



**BlueCross BlueShield
of New Mexico**

Long Term Services & Supports

Blue Cross and Blue Shield of New Mexico • Provider Training • 2025

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Nursing Facility (NF) Admissions and Discharges

Nursing facilities are required to notify Blue Cross and Blue Shield of New Mexico (BCBSNM) within 24 hours of a member's:

- Admission or request for admission including short-term stays
- Discharge:
 - Notify UM within 24 hours of the discharge
 - 30 days prior to planned a discharge
 - Facilities should notify their assigned Nursing Facility Care Coordinator as soon as possible to start the process of a safe reintegration
 - Has left Against Medical Advice
 - Hospital and/or Emergency Room encounters
 - Death
- Pending discharge
- Please call **877-232-5518**

Nursing Facility Level of Care (NFLOC) packets should be faxed within 30 days of admission and 60 days **prior** to current NFLOC expiration. If not submitted in a timely manner, it will affect the member's Medicaid eligibility. Note: NFLOC should not be submitted for short-term stays.

- **Long Term Care (LTC):** 505-816-2093
- **Clinical documentation:** 505-816-3854



Important Reminders to Nursing Facilities

Initial Determinations

- All Services must be medically necessary
- Please refer to the Managed Care Policy Manual regarding procedures for prior approval

Redeterminations

- Medical documentation must be received by BCBSNM at least 60 calendar days prior to the start date of the new certification period for Low Nursing Facility (LNF) and 30 calendar days for High Nursing Facility (HNF)

Retroactive Medicaid Eligibility

- Written requests for prior approval based on resident's financial eligibility must be reviewed within 30 calendar days of the date of the eligibility determination



NFLOC Packet Components

Preadmission Screening and Resident Review

NFLOC Notification Form

- All requests for prior approval will be submitted on the NFLOC Notification Form
- Please document the type of review being requested at the top of the NFLOC Notification Form:
 - Initial
 - Continued Stay
 - Medicaid Pending
 - Transfer
 - Readmit
 - Reconsideration
- All other required fields must be completed



Procedure for Transfers Between Nursing Facilities

The receiving NF must notify BCBSNM by telephone that a transfer to its NF is to occur and the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid.

- If there are **more than** 30 calendar days on the resident's current authorization, BCBSNM will fax the receiving NF the completed notification form which will include the prior authorization and date span.
- If there are **less than** 30 calendar days remaining on the current authorization, the receiving NF will request a continued stay on the notification form. BCBSNM will make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay.
- Please write "TRANSFER" in the type of request box on the notification form.

The NF receiving the resident will obtain the status of resident's reserve bed days from BCBSNM through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records.



NFLOC Packet Components (cont.)

Minimum Data Set (MDS)

- An MDS and other appropriate documentation must be completed for each resident for every situation requiring prior approval
- All locator fields must be clearly marked on the MDS
- When the resident goes from Medicare Co-Pay to Medicaid, the NF submits an Internal MDS that begins the UR process
- Appropriate documentation must accompany the MDS including a valid order and must:
 - **be signed** by a physician, nurse practitioner, clinical nurse specialist or physician assistant;
 - **be dated**; and
 - **indicate the Level of Care (LOC)** – either high NF (HNF) or low NF (LNF)

Please refer to the **New Mexico Medicaid Nursing Facility (NF) Level of Care (LOC) Criteria and Instructions.**



Agency-Based Community Benefit (ABCB) Covered Services

- 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
- Nursing Respite
- Respite (hourly and per diem)
- Skilled Maintenance Therapy Services
 - Occupational Therapy for Adults
 - Physical Therapy for Adults
 - Speech Therapy for Adults



Self-Directed Community Benefit (SDCB) Covered Services

- Behavior Support Consultation
- Customized Community Supports
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Private Duty Nursing
- Related Goods
- Respite
- Respite RN
- Self-Directed Personal Care
- Skilled Maintenance Therapy Services for Adults
- Specialized Therapies
- Start-up Goods
- Transportation (non-medical)



Self-Directed Community Benefit

SDCB Coverage Limitations

Environmental Modifications	\$6,000 every 5 years
Related Goods	\$2,000 every year
Respite	300 hours per care plan year
Respite RN	300 hours per care plan year
Specialized Therapies	\$2,000 per year
Start-up Goods	One-time coverage up to \$2,000
Non-Medical Transportation	\$1,000 per year



Home and Community-Based Services (HCBS) Settings Rule Overview

- ❖ The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule for HCBS requirements on January 16, 2014 with an effective date of March 17, 2023
- ❖ Focused on improving available HCBS programs and overall quality
- ❖ Compliance with this Rule impacts state reimbursement from the Federal Government
- ❖ As a first step towards determining the compliance of New Mexico's HCBS provider settings, all selected Turquoise Care providers are required to complete an online survey

Services impacted by the Final Rule Include:

Employment Supports (non-residential service)

Adult Day Health (non-residential service)

Assisted Living (residential service)



HCBS Final Settings Rule Annual Attestation/Screening Tool and Audit

HCBS Providers are required to complete an annual attestation & screening tool, along with an on-site audit completed by one of the Managed Care Organizations (MCO).

Assisted Living Facility, Adult Day Health and Employment Supports providers are required to complete the following;

- Providers must complete an annual Attestation & Screening Tool for each location.
- Providers must train staff on HCBS requirements and the role of person-centered planning. All applicable training documents and policy and procedures must be up to date and align with HCBS requirements.
- MCOs will coordinate with the provider and conduct annual on-site audits/screenings to initiate remediation process as applicable.
- MCO Care Coordination assessments and touchpoints will allow MCOs to gather valuable information on the HCBS Final Settings Rule Requirements. MCO Care Coordination teams will escalate any HCBS concerns with the appropriate Provider Network Representative.



HCBS Settings Rule Details

The Home and Community-Based settings must:

- Support individuals access to the greater community
- Provide opportunities for individuals to participate in individual and group outings (shopping, church, appointments)
- Provide the ability for individuals to seek employment
- Support individuals to receive the same degree of access to services in the community as those not living in a HCBS setting
- Allow individuals control over the scheduling of daily activities
- Allow visitors at any time approved by the individuals and access to private areas for conversation
- Must allow individuals to come and go as they please
- Provide access to transportation
- Compliance with all applicable rules and regulations.



Residential vs. Non-Residential Settings

Residential Settings Tool

Assisted Living Facilities

- ▶ Choice of Residence
- ▶ Community Access and Integration
- ▶ Living Space
- ▶ Staff Interactions and Privacy
- ▶ Services

Non-Residential Settings Tool

Adult Day Health & Employment Supports

- ▶ Choice of Setting
- ▶ Community Access and Integration
- ▶ Setting Space
- ▶ Staff Interactions, Privacy and Choice



HCBS Setting Requirements for Provider-Owned or Controlled Residential Settings

- Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
- Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law
- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- Setting is physically accessible to the individual
- Modifications of the additional requirements must be:
 - Supported by specific assessed need
 - Justified in the person-centered service plan
 - Documented in the person-centered service plan

HCBS Setting Requirements for Non-Residential Settings

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting is selected by the individual from among setting options including non disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the individual's needs, preferences.
- The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact.
- The setting facilitates individual choice regarding services and supports, and who provides them.

Person Centered Service Plan / Individual Plan of Care (IPOC)

- Documentation in the person-centered service plan and any modifications of the requirements includes but is not limited to:
 - Specific individualized assessed need
 - Prior interventions and supports including less intrusive methods
 - Description of condition proportionate to assessed need
 - Ongoing data measuring effectiveness of modification
 - Established time limits for periodic review of modifications
 - Individual's informed consent
 - Assurance that interventions and supports will not cause harm

Important Reminders to HCBS Providers

Information you provide helps BCBSNM and other providers to better serve members. Please remember to:



Complete and submit the Critical Incident Report when a member has an adverse event



Assist members with contacting BCBSNM Member Services and/or their care coordinator when they move or change phone numbers



Provide the Individualized Plan of Care when requested



Notify the member's care coordinator if you become aware of any issues that may affect a member's health and safety

Agency Based Community Benefit (ABCB) Annual Audits

MCOs will audit ABCB providers on an annual basis to determine compliance with the requirements set forth for all ABCB's as defined in the Turquoise Care Managed Care Policy Manual and the New Mexico Administrative Code (NMAC).

All elements of the audit are included under Section 8 of the Managed Care Policy Manual and Section 8.320.2.18.C NMAC.

This audit includes all ABCB Provider Types



Agency Based Community Benefit (ABCB) Annual Audits

Providers will receive a formal documentation request along with an audit tool with the details and a timeline to return the requested documents. Providers are to submit the requested documentation within fourteen (14) calendar days from the date of the letter.

Providers will receive a non-compliance letter if they fail to comply with the audit request. The goal is to help providers come into compliance.

Upon completion of the audit, providers will receive a Final Results letter which will score providers as "compliant" or "non-compliant".



Electronic Visit Verification (EVV)

EVV is a CMS mandate under the 21st Century Cures Act and established to improve access, quality of care, and health outcomes for Medicaid members who are receiving authorized personal care services (PCS), Home Health, and Respite.

- EVV for the Agency-Based Community Benefit population receiving PCS was implemented statewide in 2016.
- EVV implementation for Early and Periodic Screening, Diagnostic and Treatment – Personal Care Services (EPSDT PCS) on January 1, 2020
- EVV for the Self-Directed Community Benefit population began on January 1, 2021.
- EVV for Home Health and Respite went live on January 1, 2024.



EVV Resources

AuthentiCare User Guides and Trainings

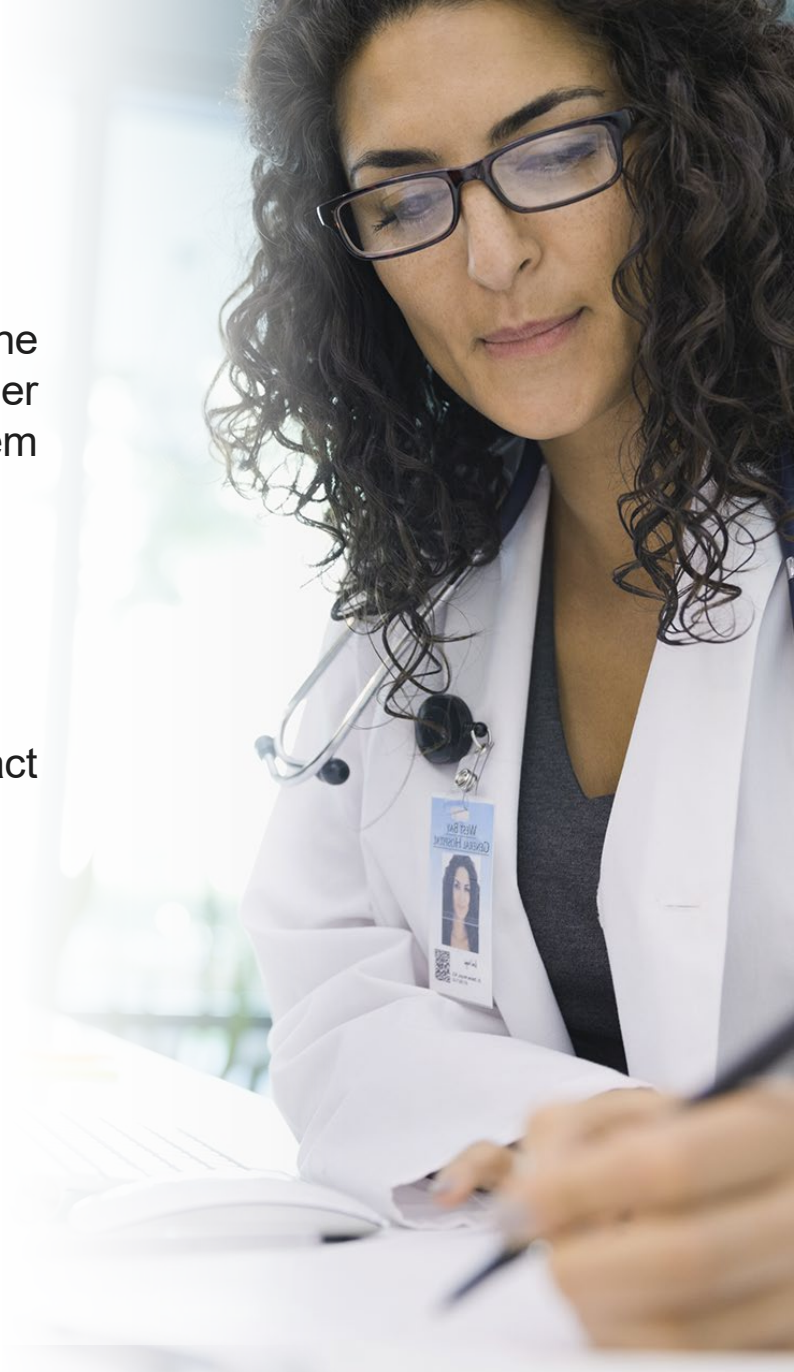
When logged into the AuthentiCare system, the agency can find helpful resources under the Custom Links tab on the main screen. These include the AuthentiCare User Manual, Provider Documents and recorded trainings. Contact Authenticare.Support@fiserv.com for any system issues, concerns, access issues, or training requests.

MobexHealth

To place orders for tablets, agencies can access MobexHealth at www.orders.mobexhealth.com. For issues or concerns regarding a tablet, you may contact the helpline at 1 (949) 527-6356 or email at mobexhealthsupport@mobexhealth.com.

BCBS EVV Contact Information

Send all EVV related inquiries to EVVBCBS@bcbsnm.com



EVV Access Options

Multiple AuthentiCare® Access Options Available

- Option #1: Member's home phone/landline or cell phone – If allowed by the member, caregivers will use their member's home phone/landline or cell phone to call into the AuthentiCare Interactive Voice Response (IVR) system; or
- Option #2: Caregiver's Mobile Device (smartphone or tablet) with Stipend – Each managed care organization (MCO) will provide a stipend to the provider agency to create an incentive for caregivers to utilize their personal mobile device (smartphone or tablet) and existing data plan when using the AuthentiCare mobile application for data transfer. The entire stipend must be paid to the caregiver and the agency may not retain any of it. All stipend payments made by the MCOs are inclusive of gross receipts tax (GRT); or
- Option #3: Tablets – The option to order a BCBSNM-owned Wi-Fi-enabled tablet for those caregivers who do not have access to a personal mobile device (smartphone or tablet) or a member's home phone/landline or cell phone. Provider agencies can place orders through www.orders.mobexhealth.com. Please ensure all orders include a valid BCBSNM member subscriber number or New Mexico Medicaid ID.



Managed Care Policy Manual

The purpose for the Managed Care Policy Manual (the Manual) is to provide a reference for the policies established by the New Mexico Health Care Authority (HCA) for the administration of the Medicaid managed care program and to provide direction to the managed care organizations (MCOs) and other entities providing services under managed care.

This Manual should be used as a reference and a general guide. It is a resource for interpreting the Medicaid Managed Care Services Agreement (the Agreement) and New Mexico Administrative Code (NMAC) rules pertaining to managed care.

- ✓ Section 6: Nursing Facilities (NF)
- ✓ Section 7: Community Benefits
- ✓ Section 8 : Agency Based Community Benefits (ABCB)
- ✓ Section 9 : Self Directed Community Benefits (SDCB)



BCBSNM LTC Key Contacts

BCBSNM Long Term Care Network Representatives are organized by geographical region.

- For the most up to date list of LTC Provider Representative assignments, please visit <https://www.bcbsnm.com/provider/contact-us>

Arlene Angel-Armijo

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Northern Region

Central Territory A-I

BCBSNM Long Term Care Contractor:

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Electronic Visit Verification

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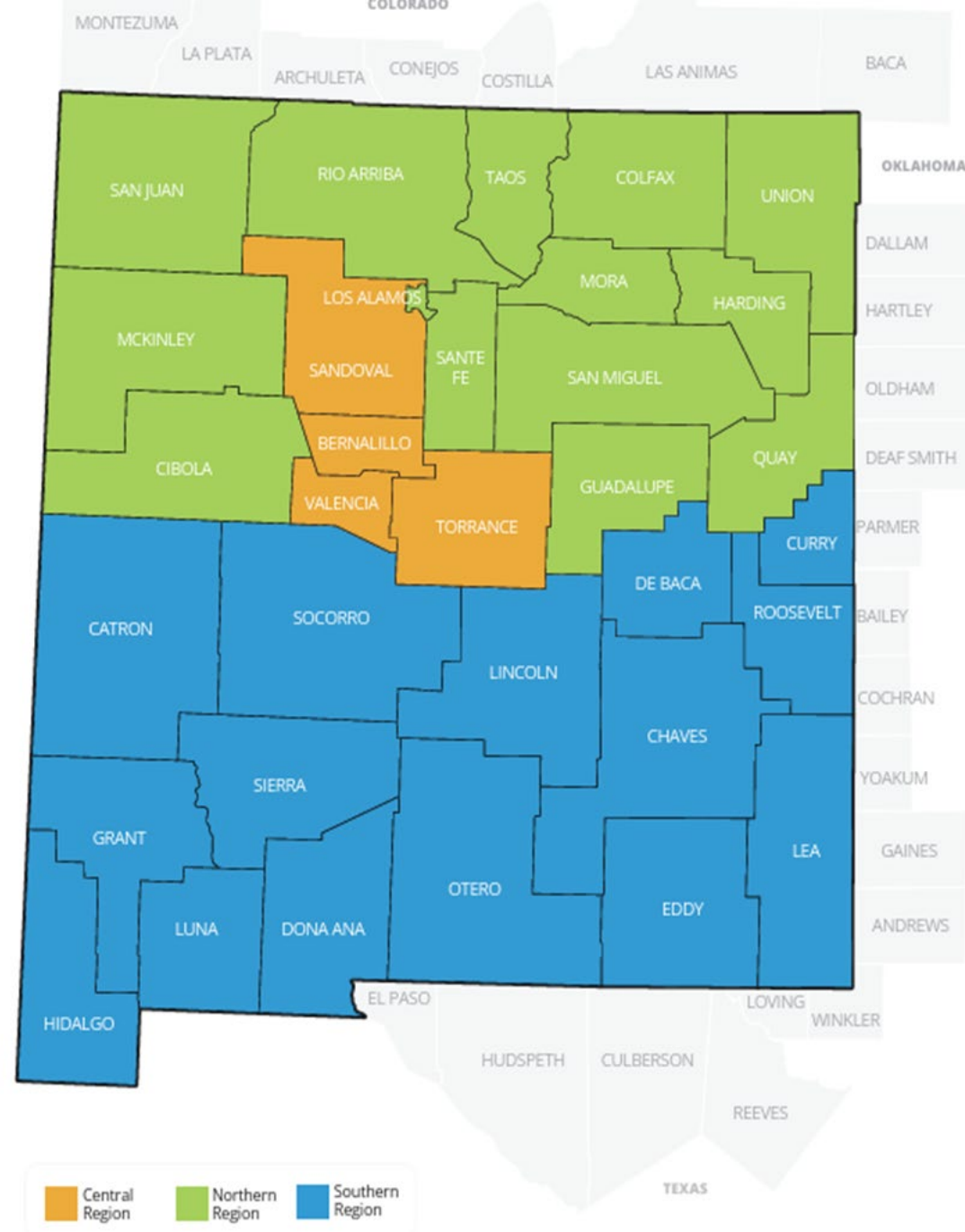
Frankie_Nava@bcbsnm.com

Southern Region

Central Territory J-Z

Authorizations

PCS@bcbsnm.com



Reoccurring Meetings/Trainings

BCBSNM holds regular provider meetings which allows providers to collaborate with BCBSNM and identify trends and issues that need resolution. It also allows providers an opportunity to request specialized trainings.

Some of these meetings are in partnership with the other MCOs and/or HCA.

- Personal Care Service (PCS) Provider Meeting

- Personal Care Service (PCS) / Caregiver Requirements Training (*new*)

- Assisted Living Facility (ALF) Provider Meetings

- Nursing Facility (NF) Provider Meetings

- Critical Incident Reporting (CIR) Training

If you are interested in attending or need to update your agency's contact information, please reach out to your assigned provider representative.

