Patient Risk List (PRL) and the PRL Companion Guide

December 12, 2022

Welcome to the Patient Risk List Companion Guide Webinar

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Training Objectives

1. Review Patient Risk List data exchange, structure and field formats
2. Provide an update on the interface deployment schedule for Tailored Care Management
3. Discuss resources for stakeholders to leverage to facilitate appropriate use of Patient Risk List data

Patient Risk List

Patient Risk List

Purpose

The Patient Risk List is used to share information on patient risk, priority, and care management interactions among stakeholders.

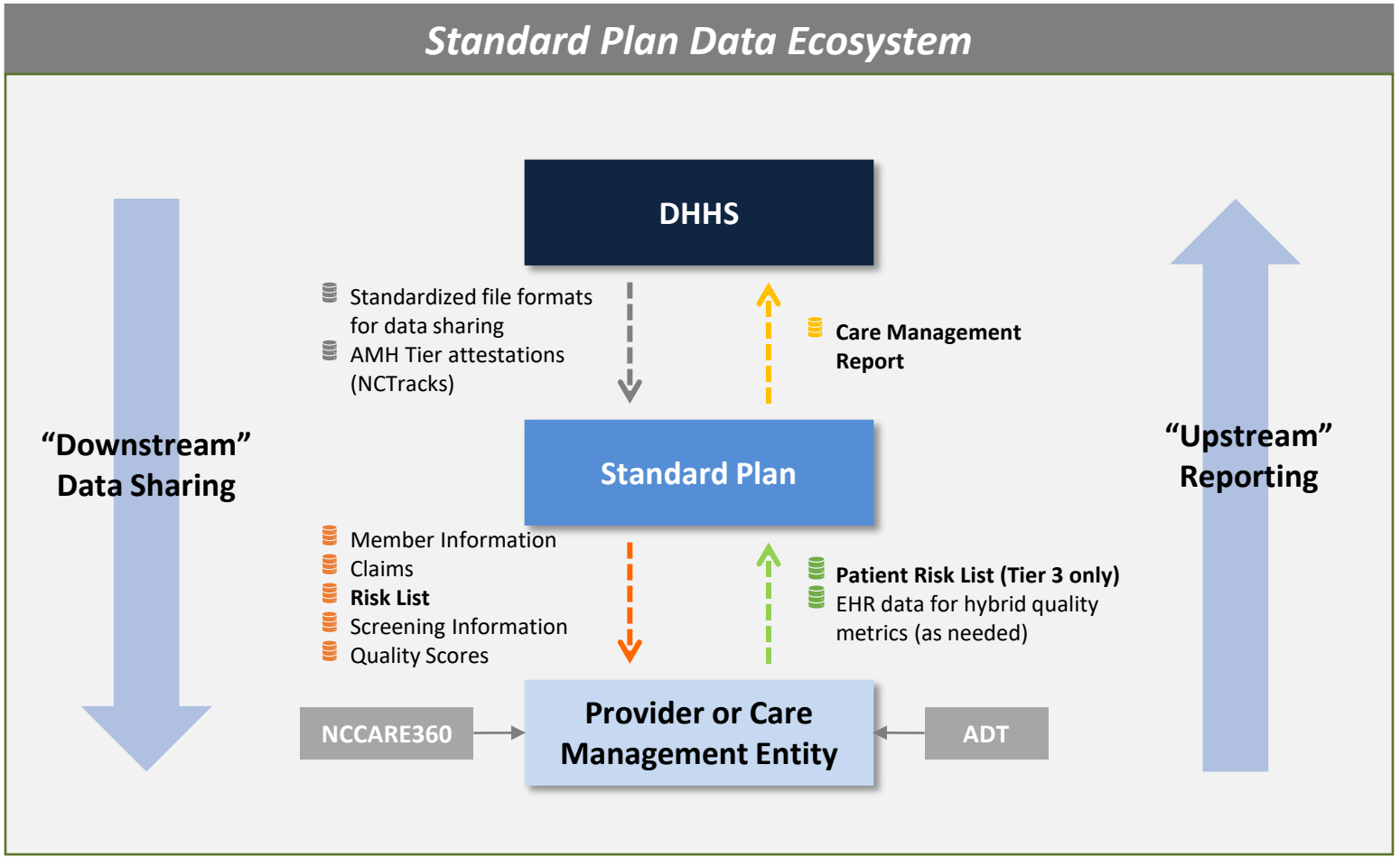
Uses of the Patient Risk List Data File by Entity

DHHS	Monitor risk and care management for the entire Medicaid population *(through Care Management Interaction Report)*
Health Plans	Identify and communicate risk scores and priority populations to their delegated care management entities
Provider or Care Management Entity	Understand their attributed population and communicate risk and care management interactions back to PHPs.

Patient Risk List

Standard Plan Data Ecosystem

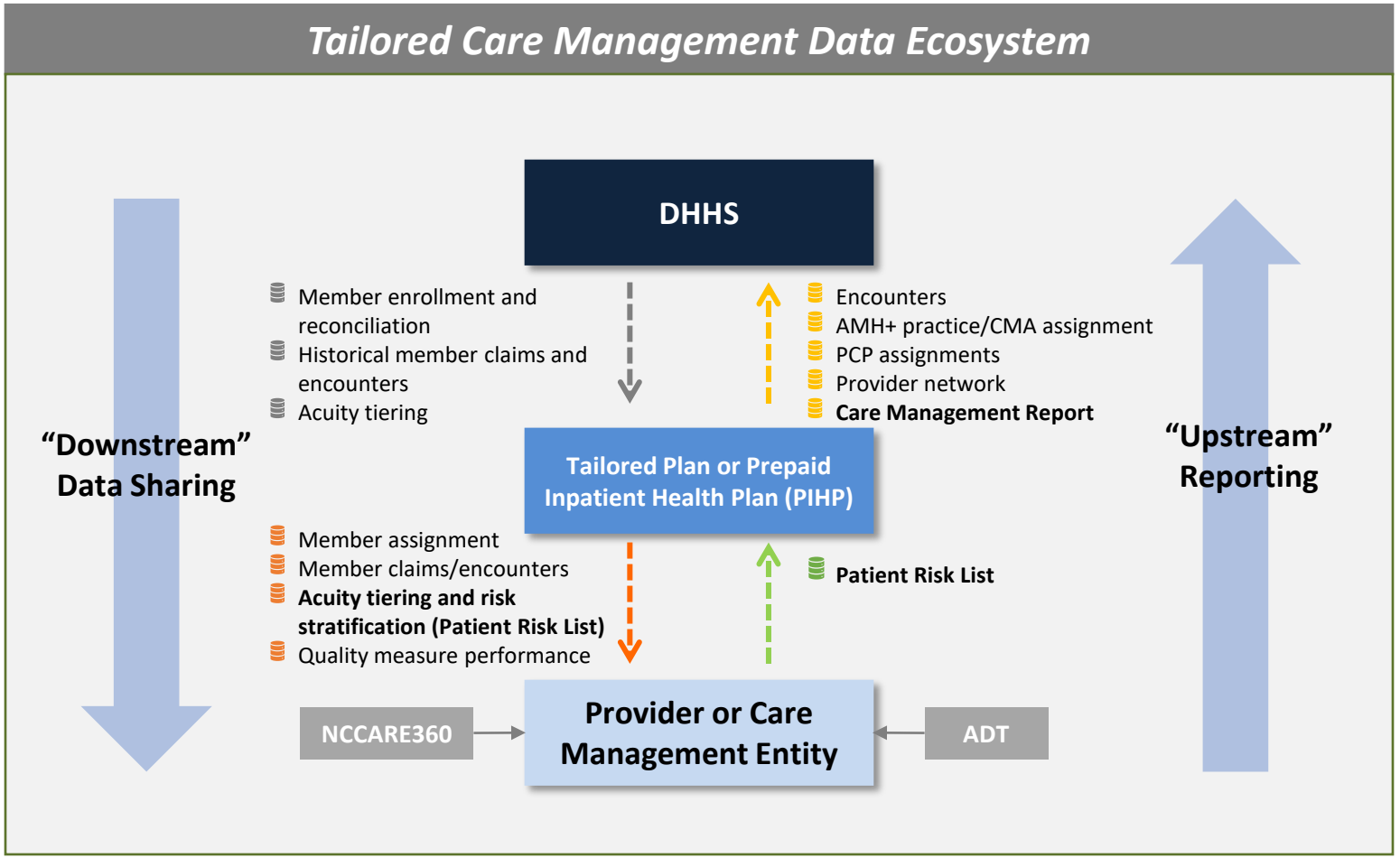
The Patient Risk List is one of several standardized datafiles that are exchanged among the Department, health plans, and providers/care management entities.



Patient Risk List

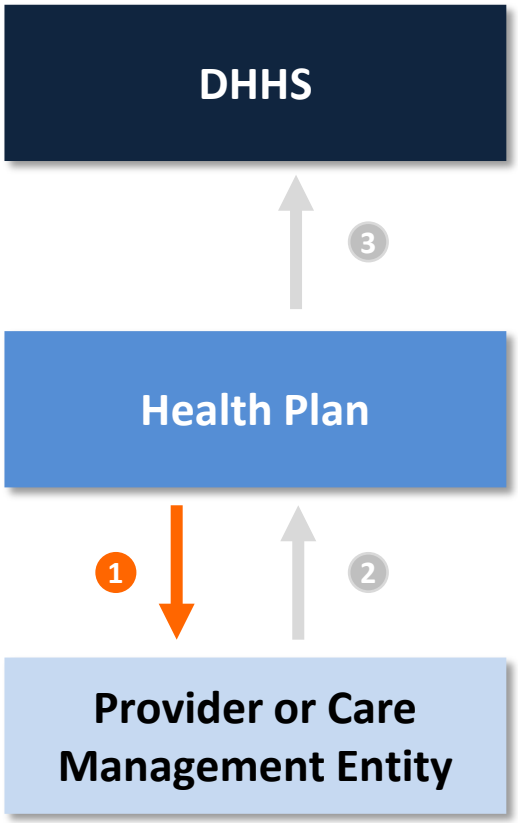
Tailored Plan Data Ecosystem

The Patient Risk List is one of several standardized datafiles that are exchanged among the Department, health plans, and providers/care management entities.



Patient Risk List

Data Flow from Health Plans to Care Management Entities



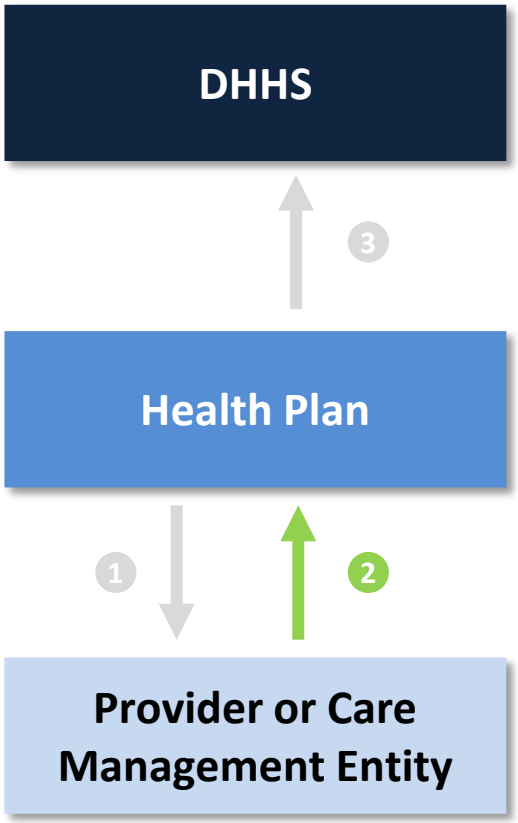
1

Health plans must transmit Patient Risk List data to AMH Tier 3 practices, AMH+ practices, CMAs, and/or their affiliated CINs/Other Data Partners.

- **Population:** The health plan will send data only on assigned current and future beneficiaries for each care management entity.
- **Cadence:** The health plan will send data monthly.
  - Standard Plans will share an initial full and subsequent incremental datafiles with AMH Tier 3 practices.
  - Tailored Plans will share full datafiles with AMH+ practices/CMAs.
- **Content:** The data will include information on beneficiaries':
  - Risk score, based on the health plan's risk stratification algorithm, and
  - Priority care management populations, based on health plan or DHHS stratification.

Patient Risk List

Data Flow from Care Management Entities back to Health Plans



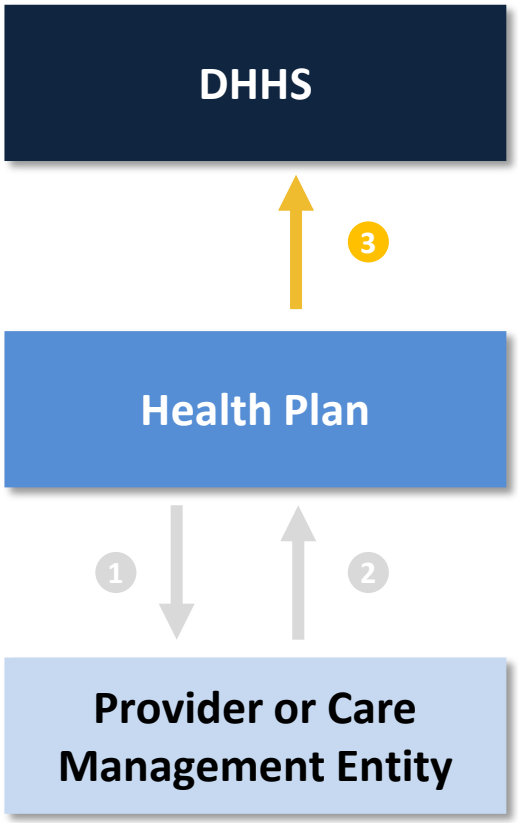
2

AMH Tier 3 practices, AMH+ practices, CMAs and/or their affiliated CINs/Other Data Partners must send back the Patient Risk List to health plans.

- **Population:** The care management entity should include all beneficiaries in the plan's downstream datafile.
- **Cadence:** The care management entity should send back data at least monthly.
  - AMH Tier 3 practices will share an initial full and subsequent incremental datafiles back with Standard Plans.
  - AMH+ practices and CMAs will share full datafiles back with Tailored Plans.
- **Content:** The data will include information on beneficiaries':
  - Risk score, based on the care management entity's risk stratification algorithm, and
  - Care management interactions

Patient Risk List

Data Flow from Health Plans to DHHS



3

Health plans must report to the Department the care management activities for their members monthly.

- Information in the Patient Risk List is used to populate the care management activities in the *BCM051: Care Management Interaction Beneficiary* report that plans submit to DHHS.

Patient Risk List

Data Fields

Patient Risk List Data Fields

File Layout Versions

There are two versions of the Patient Risk List file layout currently in use. Health plans and care management entities should pay close attention to ensure that their transmission of the Patient Risk List data includes all required data fields.

File Layout Version	Notes	Standard Plan	Tailored Care Management
Patient Risk List Release 1.0	Original release	Standard Plans and any AMH 3/CIN not participating in InCK should use Release 1.0.	N/A
Patient Risk List Release 2.0	New release to support the Integrated Care for Kids (InCK) and Tailored Care Management programs; contains additional fields on care management interactions.	AMH 3/CIN participating in the InCK program should use Release 2.0.	All entities participating in Tailored Care Management should use Release 2.0.

Patient Risk List Data Fields

Data Sections

Both release versions of the Patient Risk List file layout include four sections for stakeholders to complete.

Section	Description	Source System
Header Information	Contains metadata information about the file content	Both
Patient Identifier	Contains information about attributed members and their inclusion in priority populations	Both
PHP Risk Profile	Contains the health plan's assessment of members' risk	Health Plan
Care Management Entity Risk Profile and Interactions	Contains the care management entity's assessment of their attributed population's risk and documents care management interactions completed	Care Management Entity

Patient Risk List Data Fields

Data Section: Header Information

Section	Data Fields	Health Plan	Care Management Entity
Header Information	PHP ID	Mandatory	Mandatory
	PHP Name	Mandatory	Mandatory
	Full vs. Incremental	Mandatory	Mandatory
	File Name	Mandatory	Mandatory
	File Type	Mandatory	Mandatory
	Version/Release	Mandatory	Mandatory
	Create Date	Mandatory	Mandatory
	Create Time	Mandatory	Mandatory
	Number of Records	Mandatory	Mandatory

Full vs. Incremental Files

After the initial first full file:

- Standard Plan entities are expected to send incremental files monthly.
- Tailored Care Management entities are expected to send full files monthly.

Create Date and Time

This field should reflect the date and time that the file is transmitted from the source to target systems.

Number of Records

The record count for the health plan's outbound and inbound Patient Risk List file must match and include all members sent on the outbound file from the health plan to the care management entity.

Patient Risk List Data Fields

Data Section: Patient Identifier

Section	Data Fields	Health Plan	Care Management Entity
Patient Identifier	CNDS ID	Mandatory	Mandatory
	Maintenance Type Code	Mandatory	Mandatory
	Priority Population 1	Mandatory	Mandatory, Optional for TCM Providers
	Priority Population 2	Optional	Situational
	Priority Population 3		
	Priority Population 4		
	Priority Population 5		
	Priority Population 6		

Priority Population

The health plan should identify the priority care management populations that a member falls into based on the health plan's or DHHS stratification *(see next slide)*.

Care management entities are <u>not permitted</u> to change the priority population identifiers.

Patient Risk List Data Fields

Priority Population Identifiers

Health plans must assign at least one priority population identifier to every member. Stakeholders should refer to source documentation for priority population definitions.

Code	Description	Definition	Source
000	Null	N/A	N/A
001	Care Management for At-Risk Children (CMARC)	Eligibility	CMARC & CMHRP Program Guide
002	Care Management for High-Risk Pregnancies (CMHRP)	Eligibility	
003	Long-Term Services and Supports	Eligibility	LTSS Program Guide
004	Unmet Resources	PHP Screening	DHHS-Standard Plan Contract Amendment 2/3
005	Adults and Children with Special Health Care Needs	Eligibility	DHHS-Standard Plan Contract Amendment 8/9
006	Rising Risk	PHP Risk Stratification	DHHS-Standard Plan Contract Amendment 2/3
007	Other Priority Population	PHP Screening	PHP - Other priority populations as determined by the PHP (i.e., Members with complex conditions like HIV, Hepatitis C, or Sickle Cell)
008	Transitioning Member	Eligibility	NC Medicaid Managed Care Transition of Care Policy
009	InCK SIL 1	DHHS Risk Stratification	NC InCK Playbook for Health Care Providers
010	InCK SIL 2		
011	InCK SIL 3		
012	NICU Referral	Eligibility	Medicaid and Health Choice Clinical Coverage Policy No: 1A-7
013	Healthy Opportunities Pilots	Eligibility	Healthy Opportunities Pilots FAQ Document

Patient Risk List Data Fields

Data Section: PHP Risk Profile

The PHP Risk Profile data fields should be completed by health plans only.

Section	Data Fields	Health Plan	Care Management Entity
PHP Risk Profile	PHP Risk Score Category	Mandatory	Situational
	PHP Risk Evidence	Optional	Situational

Care management entities should not change the values that health plans provide in this field; instead, they should use the Care Management Entity Risk Score Category field to communicate their risk scores *(see next slide)*.

PHP Risk Score

The health plan should indicate each member's risk score (high, medium, low, or null) based on the health plan's own risk stratification algorithm.

Null should be used when the health plan lacks sufficient data to determine a risk stratification level for a member and no risk stratification level has been assigned to a member. Null should not be used when a health plan determines a member risk stratification has changed.

PHP Risk Evidence

The health plan can choose to provide additional information on the member's risk (i.e., sickle cell anemia, high emergency department utilization, homelessness). Health plans should include risk evidence for members with a high-risk score.

Patient Risk List Data Fields

Care Management Entity Risk Profile and Interactions (1/3)

The Care Management Entity Risk Profile and Interactions data fields should be completed by care management entities only.

Section	Data Fields	Health Plan	Care Management Entity	Description
Care Management Entity Risk Profile and Interactions	Care Management Entity Risk Score Category	Optional	Optional for TCM Providers, Mandatory for AMH Providers	The risk level that the member falls into (high, medium, low) based on the provider or care management entity's risk stratification algorithm. **It is acceptable to have the risk category differ from that assigned by the PHP.**
	Assigned Care Management Entity	Optional	Mandatory	Assigned Entity performing care management services. This should match with the NPI in NC Tracks.
	Number of Care Management Interactions	Optional	Mandatory	Total number of beneficiary care management interactions completed **in the reporting month** *(see next slide for definition of care management interaction)*.
	Number of Face-to-Face Encounters	Optional	Mandatory	Total number of face-to-face beneficiary interactions completed in the reporting month.
	Date Comprehensive Assessment Completed	Optional	Mandatory	The date that a Comprehensive Assessment was completed for a beneficiary. Report should include the most recent date for each member inside the reporting period.

Patient Risk List Data Fields

Reminder: Definition of Care Management Interaction

AMH Tier 3 Agencies and their affiliated CINs/Other Data Partners should report all care management contacts.

Care Management Interaction

An interaction is defined as:

- In-person or virtual visit with care management (e.g., delivery of Comprehensive Assessment, development of Care Plan or other discussion of health-related needs)
- Phone call or active email/text exchange between member of care team and Member (must include active participation by both parties; unreturned emails/text messages do NOT count).
- Phone call or active email/text exchange between member of care team and Member discussing Care Plan or other health-related needs.

The following should not be reported as care management encounters:

- Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnancy (CMHRP) encounters
- Care managers leaves a voicemail with Member or sends unreturned email/text message.
- Health Plan/care manager sends mailer to Member.
- Phone calls between Member and practice front desk staff for scheduling purposes.
- Scheduled in-person visit to which the Member fails to show up.

Source: Advanced Medical Home Provider Manual

Patient Risk List Data Fields

Reminder: Definition of Care Management Interaction

Tailored Care Management is built around the six core Health Home services. AMH+ Practices & CMAs and their affiliated CINs/Other Data Partners should report all care management contacts.

Tailored Care Management Interaction

An In-Person or Telephone interaction to carry out one of the **six core Health Home services**

- In-person Contact
  - In-Person contact must involve the member.
- Telephone Contacts with Member
  - For members with an I/DD or a TBI who have a guardian, telephonic contact may be with a guardian in lieu of the member, only where appropriate or necessary.

The following should not be reported as care management encounters:

- Email/text exchange do not count as a contact.

*If a care manager or extender delivers multiple contacts to a member in one day, only one contact shall count towards meeting the contact requirements.

Source: Tailored Care Management Provider Manual

Patient Risk List

Care Management Entity Risk Profile and Interactions (2/3)

Section	Data Fields	Health Plan	Care Management Entity	Description
Care Management Entity Risk Profile and Interactions	*Care Plan Created (Y/N)** v2.0 only	Optional	Mandatory	Identifies if a Care Plan has or has not yet been created. If a member has only a Shared Action Plan for InCK, it should be documented separately in the Shared Action Plan field.
	Date Care Plan Created*	Optional	Mandatory	The date that Care Plan was completed for a beneficiary. If the Care Plan Created field is a 'N', this field should be left blank. If a Care Plan Created field is a 'Y', the date should be populated. This field should only include the date the Care Plan was created if it was created in the reporting period.
	Date Care Plan Updated*	Optional	Mandatory	The date that a Care Plan was most recently updated for a beneficiary within the reporting period. If the Care Plan was never updated or if a Care Plan was never created, this field can be left blank.
	Date Care Plan Closed*	Optional	Mandatory	The date that a Care Management episode was closed for a beneficiary within the reporting period. This should align with end-dating a care plan.

* The care plan and shared action plan are two separate documents. Care plans must be developed for all high-need beneficiaries, while shared action plans must be developed for InCK SIL 3 beneficiaries. A beneficiary may have a care plan, a shared action plan, both, or none. Stakeholders should complete Patient Risk List data fields appropriately based on the specific documents that have been developed for each beneficiary.

Patient Risk List

Care Management Entity Risk Profile and Interactions (3/3)

Section	Data Fields	Health Plan	Care Management Entity	Description
Care Management Entity Risk Profile and Interactions	*Date Care Manager Assigned* v2.0 only	Optional	Mandatory	The date that a beneficiary's last/current Care Manager was assigned.
	Initial Care Manager Outreach Date v2.0 only	Optional	Mandatory	The date that a Care Manager first attempted outreach to a beneficiary. This includes attempted outreach where a member declines.
	Name of Care Manager Assigned v2.0 only	Optional	*Mandatory for InCK*	The name of the last/current Care Manager assigned to a beneficiary during the reporting month.
	Phone Number for Care Manager Assigned v2.0 only	Optional	*Mandatory for InCK*	The phone number of a beneficiary's last/current Care Manager. This field is mandatory for only InCK beneficiaries.
	Email for Care Manager Assigned v2.0 only	Optional	*Mandatory for InCK*	The email address of a beneficiary's last/current Care Manager.
	*Date Shared Action Plan Created** v2.0 only	Optional	*Mandatory for InCK*	The date that a Shared Action Plan was created for an SIL 3 InCK beneficiary.
	Assigned Care Management Entity Location Code v2.0 only	Optional	Mandatory	The location code of the AMH that performed the care management. Each AMH site has an NPI + location code. Only applicable to AMH Tier 3 and AMH+ practices. When populated, this should match with the NPI in NC Tracks.

* The care plan and shared action plan are two separate documents. Care plans must be developed for all high-need beneficiaries, while shared action plans must be developed for InCK SIL 3 beneficiaries. A beneficiary may have a care plan, a shared action plan, both, or none. Stakeholders should complete Patient Risk List data fields appropriately based on the specific documents that have been developed for each beneficiary.

Patient Risk List
Scenarios

1. How should the Comprehensive Assessment be reported by Providers on the PRL?

- Most recent Comprehensive Assessment completion date **within the reporting period** should always be populated within the PRL submission.
- This field should be left blank by the provider if a Comprehensive Assessment has never been completed or still in progress.

2. How do providers populate Date Care Plan Created field?

- Providers should populate this field in each PRL submission to the plan and report the date on which the Care Plan was last created within the reporting period
- If the Care Plan Created field is a Y, the Care Plan Created field should have a valid date in the format requested.
- If the Care Plan Created field is a N, the Date Care Plan created should be left blank.
- If the member has a Shared Action Plan but no Care Plan, that should be documented in the Shared Action Plan field only
- It is possible to have both a Care Plan and a Shared Action Plan

3. How do providers populate the Date Care Plan Updated field?

- Providers should populate this field in each PRL submission to the plan and report the most recent date on which the Care Plan update was completed within the reporting month. If the Care Plan was never updated or if a Care Plan was never created, this field can be left blank.

4. How should Plans populate PHP Risk Score Category when there are discrepancies between plans and providers risk stratification?

- There may be instances in which AMH Tier 3's, AMH+'s, CMA's risk score categorization for an individual varies from a PHP's, BH I/DD TP's, or PIHP's risk score categorization.
- Although the PHPs, BH I/DD TPs, or PIHPs may resolve discrepancies based on their internal processes, DHHS expects each PHP, BH I/DD TP, or PIHP to describe and document their approach to resolving risk level categorization discrepancies in the Care Management Policy.
- The PHP, BH I/DD TP, or PIHP and the AMH Tier 3's, AMH+'s, CMA's do not have to automatically equate high risk with a priority population identifier.

Tailored Care Management Interface Deployment Schedule

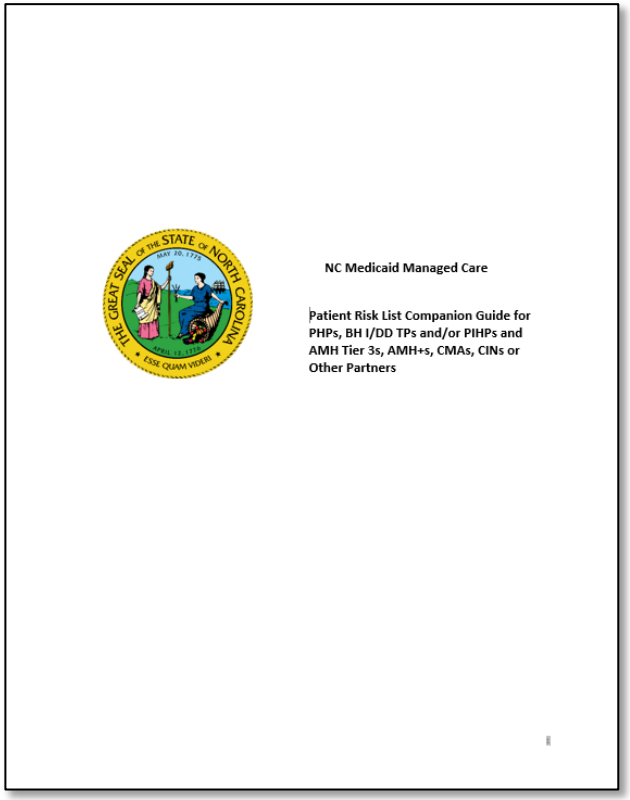
Interface	Frequency	First Deployment Date for LME-MCO Launch	First Deployment Date for TP Launch
Beneficiary Assignment File (LME-MCO/TP to Provider)	Daily incremental and weekly full file	11/20/2022	3/12/2023
Pharmacy Lock-in (LME-MCO /TP to Provider)	Weekly full file	1/15/2023	3/19/2023
Medical Professional Claims Header and Line (LME-MCO /TP to Provider)	Weekly incremental	1/15/2023	3/19/2023
Medical Institutional Claims Header and Line (LME-MCO /TP to Provider)	Weekly incremental	1/15/2023	3/19/2023
Pharmacy Claims Header and Line (LME-MCO /TP to Provider)	Weekly incremental	1/15/2023	3/19/2023
Dental Claims Header and Line (LME-MCO /TP to Provider)	Weekly incremental	1/15/2023	3/19/2023
Patient Risk File (LME-MCO /TP to Provider)	26th of each month	1/3/2023	4/26/2023
Patient Risk File (Provider to LME-MCO /TP)	7th of each month	1/15/2023	5/7/2023

Patient Risk List

Resources and Guidance

Patient Risk List Companion Guide

The Department is developing a Patient Risk List Companion Guide to provide health plans as well as providers and care management entities with additional instructions on appropriate use of the Patient Risk List file.


NC Medicaid Managed Care

Patient Risk List Companion Guide for PHPs, BH I/DD TPs and/or PIHPs and AMH Tier 3s, AMH+s, CMAs, CINs or Other Partners

- Intended for business and technical users responsible for testing, setup, and ongoing transmission of Patient Risk List data
- To be used in conjunction with the previously published *Data Specifications and Requirements for Sharing Patient Risk List Data* documents

Q&A

- Enter questions using the Q&A function within Zoom Webinar.
- Send additional questions to:
  - Loul Alvarez: loul.alvarez@dhhs.nc.gov
  - Seirra Hamilton: seirra.n.hamilton@dhhs.nc.gov
  - Leonard Croom: leonard.a.croom@dhhs.nc.gov
  - Sachin Chintawar: sachin.chintawar_acn@dhhs.nc.gov
  - Gigi Cloney: giovanna.cloney_acn@dhhs.nc.gov

Next Steps

1. **Stakeholders should send any additional questions to:**

   Loul Alvarez: loul.alvarez@dhhs.nc.gov
   Seirra Hamilton: seirra.n.hamilton@dhhs.nc.gov
   Leonard Croom: leonard.a.croom@dhhs.nc.gov
   Sachin Chintawar: sachin.chintawar_acn@dhhs.nc.gov
   Gigi Cloney: giovanna.cloney_acn@dhhs.nc.gov

2. **The Department will add addendums to the Patient Risk List Data Specification documents that can be accessed through PCDU and NC Medicaid Webpage.**

Appendix

Patient Risk List Data Fields

Reminder: What Counts as a Tailored Care Management Contact?

Tailored Care Management is built around the six core Health Home services. Below are examples of activities care managers may complete in delivering a Tailored Care Management contact (see provider manual for additional details):

Tailored Care Management Interaction

- **Comprehensive care management**, including
  - Completion of care management comprehensive assessments and care plan/ISP
  - Phone call or in-person meeting focused on chronic care management (e.g., management of multiple chronic conditions)
- **Care coordination,** including
  - Working with the member on coordination across settings of care and services (e.g., appointment/wellness reminders and social services coordination/referrals)
  - Assistance in scheduling and preparing members for appointments (e.g., phone call to provide a reminder and help arrange transportation)
- **Health promotion,** including
  - Providing education on members' chronic conditions
  - Teaching self-management skills and sharing self-help recovery resources
  - Providing education on common environmental risk factors including but not limited to the health effects of exposure to second- and third-hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children

Source: Tailored Care Management Provider Manual

Patient Risk List Data Fields

Reminder: What Counts as a Tailored Care Management Contact?

Tailored Care Management is built around the six core Health Home services. Below are examples of activities care managers may complete in delivering a Tailored Care Management contact (see provider manual for additional details):

Tailored Care Management Interaction

- **Comprehensive transitional care/follow-up,** including
  - Visiting the member during the member's stay in the institution and be present on the day of discharge
  - Reviewing the discharge plan with the member and facility staff
  - Referring and assisting members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing
  - Developing a 90-day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff, and the member's care team
- **Individual & family support,** including
  - Providing education and guidance on self-advocacy to the member, family members, and support members
  - Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
  - Providing information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes
- **Referral to community & social support services,** including
  - Providing referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services
  - Providing comprehensive assistance securing key health-related services (e.g., filling out and submitting applications

Source: Tailored Care Management Provider Manual