Date: March 8, 2018

To: Fallon Vincell, Director / Consultant
Provider: CNRAG, Inc.
Address: 225 East Idaho Ave. #27
State/Zip: Las Cruces, New Mexico 88001

E-mail Address: Fvincell@cnragusa.com

CC: Roxanne Gates, Owner
E-Mail Address rgates@cnragusa.com

Region: Metro, Southwest and Southeast
Survey Date: February 2 - 7, 2018
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

Dear Ms. Vincell;

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

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter. During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to Attachment A for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action:

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

On-going Quality Assurance/Quality Improvement Processes:

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

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the 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:	February 2, 2018
Entrance Conference Date:	February 5, 2018
Present:	**CNRAG, Inc.** Fallon Vincell, Director/Consultant **DOH/DHI/QMB** Kandis Gomez, AA, Team Lead/Healthcare Surveyor Valerie Valdez, MS, Bureau Chief Crystal Lopez-Beck, BA, Deputy Bureau Chief
Exit Conference Date:	February 7, 2018
Present:	**CNRAG, Inc.** Fallon Vincell, Director/Consultant Shaleen Diaz, Assistant Director/Consultant **DOH/DHI/QMB** Kandis Gomez, AA, Team Lead/Healthcare Surveyor Valerie Valdez, MS, Bureau Chief **DDSD - Metro Regional Office** Regina Lewis, Mi Via Program Manager Fleur Dahl, Mi Via Project Coordinator

Administrative Locations Visited	Number:	1
Total Sample Size	Number:	30
Participant Records Reviewed	Number:	30
Consultant Staff Records Reviewed	Number:	6

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: https://nmhealth.org/about/dhi/cbp/irf/
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, 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:	**CNRAG, Inc. –Statewide Region**
Program:	Mi Via Waiver
Service:	Consultant Services
Monitoring Type:	Routine Survey
Survey Date:	**February 2 – 7, 2018**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Date Due
Agency Record Requirements:			
TAG #MV 108 **Primary Agency Case File**			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **<u>Ongoing Consultant Services</u>** **V. Administrative Requirements** **G.** The consultant provider shall maintain HIPAA compliant primary records for each participant including, but not limited to: 1. Current and historical SSPs and budgets; 2. Contact log that documents all communication with the participant; 3. Completed/signed monthly and quarterly visit form(s); 4. TPA documentation of approvals/denials, including budgets and requests for additional funding; 5. TPA correspondence; (requests for additional information; requests for	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 30 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Employer of Record Questionnaire (#10, 17, 28)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

additional funding, etc); 6. Assessor's individual specific health and safety recommendations; 7. Notifications of medical and financial eligibility; 8. Approved Long Term Care Assessment Abstract with level of care determination and Individual Budgetary Allotment from the TPA; 9. Budget utilization reports from the FMA; 10. Environmental modification approvals/denials; 11. Legally Responsible Individual (LRI) approvals/denials; 12. Documentation of participant and employee training on reporting abuse, neglect and exploitation, suspicious injuries, environmental hazards and death; 13. Copy of legal guardianship or representative papers and other pertinent legal designations; and 14. Copy of the approval form for the personal representative. 15. Primary Freedom of Choice form (PFOC) and/or, Waiver Change Form (WCF) and/or Consultant Agency Change Form (CAC) as applicable. **NMAC 8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA:** C. Consultant pre-eligibility and enrollment services: Consultant pre-eligibility and enrollment services are intended to provide			

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

TAG #MV 110.1 Orientation/Enrollment Meeting			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **<u>Pre-Eligibility/Enrollment Services</u>** **II. Scope of Service** 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: A. 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: 1. General program overview including key agencies and contact information; 2. Discuss medical and financial eligibility requirements and offer assistance in completing these requirements as needed; 3. Provide information on Mi Via participant roles and responsibilities documented by participant signature on the roles and responsibilities form. 4. Discuss the Employer of Record (EOR) including discussion and possible identification of an EOR and completion of the EOR information form; 5. Review the processes for hiring employees and contractors and required paperwork;	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 30 of 30 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Evidence the Consultant initially explained what goods and services are covered and non-covered in Mi Via (#1, 2, 3, 4, 5, 6, 7, 12, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30) (*NOTE: No Plan of Correction required. During the on-site survey the document was completed and signed by each participant on 2/7/2018).* • Evidence the Consultant initially explained what goods and services are covered and non-covered in Mi Via (# 8, 9, 10, 11,13, 14, 20) • Choosing Mi Via: Understanding Participant Responsibilities Acknowledgement Form (#1, 2, 3, 4, 5, 6, 7, 8, 10, 12 ,14, 16, 18, 19, 22, 23, 24, 25, 26, 27, 28, 29, 30) (*NOTE: No Plan of Correction required. During the on-site survey the document was completed and signed by each participant on 2/7/2018).* • Choosing Mi Via: Understanding Participant Responsibilities Acknowledgement Form (#9, 11, 13, 20)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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*online*); 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. 12. Ensure the completion and submission of			

the initial SSP within sixty (60) days of eligibility determination so that it can be in effect within ninety (90) days. **<u>Ongoing Consultant Services</u>** **II. Scope of Service** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall: 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: 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 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.			

TAG #MV 112 Approvals and Assessments			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **Pre-Eligibility/Enrollment Services** **II. Scope of Service** 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: 1. Assistance with required LOC documentation and paperwork: 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 and paperwork as needed; 3. Inform the state, as requested on the progress with eligibility/enrollment activities	Based on record review, the Agency did not maintain verification of approvals and/or assessments in the case file at the administrative office for 3 of 30 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Client Individual Assessment (CIA) (#15, 27) • Vineland Assessment or Adaptive Behavior Scale (ABS) (#15, 28)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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. **<u>Ongoing Consultant Services</u>** **II. Scope of Service** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall: 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 comprehensive individual assessment and the level of care abstract, to develop the SSP. 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. 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. 13. Provide a copy of TPA Assessments to the participant upon their request. **NMAC 8.314.6.13 ELIGIBILITY REQUIREMENTS FOR RECEIPIENT ENROLLMENT IN MI VIA:** 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 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. **NMAC 8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET (AAB):** 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. 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. 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.			

TAG #MV 130 Service and Support Plan Development Process			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **6. Planning and Budgeting for Services and Goods** **A. Service and Support Plan Development Processes** The Service and Support Plan (SSP) development process starts with person-centered planning. This process obtains information about the participant's strengths, capacities, preferences desired outcomes and risk factors. In person-centered planning, the SSP must revolve around the individual participant and reflect his or her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the planning process is for the participant to achieve a meaningful life in the community, as defined by the participant. Upon eligibility for the Mi Via Waiver and choosing his/her consultant, each participant shall receive an IBA and information and training from the consultant about covered/non- covered Mi Via services and the requirements for the content of the SSP. The participant is the leader in the development of the SSP. The participant will take the lead or be encouraged and supported to take the lead to the best of their abilities to direct development of the SSP. The participant may involve, if he/she so desires, family members or other individuals, including service workers or providers, in the planning process. Mi Via program covered services include personal plan facilitation, which supports planning activities that may be used by the participant to develop	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 3 of 30 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Emergency Backup Plan Acknowledgement Form (#10, 15, 17)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

his/her SSP as well as identify other sources of support outside the SSP process. This service is available to participants one (1) time per SSP/budget year. **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **<u>Pre-Eligibility/Enrollment Services</u>** **II. Scope of Service** B. The actual enrollment meeting should be conducted within 30 days of receiving the PFOC. The enrollment process and activities include but are not limited to: 12. Ensure the completion and submission of the initial SSP within sixty (60) days of eligibility determination so that it can be in effect within ninety (90) days. **<u>Ongoing Consultant Services</u>** **II. Scope of Service** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall: 8. Ensure that the SSP for each participant includes the following: a. The services and supports, covered by the Mi Via program, to address the needs of the participant as determined through an assessment and person-centered planning process; b. The purposes for the requested services, expected outcomes, and methods for monitoring progress must be specifically identified and addressed;			

c. The twenty-four (24) hour emergency backup plan for services that affect health and safety of participants; and d. The quality indicators, identified by the participant, for the services and supports provided through the Mi Via Program. 9. Ensure that the SSP is submitted in the appropriate format as prescribed by the state which includes the use of FOCoSonline. 11. Ensure the completion and submission of the annual SSP to the Third Party Assessor (TPA) at least thirty (30) days prior to the expiration of the plan so that sufficient time is afforded for TPA review. 24. It is the State's expectation that consultants will work with participants transferring from another waiver to ensure that an approved services and supports plan (SSP) is in effect within ninety (90) days of the waiver change. Any exceptions to this timeframe must be approved by the State. Approval must be obtained in writing from the DOH Mi Via Program Manager or their designate for any plan not in effect within ninety (90) days of the waiver change. The consultant request must contain an explanation of why the ninety (90) day timeline could not be met. **Appendix B: Service and Support Plan (SSP) Template**			

TAG #MV 150 Contact Requirements			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **Pre-Eligibility/Enrollment Services** **III. Contact Requirements** Consultant providers shall make contact with the participant at least monthly for follow up on eligibility and enrollment activities. This contact can either be face-to-face or by telephone. During the pre-eligibility phase, at least one (1) face to face visit is required to ensure participants are completing the paperwork for medical and financial eligibility, and to provide additional assistance as necessary. Consultants should provide as much support as necessary to assist with these processes. **Ongoing Consultant Services** **III. Contact Requirements** Consultant providers shall make contact with the participant at least monthly for a routine follow up. This contact can either be face to face or by telephone. If support guide services are provided, contact may be more frequent as identified in the SSP. The monthly contacts are for the following purposes: 1. Review the participant's access to services and whether they were furnished per the SSP;	Based on record review, the Agency did not make contact with the participants as required by Standard and Regulations for 17 of 30 participants. Review of the Agency's participant case files found no evidence of contacts for the following: **Ongoing Contacts:** • **Monthly Contacts** ○ Individual #5 ▪ Documentation for *monthly contact* on 5/18/2017 and 6/15/2017 did not contain the following required element: ➢ The type of contact with the eligible recipient. ○ Individual #7 ▪ Documentation for *monthly contact* on 1/19/2018 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #8 ▪ Documentation for *monthly contact* on 4/19/2017, 6/27/2017 and 10/27/2017 did not contain the following required element: ➢ The type of contact with the eligible recipient. ○ Individual #15 ▪ Documentation for *monthly contact* on 5/8/2017, 6/22/2017, 8/18/2017, 9/18/2017, 11/27/2017 and 12/13/2017 did not contain the following required element: ➢ The type of contact with the eligible recipient.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 concerns; Consultant providers shall meet in person with the participant at a minimum of quarterly. At least one	○ Individual #16 ▪ Documentation for ***monthly contact*** on 1/30/2018 did not contain the following required element: ➢ The type of contact with the eligible recipient. ○ Individual #18 ▪ Documentation for ***monthly contact*** on 3/16/2017, 5/23/2017, 6/22/2017, 9/25/2017, 11/22/2017 and 12/22/2017 did not contain the following required element: ➢ The type of contact with the eligible recipient. ▪ Documentation for ***monthly contact*** on 8/14/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. • **Quarterly Contacts** ○ Individual #1 ▪ Documentation for ***quarterly contact*** on 10/18/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #2 ▪ Documentation for ***quarterly contact*** on 7/11/2017 did not contain the following required element: ➢ The signature of eligible recipient. ○ Individual #5 ▪ None found for 8/2017 – 10/2017. *(SSP term 10/29/2016 – 10/28/2017)* ○ Individual #6 ▪ Documentation for ***quarterly contact*** on		

visit per year must be in the participant's residence. If support guide services are provided, contact may be more frequent as identified in the SSP. The quarterly visits are for the following purposes: 1. Review and document progress on implementation of the SSP; 2. Document any usage and the effectiveness of the twenty-four (24) hour Emergency Backup Plan; 3. Review SSP/budget spending patterns (over and under utilization); 4. Assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP and any applicable Mi Via service standards; 5. Document the participant's access to related goods identified in the SSP; 6. Review any incidents or events that have impacted the participant's health and welfare or ability to fully access and utilize support as identified in the SSP; and 7. Identify other concerns or challenges, including but not limited to complaints, eligibility issues, health and safety issues as noted by the participant and/or representative. **NMAC 8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA** **C. Consultant services:** Consultant services are required for all mi via eligible recipients to	4/25/2017 and 12/8/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #7 ▪ Documentation for ***quarterly contact*** on 5/9/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #8 ▪ Documentation for ***quarterly contact*** on 5/8/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #10 ▪ None found for 7/2017 – 9/2017. *(SSP term 5/30/2017 – 5/29/2018)* ○ Individual #11 ▪ Documentation for ***quarterly contact*** on 5/9/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #16 ▪ Documentation for ***quarterly contact*** on 2/9/2017 and 5/24/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #20 ▪ Documentation for ***quarterly contact*** on 2/2/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient.		

educate, guide, and assist the eligible recipients to make informed planning decisions about services and supports. The consultant helps the eligible recipient develop the SSP based on his or her assessed needs. The consultant assists the eligible recipient with implementation and quality assurance related to the SSP and AAB. Consultant services help the eligible recipient identify supports, services and goods that meet his or her needs, meet the mi via requirements and are covered mi via services. Consultant services provide support to eligible recipients to maximize their ability to self-direct their mi via services. 1) **Contact requirements:** Consultant providers shall make contact with the eligible recipient in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet face-to-face with the eligible recipient at least quarterly; one visit must be conducted in the eligible recipient's home at least annually. During monthly contact the consultant: (a) reviews the eligible recipient's access to services and whether they were furnished per the SSP; (b) reviews the eligible recipient's exercise of free choice of provider; (c) reviews whether services are meeting the eligible recipient's needs; (d) reviews whether the eligible recipient is receiving access to non-waiver services per the SSP; (e) reviews activities conducted by the support guide, if utilized; (f) documents changes in status;	○ Individual #21 ▪ Documentation for *quarterly contact* on 4/10/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #25 ▪ Documentation for *quarterly contact* on 4/11/2017 did not contain the following required element: ➢ The time of contact with the eligible recipient. ○ Individual #30 ▪ Documentation for *quarterly contact* on 7/14/2017 did not contain the following required element: ➢ Face to Face contact with the eligible recipient. • **Monthly Monitoring of Participate Budget Utilization/Spending Levels** ○ Individual #10 - None found for 9/2017, 10/2017 and 12/2017. ○ Individual #26 - None found for 4/2017. • **Quarterly Monitoring of Participate Budget Utilization/Spending Levels** ○ Individual #17 - None found for 12/2017. ○ Individual #26 - None found for 3/2017.		

(g) monitors the use and effectiveness of the emergency back-up plan; (h) documents and provides follow up, if necessary, if challenging events occur that prevent the implementation of the SSP; (i) assesses for suspected abuse, neglect, or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting; (j) documents progress of any time sensitive activities outlined in the SSP; (k) determines if health and safety issues are being addressed appropriately; and (l) discusses budget utilization concerns. 2) Quarterly visits will be conducted for the following purposes: (a) review and document progress on implementation of the SSP; (b) document usage and effectiveness of the emergency backup plan; (c) review SSP and budget spending patterns (over and under-utilization); (d) assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP and any applicable sections of the mi via rules and service standards; (e) document the eligible recipient's			

access to related goods identified in the SSP; (f) review any incidents or events that have impacted the eligible recipient's health, welfare or ability to fully access and utilize support as identified in the SSP; and (g) other concerns or challenges, including but not limited to complaints, eligibility issues, and health and safety issues, raised by the eligible recipient, authorized representative or personal representative.			

Tag: # MV 1A26 Employee Abuse Registry / Consolidated Online Registry			
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 2 of 6 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #42 – Date of hire 3/20/2017. Completed on 2/7/2018. • #43 – Date of hire 10/2/2017. Completed on 2/7/2018.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

TAG#: MV 1A28.1 Critical Incident / Incident Mgt. System - Personnel Training			
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:** **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. **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. **C. Incident management system training curriculum requirements:**	Based on record review and interview, the Agency did not ensure Critical Incident / Incident Management Training for 6 of 6 Agency Personnel. • Critical Incident / Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (#40, 41, 42, 43, 44, 45)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

(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: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **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 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. **Mi Via Self-Directed Waiver Program Service Standards effective March 2016** **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **<u>Ongoing Consultant Services</u>** **V. Administrative Requirements** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall: 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;			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Date Due
Medicaid Billing/Reimbursement:			
Tag MV #4A1 Consultant Services Reimbursement			
Mi Via Self-Directed Waiver Program Service Standards effective March 2016 **Appendix A: Service Descriptions in Detail 2015 Waiver Renewal** **Consultant/Support Guide** **Pre-Eligibility/Enrollment Services** **IV. Reimbursement** A. Consultant pre-eligibility/enrollment services shall be reimbursed based upon a per-member/per-month unit: 1. A maximum of one (1) unit per month can be billed per each participant receiving consultant services in the pre-eligibility phase for a period not to exceed three (3) months; 2. Provider records must be sufficiently detailed to substantiate the nature, quality, and amount of consultant pre-eligibility/enrollment services provided and be in compliance with the Medicaid documentation policy NMAC 8.302.1; and 3. Consultant providers shall submit all consultant pre-eligibility/enrollment services billing through the Human Services Department (HSD) or as determined by the State. B. Consultants must obtain approval in writing from the DOH Mi Via Program Manager or their	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 3 of 30 individuals. Individual #1 October 2017 • The Agency billed 1 unit of Consultant Services (T2025) from 10/1/2017 through 10/31/2017. Documentation did not contain the time of contact with the eligible recipient to justify 1 unit billed. Individual #5 October 2017 • The Agency billed 1 unit of Consultant Services (T2025) from 10/1/2017 through 10/31/2017. No documentation of a Quarterly Face to Face Visit from 8/2017 – 10/2017 to justify 1 unit billed. (*NOTE: Void/Adjust completed on-site. Provider please complete the Plan of Correction for Ongoing QA/QI.)* Individual #6 December 2017 • The Agency billed 1 unit of Consultant Services (T2025) from 12/1/2017 through 12/31/2017. Documentation did not contain the time of contact with the eligible recipient to justify 1 unit billed.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

designate for any pre-eligibility phase exceeding the ninety (90) day timeframe for any participant. The consultant will submit an explanation of why the pre-eligibility phase has exceeded the 90 day timeline. C. It is the State's expectation that consultants will work with the participant to ensure that an approved service and support plan (SSP) is in effect within ninety (90) days of the start of Medicaid eligibility. Any exceptions to this timeframe must be approved by the State. The consultant will submit an explanation of why the plan could not be effective within the 90 day timeline. Approval must be obtained in writing from the DOH Mi Via Program Manager or their designate for any plan not in effect ninety (90) days after eligibility is approved, prior to billing for that service. D. Non-billable consultant services include: 1. Services furnished to an individual who does not reside in New Mexico; 2. Participation by the consultant provider in any educational courses or training; 3. Outreach activities, including contacts with persons potentially eligible for the Mi Via Program; 4. Consultant services furnished to an individual who is in an institution (e.g., ICF/IID, nursing facility, hospital) or is incarcerated, except for discharge planning services in accordance with MAD Supplement No. 01-22; and 5. Services furnished to an individual who does not have a current allocation to the Mi Via Waiver.			

Ongoing Consultant Services **IX. Reimbursement** A. Consultant services shall be reimbursed based upon a per-member/per-month unit. **1.** There is a maximum of twelve (12) billing units per participant per SSP year. **2.** A maximum of one unit per month can be billed per each participant receiving consultant services. B. Provider records must be sufficiently detailed to substantiate the nature, quality, and amount of consultant services provided. Months for which no documentation is found to support the billing submitted shall be subject to non-payment or recoupment by the state. C. The consultant provider/agency shall provide the level of support required by the participant and a minimum of four (4) face to face quarterly visits per SSP year. One of the quarterly meetings must include the development of the annual SSP and assistance with the LOC assessment. D. It is the State's expectation that consultants will work with participants transferring from another waiver to ensure that an approved services and supports plan (SSP) is in effect within ninety (90) days of a waiver change. Consultants must obtain approval in writing from the DOH Mi Via Program Manager or their designate for any transfers occurring over the ninety (90) day timeframe. E. Consultant providers shall submit all billing through the Mi Via FMA as determined by the State. F. Non-Billable services Include:			

1. Services furnished to an individual who does not reside in New Mexico. 2. Services furnished to an individual who is not eligible for the Mi Via Program. 3. Participation by the Consultant/Support Guide in any educational courses or training. 4. Outreach activities, including contacts with persons potentially eligible for the Mi Via Program. 5. Consultant services furnished to an individual who is in an institution (e.g., ICF/IID, nursing facility, hospital) or is incarcerated, except for discharge planning services in accordance with MAD Supplement No. 01-22			

Date: May 15, 2018

To: Fallon Vincell, Director / Consultant
Provider: CNRAG, Inc.
Address: 225 East Idaho Ave. #27
State/Zip: Las Cruces, New Mexico 88001

E-mail Address: Fvincell@cnragusa.com

CC: Roxanne Gates, Owner
E-Mail Address rgates@cnragusa.com

Region: Metro, Southwest and Southeast
Survey Date: February 2 - 7, 2018
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultation Services

Survey Type: Routine

Dear Ms. Vincell;

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

Q.18.3.MiVia.41586077.3/4/5.RTN.09.18.135