Centennial Care

- Centennial Care began 1/1/14
- 1115 Waiver approved by Centers for Medicaid and Medicare (CMS)
- Renewed 1115 Waiver 1/1/19
- Integrated managed care program that offers all health care services to eligible recipients, delivered by three managed care organizations (MCOs)
  - Blue Cross Blue Shield, Presbyterian, Western Sky
  - Physical health, behavioral health, long-term services and supports (LTSS)
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, individuals must meet a nursing facility level of care (NF LOC) and have an assessed need for services
  • NF LOC=individual must require assistance with two or more activities of daily living (ADLs)

• Individual must also qualify financially with the Income Support Division (ISD)
Community Benefit (CB) Eligibility

Two ways to enter the CB:

1. If already eligible/enrolled in 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)
   • If member meets NF LOC, MCO will develop comprehensive care plan based on the member's assessed needs

2. If individual 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 perform an assessment of needs by telephone
   • ADRC will assign an allocation category
     • Regular, expedite, community reintegration, exception
   • HSD Allocations Unit sends packet including Medicaid application to individual for completion, and assists with the process
Community Benefit (CB) Eligibility

• If an individual has already been placed on the central registry, and his/her health condition changes, he/she should contact the ADRC for a new assessment
• If member is in Medicaid (receiving the CB) and loses eligibility due to age or excess income, he/she should contact the ADRC to request an exception allocation to ensure continuity of care
• ADRC: 1-800-432-2080  www.nmaging@state.nm.us

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* Limits and restrictions may apply
Agency Based Community Benefit

ABCB members under the age of 21:

- Are able to receive PCS and other services through EPSDT
- Will most likely only be eligible for Respite (300 hours per year limit) and possibly Behavior Support Consultation
- 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 Employer of Record

Self-Directed Community Benefit

- CB members can switch to the SDCB model anytime after receiving services for at least 120 days in ABCB
  - Must work with MCO/care coordinator
  - Support Broker
- 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 Conduent, arrange for back-up caregivers, coordinate with NM Department of Labor
Community Benefit Rule and Policy

Rule:
• [http://164.64.110.134/parts/title08/08.308.0012.html](http://164.64.110.134/parts/title08/08.308.0012.html)

Policy:

Contact Information

• 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

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