



PROVIDER APPLICATION

FOR

**Mi Via, New Mexico's Self-Directed Home and
Community-Based Medicaid Waiver Program**

CONSULTANT AGENCY

**DEPARTMENT OF HUMAN SERVICES (HSD)
AGING AND LONG TERM SERVICES DEPARTMENT (ALTSD)
DEPARTMENT OF HEALTH (DOH)
(Tri Agency Team)**

Updated
July 14, 2010

TABLE OF CONTENTS

LETTER OF INTRODUCTION

SECTION I

OVERVIEW OF MI VIA SELF-DIRECTED HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

SECTION II

OVERVIEW OF MI VIA CONSULTANT AGENCY PROVIDER APPLICATION

- A. Application Requirements
- B. Where to Submit
- C. Application Format
- D. Term of Agreement

SECTION III

CONSULTANT AGENCY PROGRAM DESCRIPTION

SECTION IV

REQUIRED DOCUMENTATION AND FORMS

- Mi Via Provider Information Form
- Region Selection Form
- Mi Via Statement of Assurances
- Requested documentation
 - Disclosure of Ownership & Control Statement
 - Statement of Financial Solvency
 - W-9
 - Articles of Incorporation or Organization
 - IRS Letter
 - Taxation and Revenue CRS Registration
 - Surety / Fidelity Bond
 - Professional Insurance
 - NM Business License
- Policy and Procedures
- Quality Improvement Plan and Survey

SECTION V

MI VIA CONTACT INFORMATION

SECTION VI

APPENDICES



Governor **Bill Richardson**
Michael A. Spanier, Secretary, Aging & Long-Term Services Department
Alfredo Vigil, Secretary, Department of Health
Kathryn "Katie" Falls, Secretary, Human Services Department

LETTER OF INTRODUCTION

Dear Consultant Agency Provider Applicant:

This provider application packet contains the instructions, forms and other information needed to apply to become a consultant services provider for Mi Via, New Mexico's Self-Directed Home and Community- Based Services Waiver Program. The first section is an overview of the Mi Via program and a brief explanation of the central role of the consultant agency in the program. Subsequent sections include a summary of the application process, required application forms, a list of other required documentation, and other pertinent resources such as the Mi Via Service Standards and applicable State Medicaid and Mi Via regulations.

The Mi Via Waiver is a tri-agency partnership, and the operation and oversight for the program is shared between the New Mexico Human Services Department (HSD), the Aging and Long-Term Services Department (ALTSD) and the Department of Health (DOH). The Consultant Agency Provider Application will be reviewed, approved and overseen by the three State agencies via the Tri Agency Review Team, comprised of the Mi Via Program Managers and other designated staff from each Department.

All Medicaid Waiver Programs are subject to all HSD, Medical Assistance Division regulations governing Medicaid and Home and Community-Based Waiver Services. In addition, all provider agreements awarded shall be subject to the applicable HSD, ALTSD or DOH policies.

Please begin the application process by familiarizing yourself with the program by reading the Mi Via Service Standards and Regulations carefully. These documents are crucial for obtaining a clear understanding of the program and the expectations and requirements for consultant agencies.

Thank you for your interest in serving the participants in the Mi Via Waiver program. For assistance in completing the application, please contact Gayla Delgado at (505) 476-8915 or send an email to gayla.delgado@state.nm.us.

Sincerely,

SIGNATURE ON FILE

Kimberley Austin-Oser, Director
Elderly and Disability Services Division

SIGNATURE ON FILE

Cathy Stevenson, Deputy Director
Developmental Disabilities Supports Division



SECTION I

OVERVIEW OF THE MI VIA SELF DIRECTED HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM



OVERVIEW OF MI VIA

New Mexico's program called Mi Via, "my path," "my way," or "my road," is the State's Self-Directed Home and Community-Based Services (HCBS) Medicaid Waiver program. The goal of Mi Via is to provide a community-based alternative to institutional care that facilitates greater participant choice and direction of services and supports.

Mi Via's Guiding Principles state that all participants have value and potential, shall be viewed in terms of their abilities, have the right to participate and be fully included in their communities, and have the right to live, work, learn, and receive all services and supports, appropriate to their individual needs, in the most integrated settings within their communities. Self-direction is a tool that leads to self-determination through which participants can take control of their lives and have more freedom to lead a meaningful life in their home and community, instead of living in an institution.

Participants who are eligible to receive home and community-based services are required to meet either Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF-MR) requirements, or those who meet eligibility with a qualifying brain injury, may choose to receive services and supports through Mi Via. The program is administered through a partnership among the New Mexico Aging and Long-Term Services Department (ALTSD), the Department of Health (DOH), and the Human Services Department (HSD), referred to in this document as the Tri-Agency Review Team.

The State determines each participant's annual budgetary allotment. The State contracts with a Third Party Assessor (TPA) for medical level of care (LOC) determination, utilization review and authorization of the plan and budget. The State also contracts with a Financial Management Agent (FMA). Based on the authorized and approved budget, the FMA handles employer-related functions for the Mi Via participant such as processing timesheets, payroll and taxes, and makes payment to the employees, service providers and vendors for services and goods on the approved service and support plan and budget, provides participants with a monthly report of expenditures and budget status, and provides the State with documentation of expenditures.

CONSULTANT AGENCY PROVIDER ROLE

Mi Via recognizes the essential role of participants in planning and purchasing services and supports within a State-approved budget. The consultant agency must be well-versed in the philosophy and practice of self-direction and home and community-based services that provide participant choice and direction of services and supports. The Consultant agency must also have an understanding of full inclusion of the elderly and people with disabilities living in their home and in their community.

Education, guidance and assistance are keys to successfully navigating the Mi Via program. Mi Via's covered services include those services and supports necessary for participants to live in their home and in the community as independently as possible and avoid institutionalization. The service and supports array for Mi Via allows the participant to design services and supports in a flexible and

individualized fashion, utilizing qualified employees and service providers of their choice and/or generic resources in key life areas: living supports, community integration and health and wellness. Through the consultant agency, Mi Via participants are offered an orientation and on-going education which includes information, tools, training and support, in order to make informed choices and to plan, direct, hire and manage their services and supports. The consultant agency performs an essential role in monitoring the health and safety of a Mi Via participant.

Consultant services shall include sharing information regarding the range and scope of services, supports, participant rights and risks and responsibilities. The consultant agency will assist the participant with development of the Service and Support Plan (SSP) and budget, the emergency back-up plan and implementation of the SSP and budget. The consultant agency will assist the participant in managing their budget. The consultant agency will ensure there is adequate support for participants needing additional “hands-on” support to be successful in self-directing their plan. This “hands on” level of support to participants is referred to as “support guide functions”. If the consultant agency elects to hire an employee/employees to provide support guide functions rather than have the consultant provide all services necessary for participant success, minimum qualifications have been established.

The Consultant will make phone contact monthly and make, at a minimum, quarterly face-to-face home visits with participants to review the effectiveness of their plan and emergency back up plan , address any concerns regarding implementation and budgeting, suggest further resources as needed or requested and assist in making plan revisions.

Other Consultant/Support Guide responsibilities may include, but are not limited to, assisting as needed with employer/vendor functions such as developing job descriptions hiring and supervising employees and evaluating employee training needs.

Consultant agencies will be responsible for gathering data about the effectiveness of the services they are providing and for developing plans to identify and act on opportunities for improvement. State agencies will conduct periodic and random audits to ensure compliance with Mi Via program rules and regulations, and with state and federal law.

SECTION II

Consultant Agency Program Description

OVERVIEW OF MI VIA WAIVER CONSULTANT AGENCY PROVIDER APPLICATION

A. Provider Application Requirements

- All applications submitted to DOH/DDSD Provider Enrollment Unit (PEU) are required to include all necessary information and forms. Incomplete applications may be denied.
- Under certain circumstances, the Tri Agency Review team may request additional information from the applicant, which must be submitted within timelines determined by the Tri Agency Review team.
- Please do not staple or bind your application.

B. Submit one (1) complete original application.

Gayla Delgado
DDSD, Provider Enrollment Unit (PEU)
P O Box 26110
Santa Fe, NM 87502
810 San Mateo Suite 101
Santa Fe, NM 87505
505-476-8915

C. Provider Application Format

- Applications that do not include all of the required documentation and information described in Section IV may be denied.
- DOH/DDSD/PEU will not collate, merge copy or otherwise manipulate the application.
- Please do not staple or bind you application. You may use binder clips, rubber bands or paper clips to hold your application together.
- It is the applicant's responsibility to ensure that all pages and appropriate documents are included.

D. Term of Agreement

- Agencies will initially receive a one-year term and at renewal of the provider agreement providers may receive up to a three-year (3) term based on audit findings and recommendations by the Tri-Agency Review Team.
- As outlined in the provider agreement, agencies must maintain all required documentation at the provider location, which is subject to audit by the State without notice. Failure to comply with this requirement may result in recoupment and/or sanctions and/or provider agreement termination by the NM Human Services Department, or its designee.
- Agencies are required to submit a renewal application at least ninety (90) days prior to the expiration of the approved provider agreement. Failure to submit a renewal application will result in suspension or termination of payment for consultant services.
- The Agreement may be terminated by any of the parties hereto upon written notice delivered to the other party at least thirty (30) days prior to the intended date of termination. A written transition plan must be submitted by the provider and approved by the state to insure all participants are transitioned prior to the termination of the agreement.
- A modified scope of work may be required the first quarter of FY11.

SECTION III

CONSULTANT AGENCY PROGRAM DESCRIPTION

CONSULTANT AGENCY PROGRAM DESCRIPTION Please write a narrative description that includes answers to the following questions. This section may not exceed ten (10) typed pages.

1. Provide a statement describing your agency's mission, purpose and goals, as they relate to the provision of consultant services in Mi Via.
2. Please summarize your agency's philosophy on self-directed services and working with the elderly or for persons with disabilities.
3. Why do you want to provide services to individuals on the Mi Via Waivers
4. Please describe your agency's experience (or your personal experience) working with the elderly or individuals with disabilities, and with providing consultant (or similar) services.
5. Please describe in detail how your agency will assist participants in developing and monitoring 24-hour emergency backup plans for effectiveness. *(This is a critical aspect of ensuring the health and safety of individuals receiving services).*
6. Describe your agency's master staffing plan, including proposed number of staff by title or position, hours scheduled and their qualifications.
7. Describe your agency's plans for staff orientation and training requirements.
8. Identify the consultant functions each staff member will provide to participants.
9. Participant files must be kept current and accessible to authorized parties at all times. Participant files must also be maintained in a safe and secure environment in compliance with Medicaid and HIPAA regulations. Please briefly explain how your agency will ensure adherence to these standards.
10. Describe your plan for developing and updating a resource directory that will be available to staff and participants in the region/s in which your agency will operate. Include the anticipated date the directory will be completed.
11. Describe how your agency will promote the development of individualized service and support plans and budgets that include health and safety.
12. Describe how your agency will inform and educate participants about self direction, development and management of the SSP and budget.
13. Describe how your agency will inform and educate participants to operate within their approved Service and Support Plan.
14. Describe how your agency will inform and educate participants about the rules and requirement of the Mi Via program, including covered and non-covered services and supports.

SECTION IV

REQUIRED DOCUMENTATION AND FORMS

REQUIRED DOCUMENTATION FORMS, LICENSES & CERTIFICATIONS

The Tri Agency requires that each applicant submit all forms and documentation as outlined below. Incomplete forms may cause the application to be denied. Please note that certain forms must be signed and dated by the applicant.

1. Mi Via Consultant Agency Provider Information Form

This form must be completed and used as a cover page when the application is submitted.

2. Mi Via Statement of Assurances

Each Statement of Assurance must be initialed and dated.

3. Additional required application documentation

See list of additional documentation on page 14

4. Policy and Procedures

Submit a copy of your agency's Policy and Procedures.

5. Quality Improvement Plan and Participant Survey

(Renewing providers must submit their survey results).

1. MI VIA PROVIDER INFORMATION FORM

___ Initial application ___ Renewal application

Please print:

Provider Agency _____

Physical Address _____

City _____ **County** _____ **Zip Code** _____

Mailing Address _____

City _____ **County** _____ **Zip Code** _____

Agency Director _____

Phone number _____

Fax number _____

Cell Phone _____

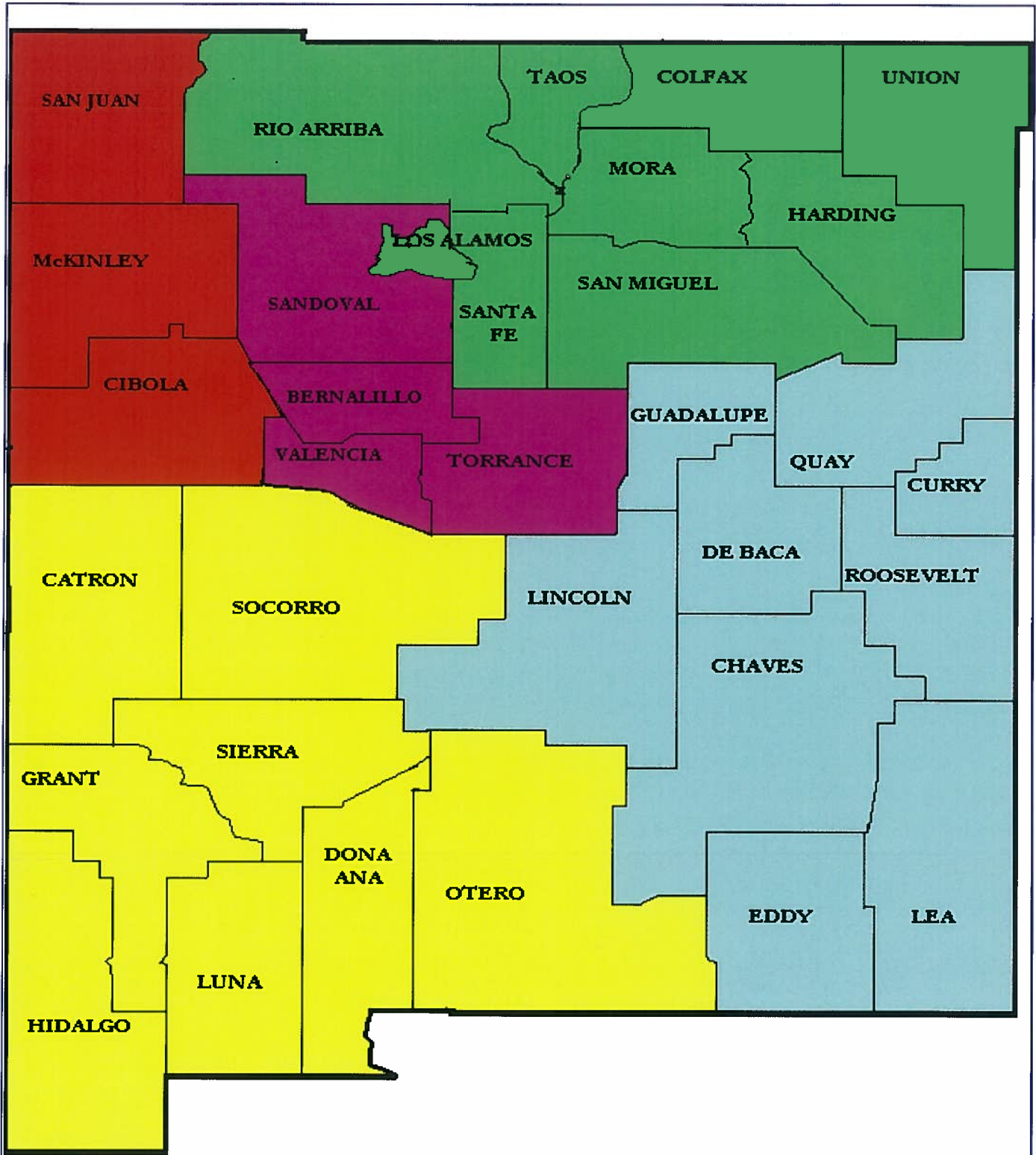
Email address _____

Tax ID Number _____

Are you or someone in your Agency serving as a Resource Facilitator for Mi Via participants currently? Please indicate name of that person here _____
If so, with what Agency (if applicable) _____

Region(s) you would like to provide services in: Refer to attached Map for location of Regions.
Please indicate if you are deleting a region and provide a detailed transition plan.

___ METRO ___ NE ___ NW ___ SE ___ SE



NORTHWEST REGION
 NORTHEAST REGION
 SOUTHWEST REGION

SOUTHEAST REGION
 METRO REGION

2. MI VIA STATEMENT OF ASSURANCES

Please read each of the following assurances carefully, initial and date each line, and sign at the bottom. Use **blue ink** only.

The applicant is required to assure that:

ASSURANCE	INITIAL	DATE
The consultant agency will comply with the regulations for Caregivers Criminal History Screening Program (CCHSP) for all employees of the agency.		
The consultant agency will ensure that all employees and/or subcontractors do not appear on the Employee Abuse Registry, prior to the first day of their employment. To obtain an access code and user name, please contact the Division of Health Improvement at (505) 476-0801.		
The consultant agency will maintain current annual financial reports as required by State and Federal law.		
The consultant agency will produce a quarterly newsletter to inform participants of events, trainings, and resources in the community, along with program updates and changes in staff. (these should also be sent to the Tri Agency team)		
The consultant agency will ensure that all Service and Support Plans (SSP) are developed and implemented in accordance with established timelines and the Mi Via Service Standards.		
The consultant agency will comply with all required tri-agency and Mi Via regulations, Service Standards and policy and procedures.		
The consultant agency will maintain current insurance policies at the agency's location with HSD named as an additional insured as required in the Provider agreement.		
The consultant agency will serve all populations in the NF and ICF/MR Mi Via Waiver within their selected geographic region(s).		
The consultant agency will maintain a conflict of interest policy that prevents a consultant from providing any services other than consultant services for any participants being served by your agency.		
The consultant agency will establish, maintain and follow an incident management process in compliance with Mi Via program requirements		
The consultant agency will establish and follow a written grievance and appeals procedure for participants and their staff, which will be reviewed and signed by the participant and/or their guardian upon intake.		
The consultant agency will adhere to all requirements communicated to them by the State, including attendance at mandatory meetings, mandated trainings and technical assistance sessions.		
The consultant agency will ensure there is adequate staff and support for participants to be successful in self-direction.		
The consultant agency will perform annual participant satisfaction surveys and submit reports with the renewal application or as requested by the State.		
The consultant's caseload will comply with the staff ratio requirements specified in the Mi Via Waiver Standards.		
The consultant agency will maintain personnel records, including but not limited to, the Mi Via staff's application, resume, education, training, and licensure/certification as required.		

ASSURANCE	INITIAL	DATE
The consultant agency must meet the qualification as defined in the Mi Via Waiver Service Standards regarding hiring or sub contracting with personnel.		
The consultant agency will insure that consultants and other staff will respond to participant and or participant representative communications within three (3) working days except in emergency situations where a response is needed within twenty four (24) hours during working days.		
The consultant agency must have sufficient staff schedule flexibility for evening and weekend appointments, as needed.		
The consultant agency will maintain participant files for up to six (6) years after the termination		
The consultant agency must maintain records in accordance with Medicaid and HIPAA requirements.		

IMPORTANT: Failure to comply with all Mi Via Statements of Assurance may result in State sanctions, up to and including a reduction in the term of the provider agreement and/or termination of the provider agreement.

Authorized Agency Representatives signature

Date

**Authorized Agency Representative
name and title (please print)**

3. ADDITIONAL APPLICATION DOCUMENTATION

Please provide a copy of the following documents with your application:

- Disclosure of Ownership & Control Statement
- Statement of Financial Solvency
- W-9 Form
- MAD 335 State of New Mexico Human Services Department Medical Assistance Division Provider Participation Agreement
- Articles of Incorporation or Organization and a list of current board members to include their mailing address and phone number (if applicable)
- IRS letter showing Tax number or 501©3 letter if non-profit (Sole Providers can use their social security number)
- Proof of registration with the NM Department of Taxation and Revenue (CRS#)
- Proof of Surety Bond (individual) or Fidelity Bond (group), naming the NM Human Services Department as a loss payee within 30 days of approval
- Proof of Professional Liability Insurance (\$1 million minimum), naming the NM Human Services Department as a loss payee within thirty (30) days of approval
- Current NM Business License
- Current copies of any professional licenses held by the agency and its staff.

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (CMS-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Secretary of appropriate State agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete part II (a) and (b) of this form. Only those title XX providers rendering medical, remedial, or health related home-maker services must complete parts II and III. Title V providers must complete parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V – 42CFR 51a.144
Title XVIII – 42CFR 420.200 – 206
Title XIX – 42CFR 455.100 – 106
Title XX – 45CFR 228.72 – 73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

- Item I** (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
(b) **For Regional Office Use Only.** If the yes box is checked for item VII, the Regional Office will enter the 5-digit number assigned by CMS to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV – VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

STATEMENT OF FINANCIAL SOLVENCY

For the purpose of establishing eligibility for payment under Title XVIII (Medicare), Title XIX (Medicaid) of the Social Security Act, hereinafter referred to as the provider of services, hereby states and declares:

1. That the provider of services has not been adjudged insolvent or bankrupt in a State or Federal court; and
2. That a court proceeding to make a judgment of bankruptcy or insolvency with respect to the provider of services is not pending in a State or Federal court.

In addition, the provider of services agrees to inform the Secretary of Health and Human Services, through the Health Care Financing Administration Regional Office, immediately if prior to the acceptance of the Health Insurance Benefits Agreement by the Secretary of Health and Human Services, a court proceeding to make a judgment of insolvency or bankruptcy is instituted with respect to the provider of services.

FOR PROVIDER OF SERVICES BY:	
NAME OF AUTHORIZED OFFICIAL:	TITLE:
SIGNATURE OF AUTHORIZED OFFICIAL:	DATE:

Taxpayer Identification Number Verification (TIN)

FOR AGENCY USE ONLY

Business Unit Number: _____ Date: ____/____/____
 Point of Contact (POC): _____
 POC Initials: _____ POC Phone # _____



Substitute W-9

New Mexico Department of Finance and Administration
 Financial Control Division
DO NOT send to IRS

PRINT OR TYPE

Complete instructions can be found on the reverse side of this form.

TAXPAYER IDENTIFICATION NUMBER (TIN) (Provide only ONE)

Sole proprietorship provide FEIN if applicable
 Federal Employer Identification Number (FEIN) _____
 or
 Social Security Number (SSN) _____

LEGAL NAME

(As registered with IRS or SSA) Sole Proprietorship enter your Last Name, First Name, Middle Initial.

TRADE NAME

If doing business as (D.B.A) or business name of Sole Proprietorship

PRIMARY ADDRESS (Address where correspondence, payment(s), purchase order(s), or 1099's should be sent)

P.O. Box or Street Address _____
 City, State, Zip _____

REMITTANCE ADDRESS (Where payment(s), if different from primary address, should be sent)

P.O. Box or Street Address _____
 City, State, Zip _____ Additional _____

CHANGE OF ADDRESS (Enter new address here)

P.O. Box or Street Address _____
 City, State, Zip _____
 Change of Address applies to: Remittance Primary

CERTIFICATION

Under penalties of perjury, I certify that:
 I have provided my correct taxpayer identification number and that
 I am not subject to backup withholding as specified on the reverse side of this form.

Print Name _____ Title _____
 Signature _____
 Phone _____ Date ____/____/____

BUSINESS DESIGNATION

(CHECK ONE)

- Corporation** (FEIN)
- Or
- Professional Corporation** (FEIN)
 - Doctor/Medical Facility*
 - Attorney/Legal Facility*
- Individual** (SSN)
- Sole Proprietorship** (SSN/FEIN)
- Partnership** (FEIN)
 - General*
 - Limited*
- Estate/Trust** (FEIN/ SSN)
- Organization Exempt from Tax** (FEIN)
 - Under section 501 (a)(c)(d)*
 Are you engaged in the business of providing medical services?
 Yes No
- Government Entity** (FEIN) or
- Government Operated Entity** (FEIN)
- LLC Taxed As:**
 - Corporation (FEIN)*
 - Sole Proprietorship (SSN/FEIN)*
 - Single Member(FEIN)*
- Other:** _____

OPTIONAL DIRECT DEPOSIT (ACH)

WARNING: The State of New Mexico will not process international ACH transactions (IAT). If any payment to you from the State will ever result in an IAT under the National Automated Clearing House Association's operating rules or if you are not sure if the rules apply to you. **DO NOT FILL OUT THIS SECTION OF THE FORM.**

Please initial here to indicate that you have read the above warning.
 If you fail to initial here, direct deposit will not be approved. _____
 Initial here

Bank Name: _____
 Routing #: _____ Account #: _____
 Checking Account **Other Account**
(Provide copy of voided check, NOT DEPOSIT SLIP)

FOR FCD USE ONLY

ENTERED BY: _____

DATE ENTERED: _____

SHARE VENDOR # _____

INSTRUCTIONS FOR COMPLETING THIS FORM

Taxpayer Identification Number (TIN)

Provide Only One: Social Security Number or Federal Employee Identification Number (FEIN)

If you do not have a TIN, apply for one immediately.

Individuals use federal form SS- 5 which can be obtained from your local Social Security Administration Office.

Businesses and all other entities use federal form SS- 4 which can be obtained from your local Internal Revenue Service Office.

Legal Name As registered with the IRS or Social Security Administration (SSA)

Individuals: Enter your Last Name, First Name, MI

Sole Proprietorships: Enter Last Name, First Name, MI

All Others: Enter Legal Name of Business

Limited Liability Company (LLC)

Enter owner's name here, enter the LLC name on trade name line. Check the LLC box, and select the appropriate filing status.

Trade Name

Individuals: Leave Blank

Sole Proprietorship: Enter Doing Business As (D/B/A) Name

All Others: Complete only if Business Name is different than Legal Name

Primary Address

Address where correspondence, payment(s), purchase order(s) or 1099's should be sent.

Remittance Address

Address where payment(s) should be sent if different from primary address.

Business Designation

Check ONE box which describes the type of business entity. If the business designation is either a corporation or organization exempt form Tax under Section 501 (a)(c)(d), you must indicate if you are engaged in the business of providing medical services by checking "yes" or "no"; this does not include providing health insurance coverage for employees.

Certification

The person signing this document should be; a partner in the partnership; an officer of the corporation; or the individual or sole proprietor noted under Legal Name above.

By signing this document you are certifying that all information provided is accurate and complete.

You are also certifying that you have not been notified by the IRS that you are subject to backup withholding because:

- A. You are exempt from backup withholding; or
- B. You are not subject to backup withholding as a result of a failure to all interest or dividends; or
- C. That the IRS has notified you that you are no longer subject to such backup withholding.

Penalties

If you fail to furnish your correct Taxpayer Identification Number (TIN) to a requester, you are subject to an IRS penalty of \$50 for each failure unless your failure is due to reasonable cause and not to willful neglect.

If you make a false statement without a reasonable basis that results in no backup withholding, you are subject to an IRS penalty of \$500.

Willfully falsifying certification or affirmations may subject you to criminal penalties including fines and/or imprisonment.

If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Privacy Act Notice

Section 6109 requires you to furnish your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to and IRA. The IRS uses the TIN for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.



For Medicaid Use Only - Provider Number

STATE OF NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION
PROVIDER PARTICIPATION AGREEMENT



THIS AGREEMENT IS FOR GROUPS, ORGANIZATIONS, OR INDIVIDUAL APPLICANTS TO WHOM PAYMENTS WILL BE MADE. IF THE APPLICANT IS AN INDIVIDUAL APPLYING FOR A PROVIDER NUMBER ONLY FOR IDENTIFYING SERVICES BILLED THROUGH A GROUP PRACTICE OR OTHER ORGANIZATION AND PAYMENTS WILL BE MADE TO THAT GROUP OR ORGANIZATION, THIS FORM SHOULD NOT BE USED. USE FORM MAD 312 INSTEAD.

RETURN completed application to:
New Mexico Medicaid Project
c/o ACS
1720 - A Randolph Rd.
Albuquerque, NM 87106

TO BE COMPLETED BY ALL APPLICANTS:

Form with fields for: Name of Applicant, Professional Title, Physical Location, Billing Address, Mailing Address, State License Number, License Issued By, License Expiration Date, Provider Type, Provider Specialty, Social Security Number, Birth Date For Individuals.

IF PAYMENTS ARE MADE DIRECTLY TO THE APPLICANT, THE FOLLOWING MUST BE COMPLETED.

Form with fields for: (14) an individual, non-corporate business entity, partnership or professional association, sole proprietorship, corporation, governmental entity or public school; Federal Tax Number, Federal Tax Name, Doing Business As (Name), NM Tax & Revenue ID Number.

COMPLETE IF APPLICABLE:

Form with fields for: (21) E-Mail Address; New Mexico Medicaid Number, HMO Affiliation, Name of plans in which you participate; CLIA Number, National Provider I.D. (NPI) or UPIN Number, DEA Number, NABP #; To be completed by physicians only. Are you board certified?; CERTIFIED UNDER TITLE XVIII MEDICARE?; JCAHO CERTIFIED?; Fiscal Year End Date; Medicare Provider Number(s), Medicare Carrier or Intermediary.

Table with 7 columns: Individual's Name, Title, License Number, Provider Type, Provider Specialty, New Mexico Medicaid Number (if previously assigned), For Medicaid Project Office Use Only. Includes instruction: Please attach a separate page if additional space is needed.

IF THE APPLICANT IS AN INDIVIDUAL, IDENTIFY ANY OTHER ORGANIZATION(S) THAT YOU WILL BILL UNDER:

Form with fields for: Organization or Group Name, Organization or Group Medicaid Number, Organization or Group Medicare Number. Includes instruction: Please attach a separate page if additional space is needed.

Form with questions (34) (a) Have you ever had a license revoked, suspended or denied in New Mexico or any other state? (b) Have you or any of the owners or principals ever been convicted of any criminal offense? (c) Have you or any of the owners or principals ever been excluded or suspended from participation in the Title XVIII (Medicare), Title XIX (Medicaid) or any other health care program?



New Mexico Medicaid Project
1720-A Randolph Road SE
Albuquerque, NM 87106
505-246-9988 505-246-8485 (fax)

Dear Medicaid Provider Applicant:

Thank you for your interest in becoming a New Mexico Medicaid provider. A provider participation agreement packet is enclosed. Please read the following instructions carefully before completing the agreement(s).

The application process takes 6-8 weeks from the date a properly completed provider participation agreement is received. When your agreement is approved, a unique provider identification number will be assigned to you. Do not provide services to New Mexico Medicaid clients until your Medicaid provider number has been assigned and you have received a copy of the New Mexico Medicaid Program Policy Manual and Billing Instructions.

In order for us to process your provider participation agreement in a timely manner, please follow these guidelines:

- The **MAD Form 312, PROVIDER PARTICIPATION AGREEMENT – INDIVIDUAL APPLICANT WITHIN A GROUP** should be completed by individual applicants who perform services within a group or organization. Payments will be made only to the group or organization. No payments will be made directly to the individual.
- The **MAD Form 335, PROVIDER PARTICIPATION AGREEMENT** should be completed by groups, organizations, or individual applicants to whom payment will be made.
- When applying for a group Medicaid provider number, include an agreement for the group (MAD 335) as well as individual agreements (MAD 312) for each practitioner who will be a member of the group if they do not already have a Medicaid number. For a group that already has an active Medicaid provider number that wishes to enroll an individual within their group, complete an agreement (MAD form 312) for the individual only. For practitioners who already have an assigned Medicaid number and who wish to be affiliated with a newly enrolling group, a signed letter must be submitted by the enrolled provider stating they wish to be affiliated with the group.
- **Please do not use “highlighter” or “whiteout” on the agreement(s) or on any of the attachments.** Agreements that are submitted with “highlighter” or “whiteout” will be returned without any further processing. To correct information on the agreement, make one line across the incorrect information and write in the corrected information. The person making the corrections should initial the changes.
- Review the enclosed *Type and Specialty List and Documentation Requirements* and select the **provider type** and **provider specialty (if applicable)** that best describes your practice, license and/or certification. If you are unsure which **provider type or specialty** to use, please contact the Provider Enrollment Unit at 1-800-299-7304 or 505-246-0710, option #3, then #5.
- If services have already been provided on an emergency basis, you may enter a requested effective date on the last page (signature page) of the Provider Participation Agreement. The date requested should be no more than 120 days prior to the date the completed agreement is being sent to ACS. **There is no guarantee that the requested effective date will be granted, as the Medical Assistance Division will make the final determination.**
- The enclosed W-9 form must be completed for applicants submitting a MAD 335, Provider Participation Agreement. The purpose of the W-9 is to assure that payments to providers are reported to the IRS with names and numbers that match IRS records. If you are a business, corporation, or sole proprietorship, enter the ID number assigned by the IRS. **Please attach a copy of the letter or other proof from the IRS assigning this tax identification number.**

- If you are enrolling as an individual, you must enter your Social Security number and date of birth on the agreement. Even if you are an individual who will be billing under a group number, you must enter your Social Security number and date of birth. You will bill your claims using the group provider number, which will be reported to the IRS with the group name and tax identification number.
- Tax exempt providers must submit a copy of their 501(c)3 tax-exempt letter.
- Every provider who completes a MAD 335 agreement and who renders services within New Mexico must provide their New Mexico Tax and Revenue identification number (box 19 of the agreement).
- The applicant's Medicare number and/or DEA number must be included on the agreement, if applicable. Also include a copy of the Medicare letter and/or DEA registration certification with the agreement. If the DEA number and/or Medicare number is/are pending at the time of application, please send ACS a copy of the certification when you receive this information.
- Applicants completing the MAD 335 form should also complete the enclosed Addendum form that requests information regarding Medicare carrier(s).
- New Mexico Medicaid project staff may need to obtain additional information from you in order to process your agreement. Please indicate a contact name and telephone number in the space provided on the last page of the Provider Participation Agreement.
- The applying provider must sign and date the agreement. **Please sign in blue ink only! Only an original signature with a date is acceptable. We cannot accept signature stamps or copies of signatures.** Applications with signatures that cannot easily be determined as original will be returned for correction. This standard is **strictly** enforced.
- Please be sure to include all required documentation as listed on the attached *Provider Participation Agreement, MAD 312 and 335 forms and Type and Specialty List and Documentation Requirements*. Required documentation may include:
 - ◆ Professional licensure
 - ◆ Agency licensure or certification
 - ◆ Business license
 - ◆ DEA registration certificate
 - ◆ New Mexico Non-Residential Pharmacy License (for certain out-of-state providers)
 - ◆ Proof of malpractice or liability insurance
 - ◆ Federal tax identification letter
 - ◆ CLIA certificate
 - ◆ Physician board specialty certification
 - ◆ Medicare certification letter
 - ◆ JCAHO accreditation letter
 - ◆ FQHC certification and interim rates
 - ◆ Medicare letter setting reimbursement rates for Rural Health Clinics (RHCs)
 - ◆ Renal dialysis Medicare composite rate letter
- If you plan to submit claims electronically, please review the *HIPAA Claims Submission Instructions* information that is attached to this packet.

If you have ANY questions at all, please do not hesitate to contact ACS's Provider Enrollment Unit at 1-800-299-7304 or 505-246-0710, option #3, then #5.

Sincerely,

Provider Enrollment
ACS

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ Yes No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ Yes No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ Yes No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ Yes No LB11

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
 Yes No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN # Yes No LB13

Address LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If yes, list Name, Address of Corporation, and EIN)
Name EIN # Yes No LB18

Address LB19

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?
 Yes No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title
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Signature	Date
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Remarks

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0086. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

OWNERSHIP INFORMATION - The following information must be provided and updated, as applicable, if payments are to be remitted to a provider group, partnership, or association:

1. Name and address of each person with an ownership or controlling interest in the entity or any subcontractors in which the entity has or had direct or indirect ownership totaling five percent (5%) or more and whether any of these person(s) named is related to another as spouse, child, or sibling.

Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship

2. Name and address of any other entity in which a person with an ownership or controlling interest in the entity also has an ownership or controlling interest.

Name of Entity	Address	Telephone Number	Name of Person with Interest

3. Name of any person, agent, managing employee, or any other person who has ownership or controlling interest equal to five percent (5%) or greater in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program, or other state Medicaid program.

Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation

(G) Is convicted under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude or acts against the elderly, children, or infirm.

(H) Is sanctioned pursuant to a violation of federal or state laws or rules relative to a health care program administered by HSD, any other state's Medicaid Program, Medicare, or any other public health care or health insurance program.

(I) Is convicted under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (C) through (H) of this subsection.

(J) Violates licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided.

(K) Fails to pay recovery properly assessed or pursuant to an approved repayment schedule under a health care program administered by HSD.

7.3. Provider status may be terminated immediately, without notice, in instances in which the health and safety of clients in institutions are deemed to be in immediate jeopardy; are subject to an immediate or serious threat; or when it has been demonstrated, on the basis of reliable evidence, that a provider has committed fraud, abuse, or other illegal or sanctionable action. For purposes of this provision, institutional providers include nursing facilities, intermediate care facilities for the mentally retarded, all residential psychiatric treatment facilities, group homes, and other facility-based residential treatment programs.

7.4. HSD reserves the right to terminate this Agreement for cause as summarized in this Agreement and as delineated in Section MAD-960, SANCTIONS AND REMEDIES of the Medical Assistance Division Provider Policy Manual.

ARTICLE VIII - IMPOSITION OF SANCTIONS FOR FRAUD OR MISCONDUCT

8.1. If the provider obtains an excess payment or benefit willfully, by means of false statement, representation, concealment of any material fact, or other fraudulent scheme or devise with intent to defraud, criminal sentences and fines and/or civil monetary penalties shall be imposed pursuant to, but not limited to, the Medicaid Fraud Act, NMSA 1978, §§ 30-44-1 et seq., 42 U.S.C. § 1320a-7b, and 42 C.F.R. § 455.23.

8.2. In addition to the above criminal civil penalties, HSD may impose monetary

or non-monetary sanctions, including civil monetary penalties for provider misconduct or breach of any of the terms of this Agreement.

8.3. HSD may take any or a combination of the following actions against a provider for violation of the Medicaid Provider Act, NMSA 1978 §§ 27-11-1 et seq.:

(A) Imposition of an administrative penalty of not more than \$5,000 for engaging in any practice that violates the Act; each separate occurrence of such practice constitutes a separate offense;

(B) Issue an administrative order requiring the provider to (1) cease or modify any specified conduct or practices engaged in by it or its employees, subcontractors, or agents; (2) fulfill its contractual obligations in the manner specified in the order; (3) provide any service that has been denied; (4) take steps to provide or arrange for any services that it has agreed or is otherwise obligated to make available; or (5) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by any opposing parties; or

(C) Suspend or revoke this Agreement.

8.4. HSD may elect to pursue one or a combination of all the delineated sanctions, as applicable.

ARTICLE IX - REFUSAL TO EXECUTE AN AGREEMENT

HSD will not execute an Agreement with a provider if the provider, his/her agent, managing employee, or any person having an ownership interest equal to five percent (5%) or greater in the health care provider commits or has committed any of the violations listed in Article 7.2. of this Agreement or other provisions delineated in Section MAD-960, REMEDIES AND SANCTIONS of the MAD Provider Policy Manual.

ARTICLE X - RECIPIENT FUND ACCOUNT

Nursing facilities, swing bed hospitals, and intermediate care facilities for the mentally retarded shall establish and maintain an acceptable system of accounting for recipients' personal funds, in the manner prescribed by HSD, in those cases in which clients entrust their personal funds to the facility.

ARTICLE XI - PRECONDITION FOR PARTICIPATION

The provider understands that signing this Agreement is a precondition for participating in health care programs administered by HSD. A provider understands that the provision of services, billing of services, and receipt of payments for services

cannot occur until this Agreement is completed by the provider and approved for execution by HSD.

ARTICLE XII - NO WAIVERS

No terms or provisions of this Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and executed by the party claiming to have waived or consented.

ARTICLE XIII - APPLICABLE LAW

This Agreement shall be governed by the laws of the State of New Mexico. All legal proceedings arising from unresolved disputes under this Agreement are subject to administrative and judicial review as provided for in MAD-980, PROVIDER HEARING, of the MAD Provider Policy Manual.

ARTICLE XIV - ASSIGNMENT

The provider shall not assign or transfer any obligation, duty, or other interest in this Agreement, nor assign any claim for monies due under this Agreement without authorization of HSD. Any assignment or transfer which is not authorized by HSD shall be void.

ARTICLE XV - INDEMNIFICATION

The provider shall indemnify, defend, and hold harmless the State, HSD, its agents, and employees from any and all actions, proceedings, claims, demands, costs, damages, and attorney's fees, from all liabilities or expenses of any kind from any sources accruing to or resulting from the provider or its employees in connection with the performance of this Agreement and from all claims of any person or entity that may be directly or indirectly injured or damaged by the provider or its employees in the performance of this Agreement.

ARTICLE XVI - ENTIRE AGREEMENT

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter contained in this Agreement, and all such covenants, agreements, and understandings have been merged into this Agreement. No prior agreements, covenants, or understandings, either verbal or otherwise, of the parties or their agents shall be valid or enforceable unless contained in this Agreement.

This Agreement shall not be altered, changed, revised, or amended except by written instrument executed by the parties in the same manner as in this Agreement. Amendments shall contain an

subsequently received a monetary award or settlement from the liable party.

1.21. When entering into contracts with the Medicaid managed care organizations (MCOs) contracting with HSD for the provision of managed care services to the Medicaid population, agree to be paid by the MCOs at any amount mutually-agreed between the provider or provider group and the MCOs, or failing that, the then current and "applicable reimbursement rate" based on the provider type. The "applicable reimbursement rate" is defined as the rate paid by HSD to providers participating in Medicaid or other medical programs administered by HSD and excludes disproportionate share hospital and medical education payments.

ARTICLE II - OBLIGATION OF THE HUMAN SERVICES DEPARTMENT *HSD shall:*

2.1. Distribute information necessary to participate in medical programs administered by HSD, including program policies, billing instructions, utilization review instructions, and other pertinent materials. The provider must contact HSD to request any additional program policy manuals, billing and utilization review instructions, and other pertinent materials.

2.2. Process payments in a manner delineated by federal guidelines either internally or through a delineated fiscal agent contractor.

2.3. Reimburse providers for furnishing covered services or procedures to eligible clients. Reimbursement is based on the HSD fee schedule, reimbursement rate, or reimbursement methodology in place at the time services are furnished by the provider. No exception to, or waiver of, standard reimbursement will be permitted without the express written consent of the MAD Director or his/her designee.

2.4. Conduct administrative investigations and administrative proceedings to ensure that providers comply with the terms of this Agreement and federal and state law pertaining to the administration of the health care programs administered by HSD, including the Medicaid Provider Act.

ARTICLE III - PATIENT SELF-DETERMINATION ACT

Nursing facility, intermediate care facility, hospital, home health agency, and hospice providers shall:

3.1. Furnish written information to all adult clients receiving medical care concerning their right to make decisions about medical care; accept or refuse medical or surgical treatment; and formulate arrangements for a living will or durable power of attorney.

3.2. Document in the client's medical record whether he/she has executed an advance directive which complies with New Mexico law on advance directives. The provision of care shall not be based on whether the client has executed an advance directive.

3.3. Inform each adult client, orally and in writing, at the time of facility admission or initiation of treatment, of the client's legal rights during his/her facility stay or course of treatment

ARTICLE IV - SUBMISSION OF COST REPORTS

4.1. Providers delineated by HSD who are reimbursed on a cost basis shall furnish HSD or its designee with such financial reports, audited or certified cost statements, and other substantiating data as necessary to establish a basis for reimbursement.

4.2. Cost statements or other data are to be furnished no later than 150 days following the closure of the provider's fiscal accounting period. Failure to comply with this provision will result in suspension of payment until the required statements and other data are provided.

ARTICLE V - STATUS OF PROVIDER

The provider, its agents, and employees are independent contractors who perform professional services for clients served through health care programs administered by HSD and are not employees of HSD. The provider shall not purport to bind HSD nor the State of New Mexico to any obligation not expressly authorized herein unless HSD has given the provider express written permission to do so.

ARTICLE VI - CHANGE IN OWNERSHIP

6.1. As soon as possible, but at least sixty (60) days prior to a change in ownership or status, any provider must notify HSD of the proposed change in ownership. Upon completion of the transfer of ownership, the initial provider participation agreement is terminated. The new owner must complete and receive approval of a new Medical Assistance Provider Participation Agreement before submitting any claims to HSD. Any payment by HSD on the basis of erroneous information due to the lack of notice is the responsibility of the previous provider and is subject to recoupment.

6.2. The previous owner shall be responsible for any overpayments and is entitled to receive payments from HSD up to the date of ownership transfer, unless otherwise specified in the contract for transfer of ownership.

6.3. The new owner shall furnish to HSD, upon receipt of a written request, the contract or other applicable documents specifying the terms of the change in ownership and responsibilities delineated in this Agreement.

6.4. HSD reserves the right to withhold all pending and other claims until the right to payments and/or recoupment is determined, unless the new owner agrees in writing to be liable for any recoupment or overpayment amounts.

6.5. For providers who are reimbursed on a cost basis and subject to cost settlements, HSD shall impose a lien and/or a penalty of up to ten percent (10%) of the purchase price against the previous owner until such time as the final cost settlement is completed and amounts owed, if applicable, are remitted to HSD.

ARTICLE VII - TERMINATION OF PROVIDER AGREEMENT

7.1. Provider status may be terminated without cause if the provider or HSD gives the other written notice of termination at least sixty (60) days prior to the effective date of the termination.

7.2. HSD will terminate this Agreement for cause, with thirty (30) days notice, if a provider, his/her agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(A) Misrepresents, by commission or omission, any information on the provider agreement enrollment form.

(B) Has previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in a health care program administered by HSD, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

(C) Is convicted under federal or state law of a criminal offense relating to the delivery of the goods, services, or supplies, under a health care program administered by HSD, any other state's Medicaid Program, Medicare, or any other public or private health or health insurance program.

(D) Is convicted under federal or state law of a criminal offense relating to the neglect or abuse of a patient in connection with the delivery of any goods, services, or supplies.

(E) Is convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

(F) Is convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

This Agreement, between the New Mexico Human Services Department (HSD) and the applicant as provider, specifies the terms and conditions for the provision of medical services to Medicaid clients. The Agreement shall be effective when completed in full with all required documentation attached and when signed by the provider and HSD, and shall remain in effect until terminated pursuant to the terms set out below.

ARTICLE I -

OBLIGATIONS OF THE PROVIDER

The Medicaid provider shall:

1.1. Abide by all federal, state, and local laws, rules, and regulations, including but not limited to, those laws, regulations, and policies applicable to providers of medical services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by HSD.

1.2. Furnish services, bill for services, and receive payment for services only upon approval of this Agreement by the MAD Director or his/her designee.

1.3. Comply with all billing instructions, reimbursement, audit, recoupment, and withholding provisions distributed by HSD. All rates, policies, procedures, or rules of any kind relating to billing instructions, reimbursement, audit, recoupment, and withholding provisions furnished to providers must be specifically approved in writing by the MAD Director or his/her designee to be effective.

1.4. Maintain and keep updated program policies, instructions on billing and utilization review, and other pertinent material distributed by HSD.

1.5. Furnish and update complete information on provider address, licensing, certification, board specialties, corporate names, and parties with direct or indirect ownership or controlling interest and information on the conviction of delineated criminal or civil offenses by providers or parties with direct or indirect ownership or controlling interest at least sixty (60) days prior to the contemplated change or within ten (10) days after the conviction. Any payment by HSD on the basis of erroneous or outdated information is the responsibility of the provider and is subject to recoupment, criminal investigative costs, and/or civil penalties.

1.6. Comply with all federal, state, and local laws and regulations regarding the provider's authority to operate a business in New Mexico including, but not limited to, licensure, registration to pay gross receipts tax, permit requirements, and employee tax filing requirements.

1.7. Assume sole responsibility for all applicable taxes, insurance, licensing, and other costs of doing business.

1.8. Verify that an individual is eligible for a specified medical program administered by HSD.

1.9. Maintain the confidentiality of client information and records in accordance with state and federal laws, including 42 C.F.R. § 431.305, 8.100.100.13 and .14

NMAC, and regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1.10. Render covered services to eligible clients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political belief, disability, or source of payment as per 45 C.F.R. § 80.3(a) and (b), 45 C.F.R. § 84.52, and 42 C.F.R. § 447.20.

1.11. Assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Submission of false claims or fraudulent representation may subject the provider to termination, criminal investigations and charges, and other sanctions specified in the MAD Provider Program Manual.

1.12. Retain any and all original medical or business records as are necessary to verify the treatment or care of any client for which the provider received payment from HSD to provide that benefit or service, services or goods provided to any client for which the provider received payment from HSD, amounts paid by HSD on behalf of any client, and other records required by HSD for at least six (6) years from the date of creation or until ongoing audits are settled, whichever is longer. Services that have been billed to HSD which are not substantiated in the provider's record are subject to recoupment.

1.13. Upon closure of office or facility, inform HSD where records pertaining to Medicaid recipients will be located.

1.14. Furnish immediately to the Medicaid Agency, the Secretary of Health and Human Services, or the Medicaid Fraud Control Unit, at no cost, access to records in any format requested as described above and any information regarding payments claimed by the provider for furnishing services to clients. Permit the inspection of facilities used in the provision of services to clients by the U.S. Secretary of Health and Human Services, HSD, the Medicaid Fraud Control Unit, or HSD designees. Failure to comply with this provision constitutes a violation of federal and state Medicaid law and may result in immediate withholding of any pending or future payments. If records are requested by mail, the provider shall furnish the records within five (5) working days of the receipt of the request or as provided for in the request.

1.15. Accept as payment in full the amount paid by HSD for services furnished to clients in accord with the reimbursement structure in effect for the period during which services were provided as per the HSD reimbursement policy. No exceptions to, or waiver, of standard reimbursements will be permitted without the express written consent of the MAD Director or his/her designee.

1.16. Not collect payments from the client or any financially-responsible relative or representative of that client for services furnished to the client, except as allowed and specifically delineated by HSD.

1.17. Seek payment from any other payor or insurer before seeking payment from HSD, in the event the client is covered by an insurance policy or health plan, including Medicare. Refund to HSD the lesser of the payment received from a liable third party or the amount payable under medical programs administered by HSD and not bill HSD the difference between the payment received from the third party based on a "preferred patient care agreement" or "discount" arrangement and the provider's billed charge.

1.18. Not refuse to furnish services to an eligible client because of a third party's potential liability for payment for the services, except in instances in which a client who is covered by an HMO plan is seeking services from a provider who does not participate in the HMO plan network and would not be paid for services by the HMO plan.

1.19. Inform HSD immediately when an attorney or other party requests information related to the services rendered to a client that were paid by HSD and upon receipt of any knowledge of pending or active legal proceedings involving clients.

1.20. When furnishing services to clients who sustained injury in an accident or another action that may be subject to a legal proceeding, agree to the following:

(A) Hospital providers must either file a claim with HSD within 120 days of the date of hospital discharge or impose a hospital lien on the potential recovery from the liable third party. If the hospital provider elects to impose a lien, the provider is prohibited from filing a claim with HSD for payment of any unpaid balance resulting from the third party recovery or from seeking payment from the client.

(B) Non-hospital providers must accept the payment made by HSD as payment in full. A non-hospital provider may not seek additional payment for those services from the client even if the client

effective date. Any amendments to this Agreement shall not be binding upon either party until approved in writing by HSD.

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and telephone number.

Contact Person:

Telephone Number:

BY SIGNATURE, THE PROVIDER AGREES TO ABIDE BY AND BE HELD TO ALL FEDERAL, STATE, AND LOCAL LAWS, RULES, AND REGULATIONS, INCLUDING, BUT NOT LIMITED TO THOSE PERTAINING TO MEDICAID AND THOSE STATED HEREIN. BY SIGNATURE, THE PROVIDER SOLEMNLY SWEARS UNDER PENALTY OF PERJURY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE.

Provider Name	Title - (If applicable)
Signature (Original - Blue ink)	Date

HUMAN SERVICES DEPARTMENT APPROVAL

<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED		
Reasons Not Approved:			
Dates of Agreement: From _____ To: _____			
Authorized Signature			
Title	Date		
ENTER QUANTITIES:	SNF / NF Beds	NF Beds	ICF Beds
Subject to Automatic Cancellation - Based upon revisit and correction of deficiencies			Date

FOR HUMAN SERVICES DEPARTMENT USE ONLY

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4. POLICY AND PROCEDURES

Please provide a copy of your agency's policies or procedures for the following:

1. Staff recruitment, retention and back-up plan;
2. Admission procedure and assignment to consultant;
3. Procedure for tracking key steps and timelines in establishing eligibility, service planning and budget submissions, SSP and budget revisions;
4. Procedure to inform participants of changes in consultant staff;
5. Procedure to transition individuals upon termination, expiration or non-renewal of your provider agreement or transitioning from one waiver or consultant agency to another waiver or consultant agency;
6. Complaint/grievance policy and procedures;
7. Training plan and policies that describe how personnel employed with your agency will meet all applicable Mi Via initial and on-going training requirements as described in the Mi Via Service Standards.
8. Incident Management Procedures related to abuse, neglect and exploitation involving participants receiving Mi Via waiver services. Incidents are required to be reported to:
 - a. Department of Health/Division of Health Improvement (DOH/DHI) for services provided by a community-based waiver service agency.
 - b. Aging and Long-Term Services Department/Adult Protection Services (ALTSD/APS) or to the Children, Youth, and Family Department/Children's Protection Services (CYFD/CPS) for services provided by any employee, contractor or vendor, other than a community-based waiver service agency.

5. QUALITY MANAGEMENT (QM) PLAN AND PARTICIPATION SATISFACTION SURVEY

A. Quality Management Plan

A quality management plan is a critical operational feature that an agency employs to continually determine whether it operates in accordance with program requirements, regulations, achieves desired outcomes and identifies opportunities for improvement. The quality management plan describes the process of discovery, remediation and improvement. Additionally, it outlines the frequency of those processes, the source and types of information gathered analyzed and utilized to measure performance.

All quality management plans are required to be approved by the Tri-Agency.

1. New applicants must submit a Quality Management Plan that addresses the following areas as required by the Centers for Medicare and Medicaid Services (CMS)
2. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
3. Service plans are developed in accordance with policies and procedures as indicated in the Mi Via Service Standards.
4. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
5. Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

The QM Plan must:

Identify individuals responsible for conducting the discovery/monitoring process;

Types of information used to measure performance;

Frequency with which performance is measured;

1. List the data that will be collected and documented (i.e. timelines, adherence to SSP/budget requirements as indicated in the Mi Via Service Standards, participant complaints and resolutions).
2. How the data will be compiled and trends will be analyzed (data must be analyzed annually).
3. How analyzed data will be used to identify opportunities to improve.
4. Describe how the data will be used to improve the Consultant Agency services.
5. Describe the methods to evaluate if implemented improvements are working. (If this is a renewal application, please provide data to support findings.)

The provider must document and be able to provide evidence of the ongoing implementation of the QM Plan.

Findings and trends identified from participant satisfaction surveys will be used as one data source in the QM Plan.

B. PARTICIPANT SATISFACTION SURVEY

The Consultant Provider shall conduct and annual Participant Satisfaction Survey.

1. A copy of the Participant Satisfaction Survey must be submitted with the application for approval by the Tri-Agency Tea.
2. A copy of a report summarizing the results of the Participant Satisfaction Survey must be submitted to the Tri Agency annually.

SECTION V

MI VIA CONTACT INFORMATION

MI VIA PROGRAM MANAGER'S CONTACT INFORMATION

Human Services Department/Medical Assistance Division

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Agency on Long Term Services Division/Elderly and Disabled Services Division

Scott Pokorny

Brain Injury & Coordination of Long Term Care Services (Colts) C (formerly Disabled and Elderly) Waiver (505) 476-4782

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Department of Health /Developmental Disabilities Supports Division

Pat Syme

Developmentally Disabled and Medically Fragile

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Department of Health /Public Health Division

Genevieve Rel
AIDS/HIV

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SECTION VI APPENDICES

- Appendix 1: Medicaid Regulations**
- Appendix 2: Mi Via Waiver Service Standards**
- Appendix 3: Billing Rates**
- Appendix 4: Mi Via Sample Provider Agreement**
- Appendix 5: Incident Management System Guide**
- Appendix 6: Criminal History Screening and Fingerprint Manuel**
- Appendix 7: Mi Via Regulations**

The following New Mexico Administrative Codes, Medicaid Regulations and Mi Via Service Standards must be adhered to when participating as a Consultant Service Provider for the Mi Via Waiver.

APPENDIX 1: MEDICAID REGULATIONS

1. Go to the NMAC Web site at:
[http://www.nmcpr.state.nm.us/NMAC/ title08/title08.htm](http://www.nmcpr.state.nm.us/NMAC/title08/title08.htm)
2. Chapter 290 Medicaid Eligibility Home and Community Based Waiver Services
 - 8.290.400 NMAC Recipient Policies
 - 8.290.500 NMAC Income and Resource Standards
 - 8.290.600 NMAC Benefit Description
3. Chapter 314 Long Term Care Services - Waivers
 - 8.314.6 NMAC Mi Via Home and Community-Based Services Waiver
4. You should also familiarize yourself with these related sections of the administrative code:
 - Chapter 150 Low Income Energy Assistance Program
 - Chapter 200 Medicaid Eligibility – General Recipient Policies
 - Chapter 300 Medicaid General Information
 - Chapter 301 Medicaid General Benefit Description
 - Chapter 302 Medicaid General Provider Policies

APPENDIX 2: MI VIA WAIVER SERVICE STANDARDS

1. Go to the DDS Website at:
<http://www.nmhealth.org/ddsd/RFP/MiViaConsultantCall.htm>

APPENDIX 3: BILLING RATES

Go to the DDS website at

<http://www.nmhealth.org/ddsd/RFP/MiViaConsultantCall.htm>

APPENDIX 4: MI VIA SAMPLE PROVIDER AGREEMENT

1. Go to the DDS website at:

<http://www.nmhealth.org/ddsd/RFP/MiViaConsultantCall.htm>

APPENDIX 5: INCIDENT MANAGEMENT SYSTEM GUIDE

Department of Health/Division of Health Improvements (DOH/DHI)

1. Go to the DOH/DHI website at:
<http://dhi.health.state.nm.us/elibrary/manuals.php>
2. Select Incident Management Services Manual.

ALTSD/Adult Protection Services

Adult Protective Services Statewide Intake toll free in New Mexico at 866-654-3219, or 505-476-4912 if calling from outside New Mexico.

[http://www.nmaging.state.nm.us/Adult Protective Services Division.html](http://www.nmaging.state.nm.us/Adult_Protective_Services_Division.html)

CYFD/Children's Protective Services

CYFD's Statewide Central Intake child abuse hotline at 1-800-797-3260, law enforcement or the appropriate tribal entity.

<http://www.cyfd.org/node/26>

APPENDIX 6: CRIMINAL HISTORY SCREENING AND FINGERPRINT MANUAL

1. Go to the Division of Health Improvements (DHI) Website at:
<http://dhi.health.state.nm.us/elibrary/manuals.php>
2. Select Criminal History Screening and Fingerprint Manual

APPENDIX 7: MI VIA REGULATIONS

1, Go to the Medicaid Website at:

http://www.hsd.state.nm.us/mad/pdf_files/provmanl/prov83146.pdf