Patient Risk List (PRL) – FAQs

3/1/2023

General

#	Questions and Answers
1	**Q: Where can I find the slide deck for tonight's webinar?** A: The slide deck for tonight's webinar, December 12, 2022, can be found here, Patient Risk List (PRL) and the PRL Companion Guide Webinar.

TCM

#	Questions and Answers
1	**Q: Tailored plans are not yet sharing accurate patient panel lists. Does the patient risk list apply to Tailored Care Management (TCM) providers?** A: Yes, the PRL applies to TCM providers. TCM providers will be utilizing the Patient Risk List release 2.0. found here: https://medicaid.ncdhhs.gov/tailored-care-management/tailored-care-management-data-specifications-guidance. For any issues where plans are not sharing accurate patient panel list on the Patient Risk List (PRL), providers are encouraged to email Provider Ombudsman (Medicaid.ProviderOmbudsman@dhhs.nc.gov) with these issues.
2	**Q: What is a prepaid inpatient health plan?** A: Behavioral Health and I/DD services for individual who remain in Medicaid Direct (fee-for-service) will continue to receive those services through Prepaid Inpatient Health Plans (PIHP).
3	**Q: Are the patient risk lists accurate if we are still having patient attribution issues with the standard plans as a primary care practice?** A: There may be instances where members sent from the LME-MCOs and BH I/DD TPs not be aligned to requirements outlined by the Department in the data specification document. Please raise any issues with patient attribution through Provider Ombudsman for the Plan to resolve.
4	**Q: How do you tell if the TCM patient that is assigned to your practice from Tailored Plans (TP's) is a NC Direct versus Advanced Medical Home (AMH) Tier 3 on Beneficiary Assignment (BA) files in the new TP TCM patients? TCM providers need to know this information to bill the patient correctly.** A: In the BA file, there is a specific loop and segment on the 2300 loop, where it defines whether a beneficiary is TCM eligible with the code TP02.

5	**Q: Care Management Agencies (CMA) and AMH+s are not required to have a Risk Stratification algorithm until year 3 - has this changed?** A: No, it has not changed. TCM providers are not required to have a risk stratification until year 3.
6	**Q**: **Do TPs have to send the PRL to AMH 3s in network with them?** A: No, TPs only send the PRL to the Tailored Plan Care Management Entities, which are AMH+ and CMA practices.
7	**Q: Are tier 2 AMHs required to complete the PRL?** A: No, tier 2 AMHs are not required to complete the PRL.
8	**Q: This may be a question for our Clinically Integrated Networks (CINs), but does the PRL need to be completed manually? Or is it expected that our respective TCM Electronic Health Records (EHRs) can populate the information we need automatically?** A: This may differ by each TCM entity and / or their CIN / Data Partner. Please work with your CIN / Data Partner.

Role of CIN

#	Questions and Answers
1	**Q: What is the process for the CIN to follow up with us regarding care management? We do not hear from our CIN.** A: Work with your CIN to understand responsibilities that the CIN has as part of your partnership.
2	**Q: If we are in a CIN, do we have to share info back to health plans? We assume the CIN does that for us.** A: This will depend on the contractual obligations set forth in your relationship with your CIN. Please work with your CIN to clarify who will be responsible No, this is only required for AMH Tier 3 providers and their CIN or Other Partner.

Data-Related

#	Questions and Answers
1	**Q: Is there a reason why Standard Plans (SPs) send only incremental after the initial full file, but Tailored Plans will share full files every month?** A: For TCM Interactions, we expect members to have multiple interactions over a reporting period, so when sharing the file, we want to make sure the TPs and the Providers always have the most accurate and complete file. We do not expect to see members having as frequent interactions in the SPs.
2	**Q: How do you define "current" beneficiaries for the month? Should they have been active on the last day of the month?** A: Current beneficiaries are all members who were active with the plan at some point in the reporting month.
3	**Q: Will the Plans send the data at a determined date each month, i.e. by the 5th of the months, etc.** A: The Data Specification guide defines that the PRL should be shared by the SP/TP/PIHPs to the Care Management (CM) Entities by the 26th of each month, and CM entities need to share information back to the Plans by the 7th of each month.
4	**Q: We receive full files every week. So which full file should we use? The first or the last one?** A: The Care Management entities for TCM will get a full file at least once a month, some plans might start sending these more frequently. TCM entities should utilize the full file that is shared on the 26th of the month. That is the requirement outlined by the State.
5	**Q: Clarification on Full File vs. Incremental - what does it include?** A: The incremental file will be any new members that are not a part of the full file load that was sent by the plans to the Care Management entities. The Full fille is all current and future members that are a part of the specific program.
6	**Q: Since the Standard Plans are only sharing incremental PRLs after the initial full file, is the expectation for AMH Tier 3s to share back with the plans full or incremental files?** A: AMH Tier 3s/CINs/Other Partners should be sharing incremental files back with PHPs. Ideally the members sent on the PHP's file should be reflected on the PRL sent by AMH Toer 3s/CINs/Other Partners.
7	**Q: Can the "Member" include (by proxy) the parent if the actual member is a child?** A: Yes, that is the legally responsible person.

8	**Q: What dates should the patient risk file being sent from the CMAs to Tailored Plans on 1/15/2023 cover? 12/14/2022-1/14/2023?** A: The CMAs to TPs on 1/15 will cover all inbound data from the Plans to the CMAs through the 26th each month, but for deployment will be 1/3. CMA should have beneficiary assignment data from the TPs, so the CMAs should be able to populate that information and share it back.
9	**Q: Clarify and define the "reporting period"?** A: Reporting period is the month in which a PRL is sent. If a PRL is sent by a PHP on 3/26/2023. The reporting is 3/1/2023 - 3/26/2023.
10	**Q: What dates should the second risk file cover regarding contacts? This would cause overlap for contacts occurring in January from the first file to the second one.** A: This should cover the current and future enrollment members shared by the Plans on the 26th of each month.

CM Entity Risk Profile & Interactions

#	Questions and Answers
1	**Q: Does this mean if a Prepaid Health Plan (PHP) risk stratifies a member as high, it is acceptable for an AMH3 to risk stratify that same member as medium or low?** A: Yes, exactly. How an AMH3 and PHP resolve the differing risk stratification is up to the providers and PHPs.
2	**Q: Why do practices need to report a risk stratification score if they are unable to deviate from what the PHP reported?** A: Practices are able to deviate from what the PHP reported.
3	**Q: Can you please clarify the email/text exchange? We have always been informed that those types of communication are not considered a valid contact that can be billed.** A: That is correct. In Tailored Care Management, email/text exchange is not considered a valid contact that can be billed. In Standard Plan, email/text exchange can be considered a contact.
4	**Q: Is a video call considered an in-person contact?** A: Video calls are not considered an in person contact in Tailored Care Management.
5	**Q: Are telehealth contacts considered Face to Face on this?** A: Yes, only for Standard Plan AMHs. Encounters can be in-person or virtual. Please refer to slide 19 https://public.3.basecamp.com/p/p7U3SES8PVnogem6c1HWVV56
6	**Q: The Care Management data fields are for the reporting month only, correct? So if a Comprehensive Assessment was not completed during the reporting month, should the field be left blank, or should we populate when the Comprehensive Assessment was last done?** A: The data should ONLY pertain to the current reporting month. So, the Comprehensive Assessment field can be marked as N if the assessment was completed prior to that month.
7	**Q: What if the care plan or comprehensive assessment was completed prior to the current reporting period?** A: The field will be left blank if the Comprehensive Assessment was completed prior to the current reporting period.
8	**Q: Should the Y/N Care Plan field be only Yes, if the care plan was created that month, or leave as Yes if it was created the month before, just don't include the date?** A: The Y/N Care Plan field should only be Y if the Care Plan was created in the reporting period.

9	**Q: What is considered to be Care Plan Created/Updated/Closed?** A: A care plan created would be for a care plan that is completed, and the date would include the date the care plan was created. For updated, the date would be the date the updates are completed. For closed, the date inputted would be the date that it was closed.
10	**Q: If we have an interaction with a beneficiary (so CM interaction =1), but the purpose was to UPDATE the care plan and not create one; then the Care Plan Created field will be blank, Care Plan Creation will be N (because we did not create one during the reporting period) but we cannot enter the UPDATE date because we chose N for the creation. So how do we count this work?** A: Per the current Data Specification document for the Patient Risk List, provider can note a 'N' in Care Plan Created field and still be able to update the Date Care Plan updated field as long as it is in the reporting month.

Other

#	Questions and Answers
1	**Q: Follow-up to that question--"Average 2 contacts" or tier-based measurement is too broad at a tax ID/agency level. Will these measurements be calculated at a NPI level? Adult/Child within a NPI?** A: Monitoring of Contacts is inclusive of the provider's total full panel per LME-MCO or Tailored Plan. The Department intends to monitor TCM entities compliance with minimum contact requirements for the 4/1/23-6/30/23 quarter using the previously presented panel-based approach. Each TCM entity must deliver at least 75% of the cumulative required contacts of engaged members in their panel to be considered compliant. This means the required contacts of their engaged members, **determined by their acuity tier**, will collectively determine the minimum number that must be delivered upon within each quarter beginning 4/1/23.
2	**Q: Are the patient risk lists available in NC Tracks? It would be helpful to get this list from one source versus multiple sources or CINs. Not asking for templates in NC Tracks. Do you mean to say the actual patients and their risk levels can be found in NC Tracks versus getting from multiple sources if we contract directly with multiple health plans and not in a CIN?** A: The patient risk list is shared between plans and Tier 3 AMHs/CINs, it is not available in NC Tracks. In the scenario above, if an AMH 3 is not affiliated with any CIN, that AMH 3 will be sending/receiving the patient risk list to and from each PHP it is contracted with. The Patient Risk List Templates are located on the Department's webpage. Please follow the links below: TCM: https://medicaid.ncdhhs.gov/tailored-care-management/tailored-care-management-data-specifications-guidance
3	**Q: If we are an AMH tier 2 practice and not in a CIN, do we have to do this with the health plans? We are in an ACO.** A: The Patient Risk List is intended to be completed by Tier 3 AMH practices/AMH+/CMAs or their affiliated CINs.
4	**Q: Can the care needs screening data be included in the PRL? This will avoid the need for CINs to process additional files while keeping all information in one place.** A: The care needs screening data is separate by design. This has been raised as an area for potential change or standardization in the future.