CARE COORDINATION

Tier 3 Practices

Advanced/Fully Integrated Care Coordination

Meets all must-pass criteria and scores 67–100 points (or NCQA PCMH + must-pass). This is the expected model under ACC 3.0.

Tier 3 payment requires demonstrated, measurable care coordination with full accountability

Care Coordination Role

- Proactive, longitudinal management of all members, with a primary focus on Tier 3 and complex populations
- Integrated coordination across physical health, behavioral health, and social needs
- Accountable for outcomes, not just activity

Key Expectations

- Demonstrate care coordination through consistent, complete documentation and actionable data
- Deliver care coordination in alignment with contractual requirements, measurable, auditable, and directly tied to payment

Expected Capabilities

- Adherence to the NHP care coordination model and policies, including participation in monthly CC Subcommittee, required trainings, and bootcamps
- Comprehensive care plans established within 90 days, updated twice a year and meeting all contract requirements (e.g., SMART goals, assigned lead CC, 25/1000)
- Consistent monthly engagement with complex members
- Strong transitions of care workflows (ADT-driven, timely follow-up)
- True closed-loop referral management (medical, BH, community)
- Integrated BH and care management staffing models
- Use of data to drive interventions and track outcomes
- Timely and complete documentation of care coordination activities in Essette or an approved NHP workbook

Online Referral Form: https://site-emju3.powerappsportals.com/en-US/