7 COMMUNITY BENEFIT

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Community Benefits (CB) are services that provide assistance to individuals who require long-term services and supports and services so they may remain in the family residence, in their own home or in community residences. This program serves as an alternative to placement in a Nursing Facility (NF). Community Benefits do not provide 24-hour care and are intended as a supplement to an individual's natural supports. Community Benefits are available to members meeting a Nursing Facility Level of Care (NF LOC). The member's Managed Care Organization (MCO) shall provide the Community Benefits as determined appropriate bybased on the Comprehensive Needs Assessment (CNA). Members eligible for the Community Benefits have the option of selecting either the Agency-Based Community Benefit (ABCB) or Self-Directed Community Benefit (SDCB).

Two eligibility components must be met prior to receiving CB: financial eligibility, determined by the Human Services Department/Income Support Division (HSD/ISD) and medical eligibility, determined by a MCO through a NF LOC assessment conducted as part of the CNA.

Members who have a Full Medicaid category of eligibility may be eligible for CB if they meet a NF LOC and indicate they have a need for CB. These individuals should request a CNA from their MCO to be assessed for CB. These individuals do not need an allocation to access CB (see Section 5 "Transitions of Care"). Individuals up to age 21 may be eligible for the Early, Periodic Screening, Diagnostic and Treatment program (EPSDT), which provides personal care services. If a Medicaid enrolled minor indicates he or she has a need for CB and meets a NF LOC, an allocation is not needed to access Community BenefitFull Medicaid services.

DEFINITIONS

1. **Active Registration:** A registration is active if there is an open category of registration on the Central Registry.
2. **Activity of Daily Living (ADL):** Tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting and transferring.
3. **Agency Based Community Benefits (ABCB):** The Community Benefit services offered through a provider agency to a member who does not wish to self-direct his or her CB services.
4. **Allocation:** The opportunity given to a registrant who is not otherwise Medicaid eligible to apply for Community Benefits.

5. **Allocation Packet:** The documents sent by HSD/MAD/LTSSB to a registrant that includes the Letter of Interest, Primary Freedom of Choice, Withdrawal Form, Medicaid Application for Assistance, and a self-addressed stamped envelope.
6. **Central Registry:** A database that maintains a list of individuals who are interested in receiving Community Benefits and may be eligible for an allocation.
7. **Community Benefits (CB):** Home and Community Based Services that provide long-term services and supports to eligible members that allow them to remain in the family residence, in their own home or in community residences such as an Assisted Living Facility.
8. **HSD 100:** “Medicaid Application for Assistance” that is used to apply for Community Benefits and is available on-line or at a local HSD/ISD office.
9. **Inactive Registration:** A registration is inactivated/closed under certain circumstances (see “Closing/Inactivating an Allocation”).
10. **Letter of Interest (LOI):** The letter that is sent to a registrant informing him or her that an allocation is available and that he or she may apply for Community Benefits.
11. **Notice of Allocation (NOA):** The letter that is sent to a registrant informing him or her that the PFOC was received at HSD/MAD/LTSSB and informs him or her of the next steps in the allocation process. The date of the NOA is the allocation date.
12. **Nursing Facility Level of Care:** The member's functional level is such that (2) two or more activities of daily living (ADLs) cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate or assistance. A member must meet a NF LOC to be eligible for community benefit services. ~~cb~~
13. **Primary Freedom of Choice (PFOC):** The form included in the Allocation Packet that allows a registrant to confirm his or her interest in pursuing the opportunity to apply for Community Benefits.
14. **Self-Directed Community Benefits (SDCB):** Community Benefit services offered to a member who is able to and who chooses to self-direct his or her CB services.
15. **Withdrawal Form:** The form that is contained in the Allocation Packet that allows a registrant to withdraw his or her request to apply for Community Benefits.

NURSING FACILITY LEVEL OF CARE (NF LOC)

NF LOC determinations for Community Benefit (CB) members:

All individuals receiving CB services must meet NF LOC eligibility requirements initially and annually thereafter, unless eligible for continuous NF LOC.

Members who have a full Medicaid Category of Eligibility (COE) do not need an allocation to access CB. The member must contact his/her MCO Care Coordinator to request a NF LOC evaluation to determine if medical eligibility can be established. The Care Coordinator must schedule a Comprehensive Needs Assessment (CNA), to be completed in the member's home. The CNA must be scheduled within 30 calendar days of the member's request for CB services.

Once medical eligibility is established, the member must be reevaluated for NF LOC eligibility annually. The MCO Care Coordinator must begin the NF LOC evaluation process (i.e., schedule the CNA) 120 calendar days prior to the existing NF LOC expiration date. The MCO must send 120 and 60 calendar day reminder letters to the member. If the member has not complied with the CNA process and there are only 30 calendar days left before the NF LOC expiration date, the MCO will send a notice of action (NOA) to the member explaining that CB services will expire in 30 calendar days due to member not complying with the NF LOC evaluation process. The NOA must advise the member that if CB services are desired, the CNA process must be completed. The notice must include member appeal and fair hearing rights.

Individuals requesting CB services who are not eligible for a full Medicaid COE, must place their name on the Central Registry as described later in this section of the Policy Manual.

CONTINUOUS NF LOC FOR CERTAIN ELIGIBLE MEMBERS

Community Benefit Members who meet the following criteria may be eligible for a continuous NF LOC. The MCO is required to complete the CNA as outlined in the Mananged Care Policy Manual Section 4.

1. The Member must have had an approved NF LOC for the prior three years.
2. The approved NF LOC must be related to the Member's primary diagnosis.
3. A continuous NF LOC status must be approved annually by the MCO Medical Director and documented in the Member's file.
4. The Member's PCP must annually complete and sign a form that documents the Member's ongoing ADL deficits related to the Member's primary diagnosis. The MCO must maintain this form in the Member's file.
5. The MCOs will be required to regularly report to HSD the number of Members with approved continuing NF LOC status and other related information.

Conditions that may warrant a continuous NF LOC include, but are not limited to:

- Cerebral Palsy;
- Chronic Obstructive Pulmonary Disease (end stage);

- Cystic Fibrosis;
- Dementias (such as Alzheimer's, Multi-Infarct, Lewy Body);
- Developmental Disability (such as microcephaly and severe chromosomal abnormalities);
- Neurodegenerative Diseases (such as ALS, muscular dystrophy, multiple sclerosis,);
- Paralysis secondary to Cerebral Vascular Accident;
- Parkinson's Disease;
- Paraplegia;
- Quadriplegia;
- Spina Bifida;
- Paralysis secondary to severe spinal cord injury; or
- Ventilator Dependent.

EXTERNAL AUDITS OF NF LOC DETERMINATIONS

HSD or its designee will sample and audit each MCO's quarterly NF LOC denial determinations to assure that the LOC criteria are being appropriately applied by the MCOs. Each MCO will submit a universe of all high-NF and Community Benefit requests that were reviewed and denied due to not meeting NF LOC. The denial universe will be submitted to HSD by the 7th day of the month following the end of the quarter. The naming convention for the universe file is MCO, quarter, year, denial universe. For example, if the MCO is submitting first quarter reviews, the file shall be named "MCO-name.Q1.18.denial universe." The universe will be broken out by high-NF denials and CB denials in separate tabs in an Excel file and will include the following information: member name, Medicaid identification number, and member's date of birth. The MCO shall submit the universe file to HSD via the DMZ (NF LOC review folder).

HSD or its designee will perform a random selection of the universe and notify the MCO of selected members' files to be audited. HSD or its designee will submit a list of members selected to the MCO via the DMZ. Upon receipt of the member selection list, the MCO will have five (5) business days to send the complete information for the selected members. The naming convention for the member selection is MCO-name, quarter, year, member file. For example, if the MCO is reporting first quarter member files, the file shall be named "MCO-name.Q1.18.member file." The MCO shall submit the following information below to HSD via DMZ (NF LOC review folder).

The MCO shall include the following information in the member's file for Community Benefit denials:

a) Member Name;
b) Medicaid Identification Number;
c) Copy of completed CNA for member;

d) Any utilization notes pertaining to the denial;
e) Allocation tool;
f) Name of care coordinator;
g) Comprehensive Care Plan, if applicable; and
h) Any additional information such as functional assessment, NF LOC, community supports and plans developed for services authorized for the member, including medication management plans.

Member file documents shall be bookmarked and/or highlighted, and text boxed to identify all elements in the file that indicate why the member received a denial.

MCO INTERNAL AUDITS OF NF LOC DETERMINATIONS

Each MCO will conduct internal random sample audits of both facility and community benefit NF LOC determinations based on HSD NF LOC instructions and tool guidelines each quarter. The audit will include, at a minimum: accuracy, timeliness, training documentation of reviewers, and consistency of reviewers. The results and findings will be reported to HSD by the 7th day of the month following the end of the quarter along with any Quality Performance Improvement Plan via DMZ (NF LOC reviews folder). The naming convention for the results and findings file is MCO, quarter, year, internal audit results. For example, if the MCO is submitting first quarter reviews, the file shall be named "MCO-name.Q1.18.internal audit results."

REGISTRATION FOR THE COMMUNITY BENEFIT FOR MEMBERS NOT OTHERWISE MEDICAID ELIGIBLE (NOME)

The Aging and Long Term Services Department/Aging and Disability Resource Center (ALTSD/ADRC, referred to as ADRC from this point forward) manages the Centennial Care Central Registry by enrolling individuals, completing the pre-assessment, assigning the category of registration, and sending Exception requests to HSD/MAD/LTSSB. Any individual has the right to place his or her name on the Central Registry if: (1) it has been determined that the individual is not currently Medicaid eligible; or (2) current Medicaid shows a termination date; or (3) the individual has applied for Medicaid and received a denial.

At the time of registration, if the individual has a Medicaid category of eligibility entitling the individual to full Medicaid benefits, the ADRC shall refer the individual to his or her MCO.

Any individual has the right to register for multiple waivers at the same time. Individuals may place their~~his or her~~ name on the Central Registry by calling or appearing in person at~~to~~ the ADRC. An individual must be a resident of the state of New Mexico in order to be registered. Residency is determined based on the State's eligibility rule for Medicaid. It is the individual's responsibility to inform the ADRC of any changes in address and/or telephone number so the Central Registry

can be updated. Individuals are also encouraged to contact the ADRC if they have significant changes in their health condition or living~~residential~~ situation. These circumstances may affect their type of registration.

Individuals should note that the Central Registry records information such as: (1) the applicant's demographic information; (2) the date of registration; and (3) the applicant's specific long term care needs. Individuals are also required to complete a pre-assessment which aids the ADRC staff in directing the applicant to the appropriate category of registration: Community Reintegration, Expedite, and Regular. The registration types are defined as follows:

A. Community Reintegration (CRI) – provides individuals the opportunity to move out of a nursing facility (NF) and back into the community for a registrant who is residing in a NF at the time of registration. In order to be eligible for CRI, the registrant must have resided in a NF for 90 consecutive days. Within the 90 days, the registrant may~~could~~ have been hospitalized and returned to the NF, for the remainder of the 90 days. The individual participating in the community reintegration process must be capable of comprehending the decisions being made or have a primary caregiver or legal guardian~~surrogate~~ that understands the options. The individual must not require Agency Based Community Benefit (ABCB) services 24 hours per day in his or her home. The intent of CRI is to assist the individual to become integrated into his/her community and be as independent as possible. The MCO must be able to ensure a reasonable level of health and safety for the member while ABCB services are being provided. ABCB services must be cost-effective and must not exceed the average annual per capita costs of Nursing Facility services as determined by The Human Services Department (HSD).

   CRI registration for the ABCB can be completed by calling the ADRC. Once a continuous 90 day stay is confirmed by the HSD/MAD/LTSSB and funding is available, a community re-integration allocation is granted. The HSD/MAD/LTSSB sends the allocation packet to the registrant/representative. The allocation paperwork must be returned to the HSD/MAD/LTSSB within 45 calendar days or the allocation will be closed and the registrant will need to re-register for placement on the Central Registry and wait for another allocation. If an extension is needed to complete the packet, HSD/MAD/LTSSB must be notified to grant the extension (see "The Allocation Process: Timelines for the Allocation Packet").

   Once the PFOC and HSD 100 are received by HSD/MAD/LTSSB, the allocation is processed (see "The Allocation Process: Processing PFOCs"). Once the allocation has been granted, it is the MCO's responsibility to ensure services are authorized and in place prior to discharge to ensure~~so the registrant will have~~ a safe and appropriate discharge.

The MCO must contact the registrant within 5 business days of receipt of the PFOC to schedule an initial assessment to determine medical eligibility. The assessor explains the CRI process to the registrant/representative. If the registrant/representative wishes to remain in the institution, the Withdrawal Form must be completed, signed and mailed to HSD/MAD/LTSSB. If the registrant/representative wishes to proceed with the eligibility process, the MCO proceeds with the medical eligibility process.

B. Expedite (EXP) – a registrant who has an urgent need for care. To be eligible, the registrant must:
   a. be pre-assessed by the ADRC to require total assistance in at least three (3) categories of activities of daily living (ADLs); and
   b. score a minimum of 48 points on the ADRC pre-assessment.

C. Regular (REG) – a registrant who does not meet the criteria for any of the other registration types, based upon the ADRC pre-assessment.

Individuals may request an Exception to their category of registration and request an Expedited allocation to the ADRC, under extreme circumstances. The ADRC will send the request to the HSD/MAD/LTSSB who will consider issuing an Expedited allocation. The following are examples of circumstances that may warrant an E~~e~~xception request for an Expedited allocation:

   a. to ensure continuity of care, an individual was receiving Community Benefits under a Full Medicaid category of assistance and ~~has had~~ his or her Full Medicaid eligibility terminated. An individual must inform the ADRC that he or she has lost ~~his or her~~ Full Medicaid ~~category of assistance,~~ and was receiving Community Benefits. The request must be made to ADRC within six (6) months of termination of the Full Medicaid category of assistance.
   b. an individual who was in a NF for 90 consecutive calendar days and was not registered for a CRI allocation prior to discharge. The request must be made to ADRC within 30 calendar days ~~three (3) months~~ after discharge from the NF.
   c. an individual is residing in a~~n~~ Medicaid approved Assisted Living Facility, has been paying out of pocket, and can no longer afford the private pay;
   d. an individual who has been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or Aids-Related Complex (ARC);
   e. an individual who no longer qualifies for the Medically Fragile Waiver and is ventilator dependent; or
   f. in rare cases, an individual ~~who meets the hardship criteria such as~~with an extreme health and safety risk~~, and has been referred to the ADRC by the HSD or the ALTSD/Adult Protective Services (APS)~~.

THE ALLOCATION PROCESS

The ADRC manages the Central Registry by enrolling individuals, completing the pre-assessment, and sending Exception requests to HSD/MAD. The HSD/MAD/LTSSB manages the allocation process by mailing Allocation Packets to registrants and forwarding completed allocation paperwork to HSD/ISD and to the MCO.

In order to facilitate the allocation process, the ADRC shall:

1. Maintain accurate registrant information in the Central Registry, including coding of category of registration for each registrant; and
2. Change a registrant's category of registration, if the ADRC obtains information that justifies the change, e.g., a registrant leaves a NF before the 90-day requirement is met.

When the HSD/MAD Director determines that a regular allocation should be released, the allocation process begins by sending the Allocation Packet to the registrant. The registrant is notified that there is an allocation available and is asked to respond by returning a completed Primary Freedom of Choice Form ("PFOC") and HSD 100, or a Withdrawal Form.

The Allocation Packet is stamped with "Allocation Packet" and contains the:

1. Letter of Interest (LOI);
2. PFOC;
3. Withdrawal Form;
4. HSD 100 "Medicaid Application for Assistance";
5. Community Benefits Informational Brochure; and
6. Self-addressed stamped envelope addressed to HSD/MAD/LTSSB~~, stamped with "Allocation Packet~~."

Timeframes for the Allocation Packet:

1. The registrant has 45 calendar days to return either a completed PFOC and HSD 100, or a Withdrawal Form to HSD/MAD/LTSSB.
2. The registrant may request a one-time extension to return the PFOC and HSD 100, or Withdrawal Form by contacting the HSD/MAD/LTSSB, and if requested, it shall be granted for up to ~~thirty (~~30~~)~~ calendar days. Any additional time (extensions) requested by the registrant must be made directly to HSD/MAD/LTSSB for approval.

3. If there is no response to the Allocation Packet either after the original 45 calendar days or after the expiration of any granted extensions, HSD/MAD/LTSSB shall send a closure letter to the registrant's mailing address on file.

Processing PFOCs:

Once HSD/MAD/LTSSB receives the PFOC and the HSD 100, HSD/MAD/LTSSB will review the documents to ensure that they are complete and signed by the registrant.

1. If the PFOC ~~and/or HSD 100 are~~is not complete and/or signed, the ~~document(s)~~ PFOC will be returned to the registrant, identifying the information required, and providing the registrant up to thirty (30) calendar days to complete and return ~~them~~ the form. Failure to return the ~~document(s)~~ PFOC within the 30 calendar day time period will result in closure upon the 45th day, as described herein.
~~1. If the PFOC is complete and signed, but the HSD 100 is not returned and/or signed, the PFOC will be sent to the HSD/ISD Eligibility system. It is the responsibility of the registrant to submit a completed/signed HSD 100 to HSD/ISD.~~
2. If the PFOC and HSD 100 are completed and signed, HSD/MAD/LTSSB will process them ~~and~~ by sending:
   A. ~~send~~ a Notice of Allocation (NOA) letter to the registrant with a copy of the PFOC, for their records;
   B. ~~send~~ a copy of the NOA, PFOC, and HSD 100 to the HSD/ISD Eligibility system; and
   C. ~~send~~ a copy of the NOA and PFOC to the registrant's MCO.

ELIGIBILITY

Once the PFOC and HSD 100 have been distributed to HSD/ISD and the MCO, HSD/MAD/LTSSB's "Processing PFOCs" is complete. HSD/MAD/LTSSB is unable to assist with medical or financial eligibility. Registrants must meet two (2) types of eligibility, initially and annually, to receive and continue receiving Community Benefits:

1. Medical Eligibility: The medical eligibility determination is completed by the MCO. In order to be medically eligible, the registrant must meet a nursing facility level of care (NF LOC). In addition, the C~~c~~omprehensive N~~n~~eeds A~~a~~ssessment (CNA) must indicate that the registrant has a need for Community Benefits.
   A. The NF LOC shall be determined and transmitted to ASPEN within ~~60~~40~~45~~ calendar days from the MCO's receipt of the PFOC.
   B. The MCO shall submit the NF LOC ~~approval~~ determination to HSD/ISD, via the

interface file, within 5 business days of the~~upon~~ NF LOC determination so it can be used by HSD/ISD to complete the eligibility process.

C. ~~The MCO shall submit the NF LOC denial to HSD/ISD, via the interface file, within 5 business days of the NF LOC denial determination.~~

~~C.~~D. If there is an existing NF LOC determination, the MCO shall submit the NF LOC effective dates to HSD/ISD, via the interface file, within 5 business days of the MCO's receipt of the PFOC so it can be used by HSD/ISD to complete the eligiblity process. ~~If a current NF LOC is already in place upon receipt of the PFOC, a~~ A new NF LOC ~~one~~ does not need to be ~~completed~~determined by the MCO, unless there are less than 120 calendar days remaining on the existing NF LOC.

~~D.~~

E. The MCO shall submit the NF LOC effective dates and applicable Setting of Care of ADB (Agency Directed Services) to the Omnicaid system, via the interface file, within 5 business days of receiving the member's initial enrollment on the Enrollment Roster file.

F. ~~If a current NF LOC is already in place upon receipt of the PFOC, a new one does not need to be completed by the MCO, unless there are less than 120 calendar days remaining on the existing NF LOC.~~

2. Financial Eligibility: In order to be financially eligible, income and assets must be below~~under~~ the Institutional Care Medicaid (ICM)/Waiver maximum allowable amount. In addition, all other financial and non-financial eligibility requirements must be met as determined by HSD/ISD.

~~The registrant must complete both the medical and financial eligibility within 4590 calendar days from the allocation date stated in the NOA. Failure to complete both the medical and financial eligibility within the 4590 calendar day time period shall result in closure of the allocation. If a registrant needs additional time to submit required documentation, the request must be submitted directly to HSD/ISD.~~

Once eligibility is approved by HSD/ISD, the registrant's ~~for~~~~will be enrolled with~~ ABCB services will be provided~~and shall receive such services as are needed,~~ based on the CNA conducted by the member's MCO.

The member must participate in the Agency Based Community Benefit (ABCB) service delivery model for a minimum of 120 calendar days before the member requests a ~~can~~ switch to the Self-Directed Community Benefit (SDCB) service delivery model. A member must contact their MCO Care Coordinator to discuss the switch from ABCB to SDCB. The Community Benefit services are described in ~~the MCO Policy Manual in~~ Sections 8 and 9 of the policy manual.

CLOSING/INACTIVATING AN ALLOCATION

An allocation will be inactivated by HSD/MAD/LTSSB if one of the following occurs:

1. The registrant returns a signed Withdrawal Form;
2. The registrant does not return the PFOC within the required timeframes;
3. The ADRC or HSD/MAD/LTSSB is informed that the registrant intends to remain in the NF;
4. The ADRC or HSD/MAD/LTSSB is informed that the registrant is no longer a resident of the State of New Mexico;
5. The ADRC or HSD/MAD/LTSSB has been notified that the registrant has expired;
6. The Allocation Packet is returned as undeliverable and no other contact information is available; or
7. The registrant has a Full Medicaid category of eligibility and has access to Community Benefit services through their MCO.

REGISTRANT NOTICE REQUIREMENTS

The registrant is notified by letter in the following circumstances:

1. New registration (mailed by the ADRC);
2. When the State is unable to contact the registrant by telephone;
3. When an allocation becomes available for the registrant (Allocation Packet);
4. When an allocation is complete (Notice of Allocation); and
5. When a registration is closed/inactivated for any reason other than a completed allocation.

When the State has been notified that the registrant is deceased, a letter will not be sent to the registrant or the registrant's representative.

UNDELIVERABLE NOTICE

It is the registrant's responsibility to inform the ADRC of any change in address and/or telephone number. If a letter is returned to the State as undeliverable, HSD/MAD/LTSSB shall review the registrant's record to determine an alternate address and attempt to call the registrant or the registrant's representative to verify a correct mailing address. If HSD/MAD/LTSSB cannot obtain the registrant's address, the registrant's Central Registry record will be inactivated due to the inability to contact the registrant. HSD/MAD/LTSSB shall document the reason the registration has closed, the specific attempts made to contact the registrant, and the date(s) of attempts, in the registrant's journal notes in the Central Registry.