Date:	April 8, 2020
To:	Christina Barden, Program Operations Director
Provider:	UNM Medically Fragile Case Management Program
Address:	2300 Menaul Blvd. NE
State/Zip:	Albuquerque, New Mexico 87107
E-mail Address:	cbarden@salud.unm.edu
CC:	Marcia Moriarta, PhD, Executive Director of CDD
E-Mail Address	mmoriarta@salud.unm.edu
Region:	Statewide
Survey Date:	March 6 - 12, 2020
Program Surveyed:	Medically Fragile Waiver
Service Surveyed:	Case Management
Survey Type:	Routine
Team Leader:	Yolanda J. Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau and Iris Clevenger, BSN, RN, CCM, MA, Medically Fragile Waiver Program Manager, Developmental Disabilities Supports Division

Dear Ms. C. Barden:

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Medically Fragile 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 contracts. Upon receipt of this letter and report of findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

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

The following tags are identified as deficiencies:

- Tag # 1A28.2 Incident Management System Training – Recipient, Family Members and Legal Guardians
- Tag # MF04 Policy and Procedure Requirements
- Tag # MF14 IDT Meeting and ISP Development
- Tag # MF19 Case Management Monitoring

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

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

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done 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, Attention: Monica Valdez, Plan of Correction Coordinator 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108**

2. **Developmental Disabilities Supports Division, Attention: Medically Fragile Waiver Program Manager**

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

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

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

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)
OR
Jennifer Goble (Jennifer.goble2@state.nm.us)

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

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

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

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

Please call the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 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,

Yolanda J. Herrera, RN

Yolanda J. Herrera, RN
Nurse Healthcare Surveyor / Team Lead
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	March 6, 2020
Contact:	**UNM Medically Fragile Case Management Program** Christina Barden, MFCMP Program Operations Director **DOH/DHI/QMB** Yolanda J. Herrera, RN, Team Lead/Nurse Healthcare Surveyor
On-site Entrance Conference Date:	March 9, 2020
Present:	**UNM Medically Fragile Case Management Program** Christina Barden, MFCMP Program Operations Director **DOH/DHI/QMB** Yolanda J. Herrera, RN, Team Lead/Nurse Healthcare Surveyor Kayla Benally, BSW, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator **DDSD – Clinical Services Bureau** Iris Clevenger, RN, BSN, MA, CCM, Medically Fragile Waiver Program Manager
Exit Conference Date:	March 12, 2020
Present:	**UNM Medically Fragile Case Management Program** Christina Barden, MFCMP Program Operations Director **DOH/DHI/QMB** Yolanda J. Herrera, RN, Team Lead/Nurse Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator **DDSD – Clinical Services Bureau** Iris Clevenger, RN, BSN, MA, CCM, Medically Fragile Waiver Program Manager
Administrative Locations Visited Number:	Number 1
Total Sample Size	Number: 14
Persons Served Records Reviewed	Number: 14
Recipient/Family Members Interviewed	Number: 10 *(One Recipient / Family / chose not to participate in interview process and 3 others were not available during the on-site survey)*
Case Managers Interviewed	Number: 13
Case Mgmt. Personnel Records Reviewed	Number: 14 *(One Administrative Personnel also provides services as a Case Manager)*
Administrative Personnel Interviewed	Number: 1

Administrative Files Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management System Process
- Personnel Files
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement (DHI)
DOH - Developmental Disabilities Supports Division (DDSD)
Medically Fragile Waiver Program Manager
Human Services Department (HSD)

Attachment A

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
5. *Do not submit supporting documentation* (evidence of compliance) to QMB *until after* your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

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

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

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

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

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

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

Agency: **UNM Medically Fragile Case Management Program - Statewide**
Program: Medically Fragile Waiver
Service: Case Management
Monitoring Type: Routine Survey
Survey Dates: **March 6 - 12, 2020**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Agency Record Requirements:			
TAG # 1A28.2 Incident Mgmt. System Training – Recipient, Family Members and Legal Guardians			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **GENERAL PROVIDER REQUIREMENTS: I. PROVIDER REQUIREMENTS** a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. **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. **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide	Based on interviews, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 2 of 14 individuals. **When the receipt/family member was asked if they had access to telephone numbers and Incident Reporting procedures for Abuse, Neglect and Exploitation, the following was reported:** • The recipient/family member for Individual #1 stated, "Call Case Manager for guidance." • The recipient/family member for Individual #10 stated, "Call Monica Case Manager."	**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?)*: →	

consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Administrative Requirements:			
TAG # MF04 Policy and Procedure Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **GENERAL PROVIDER REQUIREMENTS** **I.PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. E. All provider agencies that enter in to a contractual relationship with DOH to provide MFW services which comply with all applicable standards herein set forth and are subject to sanctions for noncompliance with the provider agreement and all applicable rules and regulations.	Based on record review, the Agency did not develop and implement written policies and procedures that comply with all DDSD Standards. **Review of Agency policies & procedures found no evidence of the following:** • Policy and Procedures for Case Management Training *(Note: Policy and Procedure was developed during the on-site survey 3/9 - 12, 2020. Please complete your on-going Quality Assurance / Improvement process related to this tag).*	**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?)*: →	

III. <u>CONTINUOUS QUALITY MANGEMENT SYSTEM</u> B. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. The agency must review the policies and procedures every three years and update as needed. C. Appropriate planning must take place with all Interdisciplinary Team (IDT) members, Medicaid state plan provider, other waiver providers and school services to facilitate a smooth transition from the MFW Program. The person's choices are given consideration whenever possible DOH policies must be adhered to during this process as per the provider's contract. D. All provider agencies, in addition to requirements under each specific service standard, are required to develop, implement, and maintain, at the designated main agency office, documentation of policies and procedures, for the following: a. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. b. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. c. Agency protocols for disaster planning and emergency preparedness. **CASE MANAGEMENT – Effective July 1, 2019** **III. <u>CASE MANAGEMENT AGENCY REQUIRMENTS</u>** **C. Administrative Requirements:** 1. The Case Management Agency must comply with all applicable Federal, State, and waiver			

regulations, policies and procedures regarding case management code of ethics. 2. The Case Management Agency will have an established method of information and data collection. 3. The Case Management Agency will comply with all Federal, State, DOH and Human Services Department (HSD) regulations, policies and procedures, including but not limited to: a. Policies and procedures related to timely submission of medical eligibility determination. b. Policies and procedures related to service provision and appropriate supervision. c. Policies and procedures related to case management training. d. Policies and procedures related to reimbursement of case management services. e. Establish and maintain written grievance procedures.			

TAG # MF14 IDT Meeting and ISP Development			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **CASE MANAGEMENT I. <u>SCOPE OF SERVICES:</u>** D. IDT Meeting and ISP Development and Budget Development (MAD 046 form): 1. The participant/guardian has the opportunity to be involved in all aspects of the ISP. 2. The purpose of IDT meetings is to develop the ISP, review effectiveness of the ISP and revise the ISP. 3. In preparation for an IDT meeting, the CM will offer the participant/participant's representative a list of waiver services as appropriate and will document selected services. 4. The IDT will be comprised of the participant/participant's representative, the PCP and all MFW providers and external providers. The MFW providers are expected to attend ISP meetings and all others are encouraged to attend. 9. The CM will facilitate the IDT meeting. The CM will contact team members at least two (2) weeks prior to the scheduled IDT meeting with date, time, location and purpose of the IDT meeting. This notification may be by phone, written or electronic communication. Documentation of phone, written or electronic notification will be maintained in the person's CM file. The CM will also notify IDT members of cancellations and changes of IDT meeting. 10. The CM is responsible for the ISP signature sheet at the IDT meeting. The date, beginning and end time of the IDT meeting will be written on the signature sheet by the CM.	Based on record review, the Agency did not contact and convene the IDT to discuss and/or modify the ISP and/or address significant changes as required by regulation 1 of 14 individuals. Review of documentation found no evidence of the following: **Evidence that IDT members (*direct care providers and others*) were notified of IDT Meetings at least two weeks in advance:** • No evidence found to verify members of the IDT were notified 2 weeks prior to the IDT Meeting held on 5/1/2019 (Individual #11)	**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. The ISP signature sheet will be attached to the person's ISP and distributed to the IDT with the ISP package. Team members who participate in the IDT by phone will be so indicated on the signature sheet in lieu of an actual signature. 12. The original copy of the ISP will be maintained at the CM agency file. 13. It is the responsibility of each IDT member to request additional documents from the CM. 14. The ISP will include the following: a. Basic information includes at a minimum: the medically fragile participant's name, address, phone number, date of birth, original identification number, parent/guardian information, insurance information, race/ethnicity, primary language, primary diagnosis, ISP cycle and date of the IDT/ISP meeting to develop the plan. b. A list of IDT members that includes both waiver and non-waiver providers with the following information: • Name of team member, including the CM name • Title • Business location • Phone number • Fax number, if possible • Email address, if possible • Funding source c. Present levels of functioning to include diagnosis, strengths and needs. d. IDT members discuss and enumerate issues, strengths and needs with the medically fragile participant and family, and strategies that will be used to address them. e. The ISP outcome is a statement of change that the participant/participant's representative wants to achieve. These include individualized goals and objectives and care activities/strategies for each service delivered. These are based on reasonable and measurable outcomes for the participant.			

f. The participant/guardian has the opportunity to generate outcomes. Team members may assist the participant/participant's representative to identify goals/outcomes and support their choices. g. Each ISP outcome statement is accompanied by a description of the methods, strategies and activities used to work towards the outcome, timelines, criteria for measuring progress and person(s) responsible. The participant/participant's representative with assistance from other medical team members (i.e., PCP and medical specialists) will prioritize the concerns involved in providing services. h. An ISP statement for services and supports necessary to achieve the outcomes. The listing of services and supports shall include the frequency, duration, location, intensity (group or individual), method of delivery, and applicable payment information. Services and supports not funded by the MFW are included. 15. The provider agencies will submit to the CM all service plan(s) within 10 working days following the initial IDT meeting and when revised. 16. The CM will complete the ISP within 15 working days following the IDT meeting. 17. The CM will submit the completed Waiver Review Form (MAD 046 form), commonly known as the budget, based on the decisions of the IDT meeting. 18. Each service requested on the MAD 046 form must have a corresponding care activity/strategy in the ISP. 19. Provider agencies must be present at the IDT meeting or provide their input to the CM or designee before the IDT meeting. The CM or designee contacts the provider following the meeting to update on changes.			

20. The signed SFOC form for each service provider must be maintained in the participant's CM file and sent to the provider agencies. 21. It is the joint responsibility of the CM, provider agency, and participant/participant's representative to monitor the MAD 046 form's maximum dollar amount allocated per LOC and ISP cycle to assure the budget does not exceed approved LOC. 22. The ISP packet is submitted to the Medicaid TPA for prior authorization. The ISP packet is comprised of the following: • ISP with all corresponding care activity/strategy; • MAD 046 form; • Signature sheet of IDT meeting; and • CIU, if necessary. 23. The applicant for the MFW may begin receiving services only after the Medicaid MF Waiver Category of Eligibility (COE) is approved and a budget is in place. 24. The LOC and ISP cycle dates do not change for the participant. If for any reason the LOC, ISP or MAD 046 form are unable to be completed prior to the end of the cycle, the CM will submit a CIU form to the MFW Program Manager or designee informing him or her of the delay in completion. The MFW Program Manager or designee will approve the extension of services.			

TAG # MF19 Case Management Monitoring			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **CASE MANAGEMENT II. <u>CASE MANAGEMENT MONITORING</u>** A. The CM monitors the effectiveness of services provided to the participant as identified through the ISP, written reports, contacts and coordination of services. B. The CM is required to have monthly contact with the participant/family. 1. Face-to-face visits with the participant must occur at least every other month. 2. The CM will have a telephone conference with participant and/or family on the months that a face-to-face visit is not done. 3. Monthly contacts must have supporting documentation by the CM that reflects active implementation of the ISP. 4. At the face-to-face visits with the medically fragile participant, health, safety and welfare are monitored. Face-to-face visits and phone contacts must have supporting documentation by the CM indicating the participant or family were actively involved in the input of strategies and decisions involving the coordination of services. 5. When the medically fragile participant is not able to participate and provide input regarding needs, effectiveness of the ISP, or health and safety needs, the CM will clearly and concisely document in the monthly CM's contact notes that the participant was unable to directly convey his/her needs and the reasons why. The participant's representative will provide information regarding the effectiveness of the ISP, health and safety measures implemented and additional needs of the person.	Based on record review, the Agency did not use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 3 of 14 individuals. **Review of the Agency individual case files revealed face-to-face visits were not being completed as required by standard for the following individuals:** Individual #4 • No home visit was noted between 5/2019 - 6/2019. ◦ 5/29/2019 – Phone Contact. ◦ 6/28/2019 – Phone Contact. • No home visit was noted between 12/2019 - 1/2020. ◦ 12/20/2019 – Phone Contact. ◦ 1/31/2020 – Phone Contact. Individual #10 • No home visit was noted between 12/2019 - 1/2020. ◦ 12/2/2019 – Phone Contact. ◦ 1/8/2020 – Phone Contact. **Review of the Agency individual case files revealed no evidence of monthly contact between the Case Manager and direct service provider or documentation of why no contact was made for the following:**	**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?)*: →	

6. The CM and the Home Health Agency are required monthly to discuss nursing and home health aide services. This will be documented in CM contact notes. The discussion and notes will reflect review budget of utilization, and review of known or newly identified person/family needs for support by Home Health Agency personnel. C. The CM is required to comply with all policies and procedures regarding utilization review, including professional documentation standards. D. The CM reviews the services identified in the ISP and perceived effectiveness of each service with the participant/family. E. The CM will have ongoing contacts with waiver providers to review quality, effectiveness of the services and progress towards the ISP goals. F. The CM will identify and resolve known situations that may be harmful or deemed potentially dangerous to the participant and/or others. G. The CM, in conjunction with participant/family, will identify problems with providers. The specific problems will be reported to the provider agency for resolution. The CM may participate in the resolution of the problems. H. The CM monitors the timeliness of services delivered. I. The CM must report child and adult abuse, neglect and exploitation to the designated State agencies as per State and Federal regulations.	• Individual #9 - None found for 7/2019.		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Medicaid Billing/Reimbursement:			
TAG #MF 1A12 All Services Reimbursement (No Deficiencies)			

New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019

CASE MANAGEMENT V. <u>REIMBURSEMENT</u>

Each Case Management Agency is responsible for providing clinical documentation that identifies case management components of the provision of ISP services, including assessment information, care planning, intervention, communications care coordination, and evaluation. There must be justification in each medically fragile participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of contacts. All services must be reflected in the ISP that is coordinated with the participant/family and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for case management services through this Medicaid Waiver is considered payment in full.
B. The case management services must abide by all Federal, State, HSD, and DOH policies and procedures regarding billable and non-billable items.
C. All billed services must not exceed the capped dollar amount for LOC.
D. Reimbursement for case management services will be based on the current rate allowed for the services.
E. The Case Management Agency must follow all current billing requirements by the HSD and DOH for CM services.
F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.
G. The Case Management Agency has the responsibility to review and assure that the information on the MAD 046 form for their services is current. If an error is identified, the Case Management Agency will work with the Medicaid TPA to correct the MAD 046 form.
H. The MFW Program does not consider the following to be case management duties and will not authorize payment for: 1. Performing specific errands for the participant/participant's representative or family that is not program specific;
2. "Friendly visiting," meaning visits with participant outside of work scheduled;
3. Financial brokerage services, handling of participant's finances or preparation of legal documents;
4. Time spent on paperwork or travel that is administrative for the provider;
5. Transportation of persons on the waiver;
6. Pick up and/or delivery of commodities; and
7. Other non-Medicaid reimbursable activities.

Billing for Case Management services was reviewed for 14 of 14 Individuals. *Progress notes and billing records supported billing activities for the months of November, December 2019 and January 2020.*

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date:	June 16, 2020
To:	Christina Barden, Program Operations Director
Provider:	UNM Medically Fragile Case Management Program
Address:	2300 Menaul Blvd. NE
State/Zip:	Albuquerque, New Mexico 87107
E-mail Address:	cbarden@salud.unm.edu
CC:	Marcia Moriarta, PhD, Executive Director of CDD
E-Mail Address	mmoriarta@salud.unm.edu
Region:	Statewide
Survey Date:	March 6 - 12, 2020
Program Surveyed:	Medically Fragile Waiver
Service Surveyed:	Case Management
Survey Type:	Routine

Dear Ms. Barden:

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 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

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