Date:	January 17, 2020
To:	Tanya Baker-McCue, Director
Provider:	UNM - Center for Development and Disability
Address:	2300 Menaul Blvd. NE
State/Zip:	Albuquerque, New Mexico 87113
E-mail Address:	tbaker-mccue@salud.unm.edu
CC:	Janelle Groover, Program Manager
E-Mail Address	jtorresgroover@salud.unm.edu
Region:	Statewide
Survey Date:	January 3 – 8, 2020
Program Surveyed:	Mi Via Waiver
Service Surveyed:	Mi Via Consultation Services
Survey Type:	Routine
Team Leader:	Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Valerie V. Valdez, MS, Bureau Chief, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau

Dear Ms. Baker-McCue and Ms. Groover;

The Division of Health Improvement/Quality Management Bureau Mi Via Survey Unit has completed a compliance survey of your agency. 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 Mi Via 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 agreements. 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 Attachment A on 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 effect? (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 available space on the two right-hand 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: Monica Valdez, Plan of Correction Coordinator 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108**

2. **Developmental Disabilities Supports Division Attention: Mi Via Program Manager 5301 Central Ave. NE Suite 200 Albuquerque, NM 87108**

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" claim 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
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)
OR
Jennifer Goble (Jennifer.goble2@state.nm.us)

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust 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, Monica Valdez at 505-273-1930 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,

Lora Norby

Lora Norby
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 3, 2020
Contact:	**UNM - Center for Development and Disability** Ms. Tanya Baker-McCue, Director **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	January 6, 2020
Present:	**UNM - Center for Development and Disability** Tanya Baker-McCue, Director Janelle Groover, Program Manager / Consultant **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor Valerie V. Valdez, MS, Bureau Chief Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator
Exit Conference Date:	January 8, 2020
Present:	**UNM - Center for Development and Disability** Tanya Baker-McCue, Director Janelle Groover, Program Manager / Consultant **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor Valerie V. Valdez, MS, Bureau Chief Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator **DDSD – Mi Via Unit** Rudy Aguilera, Project Coordinator (via phone) Elaine Hill, Program Coordinator (via phone)
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 21
Participant Records Reviewed	Number: 21
Consultant Staff Records Reviewed	Number: 5

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Participant Program Case Files
- Personnel Files
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry

- Quality Assurance / Improvement Plan

CC: Distribution List:

DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General

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 DDSD Regional Office for purposes of contract management or 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 505-273-1930 or email at MonicaE.Valdez@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 cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, 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 following details should be considered when developing your Plan of Correction:

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

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 those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site 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 to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (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 must 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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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 Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
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 documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm

(Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may 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.

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 Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
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: https://nmhealth.org/about/dhi/cbp/irf/
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, Valerie V. Valdez at valerie.valdez@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 committee.

Agency:	**UNM - Center for Development and Disability – Statewide**
Program:	Mi Via Waiver
Service:	Consultant Services
Survey Type:	Routine Survey
Survey Date:	**January 3 – 8, 2020**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Date Due
Agency Record Requirements:			
TAG #MV 108 Primary Agency Case File			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 Appendix A: Service Descriptions in Detail 2015 Waiver Renewal **<u>Ongoing Consultant Services:</u> V. Administrative Requirements: G.** The consultant provider shall maintain HIPAA compliant primary records for each participant including, but not limited to: 1. Current and historical SSPs and budgets; 2. Contact log that documents all communication with the participant; 3. Completed/signed monthly and quarterly visit form(s); 4. TPA documentation of approvals/denials, including budgets and requests for additional funding; 5. TPA correspondence; (requests for additional information; requests for additional funding, etc);	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 21 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: **Employer of Record Questionnaire:** • Not Current (#16) • Incomplete (#15)	**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. Assessor's individual specific health and safety recommendations; 7. Notifications of medical and financial eligibility; 8. Approved Long Term Care Assessment Abstract with level of care determination and Individual Budgetary Allotment from the TPA; 9. Budget utilization reports from the FMA; 10. Environmental modification approvals/denials; 11. Legally Responsible Individual (LRI) approvals/denials; 12. Documentation of participant and employee training on reporting abuse, neglect and exploitation, suspicious injuries, environmental hazards and death; 13. Copy of legal guardianship or representative papers and other pertinent legal designations; and 14. Copy of the approval form for the personal representative. 15. Primary Freedom of Choice form (PFOC) and/or, Waiver Change Form (WCF) and/or Consultant Agency Change Form (CAC) as applicable. **NMAC 8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA:** C. Consultant pre-eligibility and enrollment services: Consultant pre-eligibility			

and enrollment services are intended to provide information, support, guidance, and assistance to an individual during the Medicaid financial and medical eligibility process. The level of support provided is based upon the unique needs of the individual. When an opportunity to be considered for mi via program services is offered to an individual, he or she must complete a primary freedom of choice form. The purpose of this form is for the individual to select a consultant provider. The chosen consultant provider offers pre-eligibility and enrollment services as well as on-going consultant services. Once the individual is determined to be eligible for mi via services, the consultant service provider will continue to render consultant services to the newly enrolled eligible recipient as set forth in the consultant service standards.			

TAG # MV 111 Consultant Submission Requirements			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 Appendix A: Service Descriptions in Detail 2015 Waiver Renewal Consultant/Support Guide <u>Pre-Eligibility/Enrollment Services</u> II. Scope of Service B. The actual enrollment meeting should be conducted within 30 days of receiving the PFOC. The enrollment process and activities include but are not limited to: 12. Ensure the completion and submission of the initial SSP within sixty (60) days of eligibility determination so that it can be in effect within ninety (90) days. **IV. Reimbursement**: **D**. It is the State's expectation that consultants will work with the participant to ensure that an approved service and support plan (SSP) is in effect within ninety (90) days of the start of Medicaid eligibility. Any exceptions to this timeframe must be approved by the State. The consultant will submit an explanation of why the plan could not be effective within the 90 day timeline. Approval must be obtained in writing from the DOH Mi Via Program Manager or their designate for any plan not in effect ninety (90) days after eligibility is approved, prior to billing for that service. **<u>Ongoing Consultant Services:</u> II. Scope of Service: A.** Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:	Based on record review, the Agency did not submit required documentation in a timely manner as required by Standard for 2 of 21 participants. Review of the Agency's participant case files revealed the following were not found, incomplete, and/or submitted past required timelines: **Evidence SSP goals and budget were submitted online for TPA review at least 30 calendar days prior to the expiration of current plan:** • Individual # 5 – SSP Expiration 10/31/2019; Submitted 10/3/2019. • Individual # 11 – SSP Expiration 8/31/2019; Submitted 8/6/2019.	**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?)*: →	

11. Ensure the completion and submission of the annual SSP to the Third Party Assessor (TPA) at least thirty (30) days prior to the expiration of the plan so that sufficient time is afforded for TPA review. 23. Assist participants to transition from and to other waiver programs. Transition from one waiver to another can only occur at the first of the month. The DOH will review the LOC expiration date prior to or upon receipt of the Waiver Change Form (WCF). If a participant is within ninety (90) days of the expiration of the LOC, the DOH Regional Office or appropriate program manager will advise the participant they must wait until the LOC is approved before initiating the transfer. (Please refer to Mi Via Waiver Transition procedures for further details). 24. It is the State's expectation that consultants will work with participants transferring from another waiver to ensure that an approved services and supports plan (SSP) is in effect within ninety (90) days of the waiver change. Any exceptions to this timeframe must be approved by the State. Approval must be obtained in writing from the DOH Mi Via Program Manager or their designate for any plan not in effect within ninety (90) days of the waiver change. The consultant request must contain an explanation of why the ninety (90) day timeline could not be met. **IX. Reimbursement: D.** It is the State's expectation that consultants will work with participants transferring from another waiver to ensure that an approved services and supports plan (SSP) is in effect within ninety (90) days of a waiver change. Consultants must obtain approval in writing from the DOH Mi Via Program			

Manager or their designate for any transfers occurring over the ninety (90) day timeframe.			
TAG #MV 4.6 On-going Consultant Functions			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **<u>Ongoing Consultant Services</u>** **II. Scope of Service** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall: 5. Educate the participant regarding Mi Via covered and non-covered supports, services and goods. 6. Review the Mi Via Service Standards with the participant and either provide a copy of the Standards or assist the participant to access the Mi Via Service Standards online. 7. Assist the participant to identify resources outside the Mi Via Program that may assist in meeting their needs. 10. Complete and submit revisions, requests for additional funding and justification for payment above the range of rates as needed, in the format as prescribed by the state, which includes the use of a FOCoSonline. No more than one revision is allowed to be submitted at any given time. 12. Provide a copy of the final approved SSP and budget documents to participants.	Based on record review, the Agency did not maintain evidence of completing ongoing consultation services as required by Standard for 1 of 21 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Evidence the Participant received a completed / approved copy of their SSP (#15)	**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?)*: →	

13. Provide a copy of TPA Assessments to the participant upon their request. 14. Assist the participant with the application for LRI as employee process; submit the application to the DOH. 16. Assist the participant to identify and resolve issues related to the implementation of the SSP. 17. Serve as an advocate for the participant, as needed, to enhance his/her opportunity to be successful with self-direction. 18. Assist the participant with reconsiderations of goods or services denied by the Third party Assessor (TPA), submit documentation as required, and participate in Fair Hearings as requested by the participant or state. 19. Assist the participant with required quality assurance activities to ensure implementation of the participant's SSP and utilization of the authorized budget. 20. Assist participants to identify measures to help them assess the quality of their services/supports/goods and self-direct their quality improvement process. 21. Assist the participant to assure their chosen service providers are adhering to the Mi Via Service Standards as applicable. 22. Assist participants to transition to another consultant provider when requested. Transitions should occur within thirty (30) days of request on the Consultant Agency Change (CAC) form, but may occur sooner based on the needs of the participant.			

Transition from one consultant provider to another can only occur at the first of the month. (Please refer to Mi Via Consultant Agency Transfer procedures for details). 26. Provide support guide services which are more intensive supports that help participants more effectively self-direct services based upon their needs. The amount and type of support needed must be specified in the SSP and is reviewed quarterly. All new Mi Via participants are required to receive the level of support outlined in this section, based upon need, for the first three months of program participation. Support guide services include, but are not limited to the following: a. Providing education related to how to use the Mi Via program and provide information on program changes or updates as part of the overall information sharing; b. Assisting in implementing the SSP to ensure access to goods, services, supports and to enhance success with self-direction; c. Assisting with employer/vendor functions such as recruiting, hiring and supervising workers; establishing and documenting job descriptions for direct supports; completing forms related to employees or vendors, approving/processing timesheets and purchase orders or invoices for goods, obtaining quotes for goods and services as well as identifying and negotiating with vendors; d. Assisting participants with problem solving employee and vendor payment			

issues with the FMA and or other relevant parties; e. Assisting the participant in arranging for participant specific training of the participant's employee(s)/service provider(s) in circumstances where the participant is unable to provide the training; f. Ensuring the participant's requirements for training of employee(s)/ service provider(s) are documented in the SSP and outlined in the job description; g. Assisting the participant to identify and access other resources for training employee(s)/service provider(s), if applicable; h. Assisting the participant to identify local community resources, activities and services, and help the participant identify how they will access these resources, if applicable; and i. Assisting the participant in managing the service plan budget to include reviewing budget expenditures; preparing and submitting budgets and revisions.			

TAG #MV 150 Contact Requirements			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **Pre-Eligibility/Enrollment Services** **III. Contact Requirements:** Consultant providers shall make contact with the participant at least monthly for follow up on eligibility and enrollment activities. This contact can either be face-to-face or by telephone. During the pre-eligibility phase, at least one (1) face to face visit is required to ensure participants are completing the paperwork for medical and financial eligibility, and to provide additional assistance as necessary. Consultants should provide as much support as necessary to assist with these processes. **Ongoing Consultant Services** **III. Contact Requirements:** Consultant providers shall make contact with the participant at least monthly for a routine follow up. This contact can either be face to face or by telephone. If support guide services are provided, contact may be more frequent as identified in the SSP. The monthly contacts are for the following purposes: 1. Review the participant's access to services and whether they were furnished per the SSP; 2. Review the participant's exercise of free choice of provider; 3. Review whether services are meeting the participant's needs;	Based on record review, the Agency did not make contact with the participants as required by Standard and Regulations for 7 of 21 participants. Review of the Agency's participant case files found no evidence of contacts for the following: **Ongoing Contacts:** • **Monthly Contacts:** ○ Individual #9 ▪ None found for 8/2019. ○ Individual #10 ▪ None found for 10/2019. ○ Individual #15 ▪ None found for 5/2019. ○ Individual #17 ▪ None found for 11/2019. ○ Individual #18 ▪ None found for 2/2019 and 4/2019. ○ Individual #20 ▪ None found for 4/2019 - 5/2019. • **Quarterly Contacts:** ○ Individual #10 ▪ Documentation for *quarterly contact* on 8/30/2019 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #14	**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?)*: →	

4. Review whether the participant is receiving access to non-waiver services as outlined in the SSP; 5. Review activities conducted by the support guide, if utilized; 6. Follow up on complaints against service providers; 7. Document change in status; 8. Monitor the use and effectiveness of the emergency back up plan; 9. Document and provide follow up (if needed) if challenging events occurred; 10. Assess for suspected abuse, neglect or exploitation and report accordingly, if not reported, take remedial action to ensure correct reporting; 11. Documents progress on any time sensitive activities outlined in the SSP; 12. Determines if health and safety issues are being addressed appropriately; 13. Discuss budget utilization and any concerns; Consultant providers shall meet in person with the participant at a minimum of quarterly. At least one visit per year must be in the participant's residence. If support guide services are provided, contact may be more frequent as identified in the SSP. The quarterly visits are for the following purposes: 1. Review and document progress on implementation of the SSP; 2. Document any usage and the effectiveness of the twenty-four (24) hour Emergency Backup Plan; 3. Review SSP/budget spending patterns (over and under utilization); 4. Assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP	▪ Documentation for *quarterly contact* on 11/1/2019 did not contain the following required element: ➢ The location of contact with the eligible recipient.		

and any applicable Mi Via service standards; 5. Document the participant's access to related goods identified in the SSP; 6. Review any incidents or events that have impacted the participant's health and welfare or ability to fully access and utilize support as identified in the SSP; and 7. Identify other concerns or challenges, including but not limited to complaints, eligibility issues, health and safety issues as noted by the participant and/or representative. **NMAC 8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA** **C. Consultant services:** Consultant services are required for all mi via eligible recipients to educate, guide, and assist the eligible recipients to make informed planning decisions about services and supports. The consultant helps the eligible recipient develop the SSP based on his or her assessed needs. The consultant assists the eligible recipient with implementation and quality assurance related to the SSP and AAB. Consultant services help the eligible recipient identify supports, services and goods that meet his or her needs, meet the mi via requirements and are covered mi via services. Consultant services provide support to eligible recipients to maximize their ability to self-direct their mi via services. 1) **Contact requirements:** Consultant providers shall make contact with the eligible recipient in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet face-to-face with the eligible recipient at least quarterly;			

one visit must be conducted in the eligible recipient's home at least annually. During monthly contact the consultant: (a) reviews the eligible recipient's access to services and whether they were furnished per the SSP; (b) reviews the eligible recipient's exercise of free choice of provider; (c) reviews whether services are meeting the eligible recipient's needs; (d) reviews whether the eligible recipient is receiving access to non-waiver services per the SSP; (e) reviews activities conducted by the support guide, if utilized; (f) documents changes in status; (g) monitors the use and effectiveness of the emergency back-up plan; (h) documents and provides follow up, if necessary, if challenging events occur that prevent the implementation of the SSP; (i) assesses for suspected abuse, neglect, or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting; (j) documents progress of any time sensitive activities outlined in the SSP; (k) determines if health and safety issues are being addressed appropriately; and			

(l) discusses budget utilization concerns. 2) Quarterly visits will be conducted for the following purposes: (a) review and document progress on implementation of the SSP; (b) document usage and effectiveness of the emergency backup plan; (c) review SSP and budget spending patterns (over and under-utilization); (d) assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP and any applicable sections of the mi via rules and service standards; (e) document the eligible recipient's access to related goods identified in the SSP; (f) review any incidents or events that have impacted the eligible recipient's health, welfare or ability to fully access and utilize support as identified in the SSP; and (g) other concerns or challenges, including but not limited to complaints, eligibility issues, and health and safety issues, raised by the eligible recipient, authorized representative or personal representative.			

Standard of Care	**Deficiencies**	**Agency Plan of Correction, On-going QA/QI, Responsible Party**	**Date Due**
Agency Personnel Requirements:			
TAG #MV 1A25 Caregiver Criminal History Screening			
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **(1)** In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in	Based on record review, the Agency did not maintain documentation in the employee's personnel records indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 5 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #201 – Date of hire 7/1/2019.	**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?)*: →	

the department's notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime. **(2)** An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the applicant's, caregiver's or hospital caregiver's temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9. **(3)** The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall			

then follow the procedure of Subsection A, of Section 7.1.9.9. **B. Employment Pending Reconsideration Determination:** At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide <u>Ongoing Consultant Services:</u> V. Administrative Requirements** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall: 6. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.			

Standard of Care	**Deficiencies**	**Agency Plan of Correction, On-going QA/QI, Responsible Party**	**Date Due**
Medicaid Billing/Reimbursement:			
Tag MV #4A1 Consultant Services Reimbursement			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 Appendix A: Service Descriptions in Detail 2015 Waiver Renewal Consultant/Support Guide <u>Pre-Eligibility/Enrollment Services</u> IV. Reimbursement A. Consultant pre-eligibility/enrollment services shall be reimbursed based upon a per- member/per-month unit: 1. A maximum of one (1) unit per month can be billed per each participant receiving consultant services in the pre-eligibility phase for a period not to exceed three (3) months; 2. Provider records must be sufficiently detailed to substantiate the nature, quality, and amount of consultant pre-eligibility/enrollment services provided and be in compliance with the Medicaid documentation policy NMAC 8.302.1; and 3. Consultant providers shall submit all consultant pre-eligibility/enrollment services billing through the Human Services Department (HSD) or as determined by the State.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed, which contained the required information for 2 of 21 individuals. Individual #10 October 2019 • The Agency billed a total of 1 unit of Consultant Services (T2025) for 10/1 – 31, 2019 on 11/11/2019. No documentation was found to justify 1 unit billed. Individual #17 November 2019 • The Agency billed a total of 1 unit of Consultant Services (T2025) for 11/1 – 30, 2019 on 12/9/2019. No documentation was found to justify 1 unit billed.	**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?)*: →	

B. Consultants must obtain approval in writing from the DOH Mi Via Program Manager or their designate for any pre-eligibility phase exceeding the ninety (90) day timeframe for any participant. The consultant will submit an explanation of why the pre-eligibility phase has exceeded the 90 day timeline. C. It is the State's expectation that consultants will work with the participant to ensure that an approved service and support plan (SSP) is in effect within ninety (90) days of the start of Medicaid eligibility. Any exceptions to this timeframe must be approved by the State. The consultant will submit an explanation of why the plan could not be effective within the 90 day timeline. Approval must be obtained in writing from the DOH Mi Via Program Manager or their designate for any plan not in effect ninety (90) days after eligibility is approved, prior to billing for that service. D. Non-billable consultant services include: 1. Services furnished to an individual who does not reside in New Mexico; 2. Participation by the consultant provider in any educational courses or training; 3. Outreach activities, including contacts with persons potentially eligible for the Mi Via Program; 4. Consultant services furnished to an individual who is in an institution (e.g., ICF/IID, nursing facility, hospital) or is			

incarcerated, except for discharge planning services in accordance with MAD Supplement No. 01-22; and 5. Services furnished to an individual who does not have a current allocation to the Mi Via Waiver. **Ongoing Consultant Services** **IX. Reimbursement** A. Consultant services shall be reimbursed based upon a per-member/per-month unit. **1.** There is a maximum of twelve (12) billing units per participant per SSP year. **2.** A maximum of one unit per month can be billed per each participant receiving consultant services. B. Provider records must be sufficiently detailed to substantiate the nature, quality, and amount of consultant services provided. Months for which no documentation is found to support the billing submitted shall be subject to non-payment or recoupment by the state. C. The consultant provider/agency shall provide the level of support required by the participant and a minimum of four (4) face to face quarterly visits per SSP year. One of the quarterly meetings must include the development of the annual SSP and assistance with the LOC assessment. D. It is the State's expectation that consultants will work with participants transferring from another waiver to ensure			

that an approved services and supports plan (SSP) is in effect within ninety (90) days of a waiver change. Consultants must obtain approval in writing from the DOH Mi Via Program Manager or their designate for any transfers occurring over the ninety (90) day timeframe. E. Consultant providers shall submit all billing through the Mi Via FMA as determined by the State. F. Non-Billable services Include: 1. Services furnished to an individual who does not reside in New Mexico. 2. Services furnished to an individual who is not eligible for the Mi Via Program. 3. Participation by the Consultant/Support Guide in any educational courses or training. 4. Outreach activities, including contacts with persons potentially eligible for the Mi Via Program. 5. Consultant services furnished to an individual who is in an institution (e.g., ICF/IID, nursing facility, hospital) or is incarcerated, except for discharge planning services in accordance with MAD Supplement No. 01-22			

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: March 12, 2020

To: Tanya Baker-McCue, Director
Provider: UNM - Center for Development and Disability
Address: 2300 Menaul Blvd. NE
State/Zip: Albuquerque, New Mexico 87113

E-mail Address: tbaker-mccue@salud.unm.edu

CC: Janelle Groover, Program Manager
E-Mail Address jtorresgroover@salud.unm.edu

Region: Statewide
Survey Date: January 3 – 8, 2020
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultation Services

Survey Type: Routine

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.

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,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.3.MVW.18076823.1/2/3/4/5.RTN.11.20.072