Medicaid Analytics Performance Portal Health Home Tracking System

MAPP HHTS | TRAINING UPDATES

Welcome

Welcome to the MAPP Health Home Tracking System (HHTS) Training Updates Newsletter. This document serves as an addendum to the Phase 2 Training Materials and focuses on system functionality workarounds, system enhancements, general training updates, and helpful tips to assist the end-user with completing certain tasks within the system.

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How to Verify CANS-NY Assessment has Transmitted to MAPP HHTS

Training Update: 1/31/2017
Information for: HH and CMA Workers serving Children

The Child and Adolescent Needs and Strengths Assessment (CANS-NY) is completed outside of the MAPP HHTS. Only the completion details are viewable within the member's Assessment tab (if applicable). Only a user with the Worker or Read-Only role can confirm if a CANS-NY Assessment was finalized in the UAS NY and processed in the MAPP HHTS.

The MAPP HHTS will process a signed and finalized CANS-NY Assessment if an Enrollment Segment has an *"Active,"* *"Closed,"* or *"Pended"* status for the CIN and Health Home (HH) MMIS ID on the record with a date of service that is in the same month:

- Of the CANS-NY Date of Completion OR
- In the subsequent 6 months from the CANS-NY Date of Completion, AND
- The member is being serviced through the HH's Children's Network

If the Health Home serves both children and adults, then the MAPP HHTS user must have chosen "Child Network" when answering the question, "Indicate whether the child will be served by the children's designated HH network, or with consent, the adult designated HH network."

Note: The check/feed to MAPP HHTS is done every 15 minutes (it is not immediate). If you sign and finalize a CANS-NY Assessment in the UAS-NY system, you may need to wait and refresh the Assessments tab of the enrolled member's page before you will see the CANS-NY data. CANS-NY Assessments are to be completed (signed and finalized) AFTER a member is enrolled into the HH and the Segment is reflected in MAPP HHTS.
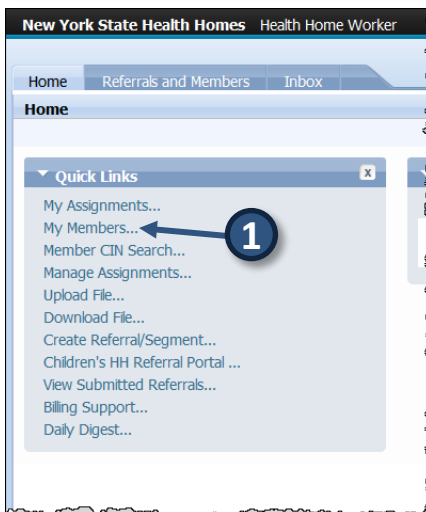
How to Access the CANS-NY Assessment Tab:

Step 1: Click the **My Members** quick link on the MAPP HHTS workspace.
Step 2: Use the search filters to perform your search. Locate the member and click the **member hyperlink** to navigate to the *Member Home Page.*
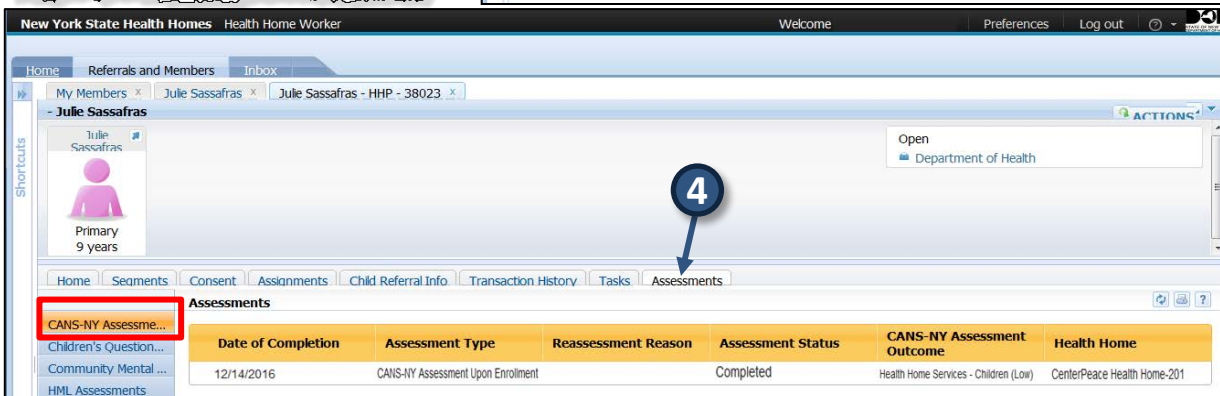**Step 3:** Click the **Go To Case** button to enter the member's case.
Step 4: Click the **Assessments** tab and then the **CANS-NY Assessments** inner tab.

Keep in Mind: If applicable, the CANS-NY Assessment Fee for a billing instance can also be found by downloading the Billing Support download file.

MAPP Customer Care: (518) 649-4335 or Email: MAPP-CustomerCareCenter@cma.com

Frequently Asked Questions (FAQs)

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Member CIN Search

Question #1: In the HH Worker user manual, the CIN search download file can be used to download up to 1000 CINs from the search. Is there any way to search more than 1000 CINs at once?

Answer: There is not a way to search more than 1000 CINs at one time in the Member CIN Search. As a reminder, the Member CIN Search is used to search for members that may or may not be associated with your Organization. For members associated with your Organization, you can use the My Members download file. This file will show all members who are assigned or have a current Segment with your Organization and is not limited to 1000 members. Alternatively, you can submit a second query when using the Member CIN Search. For example, if you would like to search for 1500 members you can first create a query to search for the first 1000 members, then create a second query to search for the last 500.

Question #2: If a member does not have coverage currently, but did formerly, will they show up in the CIN search results?

Answer: When using the Member CIN Search, a member who is currently not eligible will show up but you will be able to see the Medicaid end date, displayed in the third column under the member search, to determine eligibility. MAPP HHTS can have up to a week lag in receiving information from ePACES. The most up to date information regarding a member's eligibility and coverage can be found in ePACES.

Member Records (New Evidence):

Question #1: When creating a secondary address, what if the person is homeless?

Answer: Please use either the comments or the notes feature if you would like to document within the MAPP HHTS that a member is homeless. A user can add a note by going into the personal information tab within the member's home page and clicking the "Action" button next on the address line to open the note box.

Question #2: Is there a bulk change option if a MAPP HHTS user identifies an address change for multiple beneficiaries?

Answer: No, but a MCP worker can use the MCP Final HH Assignment File to bulk upload member contact and language information. Health Home and CMA users cannot bulk upload member address information but can change addresses individually under the member's home page in the MAPP HHTS.

Other / General Questions

Question #1: Is the Acuity of the child determined by the CANS-NY Assessment or the MAPP HHTS output?

Answer: The monthly Health Home rate for members under 21 that are working with a Health Home serving children is determined by the member's most recently completed "Active" CANS-NY Assessment. If a member that is under 21 was identified as Health Home eligible by DOH using historical claims and encounter information, then that member will contain a base acuity score in the MAPP HHTS. However, the base acuity score for a member that is under 21 that is working with a Health Home serving children will not factor into the monthly rate determination for that member since that member's rate is purely based on the member's most recently completed active CANS-NY Assessment. If a child member who is under 21 is being served as an adult and has a base acuity score, this information will be used when the HML rate is calculated for this member. This is one of several factors that is used when determining the HML rate. If the member does not have a base acuity score, this field is ignored and all other HML Assessment questions are used to determine the appropriate HML rate for the member.

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Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Outreach/Enrollment Segments

Question #1: Can you create an Outreach Segment using the Adult Referral Wizard for an adult member assigned to another HH/CMA?

Answer: You can use the Adult Referral Wizard to create an Outreach or Enrollment Segment for an adult member who has an "Active" or "Pending" status with another HH, but if the adult member currently has an "Active" Segment with another HH or CMA, you will not be able to due to overlapping Segments.

- Scenario 1
  HH 1 has an "Active" Assignment with an adult member, but no "Active" Segments. HH 2 uses the Adult Referral Wizard to create an Outreach Segment. HH 2 will get a warning message that the adult member has a relationship with HH 1, but no "Active" Outreach or Enrollment Segments and will be able to complete the Referral. The adult member will be removed from HH 1's Assignment file. HH 2 will have an "Active" Assignment and an "Active" Outreach Segment.

- Scenario 2
  HH 1 has an "Active" Assignment with an adult member and an "Active" Segment. HH 2 uses the Adult Referral Wizard to create an Outreach Segment. HH 2 will not be able to complete the Referral and will get a warning message that the adult member has an "Active" Segment with HH 1. The adult member will remain on HH 1's Assignment file and continue to have an "Active" Segment with them.

- Scenario 3

  MCP 1 has a "Pending" or "Active" Assignment with a child member. HH 1 wants to start working with a child member that they have been in contact with. HH 1 attempts to enter the member into a Segment using the Children's Referral Portal but receives a warning message that the member has an Assignment with MCP 1. In this case, HH 1 should contact MCP 1 and request that the MCP assign the member to their HH.

Note: A user cannot make an Outreach or Enrollment Segment using the Children's Health Home Referral Portal if the child member has an association ("Pending" or "Active" Assignment or "Active" Segment) with a HH organization in the MAPP HHTS.

Question #2: When a MAPP HHTS user modifies an Enrollment Segment end date, will another HH's Segment get rejected due to the creation of an overlapping segment? How does this process cease if another HH provides future services?

Answer: Two Segments cannot exist at the same time. Typically, when you modify an Enrollment Segment, you would be end dating the Enrollment Segment at the time they determine the Enrollment is ending, therefore, you would not have an issue of overlapping Segments (as no other segment exists at this time). If HH 1 had an Enrollment Segment that ended on 5/31/16, for example, and HH 2 started a Segment on 6/1/16, then HH 1 attempts to go back and modify the end date to 6/30/16, HH 1 would get an error message and not be able to modify the Segment. There would be no effect on the Segment HH 2 started on 6/1/16.

Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Outreach/Enrollment Segments (Continued)

Question #3: Can a new Enrollment Segment be created with a different CMA (CMA 2) if the member is "dissatisfied with the current service," but still has an "Active" Enrollment Segment with the first CMA (CMA 1)?

Answer: No, a member can only have one "Active" Segment in the MAPP HHTS at any given time. In this case, CMA 2 would need to work with CMA 1. CMA 1 would need to end their Segment on the last day of the month preceding the month CMA 2 would like to begin their Segment. We suggest doing this via a phone call from one Organization to the other.

Question #4: How does a "Pending" Enrollment affect billing when a pend start date is in the past? What if work has been done for most the month, but the pend start date indicated was the beginning of the month?

Answer: If you enter a pend start date for a Segment that is in the past, the MAPP HHTS will automatically end date the "Active" Segment with the last date of the month preceding the "Pended" Segment start date. When you or the billing entity uploads the next billing support file, you would see this via the "V" in the Add/Void indicator field. The billing entity should use the file to rectify any records that were submitted in error. If a core service has been provided during the service month, and the member's Segment then needs to be "Pended" towards the end of the service month, the first day of the following month can be utilized as the "Pend Start Date".

Question #5: There is an End Date reason code of "invalid reason code at conversion". How should this message be interpreted?

Answer: There are new edits in the MAPP HHTS that were not in the old system. When a Segment entered in the old system is converted into the MAPP HHTS and it hits one of these edits, the user will receive this end date reason code.

Question #6: When creating Outreach or Enrollment Segments in the MAPP HHTS, will the Children's Heath Home have to accept a Segment after the CMA enters the members information into the Children's Referral Portal? (i.e., will they be pending the HHs approval after completing the Children's Referral Portal. Some CMAs are VFCA in NYC and have the same role as the LDSS in ROS.)

Answer: When a VFCA CMA creates a Segment in the MAPP HHTS, whether the Segment is created within the Children's Referral Portal, online, or using a file, the created Segment will not go to the "Pending Active" status; it will go directly to the "Active" status. This means that a HH does not accept Segments created by VFCA CMAs.

Non-VFCA CMAs would see a Segment go into a "Pending Active" status, if they do not have auto-approval set up when creating a Segment within the Children's Referral Portal, online, or using a file. A Non-VFCA CMA would see a Segment go into an "Active" status if they do have auto-approval set up with the HH when creating a segment within the Children's Referral Portal, online, or using a file.

Question #7: Does the Billing Assessment (Children's Questionnaire) need to be completed during Outreach?

Answer: The MAPP HHTS will automatically generate the correct questions under the Assessments tab, Children's Questionnaire inner tab based on the members Segment status. Likewise, the MAPP HHTS user can follow the logic outlined in the File Specifications Document to answer the correct questions based on Segment type in the Billing Support Upload file. The Questionnaire must be answered during "Active" Outreach and Enrollment Segments.

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Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Outreach/Enrollment Segments (Continued)

Question #8: Why would you delete an Enrollment if the status is "Pended"? Why not deactivate? Why not modify the start date? Does it cause multiple lines on the Enrollment file? Did the client have activity as a "Pending" status? If so, how does that work in the MAPP HHTS?

Answer: MAPP HHTS does not allow an Enrollment Segment to be deactivated or for a user to modify the start date of the Segment once the Segment has been created. The delete option within the MAPP HHTS indicates that a Segment was created in error. A Segment should only be deleted if the Segment should have never been created. Deleting a Segment will create a "Canceled" status in the MAPP HHTS.

Pending a Segment allows the user/Organization to continue to retain the member while they are currently unable to work with the member. For example, a member may become incarcerated for a period of time. During incarceration, a member looses their Medicaid coverage and, therefore, is not eligible for HH services. Upon release from prison, the same HH plans to continue to provide services to the member and will then put the member back into an "Active" Enrollment Segment. The client typically is not receiving services while their Segment is in a "Pended" status. Organizations are unable to bill for a member that has a "Pended" Segment status unless the pend reason is that the member is in an inpatient facility (per HH program policy). Each Segment status (active, pended, etc.) will appear as a separate line on the Enrollment file unless the pend reason is that the member is in an inpatient facility (per HH program policy).

Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Assignments/Referrals

Question #1: What is the difference between a "Pending" Assignment and a "Pending" Referral?

Answer: All Assignments have a record type. There are three Assignment record types that are used to describe why/how an Assignment was created: Assignment, Referral, and Transfer. All "Pending" Assignments and Referrals should be assigned to a downstream Provider for Outreach or Enrollment services in a timely manner.

A. An Assignment with a "Referral" record type is an Assignment that was created through the Children's Health Home Referral Portal. Since members under 21 have to be entered into the MAPP HHTS using the Children's Referral Portal, just about all* Assignments for members under 21 will have a "Referral" record type.

B. An Assignment with an "Assignment" record type is an Assignment that was either sent to an MCP by DOH OR sent directly to a Health Home by an MCP or DOH.

C. An Assignment with a "Transfer" record type means that another HH wants to send a member's Enrollment Segment to your HH. If you accept an Assignment record with a "Transfer" record type, the MAPP HHTS will open a new window to collect Enrollment/Consent information from you. Once you complete that process, the MAPP HHTS will end date the other HH's Enrollment Segment/Consent with that member and create an Enrollment/Consent record with your HH.

The definitions above only apply when an Assignment is created for a member newly submitted into the MAPP HHTS. As a member moves in and out of Segments within the MAPP HHTS, the member's Assignment record type may change.

Question #2: For Children, is it possible for the HH to batch upload a list of children that may be HH Eligible into the MAPP HHTS, assign them to a CMA and have the CMAs complete the Children's Referral Screen? OR For children, can they only be enrolled via Children's Health Home Referral process?

Answer: Children that are under 21 AND do not currently have an Assignment with your HH in the MAPP HHTS **must** be manually entered into the MAPP HHTS using the Children's Health Home Referral Portal. The only situation where a HH user can enter a member under 21 into the MAPP HHTS outside of the Children's Referral Portal is if that member is already assigned to the HH and the HH enters a Segment for that member using the Tracking Segment file.

Question #3: When we process Referrals and assign ourselves as a client's health home it sounds like we also have to go in and accept the Assignment/Referral. Is that correct?

Answer: If you create a Referral without putting the member into an Outreach or Enrollment Segment, you are unable to assign a HH. The member would go to either the member's MCP (for MCP members) or to a HH based on the DOH's recommended HH lists (for FFS members). If the member goes to the MCP, you could ask the MCP to assign the member to your HH. If you would like to continue to work with the member, you should wait until you are able to put the member into either Outreach or Enrollment when creating the Referral to ensure you will be able to continue to work with the member.

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Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Billing Support

Question #1: Is there a time frame during which an HML Assessment can be deleted? Can it be deleted after the billing has been sent?

Answer: There is not a time limit on when an HML Assessment can be deleted. As soon as a Provider is aware that the HML Assessment is incorrect, the Provider should delete the HML Assessment immediately and then resubmit the correct HML Assessment information, if appropriate. HH users should use the Billing Support Download file on a regular basis to adjust any claims that have been voided and rectify their billing.

Question #2: Why is the diagnosis code on the HML Assessment limited by character length?

Answer: The diagnosis code is meant to be an ICD-10 code, hence the short length. This fields accepts up to 10 characters and is not required. For additional information, please reference the Power Point presentation at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/mapp_webinar_01_10_2017.pdf

Question #3: What is the purpose of the Children's Questionnaire and how is it different from the CANS-NY Assessment when determining billing for Children's HH providers?

Answer: The results of a completed CANS-NY Assessment informs the monthly Health Home serving children High, Medium, Low payments for a period of up to six months or until a new CANS-NY Assessment is completed. The Children's Questionnaire is how the Provider attests on a monthly basis that a billable service was provided during the billing month.

Question #4: Do kids have to complete the HML Assessment or just the CANS-NY Assessment?

Answer: Each month, Providers serving members under 21 in a HH serving children must complete the Children's Questionnaire for each member to attest that a billable service was provided to that member in that month. The member's monthly rate will be based on the member's most recent CANS-NY Assessment. Each month, members receiving services in a HH serving adults must complete the Adult HML Questionnaire for each member to submit HML rate information and to attest that a billable service was provided to that member in that month. The member's monthly rate is based on the HML information submitted for that month on the Adult HML Questionnaire. The Children's Questionnaire and the Adult HML Questionnaire are required to be submitted for all HH members in Outreach or Enrollment, regardless of if a core service was provided in that given month.

Question #5: Is there a list of medical codes for billing purposes for the Providers?

Answer: DOH cannot give Providers coding advice. The Provider that is submitting the claim to Medicaid should select the code that best describes the member/services provided. A Health Home claim does require a valid diagnosis code, but the diagnosis code field in the MAPP HHTS is not required.

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Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Billing Support (Continued)

Question #6: Which housing/homelessness questions are required and in what scenarios? How do I complete the new housing questions on the HML? Please explain the adding housing fields (30/32) on the Billing Support Upload file.

Answer: As of 12/1/16 dates of service and beyond, new questions have been added to the HML. These questions have been added to better reflect workloads that Care Managers may have based on a member's circumstances. One area where questions have been added/revised is surrounding homelessness. The skip logic associated with these questions can be a bit confusing at first.

The first question seen on the member's HML Assessments inner tab related to homelessness asks "Is the member homeless?"; this corresponds to field 10 on the Billing Support Upload file and is labeled 'Member Housing Status'. A 'Yes' or 'Y' response indicates that the member is currently homeless as of the date of service of the HML Assessment. If "Yes" is answered to this question, a second question appears on the screen - "Does the member meet HUD Category 1 or HUD Category 2 level of homelessness?" This question corresponds to field 11 on the Billing Support Upload and is labeled 'HUD Category'. The response here indicates the HUD Category (1 or 2).

If the member is not homeless ("No" was answered to 'Is the member homeless?'), then a different question will appear on the screen, such as "Did the member meet HUD1 category of homelessness within the past 6 months?". This question corresponds to field 30 on the Billing Support Upload file and is labeled 'HUD1 within past 6 months'. This question is required in the Billing Support Upload file if the answer to "Is the member homeless?"/field 10 remains 'No' in subsequent months when attesting to a billing instance, as the response does not carry over.

If "Yes" is answered to field 30 (the member was homeless within the last 6 months with HUD1 category) or the corresponding on-screen question, another question will appear on screen - "Date Member Housed". This corresponds to field 32 on the Billing Support Upload file and should only be answered if the member was homeless within the last 6 months with HUD1 category of homelessness, but is not currently homeless. You would then answer the question with the date the member found housing in a MM/DD/YYYY format.

Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Restriction/Exception (R/E) Codes

Question #1: Does the MAPP HHTS offer a list of R/E Codes? Where would I obtain this information?

Answer: There is a list of R/E codes posted on the DOH Health Homes website.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

Question #2: I've provided Care Management to a member and received a denial because I did not realize the member had an invalid coverage code / R/E code / not Medicaid eligible / working with another Provider, etc. Why is this member on my Assignment file and can I get paid for this member?

Answer: A requirement of the Health Home (HH) program is that all Providers (CMAs and HHs) first check a member's Medicaid eligibility and confirm that the member's R/E and Coverage codes are compatible with the HH program (please see links below for R/E and coverage code information). In addition, the Provider must look up the member's HH status using the Member CIN Search function in MAPP HHTS to see if the member has had any recent Care Management claims. If the member has recent Care Management claims, you must contact the other Care Management Provider to see if they are still working with the member.

R/E Codes:

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

Coverage Codes:

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

Additionally, Medicaid members with Principal Provider codes of AL and NH are not eligible for Health Home Care Management. Currently, the MAPP HHTS will not prevent a member from having a Segment entered into the system if they have a Principal Provider that is not compatible with the Health Home program. As a reminder, Providers are required to verify Medicaid eligibility for all members prior to creating a Segment. Any member that you are working with must be in MAPP HHTS. It is not enough to simply put the member into your own internal system. You must confirm that this information is updated in the MAPP HHTS on a regular and frequent basis. If you are a CMA and your HH submits this information to MAPP HHTS for you, you must ensure the information is submitted in a timely manner. As a CMA, you are responsible for verifying (1) the member is HH eligible before working with the member and (2) the member is reported in the MAPP HHTS. MAPP HHTS is considered the source of truth for the HH program. Members may be on Assignment files that were once eligible for the HH program. MCPs may reassign the member to a downstream Provider without realizing that the member is no longer HH eligible. All member statuses can change from month to month, which is why it is imperative to check member information each month. If a member does not meet the criteria to be eligible for the HH program, you may continue to work with them but you will not receive payment for HH services. Providers will not receive payment for denied Health Home claims because the member is not Medicaid eligible or the member has an R/E or coverage code that is not compatible with the HH program. Providers must check the member's Medicaid eligibility, R/E and coverage code on a routine basis.

Question #3: On the My Members screen, can you view a members R/E codes and members with inactive Medicaid? Are these fields on the My Members download file?

Answer: The My Members screen does not display these results, nor does the My Members download file. This information can be found within the Member CIN Search.

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Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Restriction/Exception (R/E) Codes (Continued)

Question #4: I am trying to enroll a member and keep getting a message saying that coverage code or the R/E code is not compatible with the Health Home program. What does this mean?

Answer: Within Medicaid, all members have a coverage code that describes a member's Medicaid coverage. Some members may have an R/E code. This stands for restriction exemption. Some Medicaid coverage codes or R/E codes only cover certain services and other codes indicate a member is eligible or enrolled in Care Management services outside the Health Home (HH) program. The member's coverage and/or R/E code may or may not be compatible with the HH program. When an R/E code indicates that the member receives Care Management services under a different program, the member will not be eligible for both that program and the HH program.

Access this link for a list of coverage codes and their compatibility with HH program:
www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_coverage_codes.pdf

Access this link for a list of R/E codes and their compatibility with the HH program:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

Within each of these links, you will see notes indicating if a certain coverage or R/E code is/is not compatible with the Health Home Program. If a member's coverage or R/E code are listed as incompatible with the Health Home program as of the date you attempt to begin a Segment, the MAPP HHTS will reject the Segment and, in most instances, the Health Home claim for that member will not be paid by Medicaid. When attempting to enter a Referral for a member with an invalid R/E code, you will receive the following message: "The member's R/E code is not compatible with the Health Home Program". When attempting to enter a Referral for a member with an invalid coverage code you will receive the following message: "The member's Coverage Code is not compatible with the Health Home Program".

You can use the Member CIN Search to look at codes for a member before working with the member to determine their eligibility. Some R/E codes (such as R/E 30) indicate a member is eligible for either the HH program or a different case management service through the Long Term Care Waiver Program. When a member has this R/E code you will still be prevented from entering a Referral for the member. In this case, both programs should be thoroughly explained to the member so that the member can determine which program is most appropriate for their needs. If the member determines that the HH program meets their needs most appropriately, the member would need to contact their LDSS and speak with the person who consented them into the waiver program and express their desire to no longer be part of the waiver program and that they want to enroll in the HH program. The LDSS representative will remove the coverage code and the HH will be able to enroll the member in the HH program. Please note that some Long Term Care Waiver R/E codes (i.e. R/E 60) that are an either/or situation are for members who have recently been discharged from long term care so these codes may be valid even if the member is not in a long term care setting.

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Frequently Asked Questions (FAQs) - Continued

Training Update: 1/31/2017
Information for: MCP, HH and CMA Workers

Consent (Adult and Child Members)

Question #1: When do I need Consent for a child member? I am an adult HH, why is it saying I need Consent To Enroll to enter a child into my program? What consent type should I use on the consent upload file?

Answer: Any member under 21 years of age that is being referred into the MAPP HHTS needs "Consent to Refer" in order to be entered into the MAPP HHTS via the Children's Referral Portal. In order for a member to be entered into an Enrollment Segment, the member may or may not need Consent To Enroll based on the below rules:

- If the member is 18-21 years of age and being served by an adult network HH, or a HH serving both (adults and children) that selected adult, Consent To Enroll is not required.

- If the member is under 18 years of age and being served by an adult network HH, or a HH serving both (adults and children) that selected adult, Consent To Enroll is required.

- If a member is under 21 years of age and being served by a child network HH, or a HH serving both (adults and children) that selected child, Consent To Enroll is required.

Although not required from a MAPP HHTS perspective, Consent To Share is required from a policy perspective for all members in the MAPP HHTS. On both the screen and in the Consent Upload File, three types of consent are available - Consent To Enroll, Consent To Share, and Consent To Share (Protected Services). A member can have up to all three of these Consents at once. If a member that you are working with has more than one Consent, you would enter each Consent type as a separate create consent line in the upload file. For example, if the member you are working with has a Consent To Enroll and Consent to Share Information, you would include two lines for that member on the Consent Upload File even if both Consents were signed by the same consenter at the same time.

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