

## 7 COMMUNITY BENEFIT

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Community Benefits (CB) are services that provide assistance to individuals who require long-term 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 Nursing Facility Level of Care (NF LOC). The member's Managed Care Organization (MCO) shall provide the Community Benefit as determined appropriate based on the Comprehensive Needs Assessment (CNA). Members eligible for the Community Benefit have the option of selecting 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 evaluation conducted as part of the CNA.

Members who have a Full Medicaid category of eligibility may be eligible for CB if they meet the NF LOC and indicate they have a need for CB. These individuals should not contact the New Mexico Aging & Long Term Services Department, Aging and Disability Resource Center (ADRC) but instead 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").

### ~~REGISTRATION FOR THE COMMUNITY BENEFIT FOR MEMBERS NOT OTHERWISE MEDICAID ELIGIBLE~~

~~Describes the process to register individuals who request Community Benefit services, and describes the allocation process.~~

### DEFINITIONS

- 1. Active Registration:** A registration is active if there is an open category of registration on the Central Registry, or if a paper application has been received by the New Mexico Aging & Long Term Services Department, Aging and Disability Resource Center (ADRC).
- 2. Activity of Daily Living (ADL):** ~~The ability to perform~~ 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 to a member who does not wish to self-direct his or her CB services.
- 4. Allocation:** The opportunity given to ~~an individual registrant~~ who is not otherwise Medicaid eligible to apply for Community Benefits.
- 5. Allocation Packet:** The documents packet that is sent by HSD/MAD/LTSSB to a registrant that which 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 registry that lists the 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 assistance to individuals who require long-term supports and services to eligible members that allow them to so they may 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 New Mexico Human Services Department, Income Support Division (HSD/ISD) office.
- 5.9. Inactive Registration:** A registration is inactivated/closed under certain circumstances if the registrant expired, refused services, was allocated but notice was undeliverable or the registrant moved out of state (see “Closing/Inactivating an Allocation”).
- 6.10. Letter of Interest (LOI):** The letter that is sent to an individual registrant informing him or her that an allocation is available and that he or she may apply for Community Benefits.
- 7.11. MAD 100:** “Medicaid Application for Assistance” that is available on-line or at a local New Mexico Department of Human Services, Income Support Division (HSD/ISD) office.
- 8. MAD 325:** “New Mexico Medicaid Waiver Services and Intermediate Care Facility for the Mentally Retarded Registration Form” that is available at a local HSD/ISD office.
- 9. Needs Assistance:** Registrant needs cueing, reminding and/or stand-by assistance.
- 12. Notice of Allocation (NOA):** The letter that is sent to an individual registrant informing him or her that the PFOC was received at HSD/MAD/LTSSB and informing him or her of the next steps in the allocation process. The date of the NOA is the allocation date.
- 10.13. 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 the NF LOC to be eligible for community benefit services. All community benefit members must be determined to meet nursing facility level of care initially and annually thereafter
- 11.14. Primary Freedom of Choice (PFOC):** The form included that is contained in the Allocation Packet that allows is sent to a registrant n individual which allows him or her to confirm his or her interest in pursuing the opportunity to apply for Community Benefits.
- 15. Self-Directed Community Benefits (SDCB):** The Community Benefit services offered to a member who is able to and who chooses wishes to self-direct his or her CB services.
- 12.16. Withdrawal Form:** The form that is contained in the Allocation Packet that allows a registrant to withdraw his or her request opportunity to apply for Community Benefits.

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

Describes the process to register individuals who request Community Benefit services; and describes the allocation process.

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; (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 ~~Aging and Disability Resource Center (ADRC)~~ shall refer the individual to his or her ~~managed care organization (MCO)~~.

Any individual has the right to register/~~apply~~ for multiple waivers at the same time. Individuals may place his or her name on the Central Registry apply by submitting a MAD 325, or by calling or appearing in person to the ADRC. An individual must be a resident of the ~~S~~state of New Mexico in order to be registered. Residency is determined based on the State's eligibility ~~r~~Rule for Medicaid eligibility.

Individuals should note that the Central Registry records information such as: (1) the demographic information about the applicant; (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, Regular, Expedite, and Regular, ~~or Community Reintegration~~. The registration types are defined as:

1. Community Reintegration (CRI) – provides individuals the opportunity to move out of a nursing facility S(NF) and back into the community for a registrant who is in a ~~licensed-skilled nursing facility (SNF)~~ at the time of registration. In order to be eligible for CRI, the registrant must have resided in a ~~SNF~~ for 90 consecutive days; Within the 90 days, the registrant could have been hospitalized and returned to the NF, for the remainder of the 90 days. The 90 days which may includes time the registrant was in a hospital, and returned to the SNF without a break in service. ~~CRI provides individuals the opportunity to move out of a SNF and back into the community.~~ The individual participating in the community reintegration process must be capable of comprehending the decisions being made or have a primary caregiver or legal 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, ~~on an ongoing basis;~~ as tThe 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 services provided under the ABCB must not exceed the average annual per capita costs of Nursing Facility services as determined by The Human Services Department (HSD). ~~The HSD/Medical Assistance Division (MAD) can refuse ABCB services to individuals whose health and safety would be at risk in the community as deemed by the interdisciplinary team that includes the MCO, the primary care physician (PCP) and service providers, in conjunction with technical assistance from HSD/MAD.~~

CRI registration for the ABCB can be completed by calling the [Aging and Disability Resource Center \(ADRC\)](#). 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 ([PFOC](#)) 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 [on the Central Registry](#) and wait for another allocation. If an extension is needed, 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](#), ~~it is faxed to the local HSD/ISD office~~ the allocation is processed ([see "The Allocation Process: Processing PFOCs"](#)). ~~It is also faxed to the MCO.~~ Once the allocation has been granted, ~~it is the MCO's responsibility to ensure services are authorized and in place prior to discharge so the registrant may will have leave the nursing home, if a safe and appropriate discharge is arranged.~~ [ensure services are authorized and in place](#)

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 ~~applicant~~[registrant](#)/representative. If the registrant/representative wishes to remain in the institution, the ~~Waiver Refusal~~ [Withdrawal](#) Form must be completed, signed and ~~faxed~~ [mailed](#) to HSD/MAD/[LTSSB](#). If the registrant/representative wishes to proceed with the eligibility process, the MCO proceeds with the medical eligibility process.

~~Once medical and financial eligibility is approved, ABCB services will be initiated.~~

2. [Expedited \(EXP\)](#) – a registrant who has an urgent need for care [and whose health and safety is at extreme risk](#). To be eligible, the registrant must:
  - a. [be pre-assessed by the ADRC](#) to require total assistance in at least three (3) categories of ADLs [and](#)
  - b. ~~and a meet a minimum~~ score [a minimum](#) of 48 points on the [ADRC pre-assessment](#).
  - a. ~~If an individual who was receiving Community Benefits under a Full Medicaid category of assistance, has had his or her Full Medicaid eligibility terminated, he or she can call the ADRC and request an expedited registration.~~

~~Individuals diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or Aids-Related Complex (ARC) may be registered with an expedited category of registration. Once registered, the ADRC notifies the HSD/MAD Agency Based Community Benefit program manager, and an expedited allocation will be released. The MCO will conduct the Comprehensive Needs Assessment (CNA) and Nursing Facility Level of Care (NFLOC) to verify the AIDS or ARC diagnosis and assist with access to Community Benefits.~~

~~Individuals that no longer qualify for the Medically Fragile Waiver and are ventilator dependent, may also be registered with an expedited category of registration. The University of New Mexico, Center for Development and Disability Medically Fragile Case Management Program (UNM/CDD MFCMP) will notify the HSD/MAD Agency Based Community Benefit program manager of the request to transition to Community Benefits and an expedited allocation will be released.~~

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

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 exception 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 was in an approved NF for 90 consecutive days and who was not registered for a CRI allocation prior to discharge. The request must be made to ADRC within three (3) months after of discharge from the NF.
- c. an individual is residing in an Assisted Living Facility and can no longer afford the private pay;
- d. an individual 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. an individual meets hardship criteria such as 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. ~~C~~change a registrant's category of registration, if the ADRC obtains information that justifies the change, e.g., a registrant leaves a SNF before the 90-day requirement is met.
3. ~~Close/Deactivate a registration in accordance with the closing of an allocation as described herein.~~

~~HSD/MAD shall maintain a list of registrants with the category of registration, sorted by the date of registration.~~

When the HSD/MAD Director determines that a regular allocation should be released~~made~~, the allocation process begins with by sending the Letter of Interest ("LOI") Allocation Ppacket being sent 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 LOI Allocation Ppacket shall contain:

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

Timeframes for the LOI Allocation Ppacket:

1. The registrant has 45 calendar days to return either a completed PFOC and HSD 100, or a Refusal of Services 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 by HSD/MAD.
3. If there is no response to the LOI 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 ~~sort and~~ review the documents PFOCs to ensure that they are form is complete and signed by the registrant.

1. If the PFOC and/or HSD 100 are is not complete and/or signed accurate, the document(s) PFOC will be returned to the registrant, identifying the ~~correct~~ information required ~~to process the document(s) PFOC,~~ and providing the registrant up to thirty (30) calendar days to complete and return them PFOC. Failure to ~~timely~~ return the document(s) PFOC within the 30 calendar- day time period will result in closure as described herein.
2. If the PFOC and HSD 100 are is complete, HSD/MAD/LTSSB will process them# and

- 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's Eligibility system; and
  - c. send a copy of the NOA and PFOC to the registrant's MCO and an HSD/MAD-100 "Medicaid Application for Assistance."
- ~~2.3. In addition, a copy of the NOA, PFOC and cover sheet is faxed to the registrant's local HSD/ISD's Eligibility system office and 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 component packet is completed by the registrant's MCO. In order to be medically eligible, the registrant must meet nursing facility level of care (NF LOC), which is at a minimum, daily hands-on assistance with two or more ADLs. In addition, the CNA Comprehensive Needs Assessment must indicate that the registrant has a need for Community Benefits.
  - a. The NF LOC shall be determined within calendar 60 days from the MCO's receipt of the PFOC.
  - b. The MCO shall submit the NF LOC approval to HSD/ISD, via the interface file, upon NF LOC determination so it can be used by HSD/ISD in 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.
  - d. 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 of receiving the member's initial enrollment on the Enrollment Roster file.

~~a-c. 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. This is referred to as "NF LOC follows the person" and ensures a member's continuity of care.~~
2. Financial Eligibility: In order to be financially eligible, income must be under the Institutional Medicaid (ICM)/Waiver maximum allowable amount, determined by HSD/ISD. 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 90 calendar days from the allocation date stated in the NOA. Failure to complete both the medical and financial eligibility within the 90 calendar-day time period shall result in closure of the allocation. If a registrant needs additional time to submit required documentation verification, the request must be made directly to HSD/ISD for approval by HSD/ISD.

Once eligibility is approved by HSD/ISD, registrants will be enrolled with ABCB services and

shall receive such services as are needed, based on the ~~Comprehensive Needs Assessment (CNA)~~ conducted by the member's MCO. ~~enter/update in order for~~ Thereafter, the registrant shall be ~~considered a member entitled to Community Benefits.~~

The member must participate in the Agency Based Community Benefit (ABCB) service delivery model for a minimum of 120 calendar days before the member 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.

### **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 Refusal/Withdrawal Form;
2. The registrant does not return the ~~LOI~~ or the PFOC within the required timeframes;
3. The ADRC or HSD/MAD/LTSSB is informed that the registrant intends to remain in the ~~SNF~~;
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; ~~or~~
6. The ~~LOI~~ Allocation Packet is returned as undeliverable and no other contact information is available; or
- ~~6-7.~~ The registrant has a Full Medicaid category of eligibility assistance and has access to may request Community Benefits services through their MCO.

### **REGISTRANT NOTICE REQUIREMENTS**

The registrant is notified by letter in the following circumstances:

1. New registration;
2. ~~Change~~ in category of registration;
2. When the State is unable to contact the registrant by telephone;
3. When an allocation becomes ~~potentially~~ available for the registrant (Letter of Interest);
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 ~~to send a notice~~. 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.