

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 21 QUALITY MANAGEMENT

8.308.21.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.21.1 NMAC - Rp, 8.308.21.1 NMAC, 5/1/2018]

8.308.21.2 SCOPE: This rule applies to the general public.
[8.308.21.2 NMAC - Rp, 8.308.21.2 NMAC, 5/1/2018]

8.308.21.3 STATUTORY AUTHORITY: The New Mexico Medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.21.3 NMAC - Rp, 8.308.21.3 NMAC, 5/1/2018]

8.308.21.4 DURATION: Permanent.
[8.308.21.4 NMAC - Rp, 8.308.21.4 NMAC, 5/1/2018]

8.308.21.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.21.5 NMAC - Rp, 8.308.21.5 NMAC, 5/1/2018]

8.308.21.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.21.6 NMAC - Rp, 8.308.21.6 NMAC, 5/1/2018]

8.308.21.7 DEFINITIONS: [RESERVED]

8.308.21.8 [RESERVED]
[8.308.21.8 NMAC - Rp, 8.308.21.8 NMAC, 5/1/2018]

8.308.21.9 QUALITY MANAGEMENT: A HSD managed care organization (MCO) quality management program includes a philosophy, a method of management, and a structured system designed to improve the quality of services; includes both quality assurance and quality improvement activities; and is incorporated into the health care delivery and administrative systems.

A. Quality management (QM) program structure: The MCO shall have QM structure and processes as detailed in the medicaid managed care services agreement or the medical assistance division (MAD) managed care policy manual.

B. QM program description: The MCO shall develop a written QM and a quality improvement (QI) program description that includes the requirements described in the medicaid managed care services agreement or the managed care policy manual.

C. QM and QI program principles: The MCO QM and QI programs are based on principles of continuous quality improvement (CQI) and total quality management (TQM). Such an approach will:

- (1) recognize clinical and non-clinical opportunities are unlimited;
- (2) be data driven;
- (3) use real-time input from members and MCO contracted providers to develop CQI activities; and
- (4) require on-going measurement of effectiveness and improvement.

D. QM program evaluation: The MCO will have a written QM and QI program evaluation as described in the medicaid managed care services agreement or the managed care policy manual.
[8.308.21.9 NMAC - Rp, 8.308.21.9 NMAC, 5/1/2018]

8.308.21.10 DISEASE MANAGEMENT: The MCO will have a disease management program as described

in the medicaid managed care services agreement or the managed care policy manual.
[8.308.21.10 NMAC - Rp, 8.308.21.10 NMAC, 5/1/2018]

8.308.21.11 CLINICAL PRACTICE GUIDELINES: As described in the medicaid managed care services agreement or the managed care policy manual, the MCO will have a process to adopt, review, update and disseminate evidence-based clinical practice guidelines, practice parameters, consensus statements, and specific criteria for the provision of acute and chronic physical and behavioral health care services.
[8.308.21.11 NMAC - Rp, 8.308.21.11 NMAC, 5/1/2018]

8.308.21.12 PERFORMANCE IMPROVEMENT: The MCO will implement performance assessment and improvement activities as described in the medicaid managed care services agreement or the managed care policy manual.
[8.308.21.12 NMAC - Rp, 8.308.21.12 NMAC, 5/1/2018]

8.308.21.13 INCIDENT MANAGEMENT: Critical incident reporting and management is considered part of ongoing quality management. Critical incident reporting and analysis of critical incident data helps to identify causes of adverse events in critical care and areas of focus for implementation of preventative strategies.

A. MCO incident management principles: The implementation of incident management practices and effective incident reporting processes as described in the medicaid managed care services agreement or the managed care policy manual are based on the following MAD MCO principles:

- (1) a member is expected to receive home and community based services free of abuse, neglect, and exploitation;
- (2) training addresses the response to and the report of to include the documentation of a critical incident;
- (3) a member, his or her authorized representative will receive information on his or her MCO incident reporting process; and
- (4) good faith incident reporting of or the allegation of abuse, neglect or exploitation is free from any form of retaliation.

B. Reportable incidents:

- (1) The MCO shall ensure that any person having reasonable cause to believe an incapacitated adult member is being abused, neglected, or exploited must immediately report that information.
- (2) The MCO shall develop and provide training covering the MCO's procedures for reporting a critical incident to all subcontracted individual providers, provider agencies, and its members who are receiving self-directed services, to include his or her employees.
- (3) The MCO shall comply with all statewide reporting requirements for any incident involving a member receiving a MAD covered home and community based service.
- (4) A community agency providing home and community based services is required to report critical incident involving a MCO member, including:
 - (a) the abuse of him or her;
 - (b) the neglect of him or her;
 - (c) the exploitation of him or her;
 - (d) any incident involving his or her utilization of emergency services;
 - (e) the hospitalization of him or her;
 - (f) his or her involvement with law enforcement;
 - (g) his or her exposure to or the potential of exposure to environmental hazards that compromise his or her health and safety; and
 - (h) the death of the member.

- (5) The MCO shall provide, coordinate, or both, intervention and shall follow up upon the receipt of an incident report that demonstrates the health and safety of its member is in jeopardy.

[8.308.21.13 NMAC - Rp, 8.308.21.13 NMAC, 5/1/2018]

8.308.21.14 EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO): An EQRO will conduct independent reviews of the MCO's external quality review (EQR) activities as detailed in the medicaid managed care services agreement or the managed care policy manual.

A. The MCO shall fully cooperate with the following mandatory EQRO activities, such as:

- (1) the validation of required performance improvement projects (PIP) as detailed in the

medicaid managed care services agreement or the managed care policy manual;

(2) the validation of plan performance measures reported by the MCO as defined in the medicaid managed care services agreement or the managed care policy manual;

(3) a review to determine the MCOs' compliance with state standards for access to care, structure and operations, and QM and QI requirements; and

(4) the validation of network adequacy.

B. The MCO shall fully cooperate with the following EQRO optional activities:

(1) the validation of encounter data reported by the MCO;

(2) the administration or validation of member and provider surveys on the quality of care;

(3) the calculation of additional performance measures;

(4) conducting additional PIPs validations;

(5) conducting studies on quality focused on a particular aspect of clinical or nonclinical services at a specific point in time;

(6) assist with the quality rating of MCOs; and

(7) all other optional activities as deemed appropriate.

C. The EQRO may, at the direction of MAD, provide technical guidance to the MCO to assist in conducting activities related to mandatory and optional EQR activities.

[8.308.21.14 NMAC - Rp, 8.308.21.14 NMAC, 5/1/2018]

8.308.21.15 QUALITY MANAGEMENT COMMITTEE: The MCO must have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to its members. A QM committee will provide oversight to quality monitoring and improvement activities, including safety review and the assignment of accountability.

A. Quality review:

(1) The MCO shall establish a review committee to act as the leadership body for QI activities. The review committee acts to identify and facilitate the accomplishment of a planned, systematic, valid, and valuable QM plan for members and its providers.

(2) The review committee will monitor key services delivered to members and associated supportive processes to include:

(a) the utilization of services;

(b) its member satisfaction;

(c) its clinical services, including disease management; and

(d) its administrative services.

(3) The review committee is authorized to take action upon issues related to member care and make recommendations related to contracts, compensation, and provider participation.

B. Critical incident review:

(1) The MCO shall establish a review committee to review events that result in a serious and undesired consequence; events that are not a result of an underlying health condition or from a risk inherent in providing health services, including:

(a) death;

(b) disability; and

(c) injury or harm to the member.

(2) The committee is authorized to make recommendations for the prevention from future harm of its members, as well as its system process improvement.

C. Oversight: The MCO will provide HSD with reports and records to ensure compliance with quality review and critical incident review requirements as detailed in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.15 NMAC - Rp, 8.308.21.15 NMAC, 5/1/2018]

8.308.21.16 MEDICAL RECORDS: The member's medical records, as described in the medicaid managed care services agreement or the managed care policy manual, shall be legible, timely, current, detailed and organized to permit effective and confidential patient care and quality reviews. The MCO shall:

A. have medical record confidentiality policies and procedures and medical record documentation standards for its providers and subcontractors;

B. have a process to review medical records to ensure compliance with MCO policy, procedures and standards;

- C. cooperate with the EQRO in its review of medical records to ensure compliance with its medical record policy and standards;
 - D. provide HSD or its designee access to a member's medical and behavioral health records;
 - E. include provisions in contracts with providers for MCO and HSD or its designee, access to member medical records for the purposes of compliance or quality review;
 - F. ensure that the assigned primary care provider (PCP), the patient centered medical home or the patient centered health home maintain a primary medical and as appropriate, behavioral health record for each member; this record must contain sufficient information from each provider involved in the member's care to ensure continuity of care;
 - G. ensure all providers involved in the member's care have access to the primary medical record; and
 - H. have policies and processes that ensure the confidential transfer of medical and behavioral health information between its providers, its agencies or other health plans.
- [8.308.21.16 NMAC - Rp, 8.308.21.16 NMAC, 5/1/2018]

8.308.21.17 UTILIZATION MANAGEMENT: A utilization management (UM) program is an organization-wide, interdisciplinary approach of evaluating the medical necessity, appropriateness, and efficiency of health care services. The MCO shall have an UM program as described in the medicaid managed care agreement services or the managed care policy manual.

[8.308.21.17 NMAC - Rp, 8.308.21.17 NMAC, 5/1/2018]

8.308.21.18 ADVISORY BOARDS: Advisory boards are federally mandated bodies that provide ongoing venues for discussions of policy, operations, service delivery and administrative issues for its members. The MCO will convene and facilitate an advisory board of its members and a native American advisory board in accordance with the requirements described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.18 NMAC - Rp, 8.308.21.18 NMAC, 5/1/2018]

8.308.21.19 SATISFACTION SURVEYS: For the MCO to maintain a comprehensive system of health care that supports quality, as well as cost-effectiveness depends largely on the satisfaction and cooperation of its members and its providers. The MCO will regularly survey these groups following the requirements described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.19 NMAC - Rp, 8.308.21.19 NMAC, 5/1/2018]

HISTORY OF 8.308.21 NMAC: [RESERVED]

History of Repealed Material:

8.308.21 NMAC - Managed Care Program, Quality Management, filed 12/17/2013 Repealed effective 5/1/2018.