NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

(Upheld by IRF 12/2022)

Date:	November 7, 2022
To:	Carrie Roberts, Family and Community Partnerships Division Director
Provider:	UNM - Center for Development and Disability
Address:	2300 Menaul Blvd. NE
State/Zip:	Albuquerque, New Mexico 87107
E-mail Address:	CnRoberts@salud.unm.edu
CC:	Janelle Groover, Education and Outreach Manager
E-Mail Address	JTorresGroover@salud.unm.edu
Region:	Statewide
Survey Date:	October 10 – 21, 2022
Program Surveyed:	Mi Via Waiver
Service Surveyed:	Mi Via Consultant Services
Survey Type:	Routine
Team Leader:	Kayla R. Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Jamie Pond, BS, QMB Staff Manager, Division of Health Improvement/Quality Management Bureau; Valerie V. Valdez, MS, Quality Management Bureau Chief, Division of Health Improvement/Quality Management Bureau

Dear Ms. Roberts and Ms. Groover;

The Division of Health Improvement/Quality Management Bureau Mi Via Survey Unit has completed a compliance survey of your agency. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of participants 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 Participants served at risk of harm.

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

The following tags are identified as deficiencies:

- Tag # MV108 Primary Agency Case File
- Tag # MV110.1 Orientation/Enrollment Meeting
- Tag # MV112 Approvals and Assessments ***(Upheld by IRF)***

- Tag # MV130 Service and Support Plan Development Process ***(Upheld by IRF)***
- Tag # MV4.6 Ongoing Consultant Functions
- Tag # MV150 Contact Requirements
- Tag # MV1A25 Caregiver Criminal History Screening

Plan of Correction:
The attached Report of Findings identifies the deficiencies found during your agency's on-site compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

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

On-going Quality Assurance/Quality Improvement Processes:
- What is going to be done on an ongoing basis? (i.e., file reviews, 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 within your agency)
- What steps will be taken if issues are found? (i.e., retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction in the available space on the two right-hand columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction.)*

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Monica Valdez, Plan of Correction Coordinator at** MonicaEValdez@doh.nm.gov

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

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:
If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*

HSD/OIG/Program Integrity Unit
PO Box 2348
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5300 Homestead Road NE, Suite 300-331
Albuquerque, New Mexico 87110
Attention: IRF request/QMB

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@doh.nm.gov 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,

Kayla R. Benally, BSW

Kayla R. Benally, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	October 10, 2022
Contact:	**UNM – Center for Development and Disability** Janelle Groover, Education and Outreach Manager / Consultant **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	October 10, 2022
Present:	**UNM – Center for Development and Disability** Janelle Groover, Education and Outreach Manger / Consultant Carrie Roberts, Family and Community Partnerships Division Director Cassandra DeCamp, Program Manager / Consultant Winton Wood, Program Manager / Consultant **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor Jamie Pond, B.S., QMB Staff Manager Valerie Valdez, M.S., Quality Management Bureau Chief
Exit Conference Date:	October 21, 2022
Present:	**UNM – Center for Development and Disability** Janelle Groover, Education and Outreach Manger / Consultant Carrie Roberts, Family and Community Partnerships Division Director Cassandra DeCamp, Program Manager / Consultant Winton Wood, Program Manager / Consultant **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor Jamie Pond, B.S., QMB Staff Manager Valerie Valdez, M.S., Quality Management Bureau Chief
Administrative Locations Visited	1 (2300 Menaul Blvd. NE Albuquerque, New Mexico 87107)
Total Sample Size	32 0 - *Jackson* Class Members 32 - Non-*Jackson* Class Members
Participant Records Reviewed	32
Participants Interviewed	4
Consultant Staff Records Reviewed	13
Consultant Staff Interviewed	12 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*
Administrative Interviewed	1 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records

- Accreditation Records
- Oversight of Individual Funds
- Participant Program Case Files
- Personnel Files
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / Improvement Plan

CC: Distribution List:

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

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the DDSD Regional Office for purposes of contract management or the Internal Review Committee [IRC] for possible actions or sanctions).

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-273-1930 or email at MonicaE.Valdez@doh.nm.gov. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing, and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: **Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@doh.nm.gov for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@doh.nm.gov ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5300 Homestead Road NE, Suite 300-3223 Albuquerque, New Mexico 87110
5. *Do not submit supporting documentation* (evidence of compliance) to QMB *until after* your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

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

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: https://nmhealth.org/about/dhi/cbp/irf/
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@doh.nm.gov for assistance.

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

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

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

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

Agency: **UNM Center for Development & Disability – Statewide**
Program: Mi Via
Service: Mi Via Consultant Services
Survey Type: Routine
Survey Date: **October 10 – 21, 2022**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
Tag # MV108 Primary Agency Case File			
Mi Via Self-Directed Waiver Program Service Standards effective July 2022 Appendix A: Service Descriptions in Detail effective July 1, 2022 **<u>Ongoing Consultant Services</u>** **VI. 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 (12) face to face visit form(s); 4. TPA documentation of approvals/denials, including budgets and requests for additional funding; 5. TPA correspondence; (requests for additional information; requests for additional funding, etc.); 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;	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 32 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: **Employer of Record Questionnaire** • Not signed by Participant (#17, 22, 26) *(Note: Individuals did not have legal guardians and / or POA's. Individuals were not signing their own required forms.)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

11. 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. 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 # MV110.1 Orientation/Enrollment Meeting			
Mi Via Self-Directed Waiver Program Service Standards effective July 2022 **Appendix A: Service Descriptions in Detail** **Consultant Services Pre-Eligibility/Enrollment Services 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: 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: 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. 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. 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. **Ongoing Consultant Services II. Scope of Service** A. Consultant services and supports are delivered in accordance with the	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 3 of 32 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: **Choosing Mi Via: Understanding Participant Responsibilities Acknowledgement Form:** • Not Signed by Participant (#17, 22, 26) *(Note: Individuals did not have legal guardians and / or POA's. Individuals were not signing their own required forms.)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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; 3. 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; 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… 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. 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.			

Tag # MV112 Approvals and Assessments ***(Upheld by IRF)***			
Mi Via Self-Directed Waiver Program **Service Standards effective July 1, 2022** **Appendix A: Service Descriptions in Detail** **CONSULTANT SERVICES** **PRE-ELIGIBILITY/ENROLLMENT SERVICES** **II. Scope of Service** C. Consultants will inform, support, assist, and monitor 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) 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; **ONGOING CONSULTANT SERVICES** **II. Scope of Service** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:	Based on record review, the Agency did not maintain verification of approvals and/or assessments in the case file at the administrative office for 4 of 32 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) (#2, 11, 12, 24) *(Upheld by IRF #2, 11, 12, 24)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

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 in-home assessment, 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 *the FMA online system.* 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 8.314.6.17 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 # MV130 Service and Support Plan Development Process *(Upheld by IRF)*			
Mi Via Self-Directed Waiver Program Service Standards effective July 2022 **6. Planning and Budgeting for Services and Goods A. Service and Support Plan Development Processes** Person-Centered Planning (PCP) Essential Elements of Person-Centered Planning (PCP) Person-centered planning is a process that places a person at the center of planning his/her life and supports. It is an ongoing process that is the foundation for all aspects of the Mi Via Waiver, and all supports who work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. The CMS requires use of PCP in the development of the SSP. **B. Service and Support Plan (SSP) Components** The SSP is developed annually through an ongoing PCP process. The SSP development must: 1. involve those whom the person wishes to attend and participate in developing the SSP; 2. use assessed needs to identify services and supports; 3. include individually identified goals and preferences related to relationships,	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 12 of 32 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: **SSP did not contain a completed backup plan section with all mandatory elements as applicable:** • Did not list In-Home Living Services Vendor Agency (#7, 8, 12, 16, 22, 24, 27, 28, 29, 33) *(Upheld by IRF)* **Emergency Backup Plan Acknowledgement Form:** • Not initialed / signed by Participant (#17, 22, 26) *(Note: Individuals did not have legal guardians and / or POA's. Individuals were not signing their own required forms.)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

community participation, employment, income and savings, healthcare and wellness, education, and others; 4. identify roles and responsibilities of supports who are implementing the SSP; 5. include the term of the SSP and how and when it is updated; and 6. outline how the person is informed of services which include natural and community resources as well as those funded by the Mi Via Waiver. **Appendix A** **PRE-ELIGIBILITY/ENROLLMENT SERVICES** **II. Scope of Service** 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. **ONGOING CONSULTANT SERVICES** **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.			

Appendix B: Service and Support Plan (SSP) Template			

Tag # MV4.6 Ongoing Consultant Functions			
Mi Via Self-Directed Waiver Program Service Standards effective July 1, 2022 **Appendix A: Service Descriptions in Detail** **ONGOING CONSULTANT SERVICES** **II. Scope of Service** A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall: 5. Educate the participant regarding Mi Via covered and non-covered supports, services, and goods. 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 *the FMA online system.* No more than one revision is allowed to be submitted at any given time. 12. Provide a copy of the final approved SSP and budget documents to participants.	Based on record review, the Agency did not maintain evidence of completing ongoing consultation services as required by Standard for 4 of 32 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Evidence the Participant received a completed/approved copy of their SSP (#19) • Evidence the Consultant explains what goods and services are covered and non-covered in Mi Via (#17, 22, 26)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Tag # MV150 Contact Requirements			
Mi Via Self-Directed Waiver Program Service Standards effective July 2022 **Appendix A: Service Descriptions in Detail** **PRE-ELIGIBILITY/ENROLLMENT SERVICES** **III. Contact Requirements** Consultants 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** **IV. Contact Requirements** Consultant providers shall contact the participant at least monthly for a routine follow up. This contact is required to be face to face. The monthly contacts are for the following purposes: 1. Monitor the participant's access to services and whether they were furnished per the SSP; 2. Review the participant's choice of provider; 3. Monitor whether services are meeting the participant's needs; 4. Monitor whether the participant is receiving access to non-waiver services as outlined in the SSP; 5. Follow up on complaints against service providers or vendors; 6. Document change in status; 7. Monitor the use and effectiveness of the emergency backup plan; 8. Document and provide follow up (if needed) if challenging events occurred; 9. Assess for suspected abuse, neglect or exploitation and report accordingly, if not	Based on record review, the Agency did not make contact with the participants as required by Standard and Regulations for 3 of 32 participants. Review of the Agency's participant case files found no evidence of contacts for the following: **<u>Ongoing Contacts:</u>** **Ongoing Monthly Contacts:** **Participant #6:** • None found for 6/2022 **Participant #17:** • Documentation for *<u>monthly visit</u>* on 08/31/2022 did not have a DDSD Exception for a Telehealth visit. **Participant #25:** • Documentation for *<u>monthly visit</u>* on 4/26/2022 and 5/23/2022 did not have a DDSD Exception for an E-mail visit.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

reported, take remedial action to ensure correct reporting; 10. Monitor and document progress on any time sensitive activities outlined in the SSP; 11. Monitor if health and safety issues are being addressed appropriately; 12. Monitor budget utilization and discuss/assist with any concerns; Consultant providers are required meet in person with the participant at a minimum of twelve (12) monthly visits per year. At least four visits per year, one per quarter, must be conducted in the participant's residence with the participant. The monthly, twelve (12) face to face visits are for the following purposes: 1. Review and monitor progress on implementation of the SSP; 2. Monitor any usage and the effectiveness of the twenty-four (24) hour Emergency Backup Plan; 3. Review SSP/budget spending patterns (over and underutilization); 4. Monitor and access 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. Monitor 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. 8. Assess the home environment and service settings to ensure adherence to the CMS Final Rule settings requirements.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Completions Date
Agency Personnel Requirements:			
Tag # MV 1A25 Caregiver Criminal History Screening			
Mi Via Self-Directed Waiver Program Service Standards effective July 1, 2022 Appendix A: Service Descriptions in Detail VI. Administrative Requirements A. Consultant agencies and their individual consultants 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: 6. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees. **NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.	Based on record review, the Agency did not maintain documentation in the employee's personnel records indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 13 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #507 – Date of hire 9/28/2020	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A, of Section 7.1.9.9. **B. Employment Pending Reconsideration Determination:** At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Completion Date
Medicaid Billing/Reimbursement:			
Tag # MV1A12 All Services Reimbursement	**No Deficient Practices Found**		
Mi Via Self-Directed Waiver Program Service Standards effective July 2022 **Appendix A: Service Descriptions in Detail** **CONSULTANT SERVICES** **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. **ONGOING CONSULTANT SERVICES** **XI. 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. Consultant records must be sufficiently detailed to substantiate the nature, quality,	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount, and medical necessity of services furnished to an eligible recipient who is currently receiving Mi Via Consultant Services for 32 of 32 participants. *Contact notes and billing records supported billing activities for the months of June, July, and August 2022.*		

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 twelve (12) monthly face to face visits per SSP year. One of the monthly visits must include the development of the annual SSP and assistance with the LOC assessment.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary Designate

Date: January 18, 2023

To: Carrie Roberts, Family and Community Partnerships Division Director

Provider: UNM - Center for Development and Disability
Address: 2300 Menaul Blvd. NE
State/Zip: Albuquerque, New Mexico 87107

E-mail Address: CnRoberts@salud.unm.edu

CC: Janelle Groover, Education and Outreach Manager
E-Mail Address JTorresGroover@salud.unm.edu

Region: Statewide
Survey Date: October 10 – 21, 2022
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultant Services

Survey Type: Routine

Dear Ms. Roberts and Ms. Groover:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use of these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

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

Q.23.2.MV.18076823.1/2/3/4/5.RTN.09.22.018