NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

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

Date:	December 7, 2022
To:	Christy Barden, Program Operations Director
Provider:	UNM Medically Fragile Case Management
Address:	2300 Menaul NE
State/Zip:	Albuquerque, NM 87107
E-mail Address:	cbarden@salud.unm.edu
CC:	Marcia Moriarta, Executive Director
E-mail Address:	MMoriarta@salud.unm.edu
Region:	Statewide
Survey Date:	November 7 - 17, 2022
Program Surveyed:	Medically Fragile Waiver
Service Surveyed:	Medically Fragile Case Management Services
Survey Type:	Routine
Team Leader:	Alyssa Swisher, RN, BSN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Jamie Pond, BS, Staff Manager, Division of Health Improvement/Quality Management Bureau; Valerie V. Valdez, MS, Bureau Chief, Division of Health Improvement/Quality Management Bureau; and Monica Valdez, BS, Plan of Corrections Coordinator, Advanced Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Christy 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 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 #MFC108 - Documentation Requirements – Agency Case Files
- TAG #MFC1A28.2 - Incident Mgt. System- Parent/Guardian Training
- TAG #MFC1A28.1 - Incident Mgt. System- Personnel Training

- TAG #MFC69 - Case Manager Submission Requirements
- TAG #MFC19 - Case Management Monitoring
- TAG #MFC4A1 - Case Management Reimbursement

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

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

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

On-going Quality Assurance/Quality Improvement Processes:
- What is going to be done on an ongoing basis? (i.e., file reviews, etc.)
- How many individuals is this going to effect? (i.e., percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e., weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e., retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

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

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

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

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
PO Box 2348
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

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

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

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

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5300 Homestead NE Suite #300 - 331
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@doh.nm.gov if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Alyssa Swisher, RN, BSN

Alyssa Swisher, RN, BSN
Team Lead/Nurse Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	November 7, 2022
Contact:	**UNM Medically Fragile Case Management** Christy Barden, Program Operations Director **DOH/DHI/QMB** Alyssa Swisher, RN, BSN, Team Lead/Nurse Healthcare Surveyor
On-site Entrance Conference Date:	November 7, 2022
Present:	**UNM Medically Fragile Case Management** Christy Barden, RN, MSN, Program Operations Director Ann Marie Parmenter, RN, MSN, Quality Assurance/Quality Improvement Lead, Nurse Case Manager Vail Woodard, RN, MSN, Education and Outreach, Nurse Case Manager **DOH/DHI/QMB** Alyssa Swisher, RN, BSN Team Lead/Nurse Healthcare Surveyor Jamie Pond, BS, Staff Manager Valerie V. Valdez, MS, Bureau Chief Monica Valdez, BS, Plan of Corrections Coordinator, Advanced Healthcare Surveyor **DDSD – Clinical Services Bureau** Iris Clevenger, RN, DDSD Medically Fragile Waiver Program Manager
Exit Conference Date:	November 17, 2022
Present:	**UNM Medically Fragile Case Management** Christy Barden, RN, MSN, Program Operations Director Ann Marie Parmenter, RN, MSN, Quality Assurance/Quality Improvement Lead, Nurse Case Manager **DOH/DHI/QMB** Alyssa Swisher, RN, BSN Team Lead/Nurse Healthcare Surveyor Jamie Pond, BS, Staff Manager Valerie V. Valdez, MS, Bureau Chief Monica Valdez, Plan of Corrections Coordinator, Advanced Healthcare Surveyor **DDSD – Clinical Services Bureau** Iris Clevenger, RN, DDSD Medically Fragile Waiver Program Manager
Administrative Locations Visited	1 (2300 Menaul NE, Albuquerque New Mexico 87107)
Total Sample Size	24
Participant Records Reviewed	24
Participant/Family Members Interviewed	3
Case Managers Interviewed	13
Case Mgt Personnel Records Reviewed	13
Administrative Personnel Interviewed	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
  - Case Manager Monthly Contact Notes
  - Healthcare Documentation Regarding Annual Physicals
  - 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
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General

Attachment A

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;

- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing, and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

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

POC Document Submission Requirements

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

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.

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

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

Attachment C

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

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **UNM Medically Fragile Case Management - Statewide Region**
Program: Medically Fragile Waiver
Service: Case Management
Survey Type: Routine
Survey Dates: **November 7 - 17, 2022**

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
TAG #MFC108 Documentation Requirements – Agency Case Files			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Waiver Service Standards Effective 7/1/2022 **GENERAL PROVIDER REQUIREMENTS** V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT A. All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements: a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: i. Consumer ii. Primary caregiver iii. Family/relatives, guardians or conservators v. Physician vi. Case manager vii. Provider agencies viii. Pharmacy, if appropriate b. Individual's health plan, if appropriate c. Individual's current ISP d. Progress notes and other service delivery documentation e. A medical history which may include demographic data; current and past medical diagnoses including the cause of the medically	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 24 participants. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Guardianship Documents:** • Not Found (#7)	**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?)*: →	

fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environmental, medications); immunization. B. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. **CASE MANAGEMENT** III. CASE MANAGEMENT AGENCY REQUIRMENTS D. Documentation Requirements: 1. Documentation must be completed in accordance with applicable Medically Fragile standards. 2. All documentation forms will contain at least: participant's name, date of birth, date of report, provider agency name, and CM's name and credentials. 3. All report pages and notes will include at least the participants' name, date and document title. 4. All documentation will be signed and dated by the CM. Verified electronic signatures may be used. CM name and credential typed on a document is not sufficient. 5. Each participant will have an individual clinical file (see general provider requirements).			

TAG #MFC1A28.2 Incident Mgt. System-Parent / Guardian Training			
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 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.	Based on record review and interview, the Agency did not maintain 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 1 of 24 participants. **When the Participant / Family member was asked, what State Agency do you report suspected Abuse, Neglect or Exploitation to, the following was reported:** • The participant / family member for Participant #19 stated, "Not sure off the top of my head. I would have to google it, APS."	**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?)*: →	

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Personnel Requirements:			
TAG #MFC1A28.1 Incident Mgt. System-Personnel Training			
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:**	Based on record review and interview, the Agency did not ensure Incident Management Training for 1 of 13 Agency Personnel. **When Agency Personnel were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • Agency Personnel #503 stated, "Exploitation: We don't really see that much, we don't handle their funds." Per NMAC 7.1.14 agency personnel are to receive training that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's			

request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule. **NMAC 7.1.13.10** **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Administrative Requirements:			
TAG #MFC69 Case Manager Submission Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Waiver Service Standards Effective 7/1/2022 **CASE MANAGEMENT** I. SCOPE OF SERVICES: C. Eligibility Determination and Level of Care (LOC)/Funding Following Allocation: 4. The CM completes an assessment using the MFW parameters and other appropriate resources to write the Comprehensive Individualized Assessment-Family Centered Review (CIA/FCR). Refer to the MFW Eligibility Training Manual parameter instructions for details. 5. The CM and PCP complete the DOH 378, Long Term Care Assessment Abstract (LTCAA). The PCP must sign and date the LTCAA form, stating that the PCP has seen and evaluated the person. 6. The Level of Care (LOC) packets consist of the following: ▪ LTCAA DOH 378 form ▪ PCP's signed H&P ▪ CIU for extensions ▪ Other supporting medical documents as needed 7. The LOC packet is submitted to Medicaid Third Party Assessor (TPA) who will make a determination of the LOC. The LOC determines the funding amount available to the medically fragile person based on needs identified in the ISP during the LOC/ISP cycle.	Based on record review, the Agency did not submit required documentation in a timely manner has required by Standard for 2 of 24 participants. Review of the Agency's participant case files revealed the following were not found, incomplete, and/or submitted past required timelines: **Evidence Level of Care, ISP and MAD046 (budget) were submitted prior to the expiration of current plan:** • Participant #14 – ISP Expiration 12/11/2021; Submitted 12/13/2021. • Participant #15 – ISP Expiration 3/7/2022; Submitted 3/24/2022.	**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?)*: →	

TAG # MFC19 Case Management Monitoring			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Waiver Service Standards Effective 7/1/2022 **CASE MANAGEMENT** II. CASE MANAGEMENT MONITORING 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 participant for 2 of 24 participants. **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:** • Participant #17 - None found for December 2021, April 2022, July 2022, September 2022, and October 2022. • Participant #19 - None found for February 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?)*: →	

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.			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Medicaid Billing/Reimbursement:			
TAG #MFC4A1 Case Management Reimbursement			
New Mexico Department of Health **Developmental Disabilities Supports Division** **Medically Fragile Waiver Service Standards** **Effective 7/1/2022** **CASE MANAGEMENT** V. REIMBURSEMENT 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.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed, which contained the required information for 1 of 24 participants. Participant #13 July 2022 • The Agency billed 1 unit of Case Management Services (T2022) from 7/1/2022 through 7/30/2022. Documentation for the Monthly Visit on 7/13/2022 did not contain the time out of contact with the eligible recipient to justify 1 unit billed.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: February 16, 2023

To: Ann Marie Parmenter, Program Operations Director

Provider: UNM Medically Fragile Case Management
Address: 2300 Menaul NE
State/Zip: Albuquerque, NM 87107

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

CC: Marcia Moriarta, Executive Director

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

Region: Statewide
Survey Date: November 7 - 17, 2022
Program Surveyed: Medically Fragile Waiver

Service Surveyed: Medically Fragile Case Management Services

Survey Type: Routine

Dear Ms. Parmenter:

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

Q.23.2.MFW.D0676.1/2/3/4/5.RTN.09.22.047