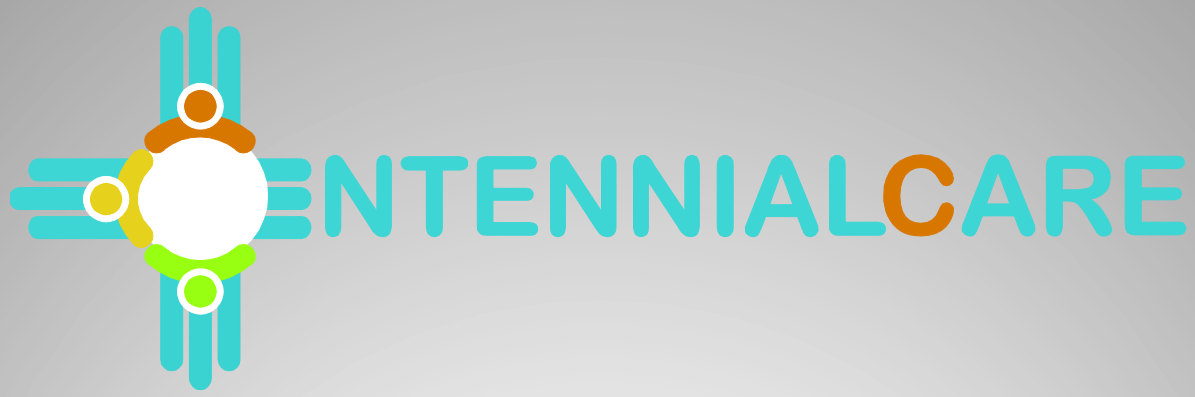

New Mexico Human Services Department

Medical Assistance Division

Long-Term Services and Supports Bureau

Presentation to the ACQ, April 13, 2017

Agenda

- Centennial Care
- Medicaid Expansion
- Community Benefit Eligibility
- Agency-Based Community Benefit
- Self-Directed Community Benefit

Centennial Care

- Centennial Care began 1/1/14
- 1115 Waiver approved by Centers for Medicaid and Medicare (CMS)
- Integrated managed care program that offers all health care services to eligible recipients, delivered by four managed care organizations (MCOs)
  - Blue Cross Blue Shield, Molina, Presbyterian, United
  - Physical health, behavioral health, long-term services and supports (LTSS)

Expanded Features of Centennial Care

- Member Rewards Program
- Health Risk Assessment
- Care Coordination
- Community Benefits (CB)

Centennial Care Community Benefits

- The Community Benefit (CB) is the name for the home and community based long-term care program in Centennial Care
- Provides in-home/community services so that members remain in the community and out of nursing facilities
- Agency-based (ABCB) or self-directed (SDCB) model

Community Benefit (CB) Eligibility

- To be eligible for the community benefit, members must meet a nursing facility level of care (NF LOC) and have an assessed need for services
  - NF LOC=member must require assistance with two or more activities of daily living (ADLs)
    - ADL- bathing, eating, dressing, toileting, transferring

Community Benefit (CB) Eligibility

Two ways to enter the CB:

1. If already eligible/enrolled in full Medicaid, member can let MCO/care coordinator know that he/she needs CB services.

- MCO will assess member for NF LOC and CB services
  - Comprehensive needs assessment
  - Community benefit services questionnaire
- If member meets NF LOC, MCO will develop comprehensive care plan based on the member's assessed needs

Community Benefit (CB) Eligibility

2. If member has applied for Medicaid and is not eligible he/she should contact the Aging and Disability Resource Center (ADRC) to be placed on the Central Registry.

- ADRC will assign an allocation category
- Regular, expedite, community reintegration, exception
- ADRC will perform an assessment of needs by telephone
- HSD Allocations Unit sends packet including Medicaid application to individual for completion, and assists with the process

Community Benefit (CB) Eligibility

- If a member loses 1915(c) waiver eligibility (DD, MF, or Mi Via), and needs Long-Term Care, he/she must follow the process outlined in steps 1 and 2.
  - If a MF waiver member is vent dependent, he/she meets expedited criteria for an allocation.

Community Benefit (CB) Eligibility

- ISD-financial eligibility – 90 days
  - Phone interview
  - Verification of income, assets, citizenship, etc.
- MCO- medical eligibility – 60 days
  - Comprehensive Needs Assessment
  - Nursing Facility Level of Care (NF LOC)
    - Hands-on assistance with 2 or more ADLs

Agency-Based Community Benefit

- New CB members must be in the ABCB for 120 days before switching to SDCB
  - Ensures that member has time to get familiar with the SDCB program requirements, build budget, have tax related forms in place, and hire providers
- Most CB members are in the ABCB model
- MCO contracts with the ABCB providers

Agency-Based Community Benefit

- ABCB Services include:
  - Personal care services (PCS)
  - Assisted Living Facility
  - Environmental Modifications
  - Emergency Response
- See CB Brochure for list of all ABCB services

Agency-Based Community Benefit

- ABCB members under the age of 21:
  - Will most likely only be eligible for respite (100 hours per year limit) and possibly BH support consultation
  - Are able to receive PCS and other services through EPSDT
  - Based on need, may be eligible for other services offered under the SDCB model such as related goods and specialized therapies
    - 120 day requirement
    - Minors cannot be their own EOR

Self-Directed Community Benefit

- CB members can switch to the SDCB model anytime after 120 days in ABCB
  - Must work with MCO/care coordinator
- Employer of Record requirements
  - Added responsibilities of being the employer of providers
  - hire, fire, train, ensure background checks are completed, submit timesheets and invoices to Xerox, arrange for back-up caregivers, coordinate with NM Department of Labor
- See CB Brochure for list of all SDCB services

Centennial Care 2.0

- Centennial Care was approved by CMS for 5 years (2014-2019)
- HSD must renew the waiver to begin on January 1, 2019
  - Medicaid Advisory Committee (MAC), Renewal Subcommittee
  - Concept paper to be released to public in next few months
  - Stakeholder input and statewide meetings to begin summer 2017
- Proposed CB changes include better alignment of benefit packages between ABCB and SDCB models, ongoing NF LOC, and Medicaid/Medicare enrollment alignment

Community Benefit Rules and Policy

Both Policy and Rule were updated 3/1/17

Policy:

- http://www.hsd.state.nm.us/providers/managed-care-policy-manual.aspx

Rule:

- http://164.64.110.239/nmac/parts/title08/08.308.0012.htm

Contact Information

HSD/MAD, Centennial Care Long-Term Services and Supports Bureau

Tallie Tolen, Bureau Chief

(505) 476-7013 or Tallie.tolen@state.nm.us

Jeannette Gurule, Community Benefit Manager

(505) 827-7765 or Jeannette.C.Gurule@state.nm.us

QUESTIONS?