1240 Pennsylvania St. NE, Ste. A
Albuquerque, NM 87110
(505) 265-2300
www.sclonm.org

WAIVER MEDICAID

HOME & COMMUNITY BASED SERVICES (HCBS) FACT SHEET

(Effective January 1, 2025)

1. Does New Mexico have a Medicaid program for seniors who want to stay in their home or other community residence instead of moving into a nursing home?

Yes. **Centennial Care**, the New Mexico Medicaid program, has a group of services called the "*Community Benefit*" (CB). This benefit is for individuals who qualify for placement in a nursing home but want to continue living independently in the community. It allows an individual to "age in place" in their community residence or in an assisted living facility. The program does not provide 24-hour care but supplements other available care an individual may have. Individuals must be, or become, *eligible for Medicaid* to get HCBS services (*see* #4 and #5).

2. What is the definition of "Home and Community Based Services" (HCBS) for this program?

HCBS is defined as services designed to help beneficiaries remain in their homes and the community. Beneficiaries generally get their services through one of two options --Agency Based CB or Self-Directed CB. The services available vary somewhat under each option. An individual who elects HCBS will start with Agency Based care and after 120 days, the individual can opt to change to Self-Directed CB. The Self-Directed CB requires the individual to participate more in care planning. The services available under each option are shown in Exhibit A attached to this Fact Sheet. Another HCBS option, called "PACE," operates differently (*see* #20).

3. Who runs the New Mexico HCBS Medicaid program?

Several agencies are involved, however the most significant are: (1) the New Mexico Health Care Authority (**HCA**) -- through its Medical Assistance Division (**MAD**) -- which runs the overall Medicaid program, and contracts with three Centennial Care *Managed Care Organizations* (MCOs) to deliver services; (2) the New Mexico Aging & Long Term Services Department's Aging & Disability Resource Center (**ADRC**), which plays a key role in determining who can be considered for eligibility for HCBS; and (3) HCA's Income Support Division (**ISD**), which processes applications (if needed) for the coverage (*see* #5 and #6). Contact information for these organizations is in Exhibit B, attached to this Fact Sheet. The NM Department of Health is involved in the administration of HCBS coverage for persons with

developmental disabilities.

4. Can everyone who wants Medicaid HCBS Services get them?

Unfortunately, no. An individual must first meet the requirements for a Medicaid eligibility category that includes CB benefits in its covered services. If the individual is already eligible for a “full benefit” Medicaid coverage, they satisfy that requirement. If the individual is not otherwise eligible for a full-benefit Medicaid eligibility category, they must *apply* for HCBS coverage, a process that begins with contacting the ADRC (*see* #5 and #6). However, there are also limits on the number of not-otherwise-eligible applicants who can receive the coverage, resulting in extremely lengthy *waiting lists* for individuals needing to apply.

5. How does an individual *apply* for the HCBS Medicaid program?

If the individual is already a member of an MCO, they should ask their MCO to determine whether they qualify for CB services (including a need for “nursing facility level of care”). Once an individual is found to qualify, they should ask the MCO to assess the services they need.

If the individual is *not* enrolled with a MCO and is not already eligible for full-benefit Medicaid coverage they must complete the application process for “**Waiver**” eligibility. This process starts with contacting the ADRC, and ends with the Health Care Authority’s Income Support Division processing a financial eligibility application (*see* #6 and #7).

6. What Is the Role of the ADRC in processing eligibility for Medicaid HCBS Services?

Individuals who seek Medicaid HCBS coverage, but who are not eligible for any full-benefit Medicaid coverage, must apply for the HCBS coverage (often referred to as “**Waiver**” eligibility). However, they cannot simply apply straight-away for the coverage, because there are only a limited number of coverage “slots” available.

People who are interested must first contact the ADRC to (1) get on the waiting list; and (2) seek an “**allocation**” -- the name for the official authorization to apply. There are currently three types of allocations: “regular” allocations from the waiting lists; allocations for individuals who have resided in nursing homes for at least 90 days but would be able to live safely in the community with supports; and “exigent” allocations, for individuals who can show an emergent need for the coverage. The ADRC, in cooperation with HCA/MAD, makes determinations of who can receive these allocations.

Getting an allocation is a critically important step, but it is *not* a determination of eligibility. Individuals who get allocations must still complete and return some paperwork (including a document on which they choose a MCO, and a lengthy application form [the HSD-100]) to MAD). Then they must communicate with the Income Support Division to verify income, resources, and other eligibility criteria. When an individual is determined eligible, the individual must work with their MCO to assess their services needs and develop a Care Plan.

7. What are the eligibility requirements, such as age, income, citizenship, residence, level of care, etc. for Medicaid HCBS services?

For those individuals who must apply for a Waiver, these requirements must be satisfied:

a) Be 65 years of age or older, or, if younger, meet Social Security's definition of disability, and furnish their Social Security Number (SSN);

b) Be physically present in New Mexico at the time of the HCBS application and have an intent to stay in New Mexico;

c) Have a medically verified *nursing facility level of care* ("NFLOC"), which is usually verified by the individual's MCO;

d) If not already covered under a full-benefit Medicaid eligibility category, meet the financial eligibility criteria for Institutional Care Medicaid but choose to remain in the community. [Regarding those financial eligibility criteria, *see* SCLO's "**Institutional Care Medicaid Fact Sheet**," posted to SCLO's web site];

Those financial eligibility criteria involve both an income *and* a resources (a/k/a "assets") test.

-- The maximum "countable" monthly **income** eligibility standard is $2,901. Some income does not count toward this: for example, the first $20 per month of unearned or earned income; substantial portions of earned income; and specified types of Native Americans' income;

-- "Countable" resources, which must be below $2,000.00 for an individual. Some resources are not counted; most notably a house and at least one car;

e) Be a United States (US) citizen, or a US National; or, if not, qualify for special exceptions related to refugee, asylum, trafficking, and other specified factors; and

f) The services provided must be "cost effective," *i.e.,* care at home must cost less than care in an institution.

8. What is an Income Diversion Trust?

If an applicant's countable income exceeds the income eligibility maximum, and the bracketed provision in #11 does not apply, they can become income eligible by establishing a special trust, into which is deposited the amount by which their gross monthly income exceeds the eligibility maximum. The trust is called an "*Income Diversion Trust*" (IDT). It uses a standard form approved by HSD. After the beneficiary's death, HSD/MAD is entitled to most of the accumulated funds in the trust, up to the amount of Medicaid payments made on the beneficiary's behalf.

9. What Is the Meaning of the terms "Applicant Spouse" and "Community Spouse?"

Because Medicaid HCBS coverage was created as an alternative to nursing home coverage, the eligibility criteria and some terminology used for Institutional Care Medicaid coverage are applied to HCBS eligibility. Nursing home coverage uses the terms "institutionalized spouse" for the individual seeking/obtaining nursing home coverage, and "community spouse" for the spouse who continues to live in the community. Since individuals who apply for and/or receive HCBS coverage continue to reside in the community, the term "applicant spouse" is more appropriate for them than "institutionalized spouse," but their spouse is still referred to as the "community spouse."

10. If a married person seeks eligibility for Medicaid HCBS, is there a way for the spouse who is *not* applying to protect some of their income and resources?

Yes, as described in the next three points.

11. Must the community spouse contribute their income to the spouse applying for or receiving coverage under the HCBS Medicaid program?

No. The community spouse does *not* have to contribute *any* of their income to the applicant/beneficiary spouse. [*NOTE*: However, in determining whether the applicant spouse satisfies the *income* eligibility test, if the amount of one half of the couple's combined monthly income is under the eligibility maximum, the applicant will be found eligible].

12. Are the community spouse's *resources* considered in determining the applicant spouse's eligibility?

Yes. To determine if or how much the applicant spouse has to "spend down" resources to get under the $2,000.00 maximum, a mathematical "assessment" is carried out by ISD. It works as follows:

First, the total value of the couple's combined, countable, community *and separate* resources is tallied;

Second, that amount is mathematically divided in half;

Third, the one half will be protected for the community spouse, *subject to* a minimum and maximum amount (*see* #13). The amount that is *not* protected for the community spouse is the amount from which the applicant spouse must spend down to meet the $2,000 eligibility maximum.

13. How much of a married couple's combined resources can be protected for the community spouse?

The community spouse is entitled to have up to half of the couple's countable resources protected, subject to a minimum of $31,584 (assuming there is at least that much in countable assets) and a maximum of $157,920. The maximum figure usually increases each year. In addition, the community spouse is entitled to have title to jointly owned property transferred to themselves within one year of the date of the favorable eligibility determination.

14. Is the home counted as a resource for Medicaid HCBS eligibility?

Generally, no, so long as the home has an equity value of $730,000 or less. In addition, if the applicant resides in the home, it is not a countable resource; and even if the applicant lives elsewhere (*e.g.,* in an Assisted Living Facility), so long as the applicant -- or their representative on their behalf -- asserts that they have an *intent to return* to their home, it will not be a countable resource. In addition, as noted in #13, if the home is jointly owned by the applicant and their spouse, the applicant can transfer their ownership interest to the community spouse.

15. When do HCBS services begin?

Whether the individual is able to apply by asking their MCO to consider them for CB services, or by pursuing the process discussed in #6, services do not begin until after the individual receives a needs assessment and Care Plan from their MCO.

16. Can an individual transfer or gift their resources and be eligible for the Medicaid HCBS Medicaid program?

Any transfers or gifts of resources or income made within the five years before the date of application (the "look back period") will be reviewed by the Income Support Division to see whether any such transfers or gifts were made for fair market value in return. If any such transfers or gifts were made for less than fair market value, there will be a "**transfer of assets penalty**" applied, which results in the **denial or termination of Medicaid HCBS coverage for up to five years**. No such transfers or gifts should be undertaken without advice and counsel from an attorney who specializes in pertinent Medicaid eligibility rules.

17. Are there any exceptions to the transfer/gift rules that might allow an individual otherwise disqualified from the HCBS Medicaid program to nonetheless obtain it?

Yes. There are several exceptions to the penalties for transferring resources made for less than fair market value, such as transfers to the individual's spouse, or minor, blind or disabled child; or, under limited circumstances, to a sibling or adult child; transfers that were intended to be made for fair market value or other valuable consideration; fraud and "undue hardship" situations. These exceptions are narrowly construed, and, as noted in #16, consultation with an attorney with expertise in this field before making any transfers is critical.

18. Can an individual put their home or other resources in a trust and be eligible for the HCBS Medicaid program?

The transfer of ownership of a home or other resources to a trust is a potentially dangerous action which should only be undertaken on the advice and counsel of an attorney with specialized knowledge of Medicaid *and* trust rules. It should be noted that a home or other resources placed in a trust that is *revocable* will be considered as available to an applicant as if the trust did not exist.

19. After a person becomes eligible for the HCBS Medicaid program, can their income be used to pay off old bills?

After an applicant is found eligible for Medicaid HCBS, they (and their spouse, if any) retain all of their income, to spend as they wish.

20. What Is the "PACE" Program"?

PACE (which stands for "Program of All Inclusive Care for the Elderly") is a special program of coordinated, integrated, long-term care health care coverage for people aged 55 and older, who have a nursing facility level of care need. It assumes responsibility for all of its enrollees' Medicaid [including HCBS] *and* Medicare coverage. Enrollees must generally use the PACE program's own providers, and their care needs are determined by an interdisciplinary team. Enrollees spend various amounts of time at the program's day center – for medical care, some meals, and socialization. Transportation to and from the center is provided by the program if not otherwise available. There is only one PACE program in New Mexico; it is currently operated by a company called

InnovAge New Mexico and serves enrollees in the greater Albuquerque area. There is a limit on the number of individuals who can enroll. The PACE program determines whether applicant can be accepted, but ISD determines whether financial and other Medicaid eligibility requirements are satisfied. [*NOTE*: during the COVID-19 public health emergency, enrollees could not access the PACE day center].

EXHIBIT A

Agency Directed CB vs. Self-Directed CB

Agency Directed	Self-Directed
Adult Day Health	Behavior Support Consultation
Assisted Living	Customized Community Supports
Behavior Support Consultation	Emergency Response Services
Community Transition	Employment Supports
Emergency Response Services	Environmental Modifications
Employment Support	Home Health Aide
Environment Modifications	Nutritional Counseling
Home Health Aide	Private Duty Nursing for Adults
Nutritional Counseling	Respite/Nursing Respite
Personal Care	Self-Directed Personal Care
Private Duty Nursing for Adults	Skilled Maintenance Therapies (PT, OT, etc.)
Respite/Nursing Respite	Specialized Therapies (i.e., Acupuncture, etc.)
Skilled Maintenance Therapies (OT, PT, etc.)	Start-Up Goods
	Transportation (non-medical)

EXHIBIT B

Community Benefit MCO & Resource Contact Information

MCOs	MCO Contact Information
Blue Cross Blue Shield (Community Centennial)	(866) 689-1523 https://www.bcbsnm.com/turquoise-care/how-to-enroll/how-to-enroll
Presbyterian Health Plan	(888) 977-2583 https://www.phs.org/health-plans/turquoise-care-medicaid/eligibility-apply-nm-medicaid

MCOs	MCO Contact Information
Molina Healthcare	(844) 826-3458 https://www.meetmolina.com/nm-medicaid
United Healthcare	1-800-283-4465 https://www.uhc.com/communityplan/new-mexico/plans/medicaid/ltss/how-to-enroll

Other Resources	Resource Contact Information
Aging & Disability Resource Center (ADRC)	1-800-432-2080 For TTY, call 505-476-4937 www.nmaging@state.nm.us
Consolidated Customer Service Center (CCSC) ISD Institutional Care and Waiver Unit	Toll Free: 1-800-283-4465 Currently same number as for the Consolidated Customer Support Center
If you are otherwise not eligible to apply for HCBS, call New Mexico Aging and Long-Term Services at 1-800-432-2080 to be placed on the Central Registry.	