PHP Responsibilities in Care Management

The RFP defines the care management that PHPs will administer as a team-based, person centered approach to effectively managing patients' medical, social and behavioral conditions.

That includes:

a. High-risk care management (e.g., high utilizers / high-cost beneficiaries);
b. Care Needs Screening;
c. Identification of Members in need of care management;
d. Development of Care Plans (across priority populations);
e. Development of comprehensive assessments (across priority populations);
f. Transitional care management: Management of Member needs during transitions of care (e.g., from hospital to home);
g. Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
h. Chronic care management (e.g., management of multiple chronic conditions);
i. Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
j. Management of unmet health-related resource needs and high-risk social environments;
k. Management of high-cost procedures (e.g., transplant, specialty drugs);
l. Management of rare diseases (e.g., transplant, specialty drugs);
m. Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
n. Development and deployment of population health programs.

In addition, there are special requirements for care management of High Risk Pregnant Women and Children with Special Health Care Needs. Children with Special Health Care Needs includes children with Severe Emotional Disturbances, Intellectual/Developmental Disabilities, and Substance Use Disorders as well as individuals receiving Medicaid waiver 1915(b)(3) services, those with an Innovations Waiver slot or TBI Waiver Slot. The RFP does not provide specifics on how services provided under the LME/MCO for the Innovations or TBI Medicaid waivers are to be connected to this care management piece.

The care management that is coordinated by the PHPs includes the Advanced Medical Home component done in partnership with enrolled practices (certified by NC DHHS). The AMH may also work with a Clinically Integrated Network (CIN) of providers to perform case management and other functions under care management.