Health Plan CMART

HP-CMART VERSION 3.6 SPECIFICATION

Last revised: October 2019

Office of Quality and Patient Safety
NEW YORK STATE | DEPARTMENT OF HEALTH

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Summary of Changes

Changes (v3.6)

- October 2019
  - Steps to submit added
  - Error Code Key added
  - Dates for 2020 submission updated
  - Plan_ID asked for instead of MMIS_ID
  - Details about segment mismatch added
  - Special Population list and definitions updated
  - Monitor segment type dropped
  - Core Services detail dropped
  - Person-centered planning information added
  - End reason code details added

Changes (v3.5)

- February 25, 2019
  - Added note for CY 2018 submission that 'Adults w/Chronic Illness' in Special Populations field is not available.
  - Added note for CY 2018 submission that 'Homeless Population' in Special Populations field is not available.
  - Added footnotes to Appendix A listing addresses to the citations for special populations.

Changes (v3.4)

- July 13, 2018
  - Added note that there should not be any overlapping segments.
  - Added note for CY 2018 submission only that all open segments as of December 31, 2017 should also be added to submission.

Changes (v3.3)

- March 6, 2018
  - Added clarification regarding what constitutes outreach and enrolled.
  - Added note that to be considered enrolled, a plan of care needs to be completed for that segment.
  - Added note that there should not be any enrolled and closed segments on the same day.
  - Updated information regarding the error report for each submission.

Changes (v3.2)

- February 8, 2018
  - Removed line 'Incomplete interventions are not required to have an Intervention Type' from the intervention type section in the interventions.txt file

specification. This change was to create consistency throughout the rest of the documentation.
- Added additional details regarding which target should be reported when multiple targets are together for an intervention on behalf of a member.

Changes (v3.1)

- December 1, 2017
  - Changes to the specification document since the original release are highlighted in yellow.
  - Move HROB flag from Segments_Start table to Interventions table.
  - Special Population flag now only in Interventions table.

New Specification (v3.0)

- November 2017

New Fields

- Dates of all interventions (complete and incomplete)
- Completion indicator field for each intervention
- Target field for each intervention
- Type field for each intervention

Dropped Fields

- Number of interventions summarized
- Program type
- Intensity
- Plan level data (FTE, Average caseload, descriptions of programs offered, eligibility requirements)

Other Changes

- Split-year care management segments will no longer occur
  - All dates of each segment type will be recorded
- Members who do not receive an intervention (complete or incomplete) during the measurement year will not be included in the submission

Overview

Care management is defined as the delivery of member-specific interventions by a multidisciplinary team, led by a dedicated care manager. Care management activities are based on a current assessment and, where applicable, a person-centered plan of care. The interventions should result in coordinated, efficient, and quality care to achieve the member's goals and optimize health outcomes for people with complex health issues and needs. For people in Medicaid health plans, care management is required to address care needs, coordinate services, and arrange efficient quality health care to promote health outcomes. The care manager should ensure enrollees receive needed medical, behavioral, and social services in accordance with the goals of the member. Where a plan of care is required, health plans are encouraged to utilize health information technology to create, document, execute, and update the plan of care.

Throughout this document, the term health plan includes the health plan staff or their subcontractor of health plan care management services. (Health Home services are not included.)

The Health Plan Care Management Assessment Reporting Tool (HP-CMART) is a tool for the collection of standardized care management data for Medicaid members who are in outreach with or in an active/enrolled segment with the health plan, special needs plans (SNP), or Health and Recovery Plans (HARP), at any time during the measurement year. Members of other special populations (SP) can be found within these aforementioned plans and should also be included: personal care services (PCS), consumer directed personal assistances services (CDPAS), residential health care facility (RHCF) for long term placement, AIDS adult/adult day health care, other long-term services and supports (LTSS), medically fragile children, adults in receipt of Home and Community Based Services (HCBS), children in receipt of HCBS, homeless, and clotting factor recipients (more detail about these special populations can be found in Appendix A).

The HP-CMART data will provide the New York State Department of Health (NYSDOH) with information about care management services regarding the volume and type of interventions for all members.

Reporting Schedule

HP-CMART submissions are due to NYSDOH by the first Monday of May following the close of the measurement year.

Measurement Timeframe	Due Date
January 1-December 31, 2019	1st Monday in May 2020; **May 4, 2020**
January 1-December 31, 2020	1st Monday in May 2021; **May 3, 2021**

What to Report

Health plans are required to provide NYSDOH with the following information submitted via the HP-CMART:

1) **Segments (Start/End)**

   The submission will contain data regarding active care management segments which start or end during the measurement year. These elements must be extracted from the health plan's Electronic Healthcare Record (EHR).

2) **Interventions**

   The submission will contain data regarding care management services (interventions) provided to health plan members during the measurement year. These elements must be extracted from the health plan's EHR.

The health plans will coordinate with the care management staff providing services to collect the data for the measurement year. Health plans are expected to submit HP-CMART data from all affiliated vendors that provide health plan care management services to health plan members. (Health Home services are not included.) HP-CMART data should be extracted from the health plan's EHR, **not** collected manually. HP-CMART submissions will include data for Medicaid members who are in outreach with or in an active/enrolled segment with the health plan, SNP, or HARP at any time during the measurement year.

How to Submit

The health plan HP-CMART data submission must be submitted to the Department via the "CMART File Upload" application on the Health Commerce System (HCS) as a zipped file. Transmitting files through the HCS is mandatory due to the identifiable content of the files. Files sent via email (whether encrypted or not) will not be accepted.

Setting up your CMART application

1) Login to Health Commerce System (HCS) – User ID and Password required
2) Click on 'My Content' tab in top banner
3) Select 'All Applications' from list
4) Select 'C' after Browse by

5) Scroll down to ‘CMART File Upload’ – If there is a ‘+’ at the end of the row, click on it (‘CMART File Upload’ into ‘My Applications’ list on home page of HCS)
6) Click on ‘CMART File Upload’

Steps to submit HP-CMART submission

1) Login to Health Commerce System (HCS) – User ID and Password required
2) Click on ‘CMART File Upload’ on left under ‘My Applications’
3) Click on ‘CMART File Upload’ button
4) Enter a ‘Subject’, we recommend your plan name, plan ID, and the year of the CMART submission
5) Enter email message into ‘Notes’
6) Click ‘Launch the Upload Wizard’
    a. Click ‘Add File’
    b. Browse and select the zipped file containing the three CMART data submission files you want to upload
    c. Click ‘Open’
    d. Click ‘Upload’
    e. Click ‘Close’
7) Click ‘Send’
    a. The zipped file will be sent to the nysqarr mailbox and DOH will run an error report on the submission.

Reporting Requirements

The specifications for each submission element are provided below, along with additional reporting guidelines and clarifications. The submission should be comprised of three comma-separated values (CSV) text files with the following names:

1) SEGMENTS_START.CSV
2) SEGMENTS_END.CSV
3) INTERVENTIONS.CSV

These files should be submitted together as a single zip file to NYSDOH via the HCS. Format the file name as “[Health Plan Name]_PlanID-YYYY.zip” where “[Health Plan Name]” is the name of the health plan, SNP, or HARP, “PlanID” is the health plan’s ID (see list in Appendix B), and “YYYY” is the measurement year submitted.

After the health plan submits data, NYSDOH will run an error check report. The results from the error report will be sent to the health plan for any necessary data cleaning.

The final submission is due Monday, May 4, 2020. We will accept test submissions beginning Monday, April 6, 2020. Health plans can submit full files or an extract during

the test period for error checks. The error check report will be run on test and final submissions to assist health plans in cleaning the submission data.

File Definitions:

The three files that make up the HP-CMART v3 submission start with the same two columns. These columns have the same definition in all three files. These data elements are defined below.

Each segment opened in SEGMENTS_START must, eventually, have a corresponding row in SEGMENTS_END with a matching SEGMENT_TYPE.

Some segments will start during one measurement year and end during the following measurement year. Plans are only expected to report events which happen during the measurement year. For example, a segment may start on August 29, 2019 and end on January 4, 2020. The plan would submit one row in SEGMENTS_START for the 2019 measurement year. The plan would report the end of the segment in SEGMENTS_END when submitting 2020 measurement data.

Col	Column Name	Data Type	Col Width
1	MBR_ID	Varchar	8
2	PLAN_ID	Varchar	8

MBR_ID: Member's eight-digit Medicaid ID. This is also referred to as the Medicaid CIN. The MBR_ID **must** match the Medicaid ID submitted by the health plan to claims and encounters. In the unlikely event a member's Medicaid ID changes during enrollment, health plans should submit the member's Medicaid ID as it was at the time of the event (segments start, segments end, interventions).

PLAN_ID: Should reflect the plan of the member at the time of the segment or intervention. Plans should use the plan ID listed in Appendix B. A submission file should have only one PLAN_ID.

File Specification: SEGMENTS_START/SEGMENTS_END

- Not all members will have a segment in these tables.
  - For example, the segment may have started in the prior year and continue to be active into the subsequent year.
- Health plans only submit data for events which happen during the measurement year.
  - NYSDOH will combine these two tables to create meaningful segments.
  - Segments in CMART represent periods of care management, regardless of the care managers or goals. The segments reported should represent the care management related to a person-centered care plan, or, if there is not a care plan requirement, to a period the enrollee is engaged with a plan care

manager. Each segment should have one start date and one end date for each segment type. If a member is enrolled with multiple care managers in the same timeframe, the earliest date and the latest date of care management should be used to create one segment. If there is any ongoing care management activity by any care manager, it can be left open until all care management activities are complete.

- Each segment (no matter the segment type) that is started should have a matching end segment before another new segment of the same segment type is started. Members can only be in one segment of one segment type at a time, so there should be no overlapping segments.
- Each segment that is ended should have a matching start segment, either within current measurement year or in prior year already reported in CMART.

File Specification: SEGMENTS_START

- Documents all outreach and active/enrolled care management segments which begin during the measurement year.

	File Spec: SEGMENTS_START			
#	**Field Name**	**Data Type**	**Col Width**	**Comments**
1	MBR_ID	Varchar	8	This field may not be NULL.
2	PLAN_ID	Varchar	8	This field may not be NULL.
3	START_DATE	Varchar	8	This field may not be NULL.
4	SEGMENT_TYPE	Varchar	1	This field may not be NULL. O = Outreach Segment A = Active/Enrolled Segment

File Definitions:

START_DATE*:* The begin date of the outreach or active/enrolled care management segment. This date should fall within the measurement year. Format the date as MMDDYYYY with no intervening "-" or "/".

SEGMENT_TYPE: There are two types of segments.

- **Outreach:** The health plan (mainstream, SNP, HARP) offers member care management services. Activities include phone calls, letters, and in-person discussions with the member where the plan explains the services offered via plan-led care management. Outreach begins when the health plan initiates contact with the member to offer care management services. Outreach ends when the member accepts or declines care management services. Outreach also includes the time frame of trying to contact the member to offer care management to that member.

NOTE: Outreach may include clarification of interest or appropriateness of care management such as screening. If there are no additional services needed that require a plan of care, then the segment is considered outreach and not enrollment.

- **Active/Enrolled:** If a member in a mainstream health plan agrees to receive care management or a member in a SNP, HARP, or SP agrees to receive active care management, an active/enrolled segment is started.

  NOTE: To be considered an active/enrolled segment, a member must be engaged with a care manager and undergoing assessment or working towards addressing a goal. Where required, the member must be engaged in a person-centered planning process or activities related to the plan of care. There should not be any active/enrolled segments that both enroll and close within the same day.

File Specification: SEGMENTS_END

- Documents the closure of all outreach or active/enrolled care management segments which end during the measurement year.

File Spec: SEGMENTS_END				
#	Field Name	Data Type	Col Width	Comments
1	MBR_ID	Varchar	8	This field may not be NULL.
2	PLAN_ID	Varchar	8	This field may not be NULL.
3	END_DATE	Varchar	8	This field may not be NULL.
4	SEGMENT_TYPE	Varchar	1	This field may not be NULL. O = Outreach Segment A = Active/Enrolled Segment
5	END_REASON	Varchar	2	This field may not be NULL. 01: Member opted-out, valid only for Outreach segments 02: Member deceased, valid for all segments 03: Member has a new CIN, valid for all segments 04: Closed for behavior, valid for all segments 05: Member moved out of state, valid for all segments 06: Member incarcerated, valid for all segments 07: Enrolled HP member lost to services, valid only for Active/Enrolled segments 08: Inability to contact/locate member, valid for all segments 09: Member doesn't meet Managed Care Plan criteria, valid only for Outreach segments 10: Switched Managed Care Plan products, valid for all segments 11: Member disenrolled from health plan, valid for all segments 12: Member disenrolled from active care management, valid only for Active/Enrolled segments 13: Member is no longer Medicaid eligible, valid for all segments 14: Member moved from Outreach to Active/Enrolled, valid only for Outreach segments 15: Met Program Goals, valid only for Active/Enrolled segments

File Definitions:

END_DATE: The end date of the outreach or active/enrolled care management segment. This date should be during the measurement year (January 1 – December 31). Format the date as MMDDYYYY with no Intervening “-“ or “/”.

Each segment opened in SEGMENTS_START must, eventually, have a corresponding row in SEGMENTS_END with a matching SEGMENT_TYPE.

SEGMENT_TYPE: See File Definition of SEGMENTS_START for type definitions.

END_ REASON: The reason the segment ended.

Most of the END_REASON choices are considered valid for use for both the Outreach and Active/Enrolled segment types. However, there are some END_REASON choices that are only valid for one of the two segment types. The valid segment types for each end reason are listed in the File Spec: SEGMENTS_END table above.

Segment Mismatch:

Reported segments should have one start date and one end date for each segment type. If a member is enrolled with multiple care managers in the same timeframe, the earliest date and the latest date of care management should be used to create one continuous segment. If there is any ongoing care management activity by any care manager, the segment can be left open until all care management activities are complete.

It is the plans' responsibility to coordinate with vendors to provide care management. If there are overlapping segments across the health plan and vendor provided care management, the health plan should align the overlapping segments into one segment before submitting.

File Specification: INTERVENTIONS

The Interventions file includes all health plan interventions/contacts. For purposes of HP-CMART reporting, this term is used broadly.

- The NYSDOH defines the term intervention as all actions taken by the care manager to conduct or arrange for member assessment, person-centered planning, or develop/achieve identified member goals. Interventions to report include all interactions during the measurement year between the health plan and:
  - Outreach members
  - Mainstream, SNP, HARP health plan active/enrolled members
  - Health plan supervisors (member specific meetings, not general-purpose staff meetings)
  - Health plan internal team meetings (member specific meetings, not general-purpose staff meetings)
  - Member's doctors, providers, etc.
  - Member's family
- Reportable actions are always member-specific. Contacts that are not member-specific, for example, establishing a Memoranda of Understanding between the health plan and an outside provider, should not be reported.
- Health plans are expected to report all interventions (completed and not completed) for a member during the measurement year. Health plans will submit more than one row of data per member, where the health plan attempts or

completes more than one intervention for the member during the measurement year.

- It is possible for there to be more than one intervention per member per day.
- All interventions from all care managers should be included.
- The interventions file should only include members who received an intervention during the measurement year.
- The file should be CSV (called INTERVENTIONS.CSV).
- CSV files must include all columns described below and cannot have additional columns beyond those described below.
- Data submitted in a CSV file should include column names. The first row should be the column names in the following table.
- Null, blank values, and spaces, will be ignored. All columns require an entered value.

File Spec: INTERVENTIONS				
#	**Field Name**	**Data Type**	**Col Width**	**Details/Comments**
1	MBR_ID	Varchar	8	This field may not be NULL.
2	PLAN_ID	Varchar	8	This field may not be NULL.
3	HROB	Varchar	1	This field may not be NULL. Y = Yes N = No
4	SPEC_POP	Varchar	2	This field may not be NULL. 01 = Clotting Factor Recipients 02 = Medically Fragile Children 03 = Children in Receipt of HCBS 04 = Adults in Receipt of HCBS 05 = RHCF 06 = PCS 07 = CDPAS 08 = AIDS Adult/Adult Day Health Care 09 = Other LTSS Services 10 = In Receipt of CFCO 11 = Homeless 99 = Not a Special Population Member NOTE: Collection of data for In Receipt of CFCO (10) will begin for 1/1/2020
5	INTERVENTION_DATE	Date	8	This field may not be NULL. MMDDYYYY A health plan may submit more than one intervention per member per day.
6	MODE	Integer	1	This field may not be NULL. 1 = Letter, 2 = Phone, 3 = In-Person (Face to face) 4 = Email, 5 = SMS/Text, 6 = Video Conference (Microsoft Skype, Google Hangouts, Apple Facetime). Submit only intervention modes approved for use by the health plan. Only one MODE per contact.

7	TARGET	Integer	1	This field may not be NULL. 1 = Member 2 = Co-worker, Senior Care Manager, Supervisor (Health plan) 3 = Multidisciplinary Team/Case Review Meeting (Internal/External) 4 = External Doctor/Provider (Anyone who provides care or service to the member.) 5 = Family of Member (Includes close friends who function as de-facto family) 6 = Other
8	COMPLETED	Integer	1	This field may not be NULL. 1 = TRUE, 5 = FALSE, 9 = Not Recorded TRUE only if contact is successful and the member responds. This field should be 9 where MODE = 1 (Letter).
9	MONITOR	Integer	1	This field may not be NULL. Intervention Type: 1 = TRUE, 5 = FALSE
10	OUTREACH	Integer	1	This field may not be NULL. Intervention Type: 1 = TRUE, 5 = FALSE Only valid within outreach segments.
11	ACTIVE/ENROLLED	Integer	1	This field may not be NULL. Intervention Type: 1 = TRUE, 5 = FALSE Only valid within active/enrolled segments.

File Definitions:

HROB (High Risk Obstetrics): The member is in an HROB care management program or not.

SPEC_POP: Member's special population status. This is the status indicator for members who meet the special populations definition. According to the Medicaid Managed Care Model Contract, a Person-Centered Services Plan (PCSP) is required to be completed from the results of an assessment of the medical, environmental, and social needs for each of the special populations defined in Appendix A. Each PCSP must include participation of the entire collaboration of services – the member, physicians, nurses, social workers, service providers, and family members – and include all services and supports to meet the assessed needs and personal goals.

The special populations are listed above in order of intensity. If a member falls into more than one special population category, choose the lowest numbered category for that member (choosing the most intensive special population).

INTERVENTION_DATE: This is the date of the intervention. This date should fall within the measurement year (January 1 – December 31). Format the date as MMDDYYYY with no intervening "-" or "/".

MODE: This is the mode of communication used in the intervention. If there is more than one mode of intervention used during the intervention, the health plan should report only the last mode used. For example, an enrolled member uses a cell-phone to call their care manager to inform her of an ED visit. The care manager is at the hospital and agrees to come see the member in-person. In this example, the health plan should not report two interventions because there is only one distinct intervention. Nor should the health plan report a single intervention with two modes. In this example, the health plan should report the mode of intervention used last during the intervention (in this case, in-person).

HP-CMART v3 includes several new intervention modes. These include 4 (Email), 5 (SMS/Text), and 6 (Video Conference). These new modes were added to broaden the specificity of the data reported. Health plans may individually determine the appropriateness of these intervention modes.

- Health plans must report only on interventions using communication modes approved by the health plan.
- Where the target is another care manager or provider, no distinction need be made between email and secure on-line tools such as the HCS. For purposes of HP-CMART reporting, these can be treated as the same communication mode.
- Health plans are expected to comply with HIPAA and health plan policy regarding the use of digital communications.

TARGET: This is the person or organization to whom the intervention is directed. Most reported interventions are between the health plan and the member. An intervention may be between the health plan and another provider or the member's family. Any action taken on behalf of a specific member and meets one of the intervention types should be reported.

If any intervention is taken on behalf of a member between two or more outside targets, it is at the health plan's discretion to determine which target to report. Whichever target is the primary focus of the intervention should be the one reported.

COMPLETED: HP-CMART v3 requires health plans to report **all** interventions and to identify which interventions were completed. This allows health plans to better document the scale of care management efforts.

- A complete intervention results in at least some interaction with the member or the member's collaborative team.

- When the intervention mode = 1 (Letter), completed should be reported as 9 (Not recorded). Interventions by mail will not affect the health plan's intervention completion rate.
- Interventions made using any mode other than 1 (Letter) should be identified as 1 (TRUE) or 5 (FALSE).
- When the interventions mode is 2 (Phone),3 (In-person), or 6 (Video Conference), health plans should record phone or in-person interventions as complete when contact is made with the member. The intervention should be considered incomplete if no contact was made via phone or in-person. A similar standard should be applied to mode 6 (Video Conference).
- When the intervention mode is 4 (Email) or 5 (SMS/Text), health plans should continue to identify interventions which result in at least some interaction with the member. For example, an SMS/text message to remind a member of an upcoming appointment would only be complete if the member responds. Email and text messages which result in no interaction with the client should be reported as incomplete, even when sent to addresses which are known to be valid.

INTERVENTION TYPE: The final three columns of the INTERVENTIONS.CSV file detail the type of intervention.

Every row of the intervention file is required to have a 1 in 'Monitor', 'Outreach', or 'Active/Enrollled'.

- MONITOR:
  - Care manager or other plan employee reaches out to the member as part of an ongoing monitoring/maintenance service.
- OUTREACH:
  - Care manager or outreach specialist attempts to contact the member to offer them health plan care management services.
  - This intervention type must take place during an outreach segment.
- ACTIVE/ENROLLED:
  - Care manager performs or arranges for member assessment.
  - Care manager or interdisciplinary team creates, updates, or reviews the person-centered plan of care.
  - Care manager follows up with member or service providers to examine the progress and completion of the plan of care.
  - Care manager contacts member or service providers to address/support identified member goal/objective/need.
  - The intervention type must take place during an active/enrolled segment.

Error Check Report

The software that the error/validation report runs through is proprietary. There is not a free version to send out with the error report. The error report key was created for plans to see what is being looked at in the error program. It is up to the plans (or their vendors) to create an internal error check. Each health plan, HARP, and SNP is encouraged to review the error code key (below) and work with their individual IT departments to create this check.

HP-CMART entries listed in the error check files do not meet the HP-CMART specifications. Only entries with errors will be included in the error check report. Any rows of data not in the error check report are accepted as valid by DOH. Health Plans may re-submit error rows that have been updated to the specifications document.

After the health plan's data is submitted to the NYSDOH, staff will run error checks and create an error report on the submitted data. Error checks are explained in greater detail later in this document.

An error report will be sent to each plan via the HCS to the designated HP-CMART contact persons for plans to see the data that was submitted for the error rows. The error report is an Excel file that contains five worksheets/tabs as described below:

1. Rows_Members: number of rows, distinct members, missing data, and rows of errors for each of the three CSV files and the two mismatch files
2. Segments_Start: All Segments_Start data and Error_Code number for each row with errors
3. Segments_End: All Segments_End data and Error_Code number for each row with errors
4. Interventions: All Interventions data and Error_Code number for each row with errors
5. Segment_Mismatch: All Segments_Start data that don't have a matching Segments_End segment and all Segments_End data that don't have a matching Segments_Start segment

Error Code Key

Error Code	Name	Description
1	Invalid CIN	CIN is not valid or CIN is not enrolled in plan at given date
2	Health plan ID incorrect	Health plan ID is not in health plan list for CMART
3	Date Not in Year	The date of the segment is not in the current measurement year
4	Segment Type invalid	The SEGMENT_TYPE code is not valid
5	End Reason invalid	The END_ REASON code is not valid, or the END_REASON code is not valid for the provided segment type
6-1	Start no End	More than one segment exists with a START_DATE before an END_DATE occurs
6-2	End no Start	A SEGMENTS_END segment exists without a corresponding SEGMENTS_START segment
7	HROB response invalid	The HROB code is not valid
8	Special Population response invalid	The SPEC_POP code is not valid
9	Mode response invalid	The MODE code is not valid
10	Mail Mode not 9	The COMPLETED code for MODE = 1 (mail) is NOT 9
11	Target response invalid	The TARGET code is not valid
12	Completed response invalid	The COMPLETE code is not valid
13	Monitor response invalid	The MONITOR code is not valid
14	Outreach response invalid	The OUTREACH code is not valid
15	Active/Enrolled response invalid	The ACTIVE/ENROLLED code is not valid
16	Intervention Type Conflict	More than one of the following intervention types (MONITOR, OUTREACH, ACTIVE/ENROLLED) = 1
17	Intervention Error	COMPLETED = 1 and MONITOR, OUTREACH, and ACTIVE/ENROLLED = 5

Error Descriptions

The errors that can occur in each of the three files submitted:

All three files:
Error #1: Invalid CIN

- CIN is not valid or CIN is not enrolled in plan at given date
- Encounter data and capitation payments are used to check member enrollment in health plan
    - An encounter or capitation payment needs to be made to the plan for the member during the time period of the segment/intervention date
    - If the member was in a different line of business for your plan or other product line that does not contribute to CMART, then switched to Medicaid Managed Care, only the dates they are in the Medicaid Managed Care plan are considered valid.
    - A 31-day grace period from the closest encounter is used to determine if the member is within the plan at the time of the segment/intervention.

Error #2: Health Plan ID incorrect

- Health Plan ID is not in the list in Appendix B of this specification document
- All records for each submission need to have the same health plan ID
    - Please make sure that all records that come to you via a vendor have the health plan ID that is listed in Appendix B of this specification document
    - More than 1 health plan ID is in the submission file

Error #3: Date not in year

- The date of the segment/intervention is not in the current measurement year

Segments_Start & Segments_End files:
Error #4: Segment type incorrect

- The Segment_Type code is NOT O or A

Segments_End file:
Error #5: End reason invalid

- The End_ Reason code is NOT in 01-15
- The End_Reason code used in incorrect segment type

Segment Mismatches
Error #6-1: Start no End

- More than one segment exists with a Start_Date before an End_Date occurs

Error #6-2: End no Start

- A Segments_End segment exists without a corresponding Segments_Start segment
    - There cannot be multiple segments with the same segment type open at the same time
    - It is assumed the first end date closes the first start date of the same type. If multiple segments of the same type remain open or cannot be matched to an end date due to overlapping segments, they will appear as errors.
    - Segments of the same type that close and open on the same day will cause overlap. For example, if a member has a close date for an outreach segment on 1/10 and another outreach segment start date on 1/10, there is now a timing overlap on 1/10. It is unclear whether the new segment opens and closes on 1/10 or closes at a future date. This will trigger the error and may throw off the remaining segments, as new segments cannot start if the prior has not been closed.

Interventions file:

Error #7: HROB response invalid

- The HROB code is NOT Y or N

Error #8: Special Population response invalid

- The SPEC_POP code is NOT 01-10 or 99

Error #9: Mode response invalid

- The MODE code is NOT 1-6

Error #10: Mail mode not 9

- When MODE = 1 (mail), COMPLETE is NOT 9

Error #11: Target response invalid

- The TARGET code is NOT 1-6

Error #12: Completed response invalid

- The Completed code is NOT 1, 5, or 9

Error #13: Monitor response invalid

- The Monitor code is NOT 1 or 5

Error #14: Outreach response invalid

- The Outreach code is NOT 1 or 5

Error #15: Active/Enrolled response invalid

- The Active/Enrolled code is NOT 1 or 5

Error #16: Intervention type conflict

- Only one of the following intervention types can be = 1

- MONITOR
- OUTREACH
- ACTIVE/ENROLLED

Error #17: Intervention Error

- COMPLETED = 1 (true) and MONITOR, OUTREACH, and ACTIVE/ENROLLED = 5 (false)

Questions

For questions about the specifications and general reporting guidelines, call the Health Plan Team in the Office of Quality & Patient Safety (518) 486-9012 or email nysqarr@health.ny.gov.

Appendix A

Other Special Populations

Special Population Number	Population	Requirement and Citation
01	Clotting Factor Recipients *	Plans must coordinate with providers to develop an individualized care plan and patient–specific care management to ensure that enrollees have appropriate and timely clotting factor supplies and services. A person-centered plan of care is required for enrollees. - Transition Policy Paper Section III
02	Medically Fragile Children	This population is subject to the Long-Term Services & Supports (LTSS) requirements at Appendix S. This would include mandatory Patient-Centered Specialty Practice (PCSP) provision. - Contract Section 10.20(b)(i)
03	Children in Receipt of Home & Community Based Services (HCBS) †	Plans are required to ensure PCSP for their enrollees, including maintaining plan of care for enrollees who opt out of Health Home and monitoring access to care for all enrollees. - 1115/1915c Children's Waiver
04	Adults in Receipt of Home & Community Based Services (HCBS)	The contractor must provide or arrange for provision of care coordination/care management. A person-centered plan of care is required for enrollees. - Contract Sections 10.1, 10.41
05	Residential Health Care Facility (RHCF) for Long Term Placement	Services provided as listed in Appendix S the responsibility of the contractor, local departments of social services (LDSS), and facility. A person-centered plan of care is required for enrollees. - Contract Section 10.40(a)
06	Personal Care Services (PCS)	The contractor will conduct such assessments and ensure the enrollee's care plan is developed in compliance with person-centered services planning requirements in accordance with Section 10.35 of this agreement. - Contract Section 10.33(b)
07	Consumer Directed Personal Assistances Services (CDPAS)	Services must be provided in a manner that is consistent with Appendix S. A person-centered plan of care is required for enrollees. - Contract Section 10.36(a)
08	AIDS Adult/ Adult Day Health Care	Services must be provided in a manner that is consistent with Appendix S. A person-centered plan of care is required for enrollees. - Contract Section 10.39(a)

Special Population Number	Population	Requirement and Citation
09	Other LTSS Services (Private Duty Nursing, Skilled Nursing, Home Health Services)	Requires care management for services identified in the PCSP. - Contract Appendix S(c)(3)
10	In Receipt of Community First Choice Option (CFCO) ‡	The member has an institutional level of care as determined by the functional assessment used by that population (Uniform Assessment System (UAS)) and are living in their own home or a family member's home. - Transition requirement
11	Homeless Population §	The member self-identifies as homeless to the care manager or has the homeless indicator on the electronic Department of Homeland Security (DHS) file from New York Medicaid Choice. - Transition Policy Paper Section II

NOTE: Collection of data for In Receipt of CFCO (09) will begin for 1/1/2020

* Transition of Clotting Factor Products and Services from Medicaid Fee-for-Service to Medicaid Managed Care (https://www.health.ny.gov/health_care/medicaid/redesign/2017/2017-05_clotting_factor_guidelines.htm)

† 1115/1915c Children's Waiver

‡ Community First Choice Option (CFCO) (https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm)

§ Policy and Guidance to Transition the Homeless Population into Medicaid Managed Care; April 2012 (https://www.health.ny.gov/health_care/medicaid/redesign/docs/guidance_for_homeless_transition.pdf)

Appendix B

Plan IDs	
Mainstream Plans	
Affinity Health Plan	2010186
CDPHP	1090384
Empire BlueCross BlueShield Health Plus	2180196
Excellus BlueCross BlueShield	1390598
Fidelis Care New York, Inc.	2060193
HealthFirst PHSP	2090194
HealthNow New York Inc.	1140685
HIP (EmblemHealth)	1050178
Independent Health's MediSource	1070680
MetroPlus Health Plan	1130185
Molina Healthcare	2161013
MVP Health Care	1080383
UnitedHealthCare Community Plan	1260187
WellCare of New York	1240287
YourCare Health Plan	2190696
HARP Plans	
Affinity-Enriched Health	4342307
CDPHP	4342316
Empire BlueCross BlueShield HealthPlus	4004537
Excellus Health Plan, Inc.	4342343
Fidelis-NYS Catholic-HealthierLife	4004486
Healthfirst Personal Wellness Plan	4003696
HIP-EmblemHealth Enhanced Care Plus	4082293
Independent Health's MediSource Connect	4342325
MetroPlus Enhanced	4053201
Molina Healthcare	4342292
MVP Harmonious Health Care Plan	4342334
UnitedHealthcare Community Plan-Wellness4ME	4054091
Your Care Option Plus	4342283
SNP Plans	
Amida Care	S99B001
MetroPlus Health Plan	S99A008
VNSNY CHOICE Select Health	S99B010