HEALTH CARE
AUTHORITY

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Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

Date:	March 27, 2025
To:	Sarah Martinez, Executive Director
Provider: Address: State/Zip:	Peak Developmental Services, Inc. 8501 Candelaria Rd NE, Building A1 Albuquerque, New Mexico 87112
E-mail Address:	smartinez@nmddwcm.com
Region: Survey Date:	Statewide February 17 – 27, 2025
Program Surveyed:	Supports Waiver
Service Surveyed:	Community Support Coordination
Survey Type:	Routine
Team Leader:	Jamie Pond, BS, Staff Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Monica Valdez, BS, Healthcare Surveyor Advanced / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau; Marissa Carpio-Carrillo, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Martinez;

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 Participants receiving services through the Support 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 # SWP03.1 Orientation and Enrollment
- Tag # SWP02 Pre-Eligibility Requirements: Monitoring and Evaluation of Services
- Tag # SWP01 Guardianship and EOR
- Tag # SWP11 Grievance Procedures
- Tag # SW1A28 Participant Abuse, Neglect and Exploitation Information

- Tag # SW4A1 Community Support Coordinator 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, 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 into 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 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 HCA 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*
HCA/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 HCA /OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.Medina-Lujan@hca.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:	February 17, 2025
Contact:	**Peak Developmental Services, Inc.** Sarah Martinez, Executive Director **HCA/DHI/QMB** Jamie Pond, BS, Team Lead/Staff Manager
Entrance Conference Date:	*Agency waived entrance meeting*
Exit Conference Date:	February 27, 2025
Present:	**Peak Developmental Services, Inc.** Sarah Martinez, Executive Director **HCA/DHI/QMB** Jamie Pond, BS, Team Lead/Staff Manager Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator Marissa Carpio-Carrillo, RN, Nurse Healthcare Surveyor **DDSD – Supports Waiver Unit** Anysia Fernandez, Supports Waiver Program Manager
Administrative Locations Visited:	0 *(Administrative portion of survey completed remotely*)
Total Sample Size:	13
Persons Served Records Reviewed	13
Total Number of *Secondary Freedom of Choices* Reviewed:	1
	9 *Pre-eligibility (Note: No SFOC's were required for 12 participants in the sample, as they were in pre-eligibility.)*
	3 *Self-Directed Services (Note: No SFOC's were required for 3 participants in the sample, as they chose self-directed services.)*
Community Support Coordinator Personnel Records Reviewed:	10
Administrative Interviews:	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Participant Program Case Files, including, but not limited to:
  - Individual Service Plans
- Personnel Files, including subcontracted staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records

- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / Improvement Committee Meeting Minutes

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 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@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 Regional Office for region of service surveyed.
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 Conduent 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/ The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
3. 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 on the decisions of the IRF committee.

Agency: **Peak Developmental Services, Inc. - Statewide**
Program: Supports Waiver
Service: Community Support Coordination
Survey Type: Routine
Survey Date: **February 17 – 27, 2025**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
TAG # SWP03.1 Orientation and Enrollment			
NMAC 8.314.7.16 INDIVIDUAL SERVICE PLAN (ISP) AND AUTHORIZED ANNUAL BUDGET (AAB): (2) Pre-planning: (a) the CSC contacts the eligible recipient upon their choosing enrollment in the supports waiver program to provide information regarding this program, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with participation in the supports waiver; (b) the CSC discusses areas of need to address on the eligible recipient's ISP. The CSC provides support during the annual re-determination process to assist with completing medical and financial eligibility in a timely manner **Support Waiver Service Standards Effective 9/1/2020** The Initial Waiver Eligibility phase is 90 days. Any CSC who is assisting a participant who has not established Medicaid eligibility in 90 days will need to receive an extension from DDSD prior to the expiration of the 90 days. Once Medicaid eligibility has been established and the initial ISP and budget are approved, ongoing CSC services begin, and the CSC must schedule an ISP meeting within 10 days. In the Initial Waiver Eligibility and Waiver Enrollment phase the CSC: 1. Contacts the individual within five (5) working days after receiving the PFOC to	Based on record review, the Agency did not maintain evidence that initial contact was made and processes were followed as indicated by Standards and Regulations for 3 of 13 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Evidence the orientation / enrollment meeting scheduled within 5 working days of receipt of the PFOC. (#5, 12, 13) • Evidence the agency assigned a CSC and contacted the new Supports Waiver Participant within five (5) working days of the receipt of the Primary Freedom of Choice or CSC Agency Change Form. (#12) • Evidence the assigned CSC conducted the waiver enrollment meeting within 30 days of the PFOC being received (#5, 13)	**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?)*: →	

schedule an initial orientation and enrollment meeting: 2. Conducts a waiver enrollment meeting within 30 days of receiving the PFOC. (Requirements for the waiver enrollment process are described in 16.3.1 Waiver Eligibility Recertification and Program Paperwork) Informs, supports, and assists new Supports Waiver participants with the requirements for establishing Level of Care (LOC) within ninety (90) calendar days of receiving the PFOC following processes described in 16.3.3 Medical Eligibility. 3. Educates the participant regarding the required documentation and submission process to establish Financial Eligibility and monitors the status of the submission of the required documentation to ISD. 4. Routinely reports the status of initial participant eligibility to the DOH – DDSD in frequency and format requested by DOH – DDSD. 5. Assist the participant to identify any barriers that may occur during this process. 6. Contacts the participant at least monthly for follow up on initial waiver eligibility and waiver enrollment activities. This contact can be either be face-to face or by telephone but at least one (1) face to face visit is required. 7. Provide as much support as needed during this phase to ensure that the medical and financial eligibility is obtained. 8. As much as possible, conducts service pre-planning during this time to ensure the completion and submission of the initial ISP so that it will be in effect within ninety (90) calendar days off eligibility determination. 9. Shall not to exceed three (3) months of monthly billing. If an extension is granted during this phase by DDSD then the monitoring requirements are subject to DDSD approval. 10. Prior to ISP development or during the development process, obtain a copy of the Approval Letter or verify that the Income			

Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the Supports Waiver program. 11. Schedule an ISP meeting within ten (10) business days of the approval verification from ISD. For those participants transferring from another waiver or benefit program like State General Fund or Centennial Care Community Benefit, the transfer meeting and transfer of program information as referenced in the Supports Waiver transition grid and the waiver change form must occur prior to the ISP meeting and according to HSD- DOH transition guidelines. 12.Submit all Initial Waiver Eligibility/ Waiver Enrollment service billing following the Human Services Department (HSD) instructions available through the Medicaid Provider Portal.			

TAG # SWP02 Pre-Eligibility Requirements: Monitoring and Evaluation of Services			
Chapter 16.2 Initial Waiver Eligibility and Waiver Enrollment Activities Initial Waiver Eligibility and Waiver Enrollment Services are intended to provide information, support, guidance, assistance, and monitoring to individuals during the Supports Waiver initial enrollment and Medicaid eligibility process. This includes both financial and medical components. The level of support provided is based upon the unique needs of the individual for the sole purpose of helping them navigate the Medicaid eligibility and enrollment processes and to ensure that the participant is successful in both. The Initial Waiver Eligibility phase is 90 days. Any CSC who is assisting a participant who has not established Medicaid eligibility in 90 days will need to receive an extension from DDSD prior to the expiration of the 90 days. Once Medicaid eligibility has been established and the initial ISP and budget are approved, ongoing CSC services begin, and the CSC must schedule an ISP meeting within 10 days. In the Initial Waiver Eligibility and Waiver Enrollment phase the CSC: 1. Contacts the individual within five (5) working days after receiving the PFOC to schedule an initial orientation and enrollment meeting: 2. Conducts a waiver enrollment meeting within 30 days of receiving the PFOC. (Requirements for the waiver enrollment process are described in 16.3.1 Waiver Eligibility Recertification and Program Paperwork) Informs, supports, and assists new Supports Waiver participants with the requirements for establishing Level of Care (LOC) within ninety (90) calendar days of receiving the PFOC following processes described in 16.3.3 Medical Eligibility. 3. Educates the participant regarding the required documentation and submission	Based on record review, the Agency did not make contact with the participants during pre-eligibility as required by Standard and Regulations for 4 of 13 participants. Review of the Agency's participant case files found no evidence of contacts for the following: **<u>Pre-Eligibility Phase:</u>** **Monthly Contacts:** • Participant #2 - None found for 7/2024, 9/2024, 11/2024. • Participant #5 - None found for 9/2024, 12/2024, and 1/2025. • Participant #12 - None found for 1/2025. • Participant #13 - None found for 12/2024 and 1/2025.	**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?)*: →	

process to establish Financial Eligibility and monitors the status of the submission of the required documentation to ISD. 4. Routinely reports the status of initial participant eligibility to the DOH – DDSD in frequency and format requested by DOH – DDSD. 5. Assist the participant to identify any barriers that may occur during this process. 6. Contacts the participant at least monthly for follow up on initial waiver eligibility and waiver enrollment activities. This contact can be either be face-to face or by telephone but at least one (1) face to face visit is required. 7. Provide as much support as needed during this phase to ensure that the medical and financial eligibility is obtained. 8. As much as possible, conducts service pre-planning during this time to ensure the completion and submission of the initial ISP so that it will be in effect within ninety (90) calendar days off eligibility determination. 9. Shall not to exceed three (3) months of monthly billing. If an extension is granted during this phase by DDSD then the monitoring requirements are subject to DDSD approval. 10.Prior to ISP development or during the development process, obtain a copy of the Approval Letter or verify that the Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the Supports Waiver program. 11.Schedule an ISP meeting within ten (10) business days of the approval verification from ISD. For those participants transferring from another waiver or benefit program like State General Fund or Centennial Care Community Benefit, the transfer meeting and transfer of program information as referenced in the Supports Waiver transition grid and the waiver change form must occur prior to the ISP			

meeting and according to HSD- DOH transition guidelines. 12.Submit all Initial Waiver Eligibility/ Waiver Enrollment service billing following the Human Services Department (HSD) instructions available through the Medicaid Provider Portal.			

TAG # SWP01 Guardianship and EOR			
Support Waiver Service Standards Effective 9/1/2020 **2.3.2 Employer of Record Responsibilities** An eligible recipient may be their own EOR unless the eligible recipient is a minor or has a plenary or limited guardianship or conservatorship over financial matters in place. If the participant is not their own EOR, the EOR must be a legal representative of the recipient. The EOR must: 1. Submit all required documents to the FMA. Documents must be completed and provided to the FMA according to the timelines and rules established by the Human Services Department through their contractor. Documents include but are not limited to vendor and employee enrollment agreements, vendor information forms, criminal background check forms, timesheets, payment request forms (PRFs), invoices, and other documentation needed by the FMA to enroll and/or process payment to employees and vendors. 2. Arrange for the delivery of services, supports and goods. 3. Ensure that all employees, vendors, and providers complete DOH/DDSD/HSD required training for the Supports Waiver and any additional training needs identified in the participants ISP and by the participant. 4. Recruit, hire, train, schedule, supervise or dismiss service providers (vendors and/or employees). 5. Maintain employee and service records and documentation (for at least six (6) years from date of service and ongoing) in accordance with Supports Waiver regulations and Federal and State employment rules. 6. When necessary, request assistance from the CSC with any of the above responsibilities. **6.4 Changing Employer of Record** A participant may choose to change the EOR	Based on record review, the Agency did not maintain a complete participant record at the administrative office for 2 of 13 participants. Review of the Agency participant case files revealed the following items were not found, incomplete, and/or not current: **Guardianship Documents or Representative Paperwork:** • Not Found (#1, 3)	**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?)*: →	

under the participant directed model. The CSC should inquire about the reason for the request and attempt to resolve any issues or concerns with the person and/or guardian and the Employer of Record if possible. If there is no resolution of the participant wishes to change EORs. The CSC: 1. Provides the participant or legal representative, when applicable, with the appropriate forms to enroll as employer of record and forward the necessary enrollment forms to the FMA and to DDSD. 2. Ensures that the new EOR has received education and program information as described in 16.3.1 Annual Waiver Eligibility Recertification and Program Paperwork. 3. Works with the participant to determine if there is a need to expedite the EOR process and make that request to DDSD. 4. Ensures that all the necessary forms including new EOR, vendor and employee packets have been submitted to establish new employees and vendors with a new EOR. **16.4 Administrative Requirements** The CSC agency shall ensure that participants have access to the CSC. This requirement includes, but is not limited to the following: 8. Maintain HIPAA compliant primary records for each participant including, but not limited to: k. Copy of legal guardianship or representative papers and other pertinent legal designations and proof that they have been submitted to the FMA if applicable; p. Supports Waiver approval of relative or legal representative; q. Employer of Record Questionnaire			

TAG # SWP11 Grievance Procedures			
NMAC 8.314.7.22 Grievance/Complaint System: An eligible recipient has the opportunity to register grievances or complaints concerning the provision of services under the supports waiver program. Eligible recipients may register complaints with either HSD/MAD or DOH/DDSD via e-mail, mail, or phone. Complaints will be referred to the appropriate department for resolution. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing. **Support Waiver Service Standards Effective 9/1/2020** **15.1.1 General Agency-Based Requirements** Supports Waiver Agencies are required to: 6. Communicate the agency grievance policy to the Supports Waiver participant **16.3.1 Annual Waiver Eligibility Recertification and Program Paperwork** The CSC conducts a program meeting annually. This meeting consists of providing program information and completing annual paperwork prior to the expiration of the budget term. Paperwork and forms related to Supports Waiver issued by the State must remain in their original format. The meeting may have to be conducted in two or more parts to assure meaningful review of all the necessary information. The CSC role is to: 7. Review the CSC agency grievance process **16.4 Administrative Requirements** The CSC agency shall ensure that participants have access to the CSC. This requirement includes, but is not limited to the following: 7. Ensure the development and implementation of a written grievance procedure in compliance with 7.26.4 NMAC.	Based on record review, the Agency did not provide documentation indicating the grievance procedure had been made available to participants or their legal guardians for 2 of 13 participants. **Agency Grievance Procedure Acknowledgement:** • Not Found (#12, 13)	**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 # SW1A28 Participant Abuse, Neglect and Exploitation Information			
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues. **Support Waiver Service Standards Effective 9/1/2020** **14.1 Reporting Requirements**	Based on record review, the Agency did not provide documentation indicating the Participant or legal guardian were provided education regarding Abuse, Neglect and Exploitation for 2 of 13 participants. • Incident Management (Abuse, Neglect & Exploitation) (#2, 12)	**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?)*: →	

For individuals in the Supports Waiver program, reports of abuse neglect and exploitation should be immediately reported to: 1. The Department of Health/Division of Health Improvement (DOH/DHI) for persons 18 years or older. The DHI hotline is (800) 445-6242. 2. The Department of Health/Division of Health Improvement (DOH/DHI) and/or Children, Youth and Families Department/Child Protective Services for persons under 18 years of age. The CYFD Hotline is (800) 797-3260. 3. Report to CSC Agency within 24 hours.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Completion Date
Medicaid Billing/Reimbursement:			
TAG # SW4A1 Community Support Coordinator Reimbursement			
Support Waiver Service Standards Effective 9/1/2020 **16.2 Initial Waiver Eligibility and Waiver Enrollment Activities** 6. Contacts the participant at least monthly for follow up on initial waiver eligibility and waiver enrollment activities. This contact can be either be face-to face or by telephone but at least one (1) face to face visit is required. 9. Shall not to exceed three (3) months of monthly billing. If an extension is granted during this phase by DDSD then the monitoring requirements are subject to DDSD approval. **16.7 CSC Reimbursement** CSC services shall be reimbursed based upon a per-member/per-month unit. A maximum of one (1) unit per month can be billed per each participant. Provider records are subject to post payment reviews and must be sufficiently detailed to substantiate the nature, quality, and amount of CSC services provided. Post payment reviews may result non-payment or recoupment. 1. There is a maximum of twelve (12) billing units per participant per ISP year. 2. A maximum of one unit per month can be billed per each participant receiving CSC services. 3. The CSC provider/agency shall provide the level of support required by the participant. 4. A minimum of four (4) face to face quarterly visits are required per ISP year, with two face to face visits being in the home. 1. One of the quarterly faces to face meetings must include the development of the annual ISP and assistance with the LOC assessment.	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 2 of 13 Participants. Participant #5 December 2024 • The Agency billed a total of 1 unit of Community Supports Coordination Services (S5190 UA) on 12/10/2024. The participant is in pre-eligibility phase and no evidence of monthly contact with the Participant was found to justify 1 unit billed. January 2025 • The Agency billed a total of 1 unit of Community Supports Coordination Services (S5190 UA) on 1/14/2025. The participant is in pre-eligibility phase and no evidence of monthly contact with the Participant was found to justify 1 unit billed. Participant #13 January 2025 • The Agency billed a total of 1 unit of Community Supports Coordination Services (S5190 UA) on 1/5/2025. The participant is in pre-eligibility phase and no evidence of monthly contact with the Participant was found 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?)*: →	

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: May 23, 2025

To: Sarah Martinez, Executive Director

Provider: Peak Developmental Services, Inc.
Address: 8501 Candelaria Rd NE, Building A1
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: smartinez@nmddwcm.com

Region: Statewide
Survey Date: February 17 – 27, 2025

Program Surveyed: Supports Waiver

Service Surveyed: Community Support Coordination

Survey Type: Routine

Dear Ms. Martinez:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Jamie Pond, BS

Jamie Pond, BS
Staff Manager
DHI - Quality Management Bureau