Services are funded in part under a contract with the State of New Mexico.

Blue Cross and Blue Shield of New Mexico refers to HCSC Insurance Services Company (HISC), which is a wholly owned subsidiary of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company. Both HISC and HCSC are independent Licensees of the Blue Cross and Blue Shield Association.
General Overview:

- Members must meet Nursing Facility Level of Care (NF LOC) criteria to receive Long Term Care benefits
  - Minimum requirement for Low NF Determination: Deficits in 2 ADLs; Member unable to accomplish without consistent, ongoing, daily supports
  - Minimum requirements for High NF Determination: Must meet requirement for Low NF determination, AND meet a minimum of 2 High NF requirements in 2 separate categories:
    - Oxygen
    - Orientation/Behavior
    - Medication Administration
    - Rehabilitative Therapy
    - Skilled Nursing
    - Other Clinical Factors (comatose, persistent vegetative state, or is otherwise bed bound and totally dependent for all ADLs and is related to a documented medical condition requiring direct skilled/licensed care)
General Overview (Continued):

- Two payment categories of NF LOC: “High NF”, and “Low NF” LOC. All Nursing Facilities shall provide for both High and Low NF LOC needs.

- Long Term Care benefits must be reviewed for approval by qualified Utilization Review staff.

- A change in functional or medical status that may affect a level of care determination warrants completion of a NF LOC within 5 days of the MCO becoming aware of the change.
Nursing Facility Setting:

*Initial Low NF LOC determinations are valid for 90 days, then a re-determination is required. A Low NF LOC re-determination is valid for 365 days.

*Initial High NF LOC determinations, or change of status from Low to High will be valid for 30 days; a re-determination will be required following the initial determination and is valid for 90 days. Re-determination is required every 90 days for High NF, using the prior 30 days of medical record documentation and services.
Members transitioning from CoLTS service programs:

- The current/transitioning NF LOC dates and existing service plans will be maintained (including existing prior authorizations to insure continuity of care) until expiration of:
  - Either between 1/1/2014 and 6/30/2014: the date of the earliest expiration date initiates the process for scheduling and completing a Comprehensive Needs Assessment (CNA), Comprehensive Care Plan, and NF LOC. (Same procedure for 07/01/2014 to 12/31/2014)

- Going forward, dates of the CNA, CCP, and NFLOC determination are in sync to reflect updated anniversary dates.
Centennial Care MCO's are required to continue provision of hours currently approved for consumers transitioning into Centennial Care program.

A Centennial Care MCO receiving a care plan for a member whose been receiving personal care services, and whose services are ending in the month of January, February or March: MCO is directed to extend the previous care plan hours until a CNA can be administered and a CCP plan is developed pursuant to the Centennial Care contract and additional direction provided in LOD #4.
Under no circumstances should a Centennial Care MCO issue arbitrary temporary hours (i.e., everyone gets 10 hours) to members who’ve been receiving personal care services until a CNA and CCP are completed.

All MCOs are required to ensure that personal care service providers are adequately educated to obtain authorization for their self-directed members, provide billing codes and definitions and trained to bill the MCO for those services delivered under both models.
NFLOC for Members Not Otherwise Medicaid Eligible

- Upon notification BCBSNM will perform a NFLOC assessment
- Case information will be forward to the UM Nurse for review - minimally including the MDS
- The UM nurse will enter the decision in the HSD eligibility system
- If the individual meets criteria for NFLOC, HSD will begin processing the member’s eligibility
- Depending on the risk stratification, the Care Coordinator will perform care coordination including the face-to-face semi-annual or annual CNA, NF LOC determination, and CCP
Self-Directed Community Benefits under Centennial Care:

- Behavior Support Consultation
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Homemaker
- Nutritional Counseling
- Private Duty Nursing for Adults
- Related Goods
- Respite
- Skilled Maintenance Therapies
- Specialized Therapies
- Non-medical transportation
Available to:

- Members who’ve received Agency Based Community Benefit (ABCB) Services for at least 120 calendar days or
- who were grandfathered from the “Mi Via” program

Affords members the opportunity to have choice and control over their benefit services

If the member chooses to select the Self-Directed option he/she must:

- be capable of doing so (or the caregiver is capable)
- sign the self-direction election form
- sign Employer of Record (EOR) form or assign a EOR
Based on the CNA, the care coordinator determines the budget dollar amount.

A Collaborative Approach: The Member, Care Coordinator, Support Broker, and Employer of Record work as a team to develop and implement the Self Directed Care Plan.

Care Coordinator & Support Broker will provide the member/EOR information about benefits, assist members in developing the budget as based on dollar amount provided by the Care Coordinator.

The Support Broker will assist the member in selecting providers; determining provider payment rates within the HSD approved payment ranges, negotiating contracts with providers, etc.
Transitioning members shall not receive any changes to their budgets or care plans until one of the following occurs:

- Expiration of the Mi Via Service/Support Plan (SSP),
- The Nursing Facility Level of Care (NFLOC) expires or
- The member’s condition changes

Members will then receive a CNA, a NFLOC determination as indicated by results of the CNA, and a Comprehensive Care Plan (CCP) - including determination of the updated budget amount.
- Budget amounts or services cannot decrease for the first new care plan year without approval by HSD (except by elimination of those services that are no longer covered under the Self-Directed Community Benefit (SDCB) option).

- Outreach to Mi Via members who have a SSP or NFLOC expiration date prior to April 2014 will be priority for completion of CAN, NFLOC, and development of new budget and Self Directed Care Plan.
(Continued)

- Members who have completed 120 days of services on the ABCB option may select the SDCB option

- PCP and/or other applicable providers shall receive a hard copy of the updated Comprehensive Care Plan
Involuntary Termination from SDCB (Self Directed Community Benefit)

- Members may be terminated from the SDCB and placed in ABCB (Agency Based Community Benefit) for any of the following:
  - When the member or their Employer of record (EOR) are having challenges managing the budget
  - Immediate health and safety risks for the member
  - Member or EOR have committed Medicaid fraud
  - It is the Care Coordinator’s role and responsibility to assemble the documentation and present the case to HSD for a termination decision
Members may choose to have Agency Based Community Benefits, with many benefits similar to the SDCB model, but with fewer responsibilities for employing, training, and paying for services.

The Agency is responsible for hiring, training, and overseeing delivery of benefits.

The PCS Agency is responsible for quality assurance and is expected to closely monitor the consumer's services through monthly home visits and 24-hour emergency telephone access.
Agency-Based Community Benefits:
- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Personal Care Services
- Private Duty Nursing for Adults
- Respite
- Skilled Maintenance Therapy Services