18. Quality

18.1. Performance Improvement Projects (PIPs)

~~In addition, to the three PIPs outlined in the Agreement (one related to long-term services, one related to prenatal and postpartum, and one related to adult obesity), the MCO shall be required to do the following two PIPs based on the most current CMS Adult Core Set.~~

- ~~Diabetes prevention and enhanced disease management:~~
  - ~~PQI01-AD: Diabetes, Short-Term Complications Admission Rate (NQF #0272); and~~
  - ~~HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF #0057)~~
- ~~Screening and management for clinical depression~~
  - ~~AMM-AD: Antidepressant Medication Management (NQF #0105); and~~
  - ~~CDF-AD: Screening for Clinical Depression and Follow-Up Plan (NQF #0418)~~

~~These PIPs shall follow all CMS EQR protocols and will be reviewed annually by the EQRO based on the most current EQR protocols.~~Performance Improvement Projects must be developed in accordance with 42 C~~FR~~.F.R. § - 438.330 as directed in section 4.12 of the Managed Care Services Agreement. The Contractor must apply the following criteria to selecting measurement indicators and establishing performance benchmarks and targets:~~i~~

- Select standardized, evidence-based measurement indicators.
- Benchmarking and baseline statistics ~~and targets~~ should align with national and regional averages.
- Performance targets should indicate a statistically significant improvement in performance compared to the baseline measurement.

Work plans for all PIPs shall be submitted for review and approval from the EQRO prior to implementation.

~~**18.2. Provider Satisfaction Survey**~~

~~**The Provider Satisfaction Survey is an annual report that provides the MCO with an assessment of its activities, policies and procedures related to identifying healthcare performance, improvements and internal systems based upon satisfaction of its contracted providers. HSD has outlined specific requirements to be included in the provider satisfaction survey. Those requirements are incorporated into the Provider Satisfaction Survey reporting instructions. The survey requirements list the detailed description of:**~~

- ~~**Three populations to target;**~~
- ~~**Rating system to follow;**~~
- ~~**Topics to address; and**~~
- ~~**Template of the required questions, which are attached in 18.4.1.**~~

18.~~3~~2. Critical Incident Reporting

All agencies in New Mexico providing HCBS and BH services are required to report Critical Incidents within 24 hours of knowledge of the occurrence. The critical incident(s) should be reported to the ~~member~~Member's MCO and/or Adult Protective Services (APS) or Child Protective Services (CPS) as necessary.

Critical incident reporting responsibilities and reporting requirements include:

- HCBS critical incidents involving members with a qualifying COE must be reported on the ~~HSD~~HCA Critical Incident Reporting System for the following reportable incidents: abuse; neglect; exploitation; deaths; environmental hazards; missing/elopement; law enforcement; and emergency services.
    - Qualifying COEs include: 001; 003; 004; 081; 083; 084; 090; 091; 092; 093; 094; 100; and 200 with a NF LOC.
- The MCO shall be required to provide appropriate training and take corrective action as needed to ensure Contracted Provider compliance with Critical Incident requirements.
    - The MCO shall require its Contract Providers to complete a reassessment of risk and update the CCP to address potential gaps in the Member's care, to mitigate assessed risks and to prevent occurrence of further incidents.
    - The MCO shall be required to execute provisions describing how services provided under the terms of the Contracted Provider contract are accessed by Members.

- The Contracted Provider shall be required to provide at least thirty (30~~) Calendar~~) Calendar days advance notice to the MCO when the Contracted Provider is no longer willing or able to provide services to a Member, including the reason for the decision and to cooperate with the Members care coordinator to facilitate a seamless transition to alternate Contracted Provider.

- The MCO be required to address and respond to new PCS authorizations.
  - The MCO shall be required to verify Contract Providers have sufficient staff to provide services, assure Contract Providers assigned have initiated care and initiate procedures in place when services have not begun within five (5) calendar days.
- The MCOs shall be required to follow a process as defined in Agency Based Community Benefit~~s~~ Section 9:~~7~~ where members who wish to receive fewer PCS hours than in~~-~~itially authorized would discuss and work together with their ~~PCS t~~assigned Care Coordinator to determine if reducing hours is reasonable. If so, the ~~member~~Member will sign a new Community Benefit Member Agreement (CBMA). The request for a reduction in hours should occur after at least 60 calendar days into the approved schedule and after a reassessment of approved PCS hours. It is essential that members willingly agree to and sign the CBMA for the reduced PCS hours, with the MCO maintaining a record of this agreement.
- The MCO shall be required to ensure that training is provided upon a Contracted Provider entering into a contract, upon hire of employees, and upon enrollment in the SDBC.
  - The MCO shall be required to ensure that training be provided at least annually thereafter.
  - The MCO shall be required to ensure the training is mandatory and is included in the contract agreement.

- Critical Incident Reports filed as the result of a ~~member~~Member's death and accepted for investigation by the Office of the Medical Investigator (OMI) shall remain in a pending state within the ~~HSD~~HCA Critical Incident Reporting Portal until the OMI has issued its findings. The MCO is responsible to update the ~~HSD~~HCA Critical Incident Reporting Portal with the results from the OMI.
- The MCO shall require all staff and Contracted Providers to document updates regarding initiated action(s) taken for the ~~member~~Member and all follow-up activities related to the intervention(s) implemented as a result of the incident. The information should be entered into the ~~HSD~~HCA

Critical Incident Reporting Portal until the established intervention(s) demonstrate the ~~member~~Member's health, safety and welfare are no longer issues of concern.

- The follow-up action(s) include but are not limited to:
  - Requiring an investigation or intervention for issues of health and safety;
  - Information related to the ~~member~~Member's health, safety and welfare;
  - Communication with internal or external agencies; and
  - Any changes in the ~~member~~Member's health status, including but not limited to; care coordination visits or care coordination investigations or interventions, and/or reassessment or change in the ~~member~~Member's comprehensive care plan.

- BH critical incidents and all Sentinel Events are defined by the BH Critical Incident Protocol.
  - Critical incidents involving BH services for members with a non-qualifying COE must be reported on the Centennial Care Behavioral Health Critical Incident form for any known, alleged or suspected events of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.
  - The MCO shall have a process and designate one fax line to receive critical incident reports from BH providers for Medicaid recipients. The MCO shall provide this fax number to ~~HSD~~HCA and the MCO contracted BH provider network.
  - The MCO is responsible for reviewing and ensuring complete follow up has occurred regarding all submitted BH critical incidents reported by or on behalf of their members, including APS and CPS.
  - The MCO will notify BHSD of all Sentinel Events in accordance with the BH Critical Incident Protocol.

- ~~**Critical Incident Reporting Upon Termination of MCO Contract**~~
  - ~~The MCO shall submit a report to HSD~~HCA ~~containing identified Critical Incident Reports (CIRs) and any pending death investigations associated with its members thirty (30) Calendar Days prior to the termination of the MCO contract, using a template provided by HSD. The MCO shall submit weekly updates regarding these outstanding CIRs until all reports are resolved and closed.~~

- ~~The MCO shall be responsible for completing all follow-up activities, such as investigations and final reporting of unresolved critical incidents for members who were part of the MCO's membership at the time the incident was filed.~~
- ~~Sixty (60) Calendar Days after the resolution of all outstanding Critical Incident Reports and death investigations, the MCO's access to the HSDHCA Critical Incident Reporting Portal will be terminated.~~

~~18.4. Appendix~~

~~18.4.1 Centennial Care Reporting Survey Template~~

~~18.4.1. Centennial Care Reporting Survey Template~~

~~Centennial Care Reporting Survey Template~~

~~MCO survey results shall utilize the following rating system:~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~The survey shall include the following required questions:~~

~~**Care Coordination/Continuity of Care**~~
~~Effectiveness of MCOs care coordination/care management programs for members.~~
~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~
~~Assistance provided by care coordination/care management staff.~~
~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~
~~MCO provides information needed to care for its members.~~
~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~
~~**Overall Satisfaction**~~
~~Likelihood you would recommend the MCO to other members?~~
~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~
~~Likelihood you would recommend the MCO to other physicians?~~
~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~
~~Overall satisfaction with MCO.~~
~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~
~~**Claims**~~
~~MCOs accuracy of claims processing.~~
~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~MCOs timeliness of claims processing.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~MCOs timeliness of adjustment/appeal claims processing.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Ease of resolving claims issues without making multiple inquiries.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~**Provider Relations**~~

~~MCOs process of obtaining member~~Member ~~information (eligibility, benefit coverage, co-pay amounts).~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Satisfaction with MCOs customer service in answering questions and/or resolving problems when calling the MCO.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~MCOs frequency and effectiveness of provider representative visits to the provider's office.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Usefulness of MCOs written communications, policy bulletins, and manuals.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Quality of provider orientation and education processes.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Ease of completing MCO credentialing and re-credentialing.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~MCOs attentiveness to the provider's overall needs.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~**Provider Network**~~

~~Quality of the MCO's primary care practitioners.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Quality of the MCO's specialists.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~The number of quality specialists to whom the provider can refer patients.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~The number of specialists in the MCO's provider network.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~**Utilization/Quality Management**~~

~~Ease of the prior authorization process.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Timeliness of obtaining outpatient authorization of services.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Timeliness of obtaining inpatient authorization of services.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Satisfaction with coordination of home health and DME services.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Procedures for obtaining pre-certification/referral/authorization information.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Degree to which the plan covers and encourages preventive care and wellness.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Clinical appropriateness of UM decision.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~**Pharmacy/Drug Benefits**~~

~~Ease of using formulary.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Ease of the pharmacy prior authorization process.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~MCOs variety of drugs available in formulary.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Timeliness of response to pharmacy prior authorization requests.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Extent to which formulary reflects current standards of care.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Ease of prescribing preferred medications within formulary guidelines.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~

~~Availability of comparable drugs to substitute those not included in the formulary.~~

~~Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1~~