

Date: December 28, 2017

To: David Murley, Executive Director / Consultant
Provider: AAA Participant Direction
Address: 4300 Silver SE, Suite B
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: dmaaapd@gmail.com

Region: Statewide
Survey Date: November 3 - 9, 2017
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultation Services

Survey Type: Routine

Team Leader: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Valerie Valdez, MS, Bureau Chief, Division of Health Improvement/Quality Management Bureau;
Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau;
Michele Beck, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Murley;

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.

DIVISION OF HEALTH IMPROVEMENT
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – AAA Participant Direction – Statewide – November 3 - 9, 2017

Survey Report #: Q.18.2.MIVIA.68289758.1/2/3/4/5.RTN.01.17.362



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 space on the right-hand column 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: Plan of Correction Coordinator
1170 North Solano Suite D Las Cruces, NM 88001

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

Upon notification 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.

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

Sincerely,

Kandis Gomez, AA

Kandis Gomez, AA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date: November 3, 2017

Contact: **AAA Participant Direction**
David Murley, Executive Director/Consultant

DOH/DHI/QMB
Kandis Gomez, AA, Team Lead/Healthcare Surveyor

Entrance Conference Date: November 6, 2017

Present: **AAA Participant Direction**
David Murley, Executive Director/Consultant

DOH/DHI/QMB
Kandis Gomez, AA, Team Lead/Healthcare Surveyor
Valerie Valdez, MS, Bureau Chief
Crystal Lopez-Beck, BA, Deputy Bureau Chief
Michele Beck, Healthcare Surveyor

Exit Conference Date: November 9, 2017

Present: **AAA Participant Direction**
David Murley, Executive Director/Consultant
Paul Kline, Consultant
Jessica Sisneros, Consultant
Vanessa Gutierrez, Consultant
Alicia Sisneros, Consultant

DOH/DHI/QMB
Kandis Gomez, AA, Team Lead/Healthcare Surveyor
Valerie Valdez, MS, Bureau Chief
Crystal Lopez-Beck, BA, Deputy Bureau Chief
Michele Beck, Healthcare Surveyor

Administrative Locations Visited	Number:	1
Total Sample Size	Number:	30
Participant Records Reviewed	Number:	30
Consultant Staff Records Reviewed	Number:	15

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 Internal Review Committee [IRC] for possible actions or sanctions).

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

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

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

Instructions for Completing Agency POC:

Required Content

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

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

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

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

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

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, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
 - a. Electronically at AmandaE.Castaneda@state.nm.us (*preferred method*)
 - b. Fax to 575-528-5019, or
 - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
 - a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
 - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
 - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
 - e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).

3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

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

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: AAA Participant Direction – Statewide Region Program: Mi Via Waiver Service: Consultant Services Monitoring Type: Routine Survey Survey Date: November 3 – 9, 2017			
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: <ol style="list-style-type: none"> 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 	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 9 of 30 participants.</p> <p>Review of the Agency’s participant case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Guardianship Documents (#2, 20, 26, 29) • Employer of Record Questionnaire (#2, 9, 17, 20, 21, 26, 27, 28) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>additional information; requests for additional funding, etc);</p> <ol style="list-style-type: none"> 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. <p>NMAC 8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA:</p> <p>C. Consultant pre-eligibility and enrollment</p>			
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<p>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.</p>			
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TAG # MV110 Initial Contact			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Pre-Eligibility/Enrollment Services</u></p> <p>II. Scope of Service</p> <p>Consultant pre-eligibility/enrollment services are delivered in accordance with the individual's identified needs. Based upon those needs, the consultant provider selected by the individual shall:</p> <p>A. Assign a consultant and contact the individual within five (5) working days after receiving the PFOC to schedule an initial orientation and enrollment meeting;</p> <p><u>Ongoing Consultant Services</u></p> <p>II. Scope of Service</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <p>1. Schedule participant enrollment meetings within five (5) working days of receipt of a Waiver Change Form (WCF) for participants transitioning from another waiver. The actual enrollment meeting should be conducted within thirty (30) days. Enrollment activities include but are not limited to:</p>	<p>Based on record review, the Agency did not maintain evidence that initial contact was made and processes were followed as indicated by Standards and Regulations for 1 of 30 participants.</p> <p>Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> Evidence an enrollment/orientation meeting was scheduled within 5 working days of receipt of the Waiver Change Form (WCF). (#1) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<ul style="list-style-type: none"> a. General program overview including key agencies and contact information; b. Discuss eligibility requirements and offer assistance in completing these requirements as needed; c. Discuss participant roles and responsibilities form; d. Discuss Employer of Record (EOR) including discussion and possible identification of an EOR and completion of the EOR information form; e. Review the processes for hiring employees and contractors and required paperwork; f. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees; g. Discuss the background check and other credentialing requirements for employees and contractors; h. Referral for accessing training for FOCOsonline; and to obtain information on the Financial Management Agency (FMA); i. Provide information on the service and support plan including Mi Via covered and non-covered goods and services, planning tools and available 			
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<p>community resources;</p> <p>j. For those participants transitioning from other waivers, a transition meeting including the transfer of program information must occur prior to the SSP meeting; and</p> <p>k. Schedule the date for the SSP meeting within ten (10) working days of the enrollment meeting.</p>			
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<p>paperwork;</p> <ol style="list-style-type: none"> 6. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees; 7. Discuss the background check and other credentialing requirements for employees and contractors; 8. Provide training to participants related to recognizing and reporting critical incidents. Critical incidents include: abuse, neglect, exploitation, suspicious injury or any participant death and environmentally hazardous conditions which create an immediate threat to life or health. This participant training shall also include reporting procedures for employees, participants/participant representatives, EORs and other designated individuals. (Please refer to 7.1.14 NMAC for requirements). 9. Discuss the process for accessing training for the Mi Via Plan of Care online system (FOCoS<i>online</i>); and to obtain information on the Financial Management Agency (FMA); and 10. Provide information on the service and support plan (SSP) including covered and non-covered goods and services, planning tools and community resources available and assist with the development of the SSP. 11. Reviews 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. 			
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<p>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.</p> <p><u>Ongoing Consultant Services</u></p> <p>II. Scope of Service</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <p>1. Schedule participant enrollment meetings within five (5) working days of receipt of a Waiver Change Form (WCF) for participants transitioning from another waiver. The actual enrollment meeting should be conducted within thirty (30) days. Enrollment activities include but are not limited to:</p> <ul style="list-style-type: none"> a. General program overview including key agencies and contact information; b. Discuss eligibility requirements and offer assistance in completing these requirements as needed; c. Discuss participant roles and responsibilities form; d. Discuss Employer of Record (EOR) including discussion and possible identification of an EOR and completion of the EOR information 			
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<p>form;</p> <ul style="list-style-type: none"> e. Review the processes for hiring employees and contractors and required paperwork; f. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees; g. Discuss the background check and other credentialing requirements for employees and contractors; h. Referral for accessing training for FOCOsonline; and to obtain information on the Financial Management Agency (FMA); i. Provide information on the service and support plan including Mi Via covered and non-covered goods and services, planning tools and available community resources; j. For those participants transitioning from other waivers, a transition meeting including the transfer of program information must occur prior to the SSP meeting; and k. Schedule the date for the SSP meeting within ten (10) working days of the enrollment meeting. 			
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TAG # MV 111 Consultant Submission Requirements			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Pre-Eligibility/Enrollment Services</u></p> <p>II. Scope of Service</p> <p>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:</p> <p>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.</p> <p>IV. Reimbursement</p> <p>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.</p> <p><u>Ongoing Consultant Services</u></p> <p>II. Scope of Service</p> <p>A. Consultant services and supports are</p>	<p>Based on record review, the Agency did not submit required documentation in a timely manner has required by Standard for 7 of 30 participants.</p> <p>Review of the Agency's participant case files revealed the following were not found, incomplete, and/or submitted past required timelines:</p> <ul style="list-style-type: none"> • Evidence SSP goals and budget were submitted online for TPA review at least 30 calendar days prior to the expiration of current plan. (#2, 7, 13, 19, 21, 28) • Exception form for pre-eligibility phases that exceeded 90 days. (#3) • Exception form for SSP not in effect within 90 days of program eligibility. (#3) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>IX. Reimbursement</p>			
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<p>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.</p>			
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TAG #MV 112 Approvals and Assessments			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Pre-Eligibility/Enrollment Services</u> II. Scope of Service</p> <p>C. Consultants will inform, support, and assist as necessary with the requirements for establishing Level of Care (LOC) within ninety (90) days of receiving the PFOC, to include:</p> <ol style="list-style-type: none"> 1. Assistance with required LOC documentation and paperwork: <ol style="list-style-type: none"> a. The Long Term Care Assessment Abstract (LTCAA) forms (MAD 378 or DOH 378 as appropriate); b. Current history and physical (H&P) and medical/clinical history; c. The Comprehensive Individual Assessment (CIA) for those with I/DD and the Comprehensive Family Centered Review for MF. The consultant may be asked to assist with the in-home assessment (IHA) when necessary; d. Norm-referenced adaptive behavioral assessment (for I/DD only) 2. Assist with financial eligibility application 	<p>Based on record review, the Agency did not maintain verification of approvals and/or assessments in the case file at the administrative office for 15 of 30 participants.</p> <p>Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Approval Letter or screen-shot indicating financial eligibility (#12, 14, 18, 19, 20, 22, 26, 27, 30) • Approval Letter from the Third Party Assessor (TPA) indicating medical eligibility (#2, 18, 22, 26, 27, 30) • Mi Via Budget/Mi Via Budget Approval Letter (#2, 18) • Long Term Care Assessment Abstract (#2, 9, 14, 18, 20, 23, 26, 30) • Client Individual Assessment (CIA) (#2, 14, 17, 18, 23, 26, 27, 29, 30) • Vineland Assessment or Adaptive Behavior Scale (ABS) (#2, 14, 17, 18, 23, 24, 26, 27, 29, 30) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>and paperwork as needed;</p> <ol style="list-style-type: none"> 3. Inform the state, as requested on the progress with eligibility/enrollment activities and the assistance provided by the consultant; 4. Prior to SSP development or during the development process, obtain a copy of the Approval Letter or verify that the county Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the Mi Via Waiver program; and, 5. Schedule SSP meeting within ten (10) days of the approval verification. <p><u>Ongoing Consultant Services</u> II. Scope of Service</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <ol style="list-style-type: none"> 1. Provide the participant with information, support and assistance during the annual Medicaid eligibility processes, including the medical level of care (LOC) evaluation and financial eligibility processes; 2. Assist existing participants with annual LOC requirements within ninety (90) days prior to the expiration of the LOC; 4. Assist the participant in utilizing all program assessments, such as the 			
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<p>comprehensive individual assessment and the level of care abstract, to develop the SSP.</p> <p>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.</p> <p>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.</p> <p>13. Provide a copy of TPA Assessments to the participant upon their request.</p> <p>NMAC 8.314.6.13 ELIGIBILITY REQUIREMENTS FOR RECEIPT ENROLLMENT IN MI VIA:</p> <p>Enrollment in the mi via program is contingent upon the applicant meeting the eligibility requirements as described in this rule, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. When sufficient funding as well as waiver positions are available, DOH will offer the opportunity to eligible recipients to select mi via. Once an allocation has been offered to the applicant, he or she must meet certain medical and financial criteria in order to qualify for mi via enrollment located in 8.290.400</p>			
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<p>NMAC. The eligible recipient must meet the LOC required for admittance to an ICF-IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis.</p> <p>NMAC 8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET (AAB):</p> <p>H. Submission for approval: The TPA must approve the SSP and associated annual budget request (resulting in an AAB). The TPA must approve certain changes in the SSP and annual budget request, as specified in 8.314.6 NMAC and mi via service standards and in accordance with 8.302.5 NMAC.</p> <ol style="list-style-type: none"> 1) At any point during the SSP and associated annual budget utilization review process, the TPA may request additional documentation from the eligible recipient. This request must be in writing and submitted to both the eligible recipient and the consultant provider. The eligible recipient has 15 working days from the date of the request to respond with additional documentation. Failure by the eligible recipient to submit the requested information may subject the SSP and annual budget request to denial. 2) Services cannot begin and goods may not be purchased before the start date of the approved SSP and AAB or approved revised SSP and revised AAB. 			
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<p>3) Any revisions requested for other than critical health or safety reasons within 60 calendar days of expiration of the SSP and AAB are subject to denial for that reason.</p>			
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<p>any change in the AAB.</p> <p>The SSP/budget may be modified once the original SSP/budget has been submitted and approved. Only one (1) SSP/budget revision may be submitted at a time, for example, an SSP/budget revision may not be submitted if an initial SSP/budget request or prior SSP/budget revision request is under initial review by the TPA. This requirement also applies to any reconsideration of the same revision request.</p> <p>Other than for critical health and safety reasons, SSP/budget revision requests may not be submitted to the TPA within the last sixty (60) days prior to the expiration date of the current SSP/budget.</p> <p>Modifications to the Authorized Annual Budget</p> <p>Revisions to the AAB may occur within the SSP/budget year, and the participant is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP/budget must be amended first to reflect a change in the participant's needs or circumstances before any revisions to the AAB can be requested.</p> <p>SSP/budget revisions involve requests to add new goods or services to a budget or to reallocate funds from any line item to another approved line item. Budget revisions must be submitted to the TPA for review and approval.</p> <p>Service support plan SERVICE AND SUPPORT PLAN (SSP0 AND AUTHORIZED ANNUAL BUDGER (AAB):</p>			
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<p>A SSP and an annual budget request are developed at least annually by the eligible recipient in collaboration with the eligible recipient's consultant and others that the eligible recipient invites to be part of the process. The consultant serves in a supporting role to the eligible recipient, assisting the eligible recipient to understand the mi via program, and with developing and implementing the SSP and the AAB. The SSP and annual budget request are developed and implemented as specified in 8.314.6 NMAC and mi via service standards and submitted to the TPA for final approval. Upon final approval the annual budget request becomes an AAB.</p> <p>E. Modification of the SSP:</p> <ol style="list-style-type: none"> 1) The SSP may be modified based upon a change in the eligible recipient's needs or circumstances, such as a change in the eligible recipient's health status or condition or a change in the eligible recipient's support system, such as the death or disabling condition of a family member or other individual who was providing services. 2) If the modification is to provide new or additional services than originally included in the SSP, these services must not be able to be acquired through other programs or sources. The eligible recipient must document the fact that the services are not available through another source. 3) The eligible recipient must provide written documentation of the change in needs or 			
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<p>circumstances as specified in the mi via service standards. The eligible recipient submits the documentation to the consultant. The consultant initiates the process to modify the SSP by forwarding the request for modification to the TPA for review.</p> <p>4) The SSP must be modified before there is any change in the AAB.</p> <p>5) The SSP may be modified once the original SSP has been submitted and approved. Only one SSP revision may be submitted at a time, e.g., a SSP revision may not be submitted if an initial SSP request or prior SSP revision request is under initial review by the TPA. This requirement also applies to any re-consideration of the same revision request. Other than for critical health and safety reasons, neither the SSP nor the AAB may be modified within 60 calendar days of expiration of the current SSP.</p> <p>F. Modifications to the eligible recipient’s annual budget: Revisions to the AAB may occur within the SSP year, and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP must be amended first to reflect a change in the eligible recipient’s needs or circumstances before any revisions to the AAB can be requested.</p> <p>1) Budget revisions involve requests to add new goods or services to a budget or to reallocate funds from any line item to another approved line item. Budget revisions must be submitted</p>			
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<p>to the TPA for review and approval. Other than for critical health and safety reasons for the eligible recipient, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year.</p> <p>2) The amount of the AAB cannot exceed the eligible recipient's annual IBA. The rare exception would be the eligible recipient whose assessed or documented needs, based on his or her qualifying condition, cannot be met within the annual IBA, in which case the eligible recipient would initiate a request for an adjustment through his or her consultant.</p> <p>3) If the eligible recipient requests an increase in his or her budget above his or her annual IBA, or AAB, as applicable, the eligible recipient must show at least one of the following four circumstances:</p> <p>a) chronic physical condition: the eligible recipient has one or more chronic physical conditions, which are identified during the initial or reevaluation of the LOC, that result in a prolonged dependency on medical services or care, for which daily intervention is medically necessary; and the eligible recipient's needs cannot be met within the assigned IBA or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a medical doctor (MD), doctor of osteopathy (DO), a certified nurse practitioner (CNP) or a</p>			
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<p>physician assistant (PA) that documents the chronic physical condition in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the chronic physical conditions are characterized by at least one of the following:</p> <ul style="list-style-type: none"> i) a life-threatening condition with frequent or constant periods of acute exacerbation that places the eligible recipient at risk for institutionalization; that could result in the eligible recipient's inability to remember to self-administer medications accurately even with the use of assistive technology devices; or that requires a frequency and intensity of assistance, supervision, or consultation to ensure the eligible recipient's health and safety in the home or in the community; or which, in the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to a NF or ICF-IID; ii) the need for administration of specialized medications, enteral feeding or treatments that are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant; which require 			
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<p>frequent and ongoing management or monitoring or oversight of medical technology;</p> <p>b) change in physical status: the eligible recipient has experienced a deterioration or permanent change in his or her health status such that the eligible recipient's needs for services and supports can no longer be met within the IBA, current AAB or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a MD, OD, CNP, or PA that documents the change in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation by others involved in the eligible recipient's care, such as a current individual service plan (ISP) if the eligible recipient is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals; types of physical health status changes that may necessitate an increase in the IBA or current AAB are as follows:</p>			
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<p>i) the eligible recipient now requires the administration of medications via intravenous or injections on a daily or weekly basis;</p> <p>ii) the eligible recipient has experienced recent onset or increase in aspiration of saliva, foods or liquids;</p> <p>iii) the eligible recipient now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube;</p> <p>iv) the eligible recipient is newly dependent on a ventilator;</p> <p>v) the eligible recipient now requires suctioning every two hours, or more frequently, as needed;</p> <p>vi) the eligible recipient now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; or</p> <p>vii) the eligible recipient now requires increased assistance with activities of daily living as a result of a deterioration or permanent changes in his or her physical health status;</p> <p>c) chronic or intermittent behavioral conditions or cognitive difficulties: the eligible recipient has chronic or intermittent behavioral conditions or cognitive difficulties, which are identified</p>			
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<p>during the initial or reevaluation LOC assessment, or the eligible recipient has experienced a change in his or her behavioral health status, for which the eligible recipient requires additional services, supports, assistance, or supervision to address the behaviors or cognitive difficulties in order to keep the eligible recipient safe; these behaviors or cognitive difficulties are so severe and intense that they result in considerable risk to the eligible recipient, caregivers or the community; and require a frequency and intensity of assistance, supervision or consultation to ensure the eligible recipient's health and safety in the home or the community; in addition, these behaviors are likely to lead to incarceration or admission to a hospital, nursing facility or ICF-IID; require intensive intervention or medication management by a doctor or behavioral health practitioner or care practitioner which cannot be effectively addressed within the IBA, current AAB or other resources, including natural supports, the medicaid state plan services, medicare or other sources;</p> <p>i) examples of chronic or intermittent behaviors or cognitive difficulties are such that the eligible recipient injures him or herself frequently or seriously; has uncontrolled physical aggression toward others; disrupts most activities to the extent that his or her SSP cannot be implemented or routine</p>			
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<p>activities of daily living cannot be carried out; withdraws personally from contact with most others; or leaves or wanders away from the home, work or service delivery environment in a way that puts him or herself or others at risk;</p> <p>ii) the eligible recipient must submit a written, dated, and signed evaluation or letter from a licensed MD, doctor of osteopathy (DO), CNP, physician assistant (PA), psychiatrist, or RLD licensed psychologist that documents the change in the eligible recipient's behavioral health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation including a current ISP if the eligible recipient is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a behavioral health practitioner or professional with expertise in intellectual or developmental disabilities, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other</p>			
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<p>support individuals involved with the eligible recipient.</p> <p>d) change in natural supports: the eligible recipient has experienced a loss, as a result of situations such as death, illness, or disabling condition, of his or her natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not. This absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested. The type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the medicaid state plan services, medicare, other programs or sources in order for the eligible recipient to live in a home and community-based setting.</p> <p>4) The eligible recipient is responsible for tracking all budget expenditures and assuring that all expenditures are within the AAB. The eligible recipient must not exceed the AAB within any SSP year. The eligible recipient's failure to properly allocate the expenditures within the SSP year resulting in the depletion of the AAB, due to mismanagement of or failure to track the funds, prior to the calendared expiration date does not substantiate a claim for a budget increase (i.e., if all of the AAB is expended within the first three months of the SSP year, it is not</p>			
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<p>justification for an increase in the annual budget for that SSP year). Amendments to the AAB may occur within the SSP year and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. Amendments to the AAB must be preceded by an amendment to the SSP.</p> <p>5) The AAB may be revised once the original annual budget request has been submitted and approved. Only one annual budget revision request may be submitted at a time, e.g., an annual budget revision request may not be submitted if a prior annual budget revision request is under initial review by the TPA. The same requirement also applies to any reconsideration of the same revision request.</p> <p>NMAC 8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:</p> <p>All MAD services, including services covered under the mi via program, are subject to utilization review for medical necessity and program requirements. Reviews by MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.310.2 NMAC</p>			
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TAG #MV 130 Service and Support Plan Development Process			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>6. Planning and Budgeting for Services and Goods</p> <p>A. Service and Support Plan Development Processes</p> <p>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.</p> <p>The participant is the leader in the development of the SSP. The participant will take the lead or be encouraged and supported 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.</p> <p>Mi Via program covered services include personal plan facilitation, which supports planning activities</p>	<p>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 8 of 30 participants.</p> <p>Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Service and Support Plan (SSP) (#2, 9, 14, 18, 27) • SSP included descriptions of purposes of services, expected outcomes and methods for monitoring the contents of the SSP (#14) • SSP contains a completed backup plan section with all mandatory elements as applicable (#14) • Emergency Backup Plan Acknowledgement Form (#2, 18, 26, 30) • Evidence that a person-centered planning process was used in the creation of the SSP (#10, 14, 30) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p>

<p>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.</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Pre-Eligibility/Enrollment Services</u></p> <p>II. Scope of Service</p> <p>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:</p> <p>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.</p> <p><u>Ongoing Consultant Services</u></p> <p>II. Scope of Service</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <p>8. Ensure that the SSP for each participant includes the following:</p> <p>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;</p> <p>b. The purposes for the requested services, expected outcomes, and methods for monitoring progress must</p>			
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<p>be specifically identified and addressed;</p> <p>c. The twenty-four (24) hour emergency backup plan for services that affect health and safety of participants; and</p> <p>d. The quality indicators, identified by the participant, for the services and supports provided through the Mi Via Program.</p> <p>9. Ensure that the SSP is submitted in the appropriate format as prescribed by the state which includes the use of FOCOsonline.</p> <p>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.</p> <p>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.</p> <p>Appendix B: Service and Support Plan (SSP) Template</p>			
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TAG #MV 4.6 On-going Consultant Functions			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Ongoing Consultant Services</u></p> <p>II. Scope of Service</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <ol style="list-style-type: none"> 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 FOCOnline. 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. 	<p>Based on record review, the Agency did not maintain evidence of completing ongoing consultation services as required by Standard for 29 of 30 participants.</p> <p>Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Evidence the Participant received a completed/approved copy of their SSP (#2, 3, 13, 17, 18, 21, 28) • Evidence the Consultant explains what goods and services are covered and non-covered in Mi Via (#2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>13. Provide a copy of TPA Assessments to the participant upon their request.</p> <p>14. Assist the participant with the application for LRI as employee process; submit the application to the DOH.</p> <p>16. Assist the participant to identify and resolve issues related to the implementation of the SSP.</p> <p>17. Serve as an advocate for the participant, as needed, to enhance his/her opportunity to be successful with self-direction.</p> <p>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.</p> <p>19. Assist the participant with required quality assurance activities to ensure implementation of the participant's SSP and utilization of the authorized budget.</p> <p>20. Assist participants to identify measures to help them assess the quality of their services/supports/goods and self-direct their quality improvement process.</p> <p>21. Assist the participant to assure their chosen service providers are adhering to the Mi Via Service Standards as applicable.</p> <p>22. Assist participants to transition to another consultant provider when requested. Transitions should occur within thirty (30) days of request on the Consultant Agency</p>			
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<p>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).</p> <p>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.</p> <p>Support guide services include, but are not limited to the following:</p> <ul style="list-style-type: none"> 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, 			
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<p>obtaining quotes for goods and services as well as identifying and negotiating with vendors;</p> <p>d. Assisting participants with problem solving employee and vendor payment issues with the FMA and or other relevant parties;</p> <p>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;</p> <p>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;</p> <p>g. Assisting the participant to identify and access other resources for training employee(s)/service provider(s), if applicable;</p> <p>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</p> <p>i. Assisting the participant in managing the service plan budget to include reviewing budget expenditures; preparing and submitting budgets and revisions.</p>			
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TAG #MV 140 Environmental Modifications			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Ongoing Consultant Services</u></p> <p>II. Scope of Service</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <p>15. Assist with the environmental modification process including submission of required forms to the TPA for their review.</p> <p>V. Administrative Requirements</p> <p>G. The consultant provider shall maintain HIPAA compliant primary records for each participant including, but not limited to:</p> <p>10. Environmental modification approvals/denials;</p> <p>NMAC 8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA:</p> <p>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</p>	<p>Based on record review, the Agency did not maintain evidence of assistance and follow up with the Environmental Modifications process for 1 of 30 participants.</p> <p>Review of the Agency's participant case files revealed no evidence of the following:</p> <ul style="list-style-type: none"> Evidence of follow up to ensure Environmental Modifications have been completed (#28) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>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.</p> <p>2) Quarterly visits will be conducted for the following purposes: (a) review and document progress on implementation of the SSP;</p> <p>H. Other supports:</p> <p>5) Environmental modifications: Environmental modification services include the purchase and installation of equipment or making physical adaptations to the eligible recipient's residence that are necessary to ensure the health, safety, and welfare of the eligible recipient or enhance the eligible recipient level of independence.</p> <p>f) Environmental modification services are limited to \$5,000 every five years. An eligible recipient transferring into the mi via program will carry his or her history for the previous five years of MAD reimbursed environmental modifications. Environmental modifications must be approved by the TPA</p>			
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TAG #MV 150 Contact Requirements			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Pre-Eligibility/Enrollment Services</u> III. Contact Requirements</p> <p>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.</p> <p>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.</p> <p><u>Ongoing Consultant Services</u> III. Contact Requirements</p> <p>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:</p> <ol style="list-style-type: none"> 1. Review the participant's access to services and whether they were furnished 	<p>Based on record review, the Agency did not make contact with the participants as required by Standard and Regulations for 18 of 30 participants.</p> <p>Review of the Agency's participant case files found no evidence of contacts for the following:</p> <p><u>Ongoing Contacts:</u></p> <ul style="list-style-type: none"> • Monthly Contacts <ul style="list-style-type: none"> ○ Individual #2 <ul style="list-style-type: none"> ▪ None found for 10/2016, 2/2017 – 9/2017. ○ Individual #9 <ul style="list-style-type: none"> ▪ Documentation for <i>monthly contact</i> on 7/22/2017 and 8/19/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #14 <ul style="list-style-type: none"> ▪ Documentation for <i>monthly contact</i> on 2/28/2017, 3/24/2017, 5/31/2017, 6/24/2017, 8/28/2017 and 9/27/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #17 <ul style="list-style-type: none"> ▪ Documentation for <i>monthly contact</i> on 8/28/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #18 <ul style="list-style-type: none"> ▪ Documentation for <i>monthly contact</i> on 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>per the SSP;</p> <ol style="list-style-type: none"> 2. Review the participant's exercise of free choice of provider; 3. Review whether services are meeting the participant's needs; 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 	<p>3/2017 and 6/2017 did not contain the following required element:</p> <ul style="list-style-type: none"> ➤ The time of contact with the eligible recipient. <ul style="list-style-type: none"> ○ Individual #20 <ul style="list-style-type: none"> ▪ None found for 2/2017. ○ Individual #22 <ul style="list-style-type: none"> ▪ Documentation for <u>monthly contact</u> on 9/12/2017 did not contain did not contain the following required element: <ul style="list-style-type: none"> ➤ The time of contact with the eligible recipient. ○ Individual #23 <ul style="list-style-type: none"> ▪ Documentation for <u>monthly contacts</u> on 2/28/2017, 3/24/2017, 5/31/2017, 6/29/2017, 8/28/2017 and 9/29/2017 did not contain the following required element: <ul style="list-style-type: none"> ➤ The time of contact with the eligible recipient. ○ Individual #26 <ul style="list-style-type: none"> ▪ None found for 5/2017 – 10/2017. ○ Individual #27 <ul style="list-style-type: none"> ▪ Documentation for <u>monthly contact</u> on 9/12/2017 did not contain the following required element: <ul style="list-style-type: none"> ➤ The time of contact with the eligible recipient. ○ Individual #29 <ul style="list-style-type: none"> ▪ None found for 10/2017. ● Quarterly Visits <ul style="list-style-type: none"> ○ Individual #2 <ul style="list-style-type: none"> ▪ None found for 3/2017 – 5/2017 and 6/2017 – 9/2017. (SSP term 6/15/2016 – 6/14/2017 & 6/15/2017 – 6/14/2018) 		
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<p>concerns;</p> <p>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.</p> <p>The quarterly visits are for the following purposes:</p> <ol style="list-style-type: none"> 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 	<ul style="list-style-type: none"> ▪ Documentation for <i>quarterly visit</i> on 11/11/2016 and 1/24/2017 not on DDSD required form. ○ Individual #3 <ul style="list-style-type: none"> ▪ None found for 12/2016 – 2/2017. (SSP term 12/1/2016 – 11/30/2017) ○ Individual #7 <ul style="list-style-type: none"> ▪ Documentation for <i>quarterly visit</i> on 7/28/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #9 <ul style="list-style-type: none"> ▪ Documentation for <i>quarterly visit</i> on 12/14/2016, 3/16/2017, 6/13/2017 and 9/12/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #12 <ul style="list-style-type: none"> ▪ Documentation for <i>quarterly visit</i> on 2/8/2017, 5/18/2017, 8/17/2017 and 11/3/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #14 <ul style="list-style-type: none"> ▪ Documentation for <i>quarterly visit</i> on 7/28/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #17 <ul style="list-style-type: none"> ▪ Documentation for <i>quarterly visit</i> on 12/1/2016, 3/31/2017 and 6/9/2017 not 		
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<p>representative.</p> <p>NMAC 8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA</p> <p>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.</p> <p>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:</p> <p>(a) reviews the eligible recipient's access to services and whether they were furnished per the SSP;</p> <p>(b) reviews the eligible recipient's exercise of free choice of provider;</p> <p>(c) reviews whether services are meeting the eligible recipient's needs;</p> <p>(d) reviews whether the eligible recipient</p>	<p>on DDSD required form.</p> <ul style="list-style-type: none"> ○ Individual #18 <ul style="list-style-type: none"> ▪ None found for 8/2017 – 10/2017. (SSP term 11/1/2017 – 10/31/2018) ○ Individual #20 <ul style="list-style-type: none"> ▪ None found for 11/2016 – 1/2017, 2/2017 – 4/2017 and 5/2017 – 7/2017. (SSP term 11/27/2016 – 11/26/2017) ○ Individual #21 <ul style="list-style-type: none"> ▪ Documentation for <u>quarterly visit</u> on 1/24/2017, 4/19/2017, 6/23/2017 and 9/1/2017 not on DDSD required form. ○ Individual #23 <ul style="list-style-type: none"> ▪ Documentation for <u>quarterly visit</u> on 1/31/2017, 4/23/2017, 7/26/2017 and 10/12/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #25 <ul style="list-style-type: none"> ▪ Documentation for <u>quarterly visit</u> on 4/28/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. ○ Individual #28 <ul style="list-style-type: none"> ▪ Documentation for <u>quarterly visit</u> on 11/30/2016, 3/20/2017, 6/13/2017 and 9/13/2017 not on DDSD required form. ○ Individual #30 <ul style="list-style-type: none"> ▪ Documentation for <u>quarterly visit</u> on 12/2016 and 7/25/2017 did not contain the following required element: <ul style="list-style-type: none"> ➢ The time of contact with the eligible recipient. 		
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<p>is receiving access to non-waiver services per the SSP;</p> <p>(e) reviews activities conducted by the support guide, if utilized;</p> <p>(f) documents changes in status;</p> <p>(g) monitors the use and effectiveness of the emergency back-up plan;</p> <p>(h) documents and provides follow up, if necessary, if challenging events occur that prevent the implementation of the SSP;</p> <p>(i) assesses for suspected abuse, neglect, or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting;</p> <p>(j) documents progress of any time sensitive activities outlined in the SSP;</p> <p>(k) determines if health and safety issues are being addressed appropriately; and</p> <p>(l) discusses budget utilization concerns.</p> <p>2) Quarterly visits will be conducted for the following purposes:</p> <p>(a) review and document progress on implementation of the SSP;</p> <p>(b) document usage and effectiveness of the emergency backup plan;</p> <p>(c) review SSP and budget spending patterns (over and under-utilization);</p>	<ul style="list-style-type: none"> ○ Monthly Monitoring of Participate Budget Utilization/Spending Levels ○ Individual #2 - None found for 9/2016 – 8/2017. ○ Individual #18 – None found for 8/2017 – 10/2017. ○ Individual 20 - None found for 11/2016, 4/2017, 5/2017 and 8/2017. ○ Individual 22 - None found for 10/2016 and 7/18/2017. ○ Individual 26 - None found for 4/2017 – 6/2017 and 7/2017 – 9/2017. 		
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<p>(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;</p> <p>(e) document the eligible recipient's access to related goods identified in the SSP;</p> <p>(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</p> <p>(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.</p>			
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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			
<p>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.</p> <p>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.</p> <p>(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 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.</p> <p>(2) An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the arrest</p>	<p>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 2 of 15 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • #42 – Date of hire 1/25/2014 • #47 – Date of hire 8/1/2016 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>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.</p> <p>(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.</p> <p>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.</p> <p>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:</p> <p>A. homicide;</p> <p>B. trafficking, or trafficking in controlled substances;</p>			
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<p>C. kidnapping, false imprisonment, aggravated assault or aggravated battery;</p> <p>D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</p> <p>E. crimes involving adult abuse, neglect or financial exploitation;</p> <p>F. crimes involving child abuse or neglect;</p> <p>G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p> <p>H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p> <p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Ongoing Consultant Services</u></p> <p>V. Administrative Requirements</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <p>6. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.</p>			
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<p>TAG#: MV 1A28.1 Critical Incident / Incident Mgt. System - Personnel Training</p>			
<p>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</p> <p>B. Training curriculum: Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer.</p> <p>C. Incident management system training</p>	<p>Based on record review and interview, the Agency did not ensure Critical Incident / Incident Management Training for 15 of 15 Agency Personnel.</p> <ul style="list-style-type: none"> • Critical Incident / Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (#40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>curriculum requirements:</p> <p>(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:</p> <p>(a) an overview of the potential risk of abuse, neglect, or exploitation;</p> <p>(b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;</p> <p>(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;</p> <p>(d) specific instructions on how to respond to abuse, neglect, or exploitation;</p> <p>(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.</p> <p>(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.</p> <p>(3) All new employees and volunteers shall receive training prior to providing services to consumers.</p> <p>D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made</p>			
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<p>available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.</p> <p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Ongoing Consultant Services</u> V. Administrative Requirements</p> <p>A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:</p> <p>5. Ensure all employees providing services under this scope of service and all other staff paid with Mi Via funds, are trained on how to identify and where to report abuse, neglect and exploitation, as well as how to report suspicious injuries, environmental hazards as well as death;</p>			
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TAG #MV 14.A Consultant Qualifications and Requirements			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide <u>Ongoing Consultant Services</u> V. Administrative Requirements</p> <p>A. The consultant provider shall comply with all applicable federal, state and waiver regulations, all policies and procedures governing consultant services, all terms of their provider agreement and shall meet all of the following requirements, as applicable:</p> <p>3. Ensure all employees providing consultant services under this standard attend all state-required orientation and trainings and demonstrate knowledge of and competence with the Mi Via policies and procedures, philosophy, including self-direction, financial management processes and responsibilities, needs assessments, person-centered planning and service plan development, and adhere to all other training requirements as specified by the state;</p> <p>4. Ensure that all employees are trained and competent in the use of the fiscal management and FOCOsonline;</p> <p>VI. Qualifications</p> <p>A. Consultants must be employed by an enrolled Mi Via Consultant agency. Consultant</p>	<p>Based on record review, the Agency did not ensure that all Qualification Requirements were met for 13 of 15 Consultant Providers.</p> <p>The following Agency personnel records contained no evidence of the Consultant meeting the following required qualifications:</p> <ul style="list-style-type: none"> • Possess a minimum of a Bachelor's degree or 6 years of related experience. (#40, 41, 42, 44, 45, 46, 47, 49) <p>The following Agency personnel records contained no evidence of FOCOsonline training being completed:</p> <ul style="list-style-type: none"> • #42 – Date of hire 1/25/2014. • #44 – Date of hire 1/25/2014. • #48 – Date of hire 4/13/2011. • #50 – Date of hire 4/13/2011. • #52 – Date of hire 4/13/2011. • #53 – Date of hire 11/1/2011. • #54 – Date of hire 1/25/2014. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p> <p> </p>

<p>providers shall ensure that all employees providing consultant services meet the criteria specified in this section:</p> <p>1. Consultant providers shall:</p> <ul style="list-style-type: none"> a. Be at least 21 years of age; b. Possess a minimum of a Bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field; c. Have one (1) year of supervised experience working with people living with disabilities; d. Complete all required Mi Via orientation and training courses; and e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC. <p>OR</p> <p>2. Consultant providers shall:</p> <ul style="list-style-type: none"> f. Be at least 21 years of age; g. Have a minimum of six (6) years of direct experience related to the delivery of social services to people living with disabilities; h. Complete all required Mi Via 			
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<p>orientation and training courses; and</p> <p>i. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.</p>			
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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			
<p>Mi Via Self-Directed Waiver Program Service Standards effective March 2016</p> <p>Appendix A: Service Descriptions in Detail 2015 Waiver Renewal</p> <p>Consultant/Support Guide Pre-Eligibility/Enrollment Services</p> <p>IV. Reimbursement</p> <p>A. Consultant pre-eligibility/enrollment services shall be reimbursed based upon a per-member/per-month unit:</p> <ol style="list-style-type: none"> 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. <p>B. Consultants must obtain approval in writing from</p>	<p>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 13 of 30 individuals.</p> <p>Individual #2 July 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 7/1/2017 through 7/31/2017. No documentation found for 7/1/2017 – 7/31/2017 to justify 1 unit billed. <p>August 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 8/1/2017 through 8/31/2017. No documentation found for 8/1/2017 – 8/31/2017 to justify 1 unit billed. <p>September 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. No documentation found for 9/1/2017 – 9/30/2017 to justify 1 unit billed. <p>Individual #7 July 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 7/1/2017 through 7/31/2017. Documentation for the Quarterly Visit on 7/28/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>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.</p> <p>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.</p> <p>D. Non-billable consultant services include:</p> <ol style="list-style-type: none"> 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 	<p>Individual #9 July 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 7/1/2017 through 7/31/2017. Documentation for the Monthly Visit on 7/22/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>August 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 8/1/2017 through 8/31/2017. Documentation for the Monthly Visit on 8/19/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>September 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. Documentation for the Quarterly Visit on 9/12/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>Individual #12 August 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 8/1/2017 through 8/31/2017. Documentation for the Quarterly Visit on 8/17/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>Individual #14 July 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 7/1/2017 through 7/31/2017. Documentation for the Quarterly Visit on 7/28/2017 did not contain the time of contact with the eligible recipient to justify 1 		
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<p>Mi Via Waiver.</p> <p><u>Ongoing Consultant Services</u> IX. Reimbursement</p> <p>A. Consultant services shall be reimbursed based upon a per-member/per-month unit.</p> <ol style="list-style-type: none"> 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. <p>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.</p> <p>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.</p> <p>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.</p> <p>E. Consultant providers shall submit all billing through the Mi Via FMA as determined by the State.</p>	<p>unit billed.</p> <p>August 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 8/1/2017 through 8/31/2017. Documentation for the Monthly Visit on 8/28/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>September 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. Documentation for the Monthly Visit on 9/27/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>Individual #17 August 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 8/1/2017 through 8/31/2017. Documentation for the Monthly Visit on 8/28/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>Individual #21 September 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. Documentation for the Quarterly Visit on 9/1/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>Individual #22 September 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. Documentation for the Monthly 		
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<p>F. Non-Billable services Include:</p> <ol style="list-style-type: none"> 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 	<p>Visit on 9/12/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed.</p> <p>Individual #23 July 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 7/1/2017 through 7/31/2017. Documentation for the Quarterly Visit on 7/26/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>August 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 8/1/2017 through 8/31/2017. Documentation for the Monthly Visit on 8/28/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>September 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. Documentation for the Monthly Visit on 9/29/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>Individual #26 July 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 7/1/2017 through 7/31/2017. No documentation found for 7/1/2017 -7/31/2017 to justify 1 unit billed. <p>August 2017</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Consultant Services (T2025) from 8/1/2017 through 8/31/2017. No documentation found for 8/1/2017 – 8/31/2017 to justify 1 unit billed. 		
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	<p>September 2017</p> <ul style="list-style-type: none"> The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. No documentation found for 9/1/2017 – 9/30/2017 to justify 1 unit billed. <p>Individual #27 September 2017</p> <ul style="list-style-type: none"> The Agency billed 1 unit of Consultant Services (T2025) from 9/1/2017 through 9/30/2017. Documentation for the Monthly Visit on 9/12/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. <p>Individual #30 July 2017</p> <ul style="list-style-type: none"> The Agency billed 1 unit of Consultant Services (T2025) from 7/1/2017 through 7/31/2017. Documentation for the Quarterly Visit on 7/25/2017 did not contain the time of contact with the eligible recipient to justify 1 unit billed. 		
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Date: April 26, 2018

To: David Murley, Executive Director / Consultant
Provider: AAA Participant Direction
Address: 4300 Silver SE, Suite B
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: dmaaapd@gmail.com

Region: Statewide
Survey Date: November 3 - 9, 2017
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultation Services

Survey Type: Routine

Dear Mr. Murley;

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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

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