Frequently Asked Questions on Monthly Reporting Requirements and Templates for ACEs and CCEs
Illinois Department of Healthcare and Family Services

Introduction

1. **Are these reports contractual obligations?**
   Yes. The Care Coordination Monthly Report is listed in Attachment M of the ACE contract and Attachment D of the CCE contract. The utilization report is a part of quality assurance described in Attachment L of the ACE contract and section 5.9.1-2 and Attachment C of the CCE contract.

2. **What is the purpose of the monthly reports?**
   The purpose is to monitor the level of engagement achieved by each CCE or ACE with their clients and to ensure that plans are meeting the triple aim of improving health outcomes, lowering costs and improving quality of care.

3. **On what date are the reports due?**
   Both the monthly care coordination report and utilization report are due on the seventh working day of the month. Documents listing dates reports are due and the dates each report covers are available on the HFS website.

4. **Where do plans submit the reports?**
   Please upload the reports to our Sharepoint libraries. Each ACE and CCE will have two people assigned usernames and passwords who may login and upload the reports. For an overview of Sharepoint, see this document.

5. **Are all fields required? What happens if we do not fill in data fields?**
   Yes. If data is missing, reports will be returned to the plan for completion. It will be available on Sharepoint marked with "revisions requested" or "rejected."

6. **Is there a difference between the claims data a plan uses for risk stratification and the claims data a plan would use for utilization reporting?**
   Because the data set contains so much information, the data fields used for each report are likely to differ. Nonetheless, it's the same data set.

7. **How do the ACE and CCE reporting templates differ?**
   They are highly similar. CCEs have one additional item in the enrollment category on the care coordination monthly report, which is the number of incarcerated persons. This does not impact any of the denominators in either report. The utilization reports are identical for the two plans.

8. **How does the monthly report differ from the annual report?**
   For CCEs, the monthly report and annual report look somewhat similar, but the annual report includes additional components (described in the annual report outline circulated to the CCEs). For annual reporting requirements for ACEs, please refer to the ACE contract.

9. **Are these our only reporting requirements?**
   No. There are several others. Consult Attachment M in the ACE contract, Attachment D in the CCE contract, and documents on reporting due dates on the HFS website.

Monthly Care Coordination Report

10. **What is the best way to count enrollees for the purposes of this report?**

This figure should match the monthly enrollment payment roster you receive at the start of the month. It is the number of clients for whom you received a care coordination fee that month.

11. **Why is this report included in the ACE template file but not the CCE template file?**
    As CCEs were operational for up to a year prior to the release of this template, most of them have already had the monthly care coordination report for some time. The ACE version is very similar to the CCE version, and because the CCE version did not change, we have chosen not to replace it. CCEs may continue using the care coordination report template that they have.

12. **What are definitions of a health risk screening, a comprehensive assessment, and a care plan?**
    Please refer to plan contracts for details. As plans are given some room to innovate on this point, this item is defined by the plan's definition of the health risk screening, comprehensive assessment, or care plan.

13. **What is the SMI Indicator and how do we know which patients have SMI?**
    SMI stands for Serious Mental Illness. This is an indicator that is available on the claims data. However, the plan may choose to apply its own working definition of SMI, based on their own assessments of their patient population. As with other fields on this template, HFS has granted the plans some room to innovate. However, HFS reserves the right to ask the plans to explain their methods. The Department also asks that the same method of applying SMI indicators to individuals be applied equally to everyone on the plan's panel.

14. **May the plans complete the report using data from the plan's or providers' EHR?**
    Most of the fields in the care coordination monthly report rely on the plan's own data. An exception is the SMI indicator, which may be drawn from claims data.

Utilization Report

15. **Where is a plan supposed to get the information to complete the utilization report?**
    You are expected to use the Care Coordination Claims Data (CCCD). You receive CCCD via this FTP each month on the dates listed here. For more information, see our comprehensive CCCD webpage on the HFS website.

16. **What date will we receive the data we need for each month's utilization report?**
    You will receive the CCCD data runs on the fifth working day of the month, as always. The earliest point you could have the data for the month being reported is two months in advance. (For example, the report due on November 12, 2014 will cover the month of August 2014, and you will get the August 2014 data in early September 2014, as always.) *However,* we strongly recommend that you wait until the month of report (i.e, November) to use the data for the reported month (August). This allows us to ensure data completeness by providing data for all dates, allowing for late claim submissions and adjustments, and giving plans the luxury of time.

17. **Which patients are included in each month of reporting for the utilization report?**
    Each report covers a given month (for example, the report due on November 12, 2014 will cover the month of August 2014). The patients who should be included in that report are the ones that were enrolled in that month (August 2014). The report covers all the people listed on the monthly payment enrollment report for the month being reported.

18. **May the plans complete the report using data from the plan's or providers' EHR?**
    To ensure a fair comparison of plan effectiveness, we'd like you to use CCCD as a single data source for the utilization report. If this instruction changes, we will give you direction at least one month in advance.

19. **The CCCD arrives on the fifth working day of the month. This report is due on the seventh working day of the month. Isn't that an exceedingly short turnaround? Also: the claims data for the preceding month often excludes the last few days of the month. How do we report for the full month? Do you want us to extrapolate numbers from the days we have? Also: some providers do not submit claims within the month. How can we ensure our data is complete?**
    None of these are problems, because the utilization report is lagged three months. To learn more about the dates claims data covers each month, the dates each utilization report is due and the months covered, consult the documentation on the HFS website.

20. **Why are utilization reports lagged three months?**
    The lag addresses the issues described in the question above. The lag allows for completeness of data, as sometimes providers do not submit claims within the month (by the large majority do within three months). It eliminates the subtle shortfall that arises when the last date of the month the enrollments and claims are included in each CCCD data run does not coincide with the last day of the calendar month.

21. **What is the definition of "In Network"?**
    Every provider on the list of providers in a plan's network is considered in network. For reporting, the plan should compile a list of HFS Provider ID numbers to use in coding.

22. **What is the definition of "Out of Network"?**
    Every provider who is not included on the list of providers in your network, as defined by the list of HFS Provider ID numbers, is out of network.

23. **What is the best way to identify in-network and out-of-network providers? Can we use NPIs?**
    To do so may become complicated, as providers may have two NPIs, no NPI, or an NPI that the HFS system does not include. The HFS Provider ID number has a much better chance of occurring reliably in our data. It is the best way to identify a provider in the data.

24. **How do we identify an ER visit?**
    We define an ER visit (also called an ED visit) as any visit having a revenue code between 0450 and 0459 or a revenue code of 0981. These revenue codes will pick up all ER visits, inpatient or outpatient. Please note that we do not distinguish between the ER visits that end in an admission and those that do not. Please also note that we do not include other forms of ambulatory care in the definition of ER care.

25. **Should we count multiple ER visits on a single date as one visit?**
    Yes.

26. **Is Emergency transportation (ambulance rides) included in what is meant by "ER Visit"?**
    No.

27. **What constitutes an inpatient admission?**
    Inpatient admissions are coded under Categories of Service 020 (Inpatient Hospital Services), 021 (Inpatient Hospital Services – Psychiatric), 022 (Inpatient Hospital Services – Physical Rehabilitation), and 023 (Inpatient Hospital Services – ESRD). Place of service and other codes that the data dictionary identifies as "hospital" often include various outpatient services that occurred at a hospital; for this reason, they are less reliable ways of assessing inpatient admissions. Therefore HFS asks all plans to use these categories of service instead.

28. **Some HEDIS measures instruct health plans to exclude ER visits and inpatient admissions that are only for mental disorders and chemical dependency. Is this the case for these templates?**
    No. This exclusion is because other measures often capture specifics of healthcare for mental illness or substance use disorders. Because we are not including any such measure, we would like you to include all ER visits irrespective of the diagnosis of the client receiving care. We also specifically ask that you include Category of Service 021 (Inpatient Hospital Services – Psychiatric) in your reporting of inpatient admissions.

29. **What constitutes an inpatient day?**
    This field can be understood as the sum of each length of stay for all persons who were admitted in the reporting month.

    HFS uses the traditional health insurance calculation for total inpatient days: Discharge Date – Admission Date = total number of inpatient days (Length of Stay). (Equivalently, one may consider this as counting only the nights of a stay, or as disregarding the day of discharge.) Under this formula, a person who is admitted to the hospital on a Monday and discharged the next Monday has a seven-day (not eight-day) inpatient stay. Length of stay (LOS) in the data set is calculated this way. This figure should equal the sum of covered and non-covered days.

    An exception occurs when a person checks into and out of the hospital on the same day. In this case the claims will report a stay of one day, even though the formula would give a result of zero days. Another exception occurs for interim (series) bills, which occur when someone is hospitalized for more than a month. These use the formula Discharge Date – First Date of Bill +1 to cover all the days in the bill. The first date of the first claim will be the admission date, while subsequent bills will typically list the first day of the month as the date of claim.

    When completing a monthly report, please include only those inpatient days that occurred during the month being reported, even if a particular patient remained hospitalized during parts of a subsequent month.

30. **Why are both inpatient admissions and number of inpatient days required?**
    We recognize that in some cases effective care coordination will result in more inpatient admissions, particularly initially, but possibly shorter stays. Capturing both can give a more comprehensive picture of how patient care is changing under a plan's care model. (A general goal is to decrease both metrics over time.)

31. **How is average length of stay calculated?**
    The template auto-calculates it as Inpatient days/Inpatient Admissions=Average Length of Stay.

32. Do we need to calculate data points per thousand?

Our templates use auto-calculates percentages. If or when the Department needs per-thousand calculations, we can interpolate them from your reports.

33. Can a plan include additional information?

The Department will accept an additional spreadsheet if a plan wants to send one. This is completely optional. Please include a ReadMe or document explaining methods, field names, etc., to facilitate understanding.