

Date: July 20, 2022

To: Roxanne Burgos, Service Coordinator / Deputy Director

Provider: Best Buddies International, Inc.  
Address: 3507 Wyoming Blvd. NE, Suite A  
State/Zip: Albuquerque, New Mexico 87111

E-mail Address: [RoxanneBurgos@bestbuddies.org](mailto:RoxanneBurgos@bestbuddies.org)

Region: Metro  
Survey Date: June 17 - 30, 2022

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Community Integrated Employment Services

Survey Type: Routine

Team Leader: Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jorge Enriquez Sanchez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Roxanne Burgos;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities 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 Division of Health Improvement, Quality Management Bureau has determined your agency is in:

**Compliance:** This determination is based on your agency's compliance with all Condition of Participation level and Standard level requirements. No deficiencies were identified during your survey and no plan of correction is required. Thank you for your cooperation with the survey process and for helping to provide for the health, safety and personal growth of the Individuals you serve.

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: [MonicaE.Valdez@state.nm.us](mailto: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.

**DIVISION OF HEALTH IMPROVEMENT**

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(505) 222-8623 • FAX: (505) 470-4797 • <https://nmhealth.org/about/dhi>

QMB Report of Findings – Best Buddies International, Inc. – Metro – June 17 - 30, 2022

Survey Report #: Q.22.4.DDW.12923541.5.RTN.01.22.201



Sincerely,

*Beverly Estrada, ADN*

Beverly Estrada, ADN  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Administrative Review Start Date:	June 17, 2022
Contact:	<b><u>Best Buddies International, Inc.</u></b> Roxanne Burgos, Service Coordinator / Deputy Director  <b><u>DOH/DHI/QMB</u></b> Beverly Estrada, ADN, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	June 21, 2022
Present:	<b><u>Best Buddies International, Inc.</u></b> Roxanne Burgos, Service Coordinator / Deputy Director Andrea Mikelsen, Manager of Job Development / DSP Elizabeth Nelson, Employment Consultant / DSP  <b><u>DOH/DHI/QMB</u></b> Beverly Estrada, ADN, Team Lead/Healthcare Surveyor Lora Norby, Healthcare Surveyor Jorge Enriquez-Sanchez, BS, Healthcare Surveyor
Exit Conference Date:	June 30, 2022
Present:	<b><u>Best Buddies International, Inc.</u></b> Roxanne Burgos, Service Coordinator / Deputy Director Andrea Mikelsen, Manager of Job Development / DSP Elizabeth Nelson, Employment Consultant / DSP  <b><u>DOH/DHI/QMB</u></b> Beverly Estrada, ADN, Team Lead/Healthcare Surveyor Amanda Castaneda Holguin, MPA, Healthcare Surveyor Supervisor Lora Norby, Healthcare Surveyor Jorge Enriquez-Sanchez, BS, Healthcare Surveyor  <b><u>DDSD - Metro Regional Office</u></b> Anne Montoya, Community Inclusion Coordinator Jaclyn Sanchez, Community Inclusion Coordinator
Total Sample Size:	3  0 - <i>Jackson</i> Class Members 3 - <i>Non-Jackson</i> Class Members  3 - Community Integrated Employment
Persons Served Records Reviewed	3
Persons Served Observed	1
Persons Served Not Seen and/or Not Available	2 ( <i>Note: 2 individuals were not available during the on-site survey</i> )
Direct Support Personnel Records Reviewed	2
Direct Support Personnel Interviewed	1
Service Coordinator Records Reviewed	1

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Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- 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  
NM Attorney General's Office  
DOH – Internal Review Committee (when needed)

## Attachment B

### Department of Health, Division of Health Improvement QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

#### Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

***Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:***

***Service Domain: Service Plan: ISP Implementation - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.***

**Potential Condition of Participation Level Tags, if compliance is below 85%:**

- **1A08.3** – Administrative Case File: Individual Service Plan / ISP Components
- **1A32** – Administrative Case File: Individual Service Plan Implementation
- **LS14** – Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14** – CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

***Service Domain: Qualified Providers - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.***

**Potential Condition of Participation Level Tags, if compliance is below 85%:**

- **1A20** - Direct Support Personnel Training
- **1A22** - Agency Personnel Competency
- **1A37** – Individual Specific Training

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**Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):**

- 1A25.1 – Caregiver Criminal History Screening
- 1A26.1 – Consolidated On-line Registry Employee Abuse Registry

**Service Domain: Health, Welfare and Safety** - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

**Potential Condition of Participation Level Tags, if compliance is below 85%:**

- 1A08.2 – Administrative Case File: Healthcare Requirements & Follow-up
- 1A09 – Medication Delivery Routine Medication Administration
- 1A09.1 – Medication Delivery PRN Medication Administration
- 1A15.2 – Administrative Case File: Healthcare Documentation (Therap and Required Plans)

**Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):**

- 1A05 – General Requirements / Agency Policy and Procedure Requirements
- 1A07 – Social Security Income (SSI) Payments
- 1A09.2 – Medication Delivery Nurse Approval for PRN Medication
- 1A15 – Healthcare Coordination - Nurse Availability / Knowledge
- 1A31 – Client Rights/Human Rights
- LS25.1 – Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

## QMB Determinations of Compliance

### **Compliance:**

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

### **Partial-Compliance with Standard Level Tags:**

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

### **Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:**

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

### **Non-Compliance:**

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag.
2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Total Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
<b>“Non-Compliance”</b>						17 or more Total Tags with 75 to 100% of the Individuals in the sample cited in any CoP Level tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
<b>“Partial Compliance with Standard Level tags and Condition of Participation Level Tags”</b>					Any Amount Standard Level Tags, plus 1 to 5 Conditions of Participation Level tags.		
<b>“Partial Compliance with Standard Level tags”</b>			up to 16 Standard Level Tags with 75 to 100% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 50 to 74% of the individuals in the sample cited any tag.			
<b>“Compliance”</b>	Up to 16 Standard Level Tags with 0 to 74% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 0 to 49% of the individuals in the sample cited in any tag.					

**Agency:** Best Buddies International, Inc. - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Integrated Employment Services  
**Survey Type:** Routine  
**Survey Date:** June 17 - 30, 2022

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
<b>Service Domain: Medicaid Billing/Reimbursement</b> – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
<b>Tag #1A12 All Services Reimbursement</b>	<b>No Deficient Practices Found</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p><b>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:</b> DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.</li> <li>2. Comprehensive documentation of direct service delivery must include, at a minimum:             <ol style="list-style-type: none"> <li>a. the agency name;</li> <li>b. the name of the recipient of the service;</li> <li>c. the location of the service;</li> <li>d. the date of the service;</li> <li>e. the type of service;</li> <li>f. the start and end times of the service;</li> <li>g. the signature and title of each staff member who documents their time; and</li> <li>h. the nature of services.</li> </ol> </li> <li>3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed</li> </ol>	<p>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 services for 3 of 3 individuals.</p> <p><i>Progress notes and billing records supported billing activities for the months of March, April and May 2022 for the following services:</i></p> <ul style="list-style-type: none"> <li>• Community Integrated Employment Services</li> </ul>		

regarding settlement of any claim, whichever is longer.

4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

- a. treatment or care of any eligible recipient;
- b. services or goods provided to any eligible recipient;
- c. amounts paid by MAD on behalf of any eligible recipient; and
- d. any records required by MAD for the administration of Medicaid.

**21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.

**21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following:

- 1. A day is considered 24 hours from midnight to midnight.
- 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.
- 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.
- 4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows:
  - a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%).
  - b. The receiving Provider Agency bills the

remaining days up to 340 for the ISP year.

**21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following:

1. A month is considered a period of 30 calendar days.
2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed.
3. Monthly units can be prorated by a half unit.
4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit.

**21.9.3 Requirements for 15-minute and hourly units:** For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:

1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2.
2. Services that last in their entirety less than eight minutes cannot be billed.

**NMAC 8.302.1.17 Effective Date 9-15-08  
Record Keeping and Documentation**

**Requirements** - A provider must maintain 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 or who has received services in the past.

**Detail Required in Records** - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed,

<p>diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.</p> <p><b>Services Billed by Units of Time -</b>  Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.</p> <p><b>Records Retention -</b> A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:</p> <ul style="list-style-type: none"> <li>(1) treatment or care of any eligible recipient</li> <li>(2) services or goods provided to any eligible recipient</li> <li>(3) amounts paid by MAD on behalf of any eligible recipient; and</li> <li>(4) any records required by MAD for the administration of Medicaid.</li> </ul>			
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