7. Community Benefits

7.1. General Information

The Community Benefits (CB) are services that provide assistance to individuals who require Long-Term Services and Supports (LTSS) 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. The CB does not provide 24-hour care and is intended as a supplement to an individual's natural supports. CB services are available to Members meeting a NF LOC. The Member's MCO shall provide the CB services as determined appropriate by the Comprehensive Needs Assessment (CNA). Members eligible for the CB 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 services: financial eligibility, determined by~~-~~ HCA/ISD, and medical eligibility, determined by an MCO through a NF LOC assessment conducted as part of the CNA. Additionally, if an individual is under the age of 65 and has not been deemed disabled by the Social Security Administration (SSA), they must be evaluated by MAD's Disability Determination Unit (DDU) to establish their disability meets SSA guidelines. See NMAC 8.290.400.10(A).

Members who have a Full Coverage Medicaid COE may be eligible for CB if they meet an NF LOC and indicate they have a need for CB. These individuals may be identified by their MCO ~~and~~ or may ~~also~~ 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 EPSDT program, which provides personal care services (PCS). If a Medicaid enrolled minor indicates ~~he or she~~ they ha~~s~~ve a need for CB and meets an NF LOC, an allocation is not needed to access CB services.

7.2. 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 CB services offered through a provider agency to a Member who does not wish to self-direct ~~his or her~~their CB services.
4. **Allocation:** The opportunity given to a registrant who is Not Otherwise Medicaid Eligible (NOME) to apply for CB.
5. **Allocation Packet:** The documents sent by HCA/MAD/LTSSB to a registrant that includes the Letter of Interest (LOI), Primary Freedom of Choice (PFOC), 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 CB and may be eligible for an allocation.
7. **Community Benefits (CB):** HCBS that provide LTSS 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. **HCA 100:** "Medicaid Application for Assistance" that is used to apply for CB and is available online or at a local HCA/ISD office.
9. **Inactive Registration:** A registration is inactivated/closed under certain circumstances (see Section 7.10 of this Manual, Closing/Inactivating an Allocation).
10. **Letter of Interest (LOI):** The letter that is sent to a registrant informing ~~him or her~~them that an allocation is available and that ~~he or she~~they may apply for CB.
11. **Notice of Allocation (NOA):** The letter that is sent to a registrant informing them~~him or her~~ that the PFOC was received at HCA/MAD/LTSSB and informs them~~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 (NF LOC):** The Member's functional level is such that two or more 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 an NF LOC to be eligible for CB services.

13. **Primary Freedom of Choice (PFOC):** The form included in the Allocation Packet that allows a registrant to confirm their~~his or her~~ interest in pursuing the opportunity to apply for CB services.
14. **Self-Directed Community Benefits (SDCB):** CB services offered to a Member who is able to and ~~who~~ chooses to self-direct ~~his or her~~their CB services.
15. **Signature:** Signature of Member or Member's legal representative. If a Member is unable to sign and does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice. Wherever signature is required, verified electronic signature may be used.
16. **Telephonic Signature:** When a Member or Member's legal representative fails to sign required documents, a telephonic signature may be obtained by an authorized HCA staff member. The staff member will verify the member's identity and note that a telephonic signature was collected.

~~14.~~17. **Verified Electronic Signature:** A verified electronic signature is an electronic signature that has been confirmed to be authentic and has not been tampered with. There are multiple ways to verify an electronic signature, including, but not limited to, Digital Certificates, Passwords, and Two-Factor Authentication.

~~15.~~18. **Withdrawal Form:** The form that is contained in the Allocation Packet that allows a registrant to withdraw their~~his or her~~ request to apply for CB services.

7.3. Nursing Facility Level of Care (NF LOC)

NF LOC determinations for 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 coverage Medicaid COE do not need an allocation to access CB. The Member must contact their~~his/her~~ MCO Care Coordinator to request an NF LOC evaluation to determine if medical eligibility can be established. The Member's MCO may also identify the Member as having a need for CB and discuss with the Member. The Care Coordinator must schedule a 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. CNA dates may be adjusted annually or as indicated to align with NFLOC CNA to eliminate need for redundant CNAs. 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 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.

The MCO shall submit the NF LOC effective date spans and SOC date spans via the applicable interface(s) within 24 business hours of determination. For renewals, this submission should be no later than 60 calendar days prior to the expiration of the existing NF LOC and SOC date spans. If the NF LOC determination has not been completed 60 days prior to expiration due to member caused delay, the NF LOC must be submitted as soon as possible to avoid any lapse in coverage.

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

7.4. Continuous NF LOC for Certain Eligible Members

CB 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 Section 4 of the Manual.

- The Member must have had an approved NF LOC for the prior three years.
- The approved NF LOC must be related to the Member's primary diagnosis.
- A continuous NF LOC status must be approved initially and annually by the MCO Medical Director and documented in the Member's file.
- 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.
- The MCOs will be required to regularly report to HCA 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.

7.5. External Audits of NF LOC Determinations

HCA or its designee will audit a sample of each MCO's NF LOC determinations to ensure the LOC criteria are being appropriately applied by the MCOs. Each MCO will submit a universe of NF LOC

determinations to HCA or its designee for review. HCA or its designee will meet with the MCO to discuss audit findings.

7.6. MCO Internal Audits of NF LOC Determinations

Each MCO will conduct internal random sample audits of both facility and CB NF LOC determinations based on HCA 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 HCA 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 "MCOname.Q1.18.internal audit results."

7.7. Registration for the CB for Not Otherwise Medicaid Eligible (NOME) Members

The ALTSD/ADRC (referred to as ADRC from this point forward) manages the CB Central Registry by enrolling individuals, completing the preassessment, assigning the category of registration, and sending Exception requests to HCA-/MAD/LTSSB. Any individual has the right to place their~~his or her~~ name on the Central Registry if: it has been determined the individual is not currently Medicaid eligible, or current Medicaid shows a termination date, or the individual has applied for Medicaid and received a denial. At the time of registration, if the individual has a Medicaid COE entitling the individual to full Medicaid benefits, the ADRC shall refer the individual to ~~his or her~~their MCO.

Any individual has the right to register for multiple waivers at the same time. Individuals may place their name on the Central Registry by calling or appearing in person at 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 situation. These circumstances may affect their type of registration.

Individuals should note that the Central Registry records information such as: the applicant's demographic information, the date of registration, and the applicant's specific LTC 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:

- **Community Reintegration** – provides individuals the opportunity to move out of an NF and back into the community for a registrant who is residing in an NF at the time of registration. In order to be eligible for CRI, the registrant must have resided in an NF for 90 consecutive days. Within 90 consecutive days, the registrant may have been hospitalized and returned to the NF for the remainder of the 90 days. If the 90-day stay was confined to only a hospital stay and the client was never in a NF this does not qualify them for a CRI, they would have to be evaluated under another allocation type such as Regular or Exception. 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 that understands the options. The individual must not require ABCB services 24 hours per day in ~~his or her~~their home. The intent of CRI is to assist the individual to become integrated into ~~his/her~~their 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 NF services as determined by HCA.

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

  Once the PFOC and HCA 100 are received by HCA~~SD~~/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 a safe and appropriate discharge.

The MCO must contact the registrant within five 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 HCA/MAD/LTSSB. If the registrant/representative wishes to proceed with the eligibility process, the MCO proceeds with the medical eligibility process.

- **Expedite (EXP)** – a registrant who has an urgent need for care. To be eligible, the registrant must:
  - Be pre-assessed by the ADRC to require total assistance in at least three categories of ADLs; and
  - Score a minimum of 48 points on the ADRC pre-assessment.
- **Regular (REG)** – a registrant who does not meet the criteria for any of the other registration types, based upon the ADRC preassessment.
- **Exception (EXC)-** 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 HCA/MAD/LTSSB who will consider issuing an Expedited allocation. The following are examples of circumstances that may warrant an Exception request for an Expedited allocation:
  - To ensure continuity of care, an individual was receiving CBs under a full Medicaid category of assistance and ~~his or her~~their full Medicaid eligibility terminated. An individual must inform the ADRC that ~~he or she has~~they have lost full Medicaid and was receiving CBs. The request must be made to ADRC within six months of termination of the full Medicaid category of assistance;
  - An individual who was in an 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 after discharge from the NF;
  - An individual is residing in a Medicaid approved Assisted Living Facility, has been paying out of pocket, and can no longer afford the private pay;
  - An individual who has been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or Aids-Related Complex (ARC);
  - An individual who no longer qualifies for the MFW and is ventilator dependent; or
  - In rare cases, an individual with an extreme health and safety risk.

7.8. Allocation Process

The ADRC manages the Central Registry by enrolling individuals, completing the preassessment, and sending Exception requests to HCA/MAD. The HCA/MAD/LTSSB manages the allocation process by mailing Allocation Packets to registrants and forwarding completed allocation paperwork to HCA/ISD and to the MCO. In order to facilitate the allocation process, the ADRC shall:

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

When the HCA/MAD Director determines that an ~~regular~~ allocation should be released, the allocation process begins by sending the Allocation Packet to the registrant. The registrant is notified there is an allocation available and is asked to respond by returning a completed PFOC and HCA 100, or a Withdrawal Form.

The Allocation Packet contains the following:

- LOI;
- PFOC;
- Withdrawal Form;
- HCA 100 "Medicaid Application for Assistance";
- CBs Informational Brochure; and
- Business Reply envelope addressed to HCA/MAD/LTSSB.

Timeframes for the Allocation Packet:

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

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

Processing PFOC and HCA 100s:

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

- ~~If the PFOC is not complete and/or signed, the PFOC will be returned to the registrant, identifying the information required, and providing the registrant with up to 30 calendar days to complete and return the form. Failure to return the PFOC within the 30 calendar days will result in closure upon the 45th day, as described herein.~~
- HCA/MAD/LTSSB will attempt contact the registrant to complete the PFOC with a telephonic signature while verifying the contact/demographic information. If MAD is unable to reach the registrant the PFOC will be mailed to the registrant, identifying the information required, and provide the registrant up to 30 calendar days to complete and return the form. Failure to return the PFOC within the 30 calendar days or within the 45th day whichever is later will result in closure, as described herein.
- If the HCA 100 is not complete and/or signed, then the form(s) will be returned to the registrant, identifying the information required, and provide the registrant up to 30 calendar days to complete and return the form. Failure to return the HCA 100 within the 30 calendar days or within the 45th day, whichever is later, will result in a closure, as described herein.
- When the PFOC and HCA 100 are complete and with signature, the forms will be date stamped with the same date the NOA was sent to the registrant. The authorized HCA/MAD/LTSSB staff will initial under the date stamp.
- If the PFOC **and** HCA 100 are completed and signed, HCA/MAD/LTSSB will process them by sending:
  - A NOA letter to the registrant;
  - A copy of the ~~NOA,~~ PFOC~~,~~ and HCA 100 to the HCA/ISD Eligibility system; and
  - A copy of the PFOC to the registrant's MCO.

7.9. Eligibility

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

- **Medical Eligibility**: The medical eligibility determination is completed by the MCO. In order to be medically eligible, the registrant must meet an NF LOC. In addition, the CNA must indicate that the registrant has a need for CBs.
    - The MCOs must have established procedures for their call centers to resolve issues and address inquiries from those who are allocated, but not yet fully enrolled with the MCO, because the NFLOC determination has not yet been completed. The MCO must be able to identify these individuals in their systems within two (2) business days of receipt of the PFOC or 112 trigger file sent from the ASPEN system and be able to address questions and concerns from these future Members who are newly allocated and may be enrolled in the MCO when eligibility is complete. If there is an existing/current NF LOC in the HCA/ISD eligibility system, there will be no 112 trigger file sent to the MCO. The MCO should reach out to HCA/MAD/LTSSB staff if they receive the trigger file and no PFOC or vice versa.
    - The NF LOC shall be determined and transmitted to ASPEN within 40 calendar days from the MCO's receipt of the PFOC.
    - The MCO shall submit the NF LOC determination to HCA/ISD, via the interface file, within 5 business days of the NF LOC determination so it can be used by HCA/ISD to complete the eligibility process.
    - If there is an existing NF LOC determination, the MCO shall submit the NF LOC effective dates to HCA/ISD, via the interface file, within 5 business days of the MCO's receipt of the PFOC so it can be used by HCA/ISD to complete the eligibility process. A new NF LOC does not need to be determined by the MCO, unless there are less than 120 calendar days remaining on the existing NF LOC.
    - The MCO shall submit the NF LOC effective dates and applicable SOC 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.

- If an individual is under the age of 65 and has not been deemed disabled by the Social Security Administration (SSA), they must be evaluated by MAD's Disability Determination Unit to establish whether they meet the disability criteria according to SSA guidelines. Current medical records regarding the individual's disability must be provided to ISD.

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

Once eligibility is approved by HCA/ISD, the registrant's ABCB services will be provided based on the CNA conducted by the Member's MCO. Although the COE for the CB Waiver is approved, CB services will not begin until the Comprehensive Care Plan is in place. CB services are not approved retroactively.

The Member must participate in the ABCB service delivery model for a minimum of 120 calendar days before the Member requests a switch to the SDCB service delivery model. A Member must contact their MCO Care Coordinator to discuss the switch from ABCB to SDCB. The CB services are described in Sections 8 and 9 of the Manual.

7.10. Closing/Inactivating an Allocation

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

- The registrant returns a signed Withdrawal Form;
- The registrant does not return the PFOC within the required time frames;
- The ADRC or HCA/MAD/LTSSB is informed the registrant intends to remain in the NF;
- The ADRC or HCA/MAD/LTSSB is informed the registrant is no longer a resident of the State of New Mexico;
- The ADRC or HCA/MAD/LTSSB has been notified the registrant has expired;
- The Allocation Packet is returned as undeliverable and no other contact information is available; or
- The registrant has a full Medicaid category of eligibility (COE) and has access to CB services through their MCO.

7.11. Registrant Notice Requirements

The registrant is notified by letter in the following circumstances:

- New registration (mailed by the ADRC);

- When the State is unable to contact the registrant by telephone;
- When an allocation becomes available for the registrant (Allocation Packet);
- When an allocation is complete (NOA);
- When a registration is closed/inactivated for any reason other than a completed allocation; and
- 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.

7.12. 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, HCA/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 HCA/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. HCA/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.