External Quality Review: Compliance with Regulations

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Federal Regulations

- 42 CFR 438.350—Each state that contracts with MCOs, PIHIPs, PAHPs, or PCCM entities (RAEs) ensures that a Qualified External Quality Review Organization (EQRO) performs an annual external quality review (EQR) *
- HSAG is Colorado's EQRO
- EQR consists of mandatory and optional activities
- Monitoring the managed care entities for compliance with all requirements at 42 CFR 438 is a mandatory activity
- Each standard must be reviewed once every three years

*Quality of Care External Quality Review | Medicaid

Compliance Review in Colorado Consists of 12 Standards

Standard Number and Title	Regulations Included	Standard Number and Title	Regulations Included
Standard I—Coverage and Authorization of Services	438.114 438.210	Standard VII—Provider Participation (Selection) and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610
Standard II—Access and Availability	438.206 438.207	Standard VIII—Credentialing and Recredentialing*	NCQA Credentialing and Recredentialing Standards and Guidelines
Standard III—Coordination and Continuity of Care	438.208	Standard IX—Subcontractual Relationships and Delegation	438.230
Standard IV—Member Rights and Protections (Includes Confidentiality)	438.100 438.224	Standard X—Quality Assessment and Performance Improvement	438.236 438.240 438.242
Standard V—Member Information	438.10	Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	441.50 441.62 10 Code of Colorado Regulations (CCR) 2505, 8.280
Standard VI—Grievance and Appeal Systems	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424	Standard XII—Enrollment and Disenrollment	438.3(d) 438.56

General Approach to Compliance Review

The goal of the audit is to determine whether:

1. The policies/procedures and other documents are in compliance with the requirements
2. There is evidence (in the form of reports, records, committee minutes, template forms, etc.) of mechanisms to implement processes described in documents, and if possible, evidence that processes were actually implemented during the review period
3. The purpose of the interview is for the interviewer to ensure that:
    a. MCE staff have an understanding of the requirements
    b. Can articulate how the MCE implements processes and mechanisms to comply with the requirements
    c. What is described during the interview is consistent with what is described in policy or documents such as reports, committee meeting minutes, etc.

Any scores of Partially Met or Not Met requires a corrective action plan, which HSAG follows until completion

Standard III—Coordination and Continuity of Care—Colorado Review

- Ten requirements in Standard III
- Seven requirements based on federal regulations at 42 CFR 438.208
- Three Requirements relate only to RAE/MCO contract requirements
- During ACC Phase I, Regional Care Collaborative Organizations (RCCOs) were not required to comply with 42 CFR 438
- The priority for reviewing was to ensure implementation of care coordination programs as the programs were being implemented
- Compliance review focused on record review and/or case presentation by the RCCOs
- As the ACC transitioned to Phase II, the priority became review for compliance with 42 CFR 438 and review of systems and processes, rather than individual cases

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
1. A. The RAE implements procedures to deliver care to and coordinate services for all members. B. The RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences.	To start the interview for this section the MCE staff are asked to describe their care coordination program—number of staff, specialization, located locally or not, delegation, care manager credentials and how work is divided among the staff, and numbers of total population and those in care coordination programs.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
1. B. Continued: • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 7: Exhibit B6—11.3.1, 11.3.7	Documents typically submitted for the Coordination and Continuity of Care standard include program descriptions, policies and procedures, stratification polices/protocols, call scripts, template welcome to care coordination letters, outreach letters, and screen shots of care coordination systems, although we often ask for a live demonstration of the system to understand how care coordination activities are documented.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact their designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 7: Exhibit B6—None	Most health plans use some type of stratification that helps them determine whether members need care coordination and if so, what type. There are typically two types of answers/evidence we see here. 1. If a member is receiving care coordination, how are they informed who the care coordinator is and how to contact the member? 2. If a member does not need care coordination, typically the PCP is who the MCE would indicate provides the ongoing source of care at this level of member need. Typically, for these members what lets these members (low risk) know who would coordinate their care (usually referrals only) is a member ID card with the PCP's name printed on it. Other methods are acceptable, as long as there is one.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
3. The RAE, no less than quarterly, compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 7: Exhibit B6—6.8.1	Typical documentation here is: • Policies and procedures specific to managing enrollment and attribution data. • Examples or excerpts of system reports of comparison lists. • Reports or committee minutes demonstrating how outliers or attribution mismatches were managed.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
4. The RAE's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extended assistance and include appropriate interventions. Contract Amendment 7: Exhibit B6—11.3.3	Typical documents for review here are policies, procedures, program descriptions, reports of quality initiatives targeted to improve communications/referrals with community agencies, resource lists used by care coordinators and customer service staff, internal protocols, scripts, practice transformation documents, provider and staff training materials, etc. We may ask for discussion of a "success story" or ask for a demo of the care coordination documentation system to see how care coordination activities are documented.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 7: Exhibit B6—10.3.2, 10.3.4, 11.3.5, 11.3.7.7, 11.3.10, 14.3	Typical documents reviewed here are specific policies or program descriptions that address transitions of care. Many health plans have separate transitions of care programs or staff. We ask for mechanisms or documentation about how they monitor and identify members discharging from facilities or corrections facilities. Other documentation may be care plan templates or examples, discharge planning examples, or workflows.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 7: Exhibit B6—7.5.2–3	Here we look for mechanisms to respond to the Department data transfer. We typically see workflows, forms, examples of documentation, risk stratification tools, etc.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
7. The RAE ensures that it has procedures to ensure: • Each member with special health care needs receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* Contract Amendment 7: Exhibit B6—14.7.1	The earlier requirement was to screen for special health care needs. In CO, the Department accomplishes that task, so the RAE is required to process it and determine who needs further assessment. This requirement is about performing that further assessment and developing service/care plans based on that assessment. Typical documents here are outreach logs, call scripts, copies of template or examples of outreach letters, assessment and care plan forms, examples of completed assessments or care plans.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
8. The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 7: Exhibit B6—None	Typical document here are policies and procedures or workflows. How this would apply in Colorado is this: If a member changes to a different PCMP, who is in a different region, thereby changing RAEs, the RAE should have a mechanism to share with the other RAE any outreach, assessment, or care plan information, as a place for the new RAE to start, and avoid duplication of efforts.

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Coordination and Continuity of Care	
Requirement	**Review Notes**
9. The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* Contract Amendment 7: Exhibit B6—11.3.7.10.6, 15.1.1.5	Here we are looking for policies, procedures and organizational processes to comply with HIPAA. We look for documents to minimally address: Electronic safeguards when sharing PHI with providers or others involved in the member's care: • Requirements for providers and others on the treatment team to use electronic safeguards. • Electronic safeguards include: ○ Password protection for access to systems that are based on job assignments (only those who have the need to know may access).

HIPAA Requirements (Continued)

- When sharing records or files, electronic transactions meet the HIPAA compliant format requirements
- Processes for members to sign a release of information if records or information are to be released to non-covered entities* such as community or social organizations or family members
- Sharing of PHI for the purpose of coordinating care and payment for health care services do not require a release of information
- Policies and procedures for the use of a Business Associate Agreement when a noncovered entity performs duties for a covered entity (such as a delegate that performs care coordination or utilization management for the MCE)

*Covered entity is defined as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.

CMS guidance about covered entities can be found here:
Covered Entity Decision Tool (cms.gov)

Standard III—Coordination and Continuity of Care—Specific Requirements

Standard III—Care Coordination and Continuity of Care	
Requirement	**Review Notes**
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided.. • Age.. • Gender identity.. • Race/ethnicity.. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators.. • Care coordination notes, activities, and member needs.. • Stratification level.. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals.. Contract Amendment 7: Exhibit B6—15.2.1.1, 15.2.1.3-4	Here we like to see a live demonstration of the functionality of the care coordination documentation system. Minimally we can look at screen shots that demonstrate that they document each of these data points.

RAE Care Coordination Score Comparison

Standard III—Applicable Review Years	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	State wide RAE Avg
Standard III—(FY 2018-2019)	100%	91%	100%	82%	91%	100%	100%	95%
Standard III—(FY 2021-2022)	100%	100%	100%	100%	100%	90%	90%	97%

MCO Care Coordination Score Comparison

Standard III—Applicable Review Years	DHMP	RMHP Prime	Statewide MCO Average
Standard III— (FY 2018-2019)	70%	100%	86%
Standard III— (FY 2021-2022)	100%	100%	100%

Care Coordination Best Practices FY 2021-2022—RMHP-RAE 1

- Diversified staff members–RNs, BH, LCSWs
- Integrated care coordination teams (ICCTs) within communities across the region
- Targeted outreach—high-risk prenatal and postnatal members, members identified by the Colorado Overutilization Program (COUP), and members in the top 2.8 percent risk group
- Beginning October 2021—Impact Pro (IPro), a predictive risk modeling program used to stratify RAE members based on over 1,000 data markers to identify high risk members with complex needs
- Welcome calls with letters to follow if unable to reach

Care Coordination Recommendations and Required Actions—RMHP-RAE 1

Rocky Mountain Health Plans-RAE 1—Recommendations	
2018-2019	2021-2022
No recommendations identified.	Although RMHP informed members of care coordinator assignments via telephone, HSAG recommended a follow up letter.

Rocky Mountain Health Plans-RAE 1—Required Actions	
2018-2019	2021-2022
No required actions identified.	No required actions identified.

Care Coordination Best Practices FY 2021-2022—NHP-RAE 2

- Mechanisms to receive daily admit, discharge, and transfer data from local hospitals
- Specific assessment tool *(Community Prepared Tool)* used to identify the impact of social determinants of health
- Auditing used to monitor care coordination delegates.

Care Coordination Recommendations—NHP-RAE 2

Northeast Health Partners—Recommendations	
2018-2019	2021-2022
HSAG suggested that NHP consider enhancing its Care Coordination Plan to include more detailed description of its regionwide model for care coordination, to include a more detailed description of its delegated organizational model, configuration of care coordination teams, embedded care coordinators, etc.	HSAG suggested expanding the language in the applicable policies, procedures, and delegate agreements to better illustrate the roles, responsibilities, and monitoring in place for NHP's multi-tiered care coordination delegation model.
HSAG recommended that NHP revise its policy to ensure that transitions of care procedures apply to all RAE members and types of health services.	

Care Coordination Required Actions—NHP-RAE 2

Northeast Health Partners—Required Actions	
2018-2019	2021-2022
NHP was required to revise provider communications regarding the requirement that each provider furnishing services to the member share, as appropriate, the member health record with other providers or organizations involved in the member's care.	No required actions identified.

Care Coordination Best Practices FY 2021-2022—COA-RAE 3

- Specialization by physical or behavioral health
- Separate resource and referral team
- 50 percent success rate on follow-up to HNAs performed by the Department
- Use of the Colorado Regional Health Information Organization (CORHIO) for admission, discharge and transfer data
- Use of a dashboard to monitor attribution
- Staff members on site at 19 hospitals

Care Coordination Recommendations—COA-RAE 3

Colorado Access RAE 3—Recommendations	
2018-2019	2021-2022
HSAG recommended that COA more specifically define documented procedures for implementing the care management program.	Although the calls to notify members of care coordinator assignments conveyed the required information, HSAG recommended a follow-up letter reiterating the information and resources provided over the phone.
HSAG encouraged COA to ensure that mechanisms exist for smooth transition from one care coordination team to another.	
As results of member needs assessments were communicated via verbal contacts, HSAG recommended that COA consider written communication for such, and to enhance provider materials to clarify provider responsibilities for sharing assessments.	

Care Coordination Required Actions—COA-RAE 3

Colorado Access RAE 3—Required Actions	
2018-2019	2021-2022
No required actions identified.	No required actions identified.

Care Coordination Best Practices FY 2021-2022—HCI-RAE 4

- Mechanisms to receive daily admit, discharge, and transfer data
- Specific assessment tool *(Community Prepared Tool)* used to identify the impact of social determinants of health
- Review of monthly care coordination reports from delegates
- Auditing used to monitor care coordination delegates

Care Coordination Recommendations—HCI-RAE 4

Health Colorado, Inc. RAE 4—Recommendations	
2018-2019	2021-2022
HSAG suggested that HCI consider enhancing its Care Coordination Plan to include more detailed description of its regionwide model for care coordination.	Care coordination policies and procedures described comprehensive care coordination services; however, HSAG suggested expanding the language in the applicable policies, procedures, and delegate agreements to better illustrate the roles, responsibilities, and monitoring in place the multi-tiered delegated care coordination model.
HSAG recommended that HCI revise its policy to ensure that transitions of care procedures apply to all RAE members and types of health services.	

Care Coordination Required Actions—HCI-RAE 4

Health Colorado Inc.—RAE 4—Required Actions	
2018-2019	2021-2022
HCI was required to implement mechanisms to ensure that the electronic care coordination tool used by each delegate includes the minimum required elements outlined in the RAE contract.	No required actions identified
HCI was required to revise provider communications regarding the requirement that each provider furnishing services to the member share, as appropriate, the member health record with other providers or organizations involved in the member's care.	

Care Coordination Best Practices FY 2021-2022—COA-RAE 5

- Specialization by physical or behavioral health
- Separate resource and referral team
- 48 percent success rate on follow-up to HNAs performed by the Department
- Use of the Colorado Regional Health Information Organization (CORHIO) for admission, discharge and transfer data
- Use of a dashboard to monitor attribution
- Staff members on site at 19 hospitals

Care Coordination Recommendations—COA-RAE 5

Colorado Access RAE 5—Recommendations	
2018-2019	2021-2022
HSAG recommended that COA more specifically define documented procedures for implementing the care management program.	Although the calls to notify members of care coordinator assignments conveyed the required information, HSAG recommended a follow-up letter reiterating the information and resources provided over the phone.
HSAG encouraged COA to ensure that mechanisms exist for smooth transition from one care coordination team to another.	
As results of member needs assessments were communicated via verbal contacts, HSAG recommended that COA consider written communication for such, and to enhance provider materials to clarify provider responsibilities for sharing assessments.	

Care Coordination Required Actions—COA-RAE 5

Colorado Access RAE 5—Required Actions	
2018-2019	2021-2022
As it was unclear how COA coordinated behavioral health services being received through the RAE with the physical health services delivered through the MCO, COA was required to more clearly outline procedures for coordinating BH services being received by individual members with those services which members receive from the Denver Health MCO.	No required actions identified.

Care Coordination Best Practices FY 2021-2022—CCHA-RAE 6

- Defined needs-related care coordination programs (e.g., Complex Care Coordination, Chronic Disease Management, Maternity, Pediatrics and Foster Care, Justice Involved, Transitions of Care, Behavioral Health Transitions of Care
- Use of provider tier levels to determine ability of each provider to furnish medical home, condition management, or care coordination services

Care Coordination Recommendations—CCHA-RAE 6

Colorado Community Health Alliance RAE 6—Recommendations	
2018-2019	2021-2022
HSAG recommended that **CCHA** consider strengthening the Accountable Care Network (ACN) provider contract requirements related to Medicaid managed care regulations.	CCHA staff members could not describe the expected follow-up or outreach methods required of delegates to outreach high-risk members. Additionally, procedures to refer newly identified members into care coordination, were unclear. HSAG recommended CCHA enhance procedures as well as create a workflow to better delineate how CCHA processes and prioritizes referrals and/or reviews service denials (in which a member may need additional care coordination) to ensure follow-up occurs when needed.
HSAG recommended that CCHA develop and implement a comprehensive ACN audit process.	
HSAG recommended that CCHA revise the provider manuals to more explicitly address care coordination requirements required in the Medicaid managed care regulations.	

Care Coordination Required Actions—CCHA-RAE 6

Colorado Community Care Alliance RAE 6—Required Actions	
2018-2019	2021-2022
No required actions identified.	CCHA was required to strengthen applicable documents to create a more detailed procedure that outlines referral and timeliness expectations of providers to more clearly define how CCHA ensures that all member needs are addressed, regardless of auto-assignment into a particular PCMP with a particular tier assignment, or with particular condition management capabilities.

Care Coordination Best Practices FY 2021-2022—CCHA-RAE 7

- Defined needs-related care coordination programs (e.g. Complex Care Coordination, Chronic Disease Management, Maternity, Pediatrics and Foster Care, Justice Involved, Transitions of Care, Behavioral Health Transitions of Care
- Use of provider tier levels to determine ability of each provider to furnish medical home, condition management, or care coordination services

Care Coordination Recommendations—CCHA-RAE 7

Colorado Community Health Alliance RAE 7—Recommendations	
2018-2019	2021-2022
HSAG recommended that CCHA consider strengthening the Accountable Care Network (ACN) provider contract requirements related to Medicaid managed care regulations.	CCHA staff members could not describe the expected follow-up or outreach methods required of delegates to outreach high-risk members. Additionally, procedures to refer newly identified members into care coordination, were unclear. HSAG recommended CCHA enhance procedures as well as create a workflow to better delineate how CCHA processes and prioritizes referrals and/or reviews service denials (in which a member may need additional care coordination) to ensure follow-up occurs when needed.
HSAG recommended that CCHA develop and implement a comprehensive ACN audit process.	
HSAG recommended that CCHA revise the provider manuals to more explicitly address care coordination requirements required in the Medicaid managed care regulations.	

Care Coordination Required Actions—CCHA-RAE 7

Colorado Community Care Alliance RAE 7—Required Actions	
2018-2019	2021-2022
No required actions identified.	CCHA was required to strengthen applicable documents to create a more detailed procedure that outlines referral and timeliness expectations of providers to more clearly define how CCHA ensures that all member needs are addressed, regardless of auto-assignment into a particular PCMP with a particular tier assignment, or with particular condition management capabilities.

Care Coordination Best Practices FY 2021-2022—DHMP

- Specialized needs-related care coordination programs
- Daily communication with its delegate—COA
- Multidisciplinary case management meetings, which include social support agencies when needed
- Member portal to facilitate self care and coordination
- Followed the Department's unsuccessful HNS attempts with a paper survey sent and phones calls

Care Coordination Recommendations—DHMP

Denver Health Medical Plan—Recommendations	
2018-2019	2021-2022
DHMP provided DHHA policies for care coordination; however, it was unclear that DHHA policies were applicable to DHMP staff or that DHHA was a care coordination delegate. HSAG recommended that DHMP clarify the care coordination policies and procedures	No recommendations identified
HSAG recommended that DH revise policies and procedures and develop additional programmatic documents to define specific activities and responsibilities within the system-wide care coordination program	

Care Coordination Required Actions—DHMP

Denver Health Medical Plan—Required Actions	
2018-2019	2021-2022
DHMP was required to implement mechanisms to provide information to members about how to contact the person or entity primarily responsible for coordinating his or her health care services.	No required actions identified.
DHMP was required to enhance and implement procedures to actively coordinate services members receive from DHMP. the RAE, and from community organizations and social support providers.	
DHMP was required to implement processes to use results of the Department's HNS to initiate applicable care coordination activities—beyond continuity of care processes—in accordance with member responses to the survey.	
DHMP was required to implement a mechanism to provide an individual intake assessment and related service plan for each member identified as having special health care needs.	

Care Coordination Best Practices FY 2021-2022—RMHP-Prime

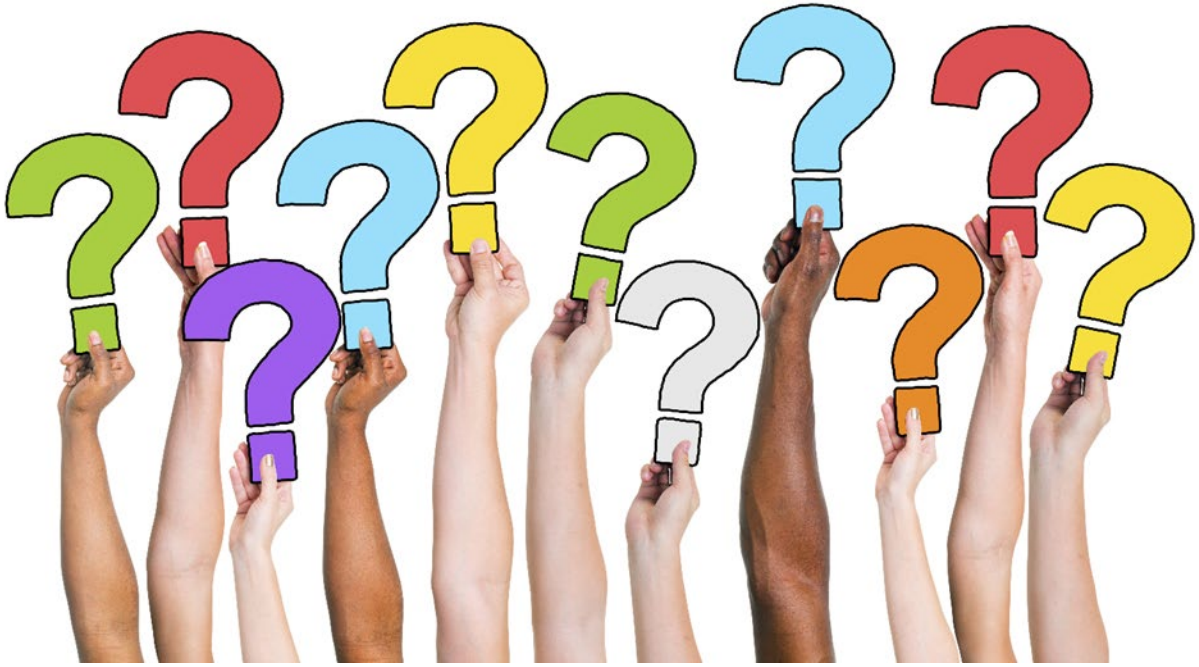
- Diversified staff members–RNs, BH, LCSWs
- Integrated care coordination teams (ICCTs) within communities across the region
- Targeted outreach—high-risk prenatal and postnatal members, members identified by the Colorado Overutilization Program (COUP), and members in the top 2.8 percent risk group
- Beginning October 2021—Impact Pro (IPro), a predictive risk modeling program used to stratify RAE members based on over 1,000 data markers to identify high risk members with complex needs
- Welcome calls with letters to follow if unable to reach

Care Coordination Recommendations and Required Actions—RMHP-Prime

Rocky Mountain Health Plans-Prime—Recommendations	
2018-2019	2021-2022
HSAG recommended that RMHP enhance Prime provider requirements to include responding to medical records requests “in a timely manner”.	Although RMHP informed members of care coordinator assignment via telephone, HSAG recommended a follow up letter.

Rocky Mountain Health Plans-Prime—Required Actions	
2018-2019	2021-2022
No required actions identified.	No required actions identified.

Questions



Thank you!

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