# 18. Quality

## 18.1. Performance Improvement Projects (PIPs)

Performance Improvement Projects must be developed in accordance with 42 C.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:

- Select standardized, evidence-based measurement indicators.
- Benchmarking and baseline statistics 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. 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'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 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 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 Section 9: where members who wish to receive fewer PCS hours than initially authorized would discuss and work together with their assigned Care Coordinator to determine if reducing hours is reasonable. If so, the 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's death and accepted for investigation by the Office of the Medical Investigator (OMI) shall remain in a pending state within the HCA Critical Incident Reporting Portal until the OMI has issued its findings. The MCO is responsible to update the 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 and all follow-up activities related to the intervention(s) implemented as a result of the incident. The information should be entered into the HCA Critical Incident Reporting Portal until the established intervention(s) demonstrate the 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's health, safety and welfare;
        - Communication with internal or external agencies; and
        - Any changes in the 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'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 nonqualifying COE must be reported on the Turquoise Care Behavioral Health Critical Incident form for any known, alleged or suspected events of abuse, neglect, exploitation, injuries of unknown origin, death 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 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.
- The MCO shall ensure follow up with members (either by the agency or care coordinator) according to their Risk Level, utilizing the following criteria:
    - Risk Level I (Low) – 10 hours or fewer of Personal Care Services (PCS) allocated per week with natural support: monthly diary entries

- Risk Level II (Medium) – 11 – 25 hours of PCS services allocated per week: every other week diary entries
- Risk Level III (High) – 26 or more hours of PCS services allocated: weekly diary entries

- A Risk Level must be assigned to all members when a Critical Incident Report (CIR) is filed. Other factors to consider when assigning a Risk Level are:
  - Member's hospitalization and/or ER visit
  - Member's change in condition
  - Member's chronic conditions
  - Member's living situation (e.g., assisted living, long-term care facility, residential treatment center)
  - Member's imminent risk or threat to self and others due to lack of caregiver supervision
- The MCO must initiate review of all incident reports regarding their members within one (1) Business Day of the report submission. This review shall include, at a minimum:
  - Verifying the member's Category of Eligibility (COE) in the YES-NM Medicaid portal and deleting reports for members who do not have a CIRS reportable COE.
  - Ensuring the accuracy of the member's demographics (name, DOB, and SSN) and diagnoses. If a report is filed with the default SSN of 123-45-6789, the MCO should update the SSN of the member. If a report lists the diagnosis as unknown, the MCO should update the CIR with a list of diagnoses.
  - Verifying whether the narrative supports the documented incident type/subcategory and ensuring the primary and secondary categories follow the correct hierarchy.
  - Determining whether the report is a reportable incident or non-reportable incident based on the narrative or additional information obtained. For example, a visit to an Urgent Care does not require a CIR but an ER visit does. If the report is deemed non-reportable then the report must be deleted by the MCO.
  - Assessing the report to ensure that the date of incident and the date the agency first knew of the incident are aligned.
  - Ensuring the report is complete and contains all necessary information or required language (e.g. PCS schedule, whether member is directed or delegated, and reason Emergency Services were utilized) and verifying aspects of the report as needed.

- Conducting outreach to the member's PCS agency for any needed corrections to the CIR
- Ensuring appropriate Adult Protective Services (APS)/Child Protective Services (CPS) follow-up.
- Determining whether an additional CIR needs to be filed related to the incident, such as a member's death related to an emergency room visit.
- Identifying and processing duplicate CIRs to preserve pertinent information and deleting duplicates from the Critical Incident Reporting System (CIRS): when duplicate incidents are identified, narrative and diary entries from the duplicate CIR are transferred into the CIR filed by the agency and the report filed by the MCO is deleted.
- Notifying the member's care coordinator of the CIR and prompting the care coordinator to follow up directly with the member, per their Risk Level requirements.
- Instructing the care coordinator and/or the agency to document their outreach attempts, which may include communication with neighbors, family, PCP, hospital admissions, or law enforcement as applicable.
- Forwarding unexplained death CIRs to OMI (Office of Medical Investigator) for investigation.
- Referring all reports of Exploitation with subcategory of Falsification of Timesheets to the MCO's internal fraud investigation unit, documenting the referral in diary notes, and ensuring the alleged fraud question is answered yes.
- Ensuring CIRs are filed in a timely manner or contain documentation regarding why the incident was reported late. Providing continued education to agencies on the importance of timely filing.

- MCOs must process all requests for CIR deletions within two (2) business days. If a diary entry requesting deletion is found in a CIR that has not been deleted within two (2) business days, HCA auditors will deduct points from the MCO's monthly CIR Audit score. This is of particular importance at the end of each quarter, as Critical Incident Report #36 data is pulled directly from the CIRS.
- The MCO must utilize the most recently updated PCS and/or Behavioral Health (BH) training presentations as a resource to ensure that CIRs are reported accurately and according to

hierarchy guidelines. The MCO must ensure that PCS and BH agencies are directed to utilize these presentations as a resource as well.

- All follow-up entries in the CIRS must be individualized to the member and include documentation of actions taken as a direct result of the CIR, such as provider appointments, medication changes, and environmental modifications. The MCO must perform ongoing reviews of CIRs to ensure that the appropriate and timely follow-up/diary entries have been completed by the agency and/or MCO care coordinator.
- A CIR remains under review until documentation in the diary entries indicates that the critical incident issue is no longer a concern and the member's health, safety, and well-being are addressed. Once this occurs, the MCO may close the CIR.
- The MCO shall utilize all available resources such as Community Health Workers, providers, and natural supports to locate all members with CIRs who are Difficult to Engage (DTE) or Unable to Reach (UTR). If, after completing the required follow-up attempts according to the member's Risk Level for ninety (90) days, a member is DTE or UTR, the MCO must make and document at least three (3) further reasonable outreach efforts (e.g., attempting to contact the Member on different days at different times of the day, using alternative contact numbers, using community agencies to engage Member) to contact a Member to follow up on the critical incident. After these protocols have been completed, a diary entry must document that the incident is being closed due to the member being DTE or UTR and that the required follow-up has been completed. This follow-up would include reviewing internal records/claims that may indicate that a member was seen by a healthcare provider or facility after the date of incident.
- The MCO's critical incident staff must address the CIRs that have remained Under Review for more than 90 days on a monthly basis, including initiating outreach to agencies and care coordinators to explore feasible options for resolving the incident as needed.