NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Cabinet Secretary

Date: October 20, 2021

To: Sandy Skaar, Director/Owner

Provider: Self Directed Choices, LLC.
Address: 3909 Juan Tabo Blvd NE STE 2
State/Zip: Albuquerque New Mexico 87111

E-mail Address: Sandy@sdchoices.com

Region: Statewide
Survey Date: September 20 - 30, 2021
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultant Services

Survey Type: Routine

Dear Ms. Skaar:

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 of 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.22.1.Mi Via.09285211.1.2.3.4.5.RTN.02.21.293

Date:	October 8, 2021
To:	Sandy Skaar, Director/Owner
Provider:	Self Directed Choices, LLC.
Address:	3909 Juan Tabo Blvd NE STE 2
State/Zip:	Albuquerque New Mexico 87111
E-mail Address:	Sandy@sdchoices.com
Region:	Statewide
Survey Date:	September 20 - 30, 2021
Program Surveyed:	Mi Via Waiver
Service Surveyed:	Mi Via Consultant Services
Survey Type:	Routine
Team Leader:	Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Kayla R. Benally, BSW, Healthcare Surveyor, 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. Skaar;

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.

The attached QMB Report of Findings indicates deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as deficiencies:

- Tag # MV130 Service and Support Plan Development Process
- Tag # MV150 Contact Requirements

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site 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.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (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 for Current Citation:

- 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**
   MonicaE.Valdez@state.nm.us

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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)

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:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

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 contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us 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:	September 20, 2021
Contact:	**Self-Directed Choices, LLC** Sandy Skaar, Director/Owner Jacob Patterson, Program Manager/Consultant **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	September 20, 2021
Present:	**Self-Directed Choices, LLC** Sandy Skaar, Director/Owner Jacob Patterson, Program Manager/Consultant Elizabeth Novar, Quality Assurance and Compliance Manager Evonne Romero, Statewide Trainer/Admin Supervisor/Consultant **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor, Kayla R. Benally, BSW, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator
Exit Conference Date:	September 30, 2021
Present:	**Self-Directed Choices, LLC** Sandy Skaar, Director/Owner Jacob Patterson, Program Manager/Consultant Evonne Romero, Statewide Trainer/Admin Supervisor/Consultant **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Kayla R. Benally, BSW, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator **DDSD - Mi Via Unit** Rudy Aguilera, Mi Via Project Coordinator
Administrative Locations Visited	0 *(Note: No administrative locations visited due to COVID- 19 Public Health Emergency.)*
Total Sample Size	30 0 - *Jackson* Class Members 30 - Non-*Jackson* Class Members
Participant Records Reviewed	30
Participants Interviewed	4 *(Note: Interviews conducted by phone due to COVID- 19 Public Health Emergency)*

Consultant Staff Records Reviewed	13
Consultant Staff Interviewed	13 *(Note: Interviews conducted by phone due to COVID- 19 Public Health Emergency)*
Administrative Interviews	1 *(Note: Interviews conducted by phone due to COVID- 19 Public Health Emergency)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records
- 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 completion 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: **Self-Directed Choices, LLC – Statewide Region**
Program: Mi Via Waiver
Service: Consultant Services
Survey Type: Routine
Survey Date: **September 20 – 30, 2021**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
Tag # MV130 Service and Support Plan Development Process			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **6. Planning and Budgeting for Services and Goods** **A. Service and Support Plan Development Processes** The Service and Support Plan (SSP) development process starts with person-centered planning. This process obtains information about the participant's strengths, capacities, preferences desired outcomes and risk factors. In person-centered planning, the SSP must revolve around the individual participant and reflect his or her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the planning process is for the participant to achieve a meaningful life in the community, as defined by the participant. Upon eligibility for the Mi Via Waiver and choosing his/her consultant, each participant shall receive an IBA and information and training from the consultant about covered/non- covered Mi Via services and the requirements for the content of the SSP. The participant is the leader in the development of the SSP. The participant will take the lead or be encouraged and supported	Based on record review Consultant providers did not ensure all requirements of Service and Support Plan (SSP) development were followed as indicated by Standards for 6 of 30 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: **SSP did not contain a completed backup plan section with all mandatory elements as applicable:** • Did not list the Legal Guardian and / or Power of Attorney in the required section of the Emergency Backup plan. (#13, 16, 17, 18, 19 & 29)	**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?)*: →	

to take the lead to the best of their abilities to direct development of the SSP. The participant may involve, if he/she so desires, family members or other individuals, including service workers or providers, in the planning process. Mi Via program covered services include personal plan facilitation, which supports planning activities that may be used by the participant to develop his/her SSP as well as identify other sources of support outside the SSP process. This service is available to participants one (1) time per SSP/budget year. **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. **<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: 8. Ensure that the SSP for each participant includes the following: a. The services and supports, covered by the Mi Via program, to address the needs of the participant as determined			

through an assessment and person-centered planning process; b. The purposes for the requested services, expected outcomes, and methods for monitoring progress must be specifically identified and addressed; c. The twenty-four (24) hour emergency backup plan for services that affect health and safety of participants; and d. The quality indicators, identified by the participant, for the services and supports provided through the Mi Via Program. 9. Ensure that the SSP is submitted in the appropriate format as prescribed by the state which includes the use of FOCoSonline. 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. 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. **Appendix B: Service and Support Plan (SSP) Template**			

Tag # MV150 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 1 of 30 participants. Review of the Agency's participant case files found no evidence of contacts for the following: **Ongoing Contacts:** **Quarterly Contacts:** Individual #13: • Documentation for *quarterly contact* on 6/4/2021 did not contain the following required element: ➢ The time of contact with the eligible recipient.	**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 backup 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 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: D. 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,			

(g) welfare or ability to fully access and utilize support as identified in the SSP; and 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	Completion Date
Medicaid Billing/Reimbursement:			
Tag # MV1A12 All Services Reimbursement	**No Deficient Practices Found**		
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. **<u>Ongoing Consultant Services:</u> 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.	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving for 30 of 30 individuals. *Contact notes and billing records supported billing activities for the months of June, July and August 2021.*		

2. A maximum of one unit per month can be billed per each participant receiving consultant services.			