HUMAN SERVICES DEPARTMENT

Michelle Lujan Grisham, Governor
Kari Armijo, Acting Secretary
Lorelei Kellogg, Acting Medicaid Director

DEPARTMENTAL MEMORANDUM
MAD-MR: 23-07
DATE: 12/5/2023

TO: **MAD STAFF**

FROM: **LORELEI KELLOGG, ACTING MEDICAID DIRECTOR**

THROUGH: **TALLIE TOLEN, BUREAU CHIEF, LONG-TERM SERVICES AND SUPPORTS BUREAU (LTSSB)**

BY: **SUSAN MATHERS, LTSSB, AGENCY BASED COMMUNITY BENEFIT (ABCB) PROVIDER ENROLLMENT**

SUBJECT: **ABCB PROVIDER ENROLLMENT FORMS**

GENERAL INFORMATION

All Agency Based Community Benefit Program (ABCB) Provider Enrollment forms are included here: revised forms, a new form, and an existing ABCB form still in use. These forms comprise the enrollment packet for agencies applying for approval to provide ABCB services. This MR is a replacement for MR 16-11.

FILING INSTRUCTIONS

1. Revised Forms

Please add the following revised forms to the Medical Assistance Forms Manual:

MAD 500A – Agency Based Community Benefits – ABCB Provider Application Packet Checklist
MAD 500B – Agency Based Community Benefits – ABCB Checklist for ABCB Provider Adding a Service
MAD 501A – Scope of Work Service Summary Form Agency Based Community Benefits – ABCB
MAD 615 – Agency Based Community Benefits – ABCB Provider Attestation Form – CMS Final Rule for HCBS
MAD 741 – Agency Based Community Benefits – ABCB Quality Improvement Assurance

(Forms should be replaced in the Medical Assistance Forms Manual as follows):

FILING INSTRUCTIONS (CONTINUED)

1. Revised Forms (continued)

- Remove: MAD 500A Revised 1/19/2018
- Replace with: **MAD 500A Revised 10/21/2022**
- Remove: MAD 500B Revised 1/19/2018
- Replace with: **MAD 500B Revised 10/21/2022**
- Remove: MAD 501A Revised 7/19/2016
- Replace with: **MAD 501A Revised 10/28/2022**
- Remove: MAD 615 Issued 1/3/2017
- Replace with: **MAD 615 Rev 9/2/2022**
- Remove: MAD 741 Revised 2/1/2018
- Replace with: **MAD 741 Revised 8/25/2022**

2. New Form

Please add the following new form to the Medical Assistance Forms Manual:

MAD 899 – Agency Based Community Benefits (ABCB) – ABCB Program Assurances (Issued 10/14/2022)

3. Existing ABCB Form still in use

Please retain this form in the Medical Assistance Forms Manual:

MAD 502 – Agency Based Community Benefits – ABCB Statement of Financial Solvency (Revised 7/19/2016)

Please address questions concerning this material to:
HSD-abcbproviderenrollment@state.nm.us

Attachments

MAD 500A Revised 10/21/2022
MAD 500B Revised 10/21/2022
MAD 501A Revised 10/28/2022
MAD 615 Revised 9/2/2022
MAD 741 Revised 8/25/2022
MAD 899 Issued 10/14/2022
MAD 502 Revised 7/19/2016

AGENCY BASED COMMUNITY BENEFITS – ABCB
PROVIDER APPLICATION PACKET CHECKLIST

Organization		Date	
Contact		Title	
Email Address		Phone No.	

THE FOLLOWING FORMS, COPIES AND OTHER DOCUMENTS ARE SUBMITTED AS PART OF THE APPLICATION PROCESS TO BECOME AN APPROVED AGENCY BASED COMMUNITY BENEFIT PROVIDER

Forms	
☐	ABCB Provider Application Packet Checklist - MAD 500A
☐	ABCB Scope of Work Service Summary Form - MAD 501A
☐	ABCB Statement of Financial Solvency - MAD 502
☐	ABCB Attestation Form - CMS Final Rule for HCBS - MAD 615
☐	ABCB Quality Assurance Form - MAD 741
☐	ABCB Program Assurances - MAD 899
☐	W-9
Copies of	
☐	Current Business License(s) - **City/Council Business License showing application address**
☐	Current Department of Health License - **Adult Day Health, Assisted Living, Home Health Aide**
☐	Current State Professional Licenses - **Environmental Modifications, Behavior Support Consultation, Private Duty Nursing, Nursing Respite, Occupational Therapy, Physical Therapy, Speech Therapy**
☐	IRS Letter - **Employer Identification Number verification**
☐	IRS 501(c)(3) letter - **If not-for-profit**
☐	NMTRD Registration Certificate - **New Mexico 11 digit Tax Identification Number**
☐	Professional Liability Insurance Certificate - **Current Certificate of Insurance is required**
☐	Workers Compensation Insurance Certificate - **Current Certificate of Insurance is required**
☐	Dishonesty/Surety Bond - **Emergency Response, Environmental Modifications applications only**
☐	Letter from bank indicating financial solvency/credit status, or Agency bank account statement with personal identifiers blacked out
☐	Articles of Incorporation - **if applicable**

PROVIDER APPLICATION PACKET CHECKLIST (continued)

Organization Name:	
Copies of (continued)	
☐	List of Board members with addresses, terms of service, and positions on Board
☐	Verification of National Provider Identifier - **Adult Day Health, Assisted Living, Private Duty Nursing, Nursing Respite**
Information about Organization	
☐	Statement regarding Agency's mission and purpose
☐	Physical location, address and phone numbers for each service site or office
Written Description of Service Provision	
☐	Statement describing the agency's experience in providing the services for which the agency is applying, including a summary of the background and experience of staff members.
☐	Description of the agency's approach to delivering the specific Agency Based Community Benefit services requested, including staff orientation and training requirements.
☐	Description of staff qualifications, including copies of individual professional licenses, as appropriate.
☐	Description of methods used to communicate with staff, regarding the needs and service goals of the individual to be served.
☐	Copies of emergency and on call procedures

Authorized Signature		Title		Date	

AGENCY BASED COMMUNITY BENEFITS - ABCB
CHECKLIST FOR ABCB PROVIDER ADDING A SERVICE

Organization		Date	
Contact		Title	
Email Address		Phone No.	

THE FOLLOWING FORMS, COPIES AND OTHER DOCUMENTS ARE SUBMITTED AS PART OF THE APPLICATION PROCESS FOR AN AGENCY BASED COMMUNITY BENEFITS PROVIDER TO ADD A SERVICE

Forms	
☐	ABCB Provider Application Packet Checklist - ABCB Provider - Add A Service - MAD 500B
☐	ABCB Scope of Work Service Summary Form - MAD 501A
☐	ABCB Attestation Form - CMS Final Rule for HCBS - MAD 615
☐	ABCB Quality Assurance Form - MAD 741
☐	ABCB Program Assurances - MAD 899
Copies of	
☐	Current Business License(s) - **City/Council Business License showing application address**
☐	Current Department of Health License **- Adult Day Health, Assisted Living, Home Health Aide**
☐	Current State Professional Licenses - **Environmental Modifications, Behavior Support Consultation, Private Duty Nursing, Nursing Respite, Occupational Therapy, Physical Therapy, Speech Therapy**
☐	Professional Liability Insurance Certificate - **Current Certificate of Insurance is required**
☐	Workers Compensation Insurance Certificate - **Current Certificate of Insurance is required**
☐	Dishonesty/Surety Bond - **Emergency Response, Environmental Modifications applications only**
Information about Organization	
☐	Statement regarding Agency's mission and purpose
☐	Physical location, address and phone numbers for each service site or office
Written Description of Service Provision	
☐	Statement describing the agency's experience in providing the services for which the agency is applying, including a summary of the background and experience of staff members.
☐	Description of the agency's approach to delivering the specific Agency Based Community Benefit service requested, including staff orientation and training requirements.
☐	Description of staff qualifications, including copies of individual professional licenses, as appropriate.
☐	Description of methods used to communicate with staff, regarding the needs and service goals of the individual to be served.
☐	Copies of emergency and on call procedures

Authorized Signature		Title		Date	

SCOPE OF WORK SERVICE SUMMARY FORM
AGENCY BASED COMMUNITY BENEFITS - ABCB

Type of Action	☐ Initial ☐ Add a Service ☐ Add a County					Date		
Organization				Medicaid Number *(if applicable)*				
Physical Address	Street		City		State		Zip	
Mailing Address (*if different)*	Street/ PO Box		City		State		Zip	
Phone		Toll Free		Fax				
Contact		Title		Email address				

ABCB Service *See HSD Managed Care Policy Manual for ABCB service descriptions*		**County(ies) Served** *Use County Code Numbers from Page 2*
☐	Adult Day Health	
☐	Assisted Living	
☐	Behavior Support Consultation	
☐	Community Transition Services	
☐	Emergency Response	
☐	Employment Supports	
☐	Environmental Modifications	
☐	Home Health Aide	
☐	Nutritional Counseling	
☐	Personal Care Services – Consumer Directed	
☐	Personal Care Services – Consumer Delegated	
☐	Private Duty Nursing for Adults	

(ABCB services continue on Page 2)

SCOPE OF WORK SERVICE SUMMARY FORM (Continued)

ABCB Services (Continued from Page 1) *See HSD Managed Care Policy Manual for ABCB service descriptions*		County(ies) Served Use County Code Numbers (see below)
☐	Nursing Respite Services	
☐	Respite Services	
☐	Occupational Therapy for Adults	
☐	Physical Therapy for Adults	
☐	Speech Language Therapy for Adults	

New Mexico County Codes to enter on Page 1 and 2 (above):

01- Bernalillo	**08**- Eddy	**15**- Los Alamos	**22**- Roosevelt	**29**- Taos
02- Catron	**09**- Grant	**16**- Luna	**23**- Sandoval	**30**- Torrance
03- Chaves	**10**- Guadalupe	**17**- McKinley	**24**- San Juan	**31**- Union
04- Colfax	**11**- Harding	**18**- Mora	**25**- San Miguel	**32**- Valencia
05- Curry	**12**- Hidalgo	**19**- Otero	**26**- Santa Fe	**33**- Cibola
06- DeBaca	**13**- Lea	**20**- Quay	**27**- Sierra	
07- Dona Ana	**14**- Lincoln	**21**- Rio Arriba	**28**- Socorro	

Provider Signature		Date	

AGENCY BASED COMMUNITY BENEFITS – ABCB
STATEMENT OF FINANCIAL SOLVENCY

Organization	

For the purpose of establishing eligibility for payment under Title XVIII 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 Centers for Medicare and Medicaid Services (CMS) 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 *please type*		Title	
Signature		Date	

MAD 502 Revised 08/18/2023

AGENCY BASED COMMUNITY BENEFITS - ABCB

PROVIDER ATTESTATION FORM - CMS FINAL RULE FOR HCBS

Please read the following summary of the Centers for Medicare and Medicaid Services (CMS) Final Rule Requirements for Home and Community Based Services (HCBS) Providers.

Any residential or non-residential provider who offers agency based community benefit services in a setting where individuals live and/or receive HCBS must comply with the provider setting requirements. A HCBS setting is provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.

The CMS Final Rule requirements for residential and non-residential HCBS settings include:

1) Providers must ensure that settings are integrated in and support full access of individuals to the greater community including:

- Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
- Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.

2) Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings the person centered plan must document resources available for room and board.

3) Providers must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4) Providers must ensure settings optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.

5) Providers must ensure settings facilitate individual choice regarding services and supports, and choice regarding who provides them.

PROVIDER ATTESTATION FORM - CMS FINAL RULE FOR HCBS (Continued)

6) Additional HCBS Final Rule requirements relate to ensuring tenant protections, privacy, and autonomy for individuals receiving HCBS who do not reside in their own private (or family) home.

   As a Medicaid enrolled HCBS provider you are required to ensure all aspects of the Final Rule are followed. **HSD/MAD recommends that you read the CMS Final Rule in the Federal Register at the following link to get the full details on the CMS Final Rule requirements:**

   https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid- programs-reform-of-requirements-for-long-term-care-facilities?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=emailZ

   I certify that I have carefully read the summary requirements for the Home and Community Based Services above and the CMS Final Rule Requirements in the Federal Register at the link provided above and attest that my organization/provider setting is in compliance with the CMS Final Rule Requirements published in the Federal Register.

   Additionally, I certify that my organization/provider setting will remain in compliance with the CMS Final Rule Requirements published in the Federal Register.

(THE APPLYING PROVIDER MUST SIGN AND DATE THIS ATTESTATION FORM).

Organization Name: _____

Name: _____ Title/Position: _____

Address: _____

_____

Telephone Number: _____

Signed: _____ Date: _____

AGENCY BASED COMMUNITY BENEFITS - ABCB
QUALITY IMPROVEMENT ASSURANCE

I. Developing and Implementing the Agency's Quality Improvement Plan

Quality improvement is an important component of any business and the Centennial Care Agency- Based Community Benefits require providers to develop and implement a quality improvement program to ensure adequate and effective operation of the agency.

There are two major steps to developing a quality improvement plan. One step is thinking about which performance outcomes you will measure, how and when you will monitor these outcomes and how you'll set targets for improvement. Another step is deciding on the structure your agency will use to implement the plan on an on-going basis. Some agencies charge the board with performing this function, some use their managers, and some create a quality improvement committee.

Your quality improvement plan must address the following four requirements:

A. Service Delivery -- how the agency on an ongoing basis will assess its performance in delivering services to consumers.

Some tools you might use are consumer satisfaction surveys, complaints and grievance records, phone logs and/or monthly supervisory visits logs.

B. Operational Activities -- how the agency will assess its operations to determine effectiveness and compliance with the regulations.

For this requirement, you will create ways to measure performance in operations, for example, you might want to track timesheet or billing errors.

C. Quality Improvement Action Plan -- what actions the agency will take to improve quality in response to the assessments in a. and b. and how the agency will measure how and whether the actions taken have improved quality.

D. Documentation of Activities -- how the agency will document and report the quarterly activities taken to improve quality.

II. Compliance with Quality Assurance Monitoring

The Provider agrees to cooperate with Human Services Department (HSD), Medical Assistance Division (MAD), other state and federal agencies, and Managed Care Organizations (MCO) with regard to all activities related to quality assurance, monitoring and management.

QUALITY IMPROVEMENT ASSURANCE (continued)

The Provider agrees that HSD and/or MAD, its employees, agents or contractors may monitor the Provider's performance at any time.

Employees or representatives of HSD/MAD or other relevant state and federal agencies, as well as employees or representatives of MCOs shall visit Provider's offices and/or service locations when necessary to examine Provider's operations and records. The Provider will allow timely access to service locations and/or provide records and/or information as requested by these entities. Advance notice may be provided, if appropriate, as determined by HSD/MAD or other state agencies.

If the Provider is found to be deficient, the Provider shall timely comply with corrective action plans issued by HSD/MAD and/or the MCOs. Failure to comply with any provisions of this Assurance regarding quality assurance, monitoring and management, including the Provider's failure to comply with corrective action plans, may result in the imposition of penalties and/or sanctions, including termination of Medicaid Centennial Care Agency- Based Community Benefits provider number.

The Provider acknowledges that quality monitoring and management are within the jurisdiction of several state agencies, including the New Mexico Attorney General, and within the scope of Provider's contracts with the MCOs. As such, information acquired through quality monitoring activities, such as HSD/MAD audits, may be referred to the appropriate state agencies or MCOs.

I have read the quality improvement plan requirement and I agree to develop and implement a quality improvement program to ensure adequate and effective operation of the agency, including documentation of quarterly activities that address, but are not limited to:

A. Service Delivery

B. Operational Activities

C. Quality Improvement Action Plan; and

D. Documentation of Activities

Organization Name _____

Please print your name and title _____

Signature _____ Date _____

AGENCY BASED COMMUNITY BENEFITS - ABCB
PROGRAM ASSURANCES

Organization		Date	
Name		Title	
Email address		Phone Number	

1. INTENT TO COMPLY

Our agency intends to comply with applicable New Mexico laws, regulations, policies and procedures for the Agency Based Community Benefits (ABCB) Program.

Initial here:_____

2. RELATIONSHIPS

Statement A

Relationships to other organizations currently providing Medicaid waiver services **that the provider directly or indirectly controls or influences**

Please enter details of relationships below, and continue on a separate sheet if necessary, or respond "None":

Response_____

_____

Statement B

Relationship to other organizations currently providing Medicaid waiver services **that directly or indirectly control or influence the provider**

Please enter details of relationships below, and continue on a separate sheet if necessary, or respond "None":

Response_____

_____

3. TRANSITION PLAN

This agency will develop a detailed Transition Plan for clients served in the event an Agency Based Community Benefits recipient is discharged or either party terminates the provider agreement.

Initial here:_____

AGENCY BASED COMMUNITY BENEFITS – ABCB PROGRAM ASSURANCES (Continued)

4. CRITICAL INCIDENT REPORTING

Critical Incidents include Abuse, Neglect, Exploitation, Death, Environmental Hazards, Missing/Elopement, Law Enforcement, and Emergency Services.

All ABCB providers must comply with the Human Services Department's Critical Incident Reporting requirements. **Please see our Managed Care Policy Manual, Section 18.3 (pages 376-377), and see:** https://www.hsd.state.nm.us/providers/critical-incident-reporting/

Please complete:

Our agency intends to comply with the New Mexico Human Services Department's Critical Incident Reporting requirements.

Initial here:_____

5. POLICY MANUAL SERVICE DESCRIPTIONS AND PROVIDER REQUIREMENTS

The Managed Care Policy Manual can be found at:
https://www.hsd.state.nm.us/providers/managed-care-policy-manual/

I have read the section(s) in Chapter 8 of the Managed Care Policy Manual containing the service description and provider requirements of the ABCB services requested on our agency's completed Scope of Work Service Summary Form, and *(please check which applies below)*:

- ☐ **I do have questions at this time** *(you will be contacted)*
- ☐ **I do not have any questions at this time**

Initial here:_____

Signed:	**Name:**	**Date:**