This is an amendment to 8.326.2 NMAC, Sections 1, 8, 10, 12, 14 and 16, effective 9/1/2026.

8.326.2.1 ISSUING AGENCY: New Mexico health care authority (HCA).
[8.326.2.1 NMAC - Rp 8.326.2.1 NMAC, 7/1/2024; A, 9/1/2026]

8.326.2.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.326.2.8 NMAC - Rp 8.326.2.8 NMAC, 7/1/2024; A, 9/1/2026]

8.326.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for providing case management services:

(1) state agencies in New Mexico providing case management services to individuals with developmental disabilities;

(2) Indian tribal governments and Indian health service clinics; and

(3) community-based agencies in New Mexico that do not furnish adult day habilitation, work related services, or adult residential services to individuals with developmental disabilities.

B. Agency qualification: Agencies must be certified by the developmental disabilities division of the HCA and meet the MAD approved standards for agencies providing case management for adults who are developmentally disabled.

(1) Agencies must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

(2) Agencies must demonstrate direct experience in case management services and success in serving the target population.

(3) Agencies must have personnel management skills, including written policies and procedures that include recruitment, selection, retention and termination of case managers, job descriptions for case managers, grievance procedures, hours of work, holidays, vacations, leaves of absence, wage scales and benefits, conduct and other general rules.

C. Case manager qualifications: Case managers employed by case management agencies must possess the education, skills, abilities and experience to perform case management service for adults with developmental disabilities. At a minimum, case managers must meet one of the following qualifications:

(1) bachelor's degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skills development, such as psychology, sociology, speech, gerontology, education, counseling, social work, human development or any other study of services related field and one [~~(1)~~] year of experience working with individuals with developmental disabilities;

(2) licensed as a registered or licensed practical nurse with one year of experience working with individuals with developmental disabilities; or

(3) In the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three years of experience working with individuals with developmental disabilities; or

(b) high school graduation or general educational development (GED) test and a minimum of four [~~(4)~~] years of experience working with individuals with developmental disabilities.

(4) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.326.2.10 NMAC - Rp 8.326.2.10 NMAC, 7/1/2024; A, 9/1/2026]

8.326.2.12 ELIGIBLE RECIPIENTS:

A. Case management services are available for eligible medicaid recipients that meet all of the following criteria:

(1) 21 years of age or older;

(2) resident of the state of New Mexico;

(3) meet the state definition of an individual with a developmental disability;

(4) placement on the list for developmental disability services by the community services team (CST) of the developmental disabilities division of the HCA;

(5) resides outside a medicaid certified intermediate care facility for [~~the mentally retarded (ICF-MR)~~] individuals with intellectual disabilities (ICF/IID); and

(6) not a participant in a home and community-based services waiver program.

B. Information on the individual is gathered by the CST and used to complete an assessment and assign an "urgency of need" priority. Recipients assigned a priority one are individuals who are in danger of becoming homeless or victims of abuse, if suitable placement services are not received. Recipients assigned a priority two are individuals whose condition will deteriorate without placement. Recipients assigned a priority three are individuals who could benefit from case management but whose present condition is acceptable.

[8.326.2.12 NMAC - Rp 8.326.2.12 NMAC, 7/1/2024; A, 9/1/2026]

8.326.2.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See [~~8.301.3 NMAC, General Noncovered Services~~] 8.310.2 NMAC, *General Benefit Description*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or do not meet the definition of an eligible recipient for these case management services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which relate to traditional academic subjects or job training;

D. outreach activities to contact potential recipients, except as described under covered services;

E. all administrative activities conducted after the initial 90 day referral by the CST;

F. institutional discharge planning which must be furnished by the institution prior to discharge;

G. services which are furnished under other categories, such as therapies, transportation or counseling;

H. services which are considered by MAD or its designee to be excessive based on the condition of the recipient;

I. monitoring the quality of service provider agencies;

J. resource development; and

K. testifying before governmental bodies, such as city council meetings or legislative committees, even if on behalf of the recipient.

[8.326.2.14 NMAC - Rp 8.326.2.14 NMAC, 7/1/2024; A, 9/1/2026]

8.326.2.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See [~~8.302.5 NMAC, Prior Approval and Utilization Review~~] 8.310.2 NMAC, *General Benefit Description*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services which are part of the recipients' plan of care can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions.

[8.326.2.16 NMAC - Rp 8.326.2.16 NMAC, 7/1/2024; A, 9/1/2026]