Date: April 6, 2017

To: Christina Barden, Program Operations Director
Provider: UNM Medically Fragile Case Management
Address: 2300 Menaul NE
State/Zip: Albuquerque, New Mexico 87107

E-mail Address: cbarden@salud.unm.edu

CC: Maggie Nechvatal, Case Manager
E-Mail Address: mnechvatal@salud.unm.edu

CC: Marcia Moriarta, Executive Director
E-Mail Address mmoriarta@salud.unm.edu

Region: Statewide
Survey Date: February 27 – March 6, 2017
Program Surveyed: Medically Fragile Waiver

Service Surveyed: Medically Fragile Waiver Case Management

Survey Type: Routine

Team Leader: Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau

Team Members: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Iris Clevenger, BSN, RN, CCM, MA, Medically Fragile Waiver Program Manager, Developmental Disabilities Supports Division

Dear Ms. Barden:

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Medically Fragile Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider contracts. Upon receipt of this letter and report of findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

During the exit interview of your on-site survey an explanation of the Plan of Correction Process was provided to you. Please refer to Attachment A for specific instruction on completing your Plan of Correction. At a minimum, your Plan of Correction should address the following for each Tag cited:

Corrective Action:

- How is the deficiency going to be corrected? (i.e., obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done? (i.e., file reviews, periodic check with checklist, etc.)
- How many individuals is this going to affect? (i.e., percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e., weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position)
- What steps will be taken if issues are found? (i.e., retraining, requesting documents, filing RORI, etc.)

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

2. **Developmental Disabilities Supports Division, Attention: Medically Fragile Waiver Program Manager**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG
Program Integrity Unit
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or if using UPS, FedEx, DHL (courier mail) send to physical address at:

Attention: *Lisa Medina-Lujan*
HSD/OIG
Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator, Amanda Castaneda, at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Crystal Lopez-Beck, BA

Crystal Lopez-Beck, BA
Team Lead/Deputy Bureau Chief
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

On-site Entrance Conference Date:	February 27, 2017	
Present:	**UNM Medically Fragile Case Management** Christina Barden, MFCMP Program Operations Director Maggie Nechvatal, MFCMP Case Manager **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Deputy Bureau Chief Kandis Gomez, AA, Healthcare Surveyor Lora Norby, Healthcare Surveyor **DDSD – Clinical Services Bureau** Iris Clevenger, Medically Fragile Waiver Program Manager	
Exit Conference Date:	March 2, 2017	
Present:	**UNM Medically Fragile Case Management** Christina Barden, MFCMP Program Operations Director Maggie Nechvatal, MFCMP Case Manager Roxanne Archuleta, MFCMP Office Manager **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Deputy Bureau Chief Lora Norby, Healthcare Surveyor **DDSD – Clinical Services Bureau** Iris Clevenger, Medically Fragile Waiver Program Manager	
Administrative Locations Visited Number:	Number	1
Total Sample Size	Number:	16
Persons Served Records Reviewed	Number:	16
Recipient/Family Members Interviewed	Number:	10 (Surveyors were unable to contact 6 recipient/family members)
Case Managers Interviewed	Number:	11
Case Mgt Personnel Records Reviewed	Number:	14 (2 Administrative Personnel interviewed also provide services as Case Managers)
Administrative Personnel Interviewed	Number:	2

Administrative Files Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Individual Medical and Program Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medical Emergency Response Plans
    - Therapy Evaluations and Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information
- Internal Incident Management System Process

- Personnel Files
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Quality Assurance / Improvement Plan

CC Distribution List: Department Health Improvement (DHI) - File
Developmental Disabilities Support Division (DDSD)
Medical Fragile Program Director
Human Services Department (HSD)

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

Instructions for Completing Agency POC:

Required Content
Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: **Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda E. Castaneda, POC Coordinator in any of the following ways:
    a. Electronically at AmandaE.Castaneda@state.nm.us *(preferred method)*
    b. Fax to 575-528-5019, or
    c. Mail to POC Coordinator, 1170 N. Solano Suite D, Las Cruces, NM 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.

7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a ***maximum*** of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
    a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    b. Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment C

Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "Administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at crystal.lopez-beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The written request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not received within 10 business days of receiving the report and/or does not include all supporting documentation or evidence to show compliance with the standards and regulations.

The IRF Committee will review the request, the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF com

Agency: **UNM Medically Fragile Case Management - Statewide**
Program: Medically Fragile Waiver
Service: Medically Fragile Waiver Case Management
Monitoring Type: Routine Survey
Survey Dates: **February 27 – March 6, 2017**

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Agency Record Requirements:			
TAG # MF05 Documentation Requirements – Agency Case Files			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS** **I. <u>PROVIDER REQUIREMENTS:</u>** L. Provider Agency Case File for the Waiver Participant: 1. All provider agencies shall maintain at the administrative office a confidential case file for each individual that includes all the following elements: a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: 1.) Consumer 2.) Primary caregiver 3.) Family/relatives, guardians or conservators 4.) Significant friends 5.) Physician 6.) Case manager 7.) Provider agencies 8.) Pharmacy b. Individual's health plan, if appropriate c. Individual's current ISP d. Progress notes and other service delivery documentation	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 16 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Other Individual Specific Evaluations:** • **Nutritional Evaluation** • Individual #9 – Per the Individual's approved budget, the individual receives nutritional supports. No evidence of evaluation found.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

e. A medical history that shall include at least: demographic data; current and past medical diagnoses including the cause of the medically fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environmental, medications); immunizations; and most recent physical exam. f. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. M. Documentation: 1. Provider agencies shall maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. 2. The documentation of the billable time spent with an individual shall be kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record shall contain at least the following information: a. Date and start and end time of each service encounter or other billable service interval. b. A description of what occurred during the encounter or service interval. c. Signature and title of staff providing the service verifying that the service and time are correct. 3. All records pertaining to services provided to an individual shall be maintained for at least six (6) years from the date of creation.			

TAG # MF15 Scope of Services – Contents of the ISP			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS** **D. IDT Meeting and ISP Development and Budget Development (MAD 046 form):** 14. The ISP will include the following: a. Basic information includes at a minimum: the participant's name, address, phone number, date of birth, original identification number, parent/guardian information, insurance information, race/ethnicity, primary language, primary diagnosis, ISP cycle and date of the IDT/ISP meeting to develop the plan. b. A list of IDT members that includes both waiver and non-waiver providers with the following information: I. Name of team member, including the CM name II. Title III. Business location iv. Frequency of visits v. Phone number vi. Email address, if possible vii. Funding source c. Present levels of functioning to include diagnosis, strengths and needs. d. IDT members will discuss and enumerate issues, strengths and needs for the participant and family, and strategies that will be used to address them. e. The ISP outcome is a statement of change that the participant/participant representative wants to achieve. These include individualized goals and objectives and care activities/strategies for each service delivered. These are based on reasonable and measurable outcomes for the participant. f. The participant/participant representative shall have the opportunity to generate outcomes. Team members may assist the	Based on record review, the Agency did not ensure Case Managers developed Individual Specific Plans which were person centered and met all requirements as required by standard for 16 of 16 Individuals. The following was found with regards to the ISP: • **ISP did not include a list of IDT members (both waiver and non-waiver) with all required information:** ◦ Did not include the title, business address, phone number and/or email address of all IDT Members (#13) • **ISP Outcomes:** ◦ ISP outcome statement was not accompanied by a description of the methods, strategies and activities used to work towards the outcomes, timelines, criteria for measuring process and the person(s) responsible (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

participant/participant representative to identify goals/outcomes and support their choices. g. Each ISP outcome statement shall be accompanied by a description of the methods, strategies and activities used to work towards the outcome, timelines, criteria for measuring progress and person(s) responsible. The participant/participant representative and other medical team members (i.e., PCP and medical specialists) will prioritize the concerns involved in providing services. h. An ISP statement for services and supports necessary to achieve the outcomes. The listing of services ai1d supports shall include the frequency, duration, location, intensity (group or individual), method of delivery, and applicable payment information. Services and supports not funded by the MFW shall also be included.			

TAG #MF 1A28.2 Incident Mgt. System-Parent / Guardian Training			
7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	Based on record review and interview, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 15 of 16 individuals. **Review of the Agency individual case files revealed the following items were not found and/or not current:** • Parent/Guardian Incident Management Orientation (Abuse, Neglect and Exploitation) (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16) **When the receipt/family member was asked if they had access to telephone numbers and Incident Reporting procedures for Abuse, Neglect and Exploitation, the following was reported:** • The recipient/family member for Individual #4 stated, "No." • The recipient/family member for Individual #5 stated, "No." • The recipient/family member for Individual #8 stated, "I don't think so." • The recipient/family member for Individual #9 stated, "I would google it." • The recipient/family member for Individual #15 stated, "No."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag# MF10 Primary Freedom of Choice (PFOC)			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 C. Eligibility Determination and LOC/Funding: 1. After allocation, the Case Management Agency will complete the initial eligibility determination and approved ISP/MAD 046 form budget within 90 days from the date the Department of Health (DOH) receives the primary freedom of choice (PFOC). If unable to complete this process, the Case Management Agency will submit a Client Information Update (CIU) with the reason why the process cannot be completed.	Based on record review, the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 2 of 16 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Primary Freedom of Choice (#9, 16)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

TAG # MF60 Assessment Activities			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 C. Eligibility Determination and LOC/Funding: 1. After allocation, the Case Management Agency will complete the initial eligibility determination and approved ISP/MAD 046 form budget within 90 days from the date the Department of Health (DOH) receives the primary freedom of choice (PFOC). If unable to complete this process, the Case Management Agency will submit a Client Information Update (CIU) with the reason why the process cannot be completed. 2. The CM will meet with participant/participant representative to review and explain the MFW services, State Medicaid services at1d identify community resources. The family will be given a Medically Fragile Family Handbook to assist in reinforcing this information. 3. The CM will assist the participant/participant representative to set up the required appointment with the primary care provider (PCP) for a history and physical (H&P) that will be submitted as part of the LOC packet for prior authorization. The initial H&P must have been completed within 90 days of submission and must have been completed within 12 months of the annual. LOC process. 4. Eligibility and LOC is determined by the CM and PCP. (The MFW parameters are used to make this determination.) Refer to the MFW Eligibility Training Manual for details. The LOC determines the funding resources available to the participant based	Based on record review, the Agency did not complete and compile the elements of the Long-Term Care Assessment Abstract (LTCAA) packet for 1 of 16 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Level of Care (#12) • Client Individual Assessment (CIA) (#12)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

on needs identified in the ISP during the LOC/ISP cycle. 5.The CM completes an assessment utilizing the MFW parameters and other appropriate resources and writes the Comprehensive Individualized Assessment-Family Centered Review (CIA/FCR). 6. The CM completes the DOH 378 form, the Long Term Care Assessment Abstract (LTCAA) form, applying the MFW parameters, the MFW Eligibility Training Manual, the CIA/FCR and the H&P. 7.The LOC packets consist of the following: a. CIA/FCR b. LTCAA form c. PCP's H&P d. CIU for extensions e. Other supporting medical documents as needed 8. The PCP is sent the LOC packet to review. The PCP must sign and date the LTCAA form, stating that the PCP has seen and evaluated the participant and recommends the LOC. 9. Financial eligibility determination is the responsibility of the Income Support Division (ISD) specialist at the local ISD field office. The CM will help manage the participant's eligibility appointment with ISD and establish communication with the relevant ISD specialist to assist as needed. 10. After the PCP has reviewed, signed and dated the LTCAA form, the complete LOC packet is sent to the Medicaid Third Party Assessor (TPA) for prior authorizations. 11. When the Medicaid TPA approves the LTCAA form, the participant is then deemed to meet the eligibility criteria for MFW and the LOC funding. The ISD specialist then needs to deem the participant financially eligible.			

12. The approved LTCAA form is forwarded to the! SD office to be included in financial eligibility determination. 13. The participant is funded for services based on LOC and age: For those participants, less than 21 years of age: a. $25, 000/year (regardless of assessed LOC) For those participants age 21 years and older: b. Adult Level I -- $70,000 c. Adult Level II -- $60,000 d. Adult Level III -- $48,000 **NMAC Title 8 Social Services Chapter 290** 8.290.400.14 REPORTING REQUIREMENTS: A Medicaid applicant/recipient, case manager, direct service provider and/or any other responsible party must report any changes in circumstances which may affect the applicant's/recipient's eligibility within ten (10) days of the date of the change to the county Income Support Division (ISD) office. These changes include but are not limited to: changes in income, resources, living arrangements, or marital status. The ISD worker must evaluate the effect of the change and take any required action as soon as possible; however, the action must take effect no later than the end of the month following the month in which the change took place. [2/1/95; 8.290.400.14 NMAC - Rn, 8 NMAC 4.WAV.450 & A; 5/1/02; A,11/1/07]			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Administrative Requirements:			
TAG # MF04 **Policy and Procedure Requirements**			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS** I. Provider Requirements A. The Medicaid Medically Fragile Home and Community Based Services Waiver requires providers to meet any pertinent laws, regulations, rules, policies and interpretive memoranda published by the New Mexico Department of Health (DOH) and HSD. B. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities' Supports Division (DDSD) Provider Enrollment Unit process. Reference: http://nmhealth.org/ddsd/providerinformation/ProviderEnrollmentApplicationPage.htm C. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. D. All provider agencies that enter into a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. Reference: http://dhi.health.state.nm.us/ E. Provider Agency Report of Changes in Operations: 1. The provider agency shall notify the DOH in writing of any changes in the disclosures required in this section within ten (10) calendar days. This notice shall include information and documentation regarding such changes as the following:	Based on record review, the Agency did not develop and implement written policies and procedures that comply with all DDSD Standards. **Review of Agency policies & procedures found no evidence of the following:** • Policy and Procedure for Cultural Sensitivity	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

any change in the mailing address of the provider agency, and any change in executive director, administrator and classification of any services provided. F. Program Flexibility: 1. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with these standards, then prior written approval from the DOH shall be obtained. Such approval shall provide for the terms and conditions under which the waiver of specific standard(s) is/are granted. The applicant or provider agency is required to submit a written request and attach substantiating evidence supporting the request to DOH. DOH will only approve requests that remain consistent with the current federally approved MFW application. G. Continuous Quality Management System: 1. On an annual basis, MFW provider agencies shall update and implement the request, the agency will submit a summary of each year's quality improvement activities and resolutions to the MFW Program Manager. H. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed. I. Appropriate planning shall take place with all Interdisciplinary Team (IDT) members, Medicaid SALUD provider, other waiver providers and school services to facilitate a smooth transition from the MFW program. The participant's individual choices shall be			

given consideration when possible. DOH policies must be adhered to during this process as per the provider's contract. J. All provider agencies, in addition to requirements under each specific service standard, shall at a minimum develop, implement and maintain at the designated provider agency main office, documentation of policies and procedures for the following: 1. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. 2. Response to the individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. 3. Agency protocols for disaster planning and emergency preparedness. **CASE MANAGEMENT** **III. Case Management Agency Requirements** **C. Administrative Requirements** 1. The Case Management Agency must comply with all applicable Federal, State and waiver regulations, policies and procedures regarding case management code of ethics. 2. The Case Management Agency will have an established method of information and data collection. 3. The Case Management Agency will comply with all Federal, State, DOH and Human Services Department (HSD) regulations, policies and procedures including but not limited to: a. Policies and procedures related to timely submission of medical eligibility determination. b. Policies and procedures related to service provision and appropriate supervision. c. Policies and procedures related to case management training. d. Policies and procedures related to reimbursement of case management services. e. Establish and maintain written grievance procedures.			

TAG # MF14 Creation of the ISP & IDT Meetings			

New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) CASE MANAGEMENT effective 01/01/2011
 	
D. IDT Meeting and ISP Development and Budget Development (MAD 046 form):
1. The participant/participant representative will have the opportunity to be involved in all aspects of the ISP.
2. The purpose of the IDT meetings is to develop the ISP, review effectiveness of the ISP and revise the ISP.
3. In preparation for an IDT meeting, the CM will offer the participant/participant representative a menu of waiver services as appropriate and will document selected services.
4. The IDT will be comprised of the participant/participant representative, the PCP and all MFW providers and external providers. The MFW providers are expected to attend ISP meetings and all others are encouraged to attend.
5. The participant/participant representative will choose a provider from the MFW secondary freedom of choice (SFOC) list. Each service listed on the MAD 046 form has a separate SFOC.
9. The CM will facilitate the IDT meeting. The CM will contact team members at least two (2) weeks prior to the scheduled IDT meeting with date, time, location and purpose of the IDT meeting. This notification may be by phone, written or electronic communication. Documentation of phone, written or electronic communication. Documentation of phone, written or electronic notification will be maintained in the participant's CM file. The CM will also notify IDT members of cancellations and changes of the IDT meeting.
	Based on record review, the Agency did not contact and convene the IDT to discuss and/or modify the ISP and/or address significant changes as required by regulation 2 of 16 individuals.
	
	Review of documentation found no evidence of the following:
	
	• **ISP Signature sheet to verify IDT members were in attendance:**
	
	  • None Found for ISP held on 1/18/2016 (Individual #3).
	
	  • None found for 6-month review held on 9/15/2016 (Individual #5).
	
	• **Evidence that IDT members (*direct care providers and others*) were notified of IDT Meetings at least two weeks in advance:**
	
	  • No evidence found to verify members of the IDT were notified 2 weeks prior to the IDT Meeting held on 9/15/2016 (Individual #5).
		Provider:
		State your Plan of Correction for the deficiencies cited in this tag here *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →
		
		Provider:
		Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

10. The CM is responsible for the ISP signature sheet at the IDT meeting. The date, begin and end time of the IDT meeting will be written on the signature sheet by the CM. 11. The ISP signature sheet will be attached to the participant's ISP and distributed to the IDT with the ISP package. Team members who participate in the IDT by phone will be indicated on the signature sheet in lieu of an actual signature. 12. The original copy of the ISP will be maintained at the participant's CM agency file. 13. It is the responsibility of each IDT member to request additional documents from the CM. 15. The provider agencies will submit to the CM all service plan(s) within 10 working days following the initial IDT meeting and when revised. 16. The CM will complete the ISP within 15 working days following the IDT meeting. 17. The CM will submit the completed Waiver Review Form (MAD 046 form), commonly known as the budget, based on the decisions of the IDT meeting. 18. Each service requested on the MAD 046 form must have a corresponding care activity/strategy in the ISP. 19. Provider agencies must be present at the IDT meeting or provide their input to the CM or designee before the IDT meeting. The CM or designee will contact the provider following the meeting to update on changes. 20. The signed SFOC form for each service provider must be maintained in the participant's CM file. 21. It is the joint responsibility of the CM, provider agency and participant/participant representative to monitor the MAD 046 form's maximum dollar amount allocated per LOC and ISP cycle to assure the budget does not exceed approved LOC. 22. The ISP packet is submitted to the Medicaid TPA for prior authorization. The ISP packet is comprised of the following:			

a. ISP with all corresponding care activity/strategy. b. MAD 046 form. c. Signature sheet of IDT meeting. d. CIU, if necessary. 23. The applicant of the MFW will be able to begin receiving services only after the Medically Fragile eligibility, funding LOC and financial eligibility have been approved, and the applicant is eligible to receive Medicaid services. 24. The LOC and ISP cycle dates do not change for the participant. If for any reason the LOC, ISP or MAD 046 form are unable to be completed prior to the end of the cycle, the MFW Program Manager or designee must approve the extension of services. The Case Management Agency will submit a CIU form requesting specific dates to be extended for LOC, ISP or MAD o46 form with rationale. E. Re-Admits 1. When the participant has been hospitalized for more than 3 overnights, a "Readmit" LTCAA form must be submitted. 2. The CM will be notified in multiple ways when a participant has been hospitalized, e.g. by family, Home Health Agency, and hospital notifications. 3. The CM will contact the hospital to obtain necessary information to complete a readmit LTCAA form. 4. The CM and the hospital CM and/or Discharge Planner and the hospital physician will communicate via phone or electronically about the LTCAA form to be submitted to Medicaid TPA. 5. The CM will prepare the fax transmittal form that includes: a. Readmit LTCAA form (to include the doctor's electronic signature). b. Hospital name. c. Admission date. d. Discharge date. e. Reason for admission.			

6. The packet of information will be submitted to the Medicaid TPA for approval of readmit to the MFW within 10 calendar days of notification of discharge. 7. If the readmit process does not occur within the designated timeframe, the MFW eligibility and LOC/budget process must be initiated again.			

TAG # MF19 Case Management Monitoring			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) CASE MANAGEMENT effective 01/01/2011 II. Case Management Monitoring A. The CM will monitor the effectiveness of services provided to the participant as identified through the ISP, written reports, contacts and coordination of services. B. The CM will have monthly contact with the participant/participant family. 1. Face-to-face visits with the participant must occur at least every other month or more often. 2. The CM will have a telephone conference with participant and/or family on the months that a face-to-face visit is not done. 3. Monthly contacts must have supporting documentation by the CM that reflects active implementation of the ISP. 4. At the face-to-face visits with the participant, health, safety and welfare are monitored. Face-to-face visits and phone contacts must have supporting documentation by the CM indicating the participant or family were actively involved in the input of strategies and decisions involving the coordination of participant services 5. When the participant is unable to participate and provide input regarding needs, effectiveness of ISP, or health and safety needs, the CM will clearly and concisely document in the monthly CM's contact notes that the participant was unable to directly convey his/her needs and the reasons why. The participant representative will provide information regarding the effectiveness of the ISP, health and safety measures implemented, and additional needs of the participant.	Based on record review, the Agency did not use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the Individual for 6 of 16 individuals. **Review of the Agency individual case files revealed no evidence of Case Manager Monthly Case Notes for the following:** • Individual #4 - None found for 8/2016 & 10/2016. • Individual #8 - None found for 7/2016. **Review of the Agency individual case files revealed no evidence indicating face-to-face visits were completed as required for the following individuals:** ◦ Individual #2 – No Documentation of Face to Face Visit found for September 2016 & January 2017. **Review of the Agency individual case files revealed face-to-face visits were not being completed as required by standard for the following individuals:** Individual #8 • No home visit was noted between 4/2016 - 6/2016. ◦ 4/07/2016 – Phone Contact ◦ 5/27/2016 – Phone Contact ◦ 6/30/2016 – Phone Contact	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

6. The CM and the Home Health Agency are required monthly to discuss nursing and home health aide services. This will be documented in CM contact notes. The discussion and notes will reflect the implementation of the nursing and home health aide plans, review budget utilization and review family needs for support by Home Health Agency personnel. C. The CM will comply with all policies and procedures regarding utilization review, including professional documentation standards. D. The CM will review with the participant/participant representative the services identified in the ISP and perceived effectiveness of each service. E. The CM will have ongoing contacts with the waiver providers to review quality, effectiveness of the services and progress toward the ISP goals. F. The CM will identify and resolve know situations that may be harmful or deemed potentially dangerous to the participant and/or others. G. The CM, in conjunction with participant/participant representative, will identify problems with providers. The specific problems will be reported to the provider agency for resolution. The CM may need to participate in the resolution of the problem. H. The CM will monitor the timeliness of the services delivered. I. The CM will report child and adult abuse, neglect and exploitation to the designated State agencies per State and Federal regulations.	Individual #11 • No home visit was noted between 6/2016 - 8/2016. ◦ 6/29/2016 – Phone Contact ◦ 7/14/2016 – Phone Contact ◦ 8/30/2016 – Phone Contact Individual #12 • No home visit was noted between 7/2016 & 8/2016. ◦ 7/28/2016 – Phone Contact ◦ 8/24/2016 – Phone Contact **Review of the Agency individual case files revealed no evidence of monthly contact between the Case Manager and direct service provider or documentation of why no contact was made for the following:** • Individual #13 - None found for 10/2016 & 11/2016.		

TAG #MF 1A28 Incident Mgt. System			
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **D. Incident policies:** All community-based service providers shall maintain policies and procedures which describe the community-based service provider's immediate response, including development of an immediate action and safety plan acceptable to the division where appropriate, to all allegations of incidents involving abuse, neglect, or exploitation, suspicious injury as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC. **E. Retaliation:** Any person, including but not limited to an employee, volunteer, consultant, contractor, consumer, or their family members, guardian, and another provider who, without false intent, reports an incident or makes an allegation of abuse, neglect, or exploitation shall be free of any form of retaliation such as termination of contract or employment, nor may they be disciplined or discriminated against in any manner including, but not limited to, demotion, shift change, pay cuts, reduction in hours, room change, service reduction, or in any other manner without justifiable reason. **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written	Based on record review and interview, the Agency did not establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. **During on-site survey, the following was found:** • The agency had not updated their Incident Management Policy/System to be consistent with the July 2014 NMAC 7.1.14. **When asked if the Agency had established policies and procedures regarding incident management, the following was reported:** • #200 stated, "We do have policy and procedures on Incident Management, but I was unaware the requirements for incident reporting had changed."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Medicaid Billing/Reimbursement:			
TAG #MF 1A12 All Services Reimbursement (No Deficiencies)			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **Case Management** **IV. REIMBURSEMENT** Each Case Management Agency is responsible for providing clinical documentation that identifies case management components of the provision of the ISP services, including assessment information, care planning, intervention, communications, care coordination and evaluation. There may be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of contacts. All services must be reflected in the ISP that is coordinated with the participant/participant representative and other caregiver as applicable. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. a. Payment for case management services through this Medicaid Waiver is considered payment in full. b. The case management services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items. c. All billed services must not exceed the capped dollar amount for LOC. d. Reimbursement for case management services will be based on the current rate allowed for the service. e. The Case Management Agency must follow all current billing requirements by the HSD and DOH for CM services. f. The Case Management Agency has the responsibility to review and assure that the information on the MAD 046 form for their service is current. If an error is identified, the Case Management Agency will work with the Medicaid TPA to correct the MAD 046 form. g. The MFW Program does not consider the following to be case management duties and will not authorized payment for: 1. Performing specific errands for the participant/participant representative or family that is not program specific. 2. "Friendly visiting," meaning visits with the participant outside of the work scheduled. 3. Financial brokerage services, handling participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities. 7. Other non-Medicaid reimbursable activities. Billing for Case Management services was reviewed for 16 of 16 individuals. *Progress notes and billing records supported billing activities for the months of October, November and December 2016.*			

Date: June 20, 2017

To: Christina Barden, Program Operations Director
Provider: UNM Medically Fragile Case Management
Address: 2300 Menaul NE
State/Zip: Albuquerque, New Mexico 87107

E-mail Address: cbarden@salud.unm.edu

CC: Maggie Nechvatal, Case Manager
E-Mail Address: mnechvatal@salud.unm.edu

CC: Marcia Moriarta, Executive Director
E-Mail Address mmoriarta@salud.unm.edu

Region: Statewide
Survey Date: February 27 – March 6, 2017
Program Surveyed: Medically Fragile Waiver

Service Surveyed: Medically Fragile Waiver Case Management

Survey Type: Routine

Dear Ms. Barden:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.17.3.MF.D0676.1/2/3/4/5.RTN.09.17.171