reason Code* field should be populated with code 01: Transfer to another HH. If a member is neither a referral nor a transfer, this field should be populated with one blank space.

Editing Logic: If the member is not a referral, then the record must be submitted by the member's assigned Health Home.

Rejection Reason Code ↑ R

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

Description: This code explains why a Health Home is rejecting a Health Home assignment.

Editing Logic: This field is required when rejecting an assignment and must contain a value listed *on Appendix D: Rejection Reason Codes*.

Risk Score ↓ HH ↓ MC

Field Length: 6

Format: Decimal, 999V99

Description: Risk scores predict the probability that Medicaid members will experience a negative outcome (e.g. inpatient admission, long term care, death) in the following year. The predictive model used to calculate the risk scores is based on prior year service utilization. Negative outcomes are less likely for Medicaid members with lower risk scores (0) and are more likely for Medicaid members with higher risk scores (100). Health Homes and Managed Care Plans should use the Risk Score to prioritize Health Home assignments to members with the high Risk Scores.

Service Address Line 1 (Service 1-5) ↓ HH ↓ MC

Field Length: 40

Format: Alphanumeric

Description: The contact information for the member's last five unique providers per claims and encounter data for case management, outpatient/clinic, physician, inpatient, and ER services (excluding pharmacy and transportation claims).

Service Address 2 (Service 1-5) ↓ HH ↓ MC

Field Length: 40

Format: Alphanumeric

Description: The contact information for the member's last five unique providers per claims and encounter data for case management, outpatient/clinic, physician, inpatient, and ER services (excluding pharmacy and transportation claims).

Service City (Service 1-5) ↓ HH ↓ MC

Field Length: 40

Format: Alphanumeric

Description: The contact information for the member's last five unique providers per claims and encounter data for case management, outpatient/clinic, physician, inpatient, and ER services (excluding pharmacy and transportation claims).

Service Date (Service 1-5) ↓ HH ↓ MC

Field Length: 8

Format: MMDDYYYY, Numeric

Description: The contact information for the member's last five unique providers per claims and encounter data for case management, outpatient/clinic, physician, inpatient, and ER services (excluding pharmacy and transportation claims).

Service Phone (Service 1-5) **↓ HH ↓ MC**

Field Length: 10

Format: Numeric

Description: The contact information for the member's last five unique providers per claims and encounter data for case management, outpatient/clinic, physician, inpatient, and ER services (excluding pharmacy and transportation claims).

Service State (Service 1-5) **↓ HH ↓ MC**

Field Length: 2

Format: Alpha

Description: The contact information for the member's last five unique providers per claims and encounter data for case management, outpatient/clinic, physician, inpatient, and ER services (excluding pharmacy and transportation claims).

Service Zip Code (Service 1-5) **↓ HH ↓ MC**

Field Length: 9

Format: Numeric

Description: The contact information for the member's last five unique providers per claims and encounter data for case management, outpatient/clinic, physician, inpatient, and ER services (excluding pharmacy and transportation claims).

Suggested Health Home MMIS Provider ID **↑ R**

Field Length: 8

Format: Numeric

Description: This field is used when a Health Home would like to reject a DOH assignment. If there is a more appropriate Health Home assignment, please submit the Health Home's MMIS Provider ID to DOH using this field. If a Health Home has an existing relationship with the Health Home they are referring the member to and has the necessary agreements in place to discuss member information (please familiarize yourself with requirements for sharing patient information prior to sharing patient information with another provider), the assigned Health Home should contact the other Health Home to directly refer the member to that Health Home.

Editing Logic: This field is not required and need only be filled in if the Health Home has reason to believe that a specific Health Home would better serve the individual. If filled in, the Suggested Health Home assignment must contain a valid Health Home MMIS Provider ID.

Appendix B: Error Reason Codes

Listed below are the Error Reason codes, which describe why a record was rejected.

Error Code	Error Code Description
001	Invalid Medicaid Member ID
002	No WMS (Medicaid) Eligibility (Post-processing edit)
003	Invalid DOB
004	Invalid Gender
005	Invalid assignment for Data Management Provider
006	Member assigned to another Health Home
007	Member in Managed Care Plan
008	Member in a different Managed Care Plan
009	Managed Care Plan information filled in for FFS member
010	Invalid Billing Provider ID
011	Begin Date is not 1st of month
012	End Date is not last day of month
013	End Date is before Begin Date
014	Invalid Outreach/Enrollment Code
015	Invalid Gender Code
016	Invalid Record Type
017	Invalid Referral Indicator
018	Invalid TCM/MATS/COBRA/CIDP Indicator
019	Invalid TCM/MATS/COBRA/CIDP Slot Type
020	Begin Date is before DOH Assignment Date for FFS Member
021	Invalid MMIS ID for Care Management Agency
022	Invalid MMIS ID for Health Home
023	Invalid MMIS ID for Managed Care Plan
024	No Medicaid Eligibility before WMS verification (Pre-processing edit)
025	Invalid line length (i.e., too many/few characters)
026	Overlaps existing segment on file
027	Invalid format on line
028	Original record does not exist for Change or Delete operation
029	Most recent Outreach within 3 months
030	Begin Date prior to Health Home Project
031	Begin Date in Future
032	Begin Date of Enrollment Prior to Outreach Segment
033	Outreach Segment Longer than 3 months
034	Member in Pioneer ACO

Appendix C: Segment End Date Reason Codes

Listed below are the Segment End Date Reason Codes, which describe why a service segment is being end dated.

Segment End Date Reason Code	Segment End Date Reason Code Description
01	Transfer to another Health Home
02	Member Opted-Out
03	Changed Care Management Agency
04	Member Deceased
05	Member has a new CIN
07	Closed for disruptive or uncooperative behavior
08	Member moved out of service county
09	Member moved out of state
10	Change in functional eligibility
11	Incarcerated
12	Refused Consent (can only be used during outreach)
13	Patient of Inpatient Facility
14	Enrolled HH Patient Lost to Services
15	Patient dissatisfied with services
16	Inability to contact/locate patient
17	Found but not interested in enrolling in HH services
18	Found and expressed interest in HH but at a future date
19	Does not currently meet HH criteria
20	Switched Managed Care Plans
21	No longer requires HH services
22	Transition to FIDA (Fully-Integrated Duals Advantage) program
23	Member disenrolled
24	Member is no longer eligible for Medicaid
25	Member moved from Outreach to Enrollment Status
99	Other

Appendix D: Rejection Reason Codes

Listed below are the Health Home Rejection Reason Codes, which explains to DOH why a Health Home is rejecting a DOH Health Home assignment.

Rejection Reason Code	Rejection Reason Code Description
01	Not suitable Health Home assignment
02	Member moved out of service county
03	Member moved out of state
04	Change in functional eligibility
05	Incarcerated
06	Member Deceased
07	Patient of Inpatient Facility
08	Transferred to another Health Home
99	Other

Appendix E: Health Home Billing Roster Error Reasons

Listed below are the Billing Roster Rejection Reasons, which explains why a billing roster record was rejected.

Rejection Reason	Rejection Reason Description
INVALID_LENGTH	Invalid line length
SEGMENT_NOT_FOUND	A record was not found in the tracking system for the member on that service date
DIRECT_BILL	The member is receiving services from direct billing CMA
OTHER_ERROR	Other formatting error
ADD_RECORD_NOT_FOUND	A void was submitted but there is no corresponding add record

Appendix F: Managed Care Final HH Assignment Error Reasons

Listed below are the Managed Care Final Health Home Assignment Submission Error Reasons, which explain why a Managed Care Final Health Home Assignment Submission record was rejected.

Rejection Reason	Rejection Reason Description
INVALID_LENGTH	Not a valid record length
INVALID_RECIP_ID	Recipient ID (member ID) not on file
MEMBER_NOT_IN_PLAN	Member is either FFS or in a different plan
INVALID_HEALTH_HOME_ID	The HH ID is not registered in the system with an active date.