HEALTH CARE
AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

Date:	October 7, 2024
To:	Charles Clayton, Managing Director
Provider: Address: State/Zip:	Visions Case Management, Inc. 4700 Lincoln Rd NE, Suite 107 Albuquerque, New Mexico 87109
E-mail Address:	charles@visionsnm.com
Region: Survey Date:	Statewide August 30 – September 12, 2024
Program Surveyed:	Mi Via Waiver
Service Surveyed:	Mi Via Consultant Services
Survey Type:	Routine
Team Leader:	Jamie Pond, BS, Staff Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Amanda Castaneda - Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Marie Passaglia, BA, Healthcare Surveyor Advanced / POC Coordinator, Division of Health Improvement/Quality Management Bureau; Valerie V. Valdez, MS, Bureau Chief, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Charles Clayton:

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 # MV111 Consultant Submission Requirements

- Tag # MV130 Service and Support Plan Development Process
- Tag # MV150 Contact Requirements
- Tag # MV1A22 Consultant Competencies: Knowledge of Service
- Tag # MV1A26 Employee Abuse Registry / Consolidated Online Registry
- Tag # MV150.1 Participant Knowledge and Awareness *(Individual Interviews)*

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 instructions 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 affect? (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 MonicaE.Valdez@hca.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@hsd.nm.gov)

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 Rd NE, Suite 200-211
Albuquerque, NM 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@hca.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,

Jamie Pond, BS

Jamie Pond, BS
Team Lead/Staff Manager
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	August 30, 2024
Contact:	**Visions Case Management, Inc.** Charles Clayton, Managing Director **HCA/DHI/QMB** Jamie Pond, BS, Team Lead/Staff Manager
Entrance Conference Date:	August 30, 2024
Present:	**Visions Case Management, Inc.** Charles Clayton, Managing Director Casie Reza, Mi Via Program Manager Evan Anderson, Assistant Mi Via Program Manager Felicia Marquez, Administrative Manager **HCA/DHI/QMB** Jamie Pond, BS, Team Lead/Staff Manager Amanda Castaneda - Holguin, MPA, Healthcare Surveyor Supervisor Kayla Benally, BSW, Healthcare Surveyor
Exit Conference Date:	September 12, 2024
Present:	**Visions Case Management, Inc.** Charles Clayton, Managing Director Casie Reza, Mi Via Program Manager Evan Anderson, Assistant Mi Via Program Manager Felicia Marquez, Administrative Manager **HCA/DHI/QMB** Jamie Pond, BS, Team Lead/Staff Manager Amanda Castaneda - Holguin, MPA, Healthcare Surveyor Supervisor Kayla Benally, BSW, Healthcare Surveyor Marie Passaglia, BA, Healthcare Surveyor Advanced / POC Coordinator Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Valerie V. Valdez, MS, Bureau Chief **DDSD – Mi Via Unit** Elaine Hill, Program Manager
Administrative Locations Visited	0 *(Administrative portion of survey completed remotely*)
Total Sample Size	67
Participant Records Reviewed	67
Participants Interviewed	20
Consultant Staff Records Reviewed	23
Consultant Staff Interviewed	21
Administrative Interviewed	4

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records
- Participant Agency Case Files, including, but not limited to:
  - Service Support Plans
  - Employer of Record Questionnaire
  - Primary Freedom of Choice / Waiver Change Form / Consultation Agency Change Form
  - Mi Via Monthly Contact Forms
- Personnel Files
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Employee Abuse Registry

CC: Distribution List:

HCA - Division of Health Improvement
HCA - Developmental Disabilities Supports Division
HCA - Medical Assistance Division

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.

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 in 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 corrections 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@hca.nm.gov for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your respective Regional DDSD Office.
4. Submit your POC to via email to MonicaE.Valdez@hca.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Mi Via Unit.
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. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

1. Your internal documents are due within a *maximum* of 45 business days of receipt of your Report of Findings.
2. Please submit your documents electronically according to the following: If documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the State email account. If documents contain PHI **do not** submit PHI directly to the State email account. *You may submit PHI **only** when **replying** to a **secure** email received from the State email account*. When possible, please submit requested documentation using a "zipped/compressed" file to reduce file size. You may also submit documents via S-Comm (Therap), or another electronic format, i.e., flash drive.
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://www.nmhealth.org/publication/view/form/2249/
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@hca.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 of the decisions of the IRF committee.

Agency: **Visions Case Management, Inc. - Statewide**
Program: Mi Via Waiver
Service: Mi Via Consultant Services
Survey Type: Routine
Survey Date: **August 30 – September 12, 2024**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
Tag # MV111 Consultant Submission Requirements			
Mi Via Self-Directed Waiver Program Service Standards effective July 1, 2022 rev March 2023 **Appendix A: Service Descriptions in Detail Consultant/Support Guide: PRE-ELIGIBILITY/ENROLLMENT: II. Scope of Service** B. The actual enrollment meeting should be conducted within 30 days of receiving the PFOC. The enrollment process and activities include but are not limited to: 12. Ensure the completion and submission of the initial SSP within sixty (60) days of eligibility determination so that it can be in effect within ninety (90) days **IV. Reimbursement** C. It is the State's expectation that consultants will work with the participant to ensure that an approved service and support plan (SSP) is in effect within ninety (90) days of the start of Medicaid eligibility. Any exceptions to this timeframe must be approved by the State. The consultant will submit an explanation of why the plan could not be effective within the 90-day timeline. Approval must be obtained in writing from the DOH Mi Via Program Manager or their designate for any plan not in effect ninety (90) days after eligibility is approved, prior to billing for that service. **ONGOING CONSULTANT SERVICES II. Scope of Service**	Based on record review, the Agency did not submit required documentation in a timely manner as required by Standard for 2 of 67 participants. Review of the Agency's participant case files revealed the following were not found, incomplete, and/or submitted past required timelines: **Evidence SSP goals and budget were submitted online for TPA review at least 30 calendar days prior to the expiration of current plan:** • Participant # 6 – SSP Expiration 6/30/2024; Submitted 6/6/2024. • Participant # 24 – SSP Expiration 6/30/2024; Submitted 6/6/2024.	**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?)*: →	

12. 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. 23. Assist participants to transition to another consultant provider when requested. Transitions should occur within thirty (30) days of request on the Consultant Agency Change (CAC) form but may occur sooner based on the needs of the participant. Transition from one consultant provider to another can only occur at the first of the month. (Please refer to Mi Via Consultant Agency Transfer procedures for details). 24. Assist participants to transition from and to other waiver programs. Transition from one waiver to another can only occur at the first of the month. The DOH will review the LOC expiration date prior to or upon receipt of the Waiver Change Form (WCF). If a participant is within ninety (90) days of the expiration of the LOC, the DOH Regional Office or appropriate program manager will advise the participant they must wait until the LOC is approved before initiating the transfer. (Please refer to Mi Via Waiver Transition procedures for further details). 25. 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 # MV130 Service and Support Plan Development Process			
Mi Via Self-Directed Waiver Program Service Standards effective July 2022 rev March 2023 **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 their 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** **SSP Development** 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;	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 1 of 67 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:** • Contact information not listed for the In Home Living Service Vendor and Community Direct Support Vendor. *(Note: Phone number was personal number of the staff not the Vendor).* (#42)	**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?)*: →	

3. include individually identified goals and preferences related to relationships, 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** **B.** The actual enrollment meeting should be conducted within 30 days of receiving the PFOC. The enrollment process and activities include but are not limited to: 12. Ensure the completion and submission of the initial SSP within sixty (60) days of eligibility determination so that it can be in effect within ninety (90) days. **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: 9. 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 support provided through the Mi Via Program. **Appendix B: Service and Support Plan (SSP) Template**			

Tag # MV150 Contact Requirements			
Mi Via Self-Directed Waiver Program Service Standards effective July 2022 rev March 2023 **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** **III. 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 contact the participants as required by Standard and Regulations for 4 of 67 participants. Review of the Agency's participant case files found no evidence of contacts for the following: **<u>Pre-Eligibility Phase:</u>** **Pre-Eligibility Monthly Contacts:** • Participant #66 - None found for August 2024. **<u>Ongoing Contacts:</u>** • Participant #8 – No required quarterly residential visits found for 9/2023 – 12/2023 and 2/2024 – 5/2024. **Monthly Monitoring of Participant Budget Utilization/Spending Levels:** • Participant #53 - None found for 10/2023, 11/2023, 3/2024. • Participant #54 - None found for 7/2024. **Monthly Monitoring of Participant Emergency Back Up Plan:** • Participant #53 - None found for 10/2023, 11/2023.	**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 to 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	Completion Date
Agency Personnel Requirements:			
Tag # MV1A22 Consultant Competencies: Knowledge of Service			
Mi Via Self-Directed Waiver Program Service Standards effective July 1, 2022 rev March 2023 **4. MI VIA CONTRACTORS AND SUPPORTS** **V. 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: 1. Have a current business license issued by the state, county, or city government as required; 2. Maintain financial solvency; 3. Ensure all employees or sub-contractors providing consultant services under this standard attend all state-required trainings and demonstrate knowledge of and competence with the Mi Via policies and procedures, philosophy of self-direction, financial management processes and responsibilities, needs assessments, person-centered planning and service plan development, the CMS HCBS Settings Requirements and other federal regulations, and adhere to all other training requirements as specified by the state; 4. Ensure that all Consultants are trained and competent in the use of the fiscal management and FMA online system; 5. Ensure all employees providing services under this scope of service and all other staff paid with Mi Via funds, are trained on how to identify and where to report abuse,	Based on interview, the Agency did not ensure the consultant had the knowledge of the requirements for the entire system to effectively provide and monitor services as indicated in standards for 1 of 21 Consultants. **When Consultants were asked, what steps do you take when a vendor does not resolve an identified issue or does not provide you with needed documents, the following was reported:** • #514 stated, "If they do not resolve, we try to get details of what is exactly going on. If they are not doing more, we talk to the Participant or EOR to see if they want to switch to another vendor." Consultant did not indicate knowledge of the RORA system. **When Consultants were asked, what state agency do you report to if you suspect Abuse, Neglect and/or Exploitation, the following was reported:** • #514 stated, "We report it to the Department of Health, DDSD."	**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?)*: →	

neglect and exploitation, as well as how to report suspicious injuries, environmental hazards as well as death; and 6. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees. B. The consultant provider shall develop a quality management plan to ensure compliance with regulatory and program requirements and to identify opportunities for continuous quality improvement. D. The consultant provider shall ensure that participants have access to their consultant. This requirement includes, but is not limited to the following: 4. The consultant provider must assure that consultants and other staff will respond to participant and/or participant representative communications within three (3) working days except in emergency situations where a response is needed within twenty-four (24) hours during the work week. **Regional Office Request for Assistance (RORA)** DDSD has statewide Regional Offices to provide information and technical assistance to anyone at any time. Specifically, each Regional Office is staffed with generalists and program area experts (e.g. Mi Via Liaisons, Community Inclusion Coordinators, Nurses, Behavior Specialists, Trainers, and Crisis Specialists) to assist with any specific Mi Via Waiver questions and to provide technical assistance. DDSD's RORA system is the mechanism to track any formal requests for Regional Office assistance. **Appendix A: Service Descriptions in Detail** **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: 6. Educate the participant regarding Mi Via covered and non-covered supports, services, and goods. 7. 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. 8. Assist the participant to identify resources outside the Mi Via Program that may assist in meeting their needs. 11. 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. 17. Assist the participant to identify and resolve issues related to the implementation of the SSP. 18. Serve as an advocate for the participant, as needed, to enhance their opportunity to be successful with self-direction. 19. Assist the participant with reconsiderations of goods or services denied by the Third-party Assessor (TPA), submit documentation as required, and participate in Fair Hearings as requested by the participant or state. 20. Assist the participant with required quality assurance activities to ensure implementation of the participant's SSP and utilization of the authorized budget. 21. Assist participants to identify measures to help them assess the quality of their services/supports/goods and self-direct their quality improvement process.			

Tag # MV1A26 Employee Abuse Registry / Consolidated Online Registry			
NMAC 8.370.8.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the authority has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the authority, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two business days following receipt. Only authority staff designated by the custodian may access, maintain and update the data in the registry. **A. Provider requirement to inquire of registry.** A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. **B. Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. **C. Applicant's identifying information required.** In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 4 of 23 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #506 – Date of hire 3/1/2023. Completed on 3/6/2023. • #507 – Date of hire 6/1/2019. Completed on 6/6/2019. • #518 – Date of hire 2/1/2023. Completed on 2/5/2024. • #521 – Date of hire 11/1/2022. Completed on 11/9/2022.	**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?)*: →	

reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. **D. Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. **E. Documentation for other staff.** With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. **F. Consequences of noncompliance.** The authority or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary			

penalty not to exceed $5,000 per instance, or termination or non-renewal of any contract with the authority or other governmental agency.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Completion Date
Administrative Requirements:			
Tag # MV150.1 Participant Knowledge and Awareness *(Individual Interviews)*			
Mi Via Self-Directed Waiver Program Service Standards effective July 1, 2022 rev March 2023 **1. INTRODUCTION TO MI VIA** **D. Participant Rights and Freedoms** As a person with an intellectual and/or developmental disability (I/DD), and a person receiving services, I have the same basic legal, civil, and human rights and responsibilities as everyone else. My rights shall never be limited or restricted unnecessarily; without due process and the ability to challenge the decision, even if I have a guardian. All my rights should be honored through any assistance, support, and services I receive. **Some Examples of My Rights Include:** ➢ Get paid competitive wages to work in an inclusive setting ➢ Contribute to my community ➢ Access services in the community the same way people who don't receive services do ➢ Full inclusion in community and cultural life ➢ Have access to education and information in a way I can understand ➢ Choose where I live based on what I can afford ➢ Choose who I live with ➢ Lock my doors and home, and choose those who may come in ➢ Access common places in my home ➢ Exercise tenant rights in accordance with state law	Based on interview, the Agency did not ensure the Participant was aware of the following requirements as indicated in standards for 1 of 20 Participants. **When Participants were asked if they know how to make a complaint about vendors or any of their staff, and if they have made a compliant was it resolved by the agency, the following was reported:** • Participant #36 stated, "No, he would tell me and then we could. It would be the DHI Hotline."	**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?)*: →	

➢ Accessibility wherever I go ➢ Choose to be alone and my privacy respected ➢ Privacy and confidentiality ➢ Access to all my personal information (financial, medical, programmatic, behavioral, legal) ➢ Receive information to make informed decisions regarding my health care. ➢ Choose supports that I need and want ➢ Choose from all available supports ➢ Independence ➢ Choose/develop my own schedule ➢ Go out at any time ➢ Develop my own person-centered plan of support ➢ Be treated with dignity and respect ➢ Control my money ➢ Be free from coercion, restraint, seclusion, and retaliation ➢ Have visitors at my home at any time ➢ Choose when/what to eat, and have access to food at any time ➢ Choose my clothing ➢ Be part of a family or start one ➢ Live with my partner or get married ➢ Form loving relationships, either platonic or sexual, with whomever I choose ➢ Be free from abuse, neglect, exploitation ➢ Have access to advocacy supports and resources ➢ Participate in any discussion about restricting my right ➢ Vote ➢ Exercise religion or belief of my choice **Any restriction or modification to these rights:** ➢ Must demonstrate informed consent by me.			

➢ Must have an assurance that interventions and supports will cause no harm to me. ➢ Must be the result of a documented health and safety issue. ➢ Must be reflected in the person-centered plan. ➢ Must have documented less intrusive supports that were attempted prior to the modification/restriction. ➢ Will be communicated to me; in a way I can understand. Requires regular review to measure and assess effectiveness of restriction/modification. ➢ Requires a fade-out plan for the restriction/modification.			

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 1, 2022 rev March 2023 **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. B. Consultants must obtain approval in writing from the DOH Mi Via Program Manager or their designate for any pre-eligibility phase exceeding the ninety (90) day timeframe for any participant. The consultant will submit an explanation of why the pre-eligibility phase has exceeded the 90-day timeline. C. It is the State's expectation that consultants will work with the participant to	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 67 of 67 participants. *Contact notes and billing records supported billing activities for the months of May, June and July, 2024.*		

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

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. D. It is the State's expectation that consultants will work with participants transferring from another waiver to ensure that an approved services and supports plan (SSP) is in effect within ninety (90) days of a waiver change. Consultants must obtain approval in writing from the DOH Mi Via Program Manager or their designate for any transfers occurring over the ninety (90) day timeframe. E. Consultant providers shall submit all billing through the Mi Via FMA as determined by the State. F. Non-Billable services Include: 1. Services furnished to an individual who does not reside in New Mexico. 2. Services furnished to an individual who is not eligible for the Mi Via Program. 3. Outreach activities, including contacts with persons potentially eligible for the Mi Via Program. 4. Consultant services furnished to an individual who is in an institution (e.g., ICF/IID, nursing facility, hospital) or is incarcerated, except for discharge planning services in accordance with MAD Supplement No. 01-22			

HEALTH CARE AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

Date:	December 5, 2024
To:	Charles Clayton, Managing Director
Provider:	Visions Case Management, Inc.
Address:	4700 Lincoln Rd NE, Suite 107
State/Zip:	Albuquerque, New Mexico 87109
E-mail Address:	charles@visionsnm.com
Region:	Statewide
Survey Date:	August 30 – September 12, 2024
Program Surveyed:	Mi Via Waiver
Service Surveyed:	Mi Via Consultant Services
Survey Type:	Routine

Dear Mr. Charles Clayton:

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.

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,

Jamie Pond, BS

Jamie Pond, BS
Staff Manager
DHI - Quality Management Bureau