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8.307.7 BENEFIT PACKAGE

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8.307.7.1 ISSUING AGENCY: Human Services Department (HSD)
[8.307.7.1 NMAC - N, 8-1-08; Repealed, 10-15-12]

8.307.7.2 SCOPE: This rule applies to the general public.
[8.307.7.2 NMAC - N, 8-1-08; Repealed, 10-15-12]

8.307.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et seq.
[8.307.7.3 NMAC - N, 8-1-08; Repealed, 10-15-12]

8.307.7.4 DURATION: Permanent
[8.307.7.4 NMAC - N, 8-1-08; Repealed, 10-15-12]

8.307.7.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[8.307.7.5 NMAC - N, 8-1-08; Repealed, 10-15-12]

8.307.7.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.307.7.6 NMAC - N, 8-1-08; A, 9-1-09; Repealed, 10-15-12]

8.307.7.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.7.7 NMAC – N, 8-1-08; Repealed, 10-15-12]

8.307.7.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.307.7.8 NMAC - N, 8-1-08; A, 9-1-09; Repealed, 10-15-12]

8.307.7.9 BENEFIT PACKAGE: The medical assistance division (MAD) benefit package for the coordination of long-term services managed care organization (MCO) and the statewide behavioral health single entity (SE) shall each be paid fixed per-member-per-month payment rates. The MCO and SE shall cover these services. The MCO is responsible for covering the physical health services except as otherwise directed in this rule or by contract. The SE is responsible for covering the behavioral health services. The MCO and the SE shall not delete benefits from the MAD-defined benefit package. The MCO and SE must utilize service providers licensed in accordance with state and federal requirements to deliver services. MAD pays for medically necessary health care services for eligible recipients. For an eligible recipient also enrolled in medicare, the medicare replacement plan becomes the primary payer for services covered by medicare.
[8.307.7.9 NMAC - N, 8-1-08; A, 9-1-09; Repealed, 10-15-12]

8.307.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: The human services department (HSD) or its designee must review and approve the CoLTS MCO's UM protocols. Health care to New Mexico eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD through a CoLTS managed care organization (MCO). MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.
[8.307.7.10 NMAC - N, 8-1-08; A, 9-1-09; Repealed, 10-15-12]

8.307.7.11 SERVICES INCLUDED IN THE COLTS 1915 (B) WAIVER PROGRAM BENEFIT PACKAGE:

A. Physical and behavioral health benefits that are available to full-benefit eligible recipient in the MAD fee-for-service (FFS) are covered for an eligible recipient enrolled in the CoLTS program. Refer to the benefit descriptions found in the MAD general benefit descriptions 8.301 NMAC; the medical and institutional services and providers found in 8.310 NMAC through 8.312, 8.314, 8.315, and 8.324 through 8.326 NMAC and as specified in the contract and the New Mexico state plan. Additional services are available under the CoLTS 1915 (b) waiver program to an eligible recipient when medically necessary. Refer to benefits descriptions found in 8.307 NMAC and as specified in the contract and CoLTS (b) waiver.

B. Physical and behavioral health benefits that are available to an early and periodic screening, diagnostic and treatment (EPSDT) eligible recipient in the MAD fee-for-service (FFS) are covered for an eligible recipient enrolled in the CoLTS program. Refer to the benefit descriptions found in 8.320 NMAC through 8.323 NMAC and as specified in the MCO contract and the New Mexico state plan. The EPSDT benefit package includes the delivery of the federally mandated EPSDT services. **Tot-to-teen health checks** The MCO shall adhere to the periodicity schedule and ensure that an eligible recipient receives EPSDT screens (tot-to-teen health checks), including:

(1) education of and outreach to an eligible recipient regarding the importance of health checks;

(2) development of a proactive approach to ensure that the services are received by an eligible recipient;

(3) facilitation of appropriate coordination with school-based providers;

(4) development of a systematic communication process with the MCO's network providers regarding screens and treatment coordination for an eligible recipient's condition;

(5) a process to document, measure and ensure compliance with the periodicity schedule; and

(6) development of a proactive process to ensure the appropriate follow-up of evaluations, referrals or treatment, especially early intervention for mental health conditions, vision and hearing screens, and current immunizations.

C. **Case management services:** The benefit package includes the following case management services:

(1) **case management services for eligible recipient pregnant women and their infants:** case management services provided to eligible recipient pregnant women up to 60 calendar days following the end of the month of the delivery, as set forth in 8.326.3 NMAC, *Case Managements Services for Pregnant Women and Their Infants*;

(2) **case management services for eligible recipient traumatically brain injured adults:** case management services provided to adult members (21 years of age or older) who are traumatically brain injured, as set forth in 8.326.6 NMAC, *Case Management Services for Traumatically Brain Injured Adults*;

(3) **case management services for eligible recipient children up to the age of three:** case management services provided to eligible recipient children up to the age of three who are medically at risk due to family conditions and not developmentally delayed, as detailed in 8.326.6 NMAC, *Case Management Services for Children Up to Age Three*;

(4) **case management services for the medically at risk :** case management services for eligible recipients who are under 21 and are medically at risk for physical or behavioral health conditions, as set forth in 8.320.5 NMAC, *EPSDT Case Management*; "medically at risk" is defined as those eligible recipients who have a diagnosed physical or behavioral health condition that has a high probability of impairing their cognitive, emotional, neurological, social, behavioral, or physical development;

(5) **case management services for eligible recipient adults with developmental disabilities:** case management services provided to eligible recipient adult members (21 years of age or older) who are developmentally disabled, as detailed in 8.326.2 NMAC, *Case Management Services for Adults with Developmental Disabilities*; and

(6) **case management services for the chronically mentally ill (SE only):** case management services provided to adults who are 18 years of age or older and who are chronically mentally ill, as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill*.

D. **Emergency services:** The benefit package includes emergency and post-stabilization care services for an eligible recipient. Emergency services are inpatient and outpatient services that are furnished by a qualified service provider and that are needed to evaluate or stabilize an emergency condition of an eligible recipient. An emergency condition shall meet the definition of emergency, as set forth in 8.307.1.7 NMAC, *definitions*. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of

diagnoses or symptoms. Emergency services shall be provided in accordance with Subsection F of 8.307.7.11 NMAC, *diagnostic imaging and therapeutic radiology services*. Post-stabilization care services are covered services related to an emergency condition that are provided after an eligible recipient is stabilized in order to maintain the stabilized condition or to improve or resolve the eligible recipient's condition, such that within reasonable medical probability, no material deterioration of the member's condition is likely to result from or occur during discharge of the eligible recipient or transfer of the eligible recipient to another facility.

E. **Health education and preventive services:** The MCO shall provide a continuous program of health education without cost to an eligible recipient. Such a program includes**:**

(1) publications, media, presentations, and classroom instruction;

(2) programs of wellness education;

(3) preventive service available to an eligible recipient; the MCO shall periodically remind and encourage an eligible recipient to use benefits, including physical examinations, that are available and designed to prevent illness;

(4) initiate targeted prevention initiatives for an eligible recipient with acute and chronic disease; and

(5) develop policies and procedures that encourage the proactive performance of home safety evaluations for all at-risk an eligible recipient transitioning from institutions to community settings.

F. **Inpatient hospital services :** The benefit package includes hospital inpatient acute care, procedures and services, as set forth in 8.311.2 NMAC, *Hospital Services*. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the eligible recipient mother and the eligible recipient newborn. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both the eligible recipient mother and the eligible recipient newborn.

G. **Pharmacy services:** The benefit package includes all pharmacy and related services, as set forth in 8.324.4 NMAC, *Pharmacy Services*.

(1) The MCO and the SE shall cover brand name drugs and drug items not generally on their formulary or PDL when determined to be medically necessary by the MCO or the SE or through an HSD fair hearing process or a MCO or SE appeal process. The MCO shall include on its formulary or PDL all covered multi-source generic drug items with the exception of items consisting of more than one therapeutic ingredient, anti-obesity items, and cough, cold and allergy medications; all of which may be limited to one or items at the discretion of the MCO. Items for cosmetic purposes or which are not medically necessary need not be on the PDL. The MCO shall reimburse family planning clinics, school-based health clinics, and DOH public health clinics for oral contraceptive agents and Plan B when dispensed to and eligible recipient and billed using HCPC codes and CMS 1500 claim forms. The MCO and the SE shall ensure that a Native American eligible recipient accessing the pharmacy benefit through an Indian health services or a tribal 638 pharmacy facility will be exempt from the preferred drug listing.

(2) The MCO shall use a PDL developed with consideration of the clinical efficiency, safety and cost effectiveness of drug items, and shall provide medically appropriate drug therapies for an eligible recipient. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Upon development, the MCO will be required to deliver its pharmacy benefit package using a single MAD approved PDL.

(a) The MCO and the SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal requirements and state rules and statutes.

(b) The MCO and the SE shall coordinate the delivery of the pharmacy benefit when medicare part D is the primary coverage.

(c) The MCO shall ensure that any eligible recipient who takes nine or more different prescription medications has his or her medications reviewed by a medical clinician for appropriateness and the identification and correction of potentially harmful practices, and shall document this review in the eligible recipient's chart at least every six months.

(3) The MCO's preferred drug list (PDL) shall also use the following guidelines:

(a) there must be at least one representing drug for each of the therapeutic categories in the first data bank blue book;

(b) generic substitution shall be based on "AB" rating or clinical need;

(c) for a multiple source, brand name product within a therapeutic class, the MCO may select a representative drug;

(d) the PDL shall follow the centers for medicare and medicaid services (CMS) special guidelines relating to drugs used to treat HIV infection;

(e) the PDL shall include coverage of over the counter (OTC) drugs prescribed by a licensed practitioner as indicated in 8.324.4 NMAC *Pharmacy Services*; and

(f) the MCO shall implement an appeals process for service providers who believe that an exception to the PDL should be made for an eligible recipient.

H. **Pregnancy termination services:** The benefit package provides a pregnant eligible recipient coverage for a pregnancy termination under specific situations and based on these situations, reimbursement is made in accordance with 42 CFR Section 441.202 or through state-funding which is excluded from the capitation payment to the MCO. See 8.325.7 NMAC, *Pregnancy Termination*.

I. **Preventive health services:** The benefit package provides for an eligible recipient the following preventive health services.

(1) **Immunizations:** The MCO shall ensure that, within six months of enrollment, an eligible recipient is current with immunizations according to the type and schedule provided by the most recent version of the recommendations of the advisory committee on immunization practices (ACIP) of the centers for disease control and prevention, public health service, U.S. department of health and human services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more than four months overdue.

(2) **Screens:** The MCO shall ensure that, to the extent possible, an asymptomatic eligible recipient receives and is current for at least the following screening services within six months of enrollment or within six months of a change in the standard. The MCO shall require its network providers to perform the appropriate interventions based on the results of the screens. "Current" is defined as no more than four months overdue. The MCO shall ensure that clinically appropriate follow-up or intervention is performed when indicated by the screening results.

(a) **Screening for breast cancer:** The benefit package provides for an eligible woman recipient age 50 and above who is not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. An eligible female recipient of any age at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) **Screening for cervical cancer:** The benefit package provides for an eligible female recipient with a cervix to receive papanicolaou (PAP) testing starting at the onset of sexual activity, but at least by 18 years of age, and every three years thereafter, if prior testing has been consistently normal and the eligible recipient has been confirmed to be not at high risk. If the eligible recipient is at high risk, the testing frequency shall be at least annually.

(c) **Screening for colorectal cancer:** The benefit package provides for an eligible recipient age 50 and older at normal risk for colorectal cancer to be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the MCO.

(d) **Blood pressure measurement:** The benefit package provides for any eligible recipient to receive a blood pressure measurement as medically indicated.

(e) **Serum cholesterol measurement:** The benefit package provides for any eligible male recipient age 35 and above and for an eligible woman recipient age 45 and above who is at normal risk for coronary heart disease to receive serum cholesterol measurement every five years. An eligible recipient with multiple risk factors shall also receive HDL-C measurement.

(f) **Screening for obesity:** The benefit package provides for any eligible recipient to receive annual body weight and height measurements to be used in conjunction with a calculation of the body mass index or referenced to a table of recommended weights.

(g) **Screening for elevated lead levels:** The benefit package provides for an eligible recipient age nine to 15 months (ideally 12 months old) to receive a blood lead measurement at least once.

(h) **Screening for diabetes:** The benefit package provides for an eligible recipient to receive a fasting or two-hour post-prandial serum glucose measurement as medically indicated.

(i) **Screening for tuberculosis:** The benefit package provides for an eligible recipient to receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) **Screening for rubella:** The benefit package provides for an eligible female recipient of childbearing age to be screened for rubella susceptibility by history of vaccination or by serology.

(k) **Screening for visual impairment:** The benefit provides for an eligible recipient three to four years of age to be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) **Screening for hearing impairment:** The benefit package provides for an eligible recipient age 50 and older to be routinely screened for hearing impairment by questioning the eligible recipient about their hearing.

(m) **Screenings for alcohol and drug usage:** The benefit package provides for an eligible adolescent recipient and for an eligible adult recipient to receive at least one time an alcohol and drug screening. The screening may be conducted either by a careful review of the patterns of alcohol or drug utilization of the eligible recipient or by the use of a standardized screening questionnaire. These may include the alcohol use disorders identification test (AUDIT); the four-question CAGE instrument; or the substance abuse screening severity inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications. An eligible recipient may be referred by his/her provider for or may self-refer for behavioral health services provided by the SE.

(n) **Prenatal screening:** The benefit package provides for an eligible recipient to be screened for preeclampsia, D (Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, and vaginal and rectal group B streptococcal infection; and counseled and offered testing for HIV.

(o) **Newborn screening:** The benefit package provides at a minimum, for an eligible newborn recipient to be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with department of health regulations, specifically 7 NMAC 30.6, *Newborn genetic screening program*.

(p) **Behavioral health screening:** The benefit package provides for an eligible recipient to be receive a behavioral health screening during an encounter with his/her primary care provider (PCP).

(3) **Non-behavioral health counseling services:** The benefit package provides for an asymptomatic eligible recipient, as applicable, to receive counseling and guidance on the following unless the eligible recipient's refusal is documented:

(a) prevention of tobacco use; promotion of physical activity;
(b) promotion of healthy diet;
(c) prevention of osteoporosis and heart disease, including a menopausal woman;
(d) prevention of motorized vehicle injuries;
(e) prevention of household and recreational injuries;
(f) prevention of dental and periodontal disease;
(g) prevention of HIV infection and other sexually transmitted diseases; and
(h) prevention of an unintended pregnancy.

(4) **Health advisor hotline:** The MCO shall provide a toll-free health advisor hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various MCO populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the eligible recipient's symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment service decision assistance based on symptoms.

(5) **Family planning policy:** The MCO shall have a written family planning policy to ensure that eligible recipients of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; risk reduction practices for HIV and other sexually transmitted diseases; options for pregnant eligible recipients.

(6) **Prenatal care program:** The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal services consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(a) educational outreach to any eligible female recipient of childbearing age;

(b) prompt and easy access to obstetrical services, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of every eligible pregnant recipient to identify high risk cases for special management;

(d) counseling that strongly advises voluntary testing for HIV;

(e) case management services to an eligible recipient of a high risk pregnancy to address special needs of the eligible pregnant recipient, especially if the risk is due to psychosocial factors such as substance abuse or a teen pregnancy;

(f) screening to determine the need of a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

J. **Reproductive health services:** The benefit package provides reproductive health services for an eligible recipient. See 8.325.3 NMAC, *Reproductive Health Services*.

(1) The MCO shall provide through its practitioners sufficient information to an eligible recipient to assist him/her make informed reproductive health decisions.

(2) An eligible female recipient shall have the right to self-refer to a woman's health specialist within the MCO's provider network for covered services necessary to provide routine and preventive reproductive health care services. This right of self-refer is in addition to the eligible recipient's designated source of primary care if that source is not a women's health specialist.

(3) The MCO will maintain a formal written family planning policy and ensure through its practitioners that an eligible recipient seeking family planning services will provide counseling (non-behavioral) and non-bias information pertaining to the following:

(a) methods of contraception, including sterilizations for an eligible male and a female recipient of childbearing age;

(b) the types of family planning services available;

(c) the eligible recipient's right to access these services in a timely and confidential manner;

(d) the freedom to choose a qualified family planning provider;

(e) risk reduction practices for HIV infection and other sexually transmitted diseases; and

(f) counseling and non-bias information for pregnancy termination options, see 8.325.7 NMAC *Pregnancy Termination Procedures.*

K. **School-based services:** The benefit package provides an eligible recipient those services provided in schools, excluding those specified in the eligible recipient's individualized education plan (IEP) or individualized family service plan (IFSP), as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

L. **Service coordination:** The benefit package provides an eligible recipient service coordination that is person-centered and the intent is to support the eligible recipient pursue desired life outcomes by assisting him/her access support and services necessary to achieve the quality of life desired in a safe and healthy environment. Service coordination assists an eligible recipient gain access to needed coordination of CoLTS 1915 (b) and 1915 (c) waiver services and other necessary services, regardless of the funding source.

M. **Transportation services:** The benefit package provides for an eligible recipient to access transportation services such as ground ambulance, air ambulance, taxicab or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services, as set forth in 8.324.7 NMAC *Transportation Services*. In addition, the MCO must abide by New Mexico laws, statutes and regulations, specifically NMSA 1978 Section 65-2-97(F), stating that rates paid by the MCO to transportation providers are not subject to and are exempt from New Mexico public regulation commission approved tariffs. The MCO is also required to coordinate, manage and be financially responsible for the delivery of the transportation benefit to an eligible recipient receiving physical health services or behavioral health services.

[8.307.7.11 NMAC - N, 8-1-08; A, 9-1-09; A, 5-1-10; A, 12-15-10; Repealed, 10-15-12]

8.307.7.12 [RESERVED]

[8.307.7.12 NMAC - N, 8-1-08; A, 9-1-09; Repealed, 10-15-12]

8.307.7.13 COORDINATION WITH THE BEHAVIORAL HEALTH SINGLE ENTITY (SE): The CoLTS MCO and the SE are to ensure an eligible recipient's physical and behavioral health services are coordinated and not duplicative. An eligible recipient enrolled in a 1915 (b) or (c) waiver program may access all appropriate MAD behavioral health services provided under the SE's contract. Under specific situations, the SE will be responsible for the service rather than the CoLTS MCO. The CoLTS MCO will:

(1) receive information from and provide information to the SE regarding an eligible recipient and a service provider;

(2) meet with the SE to resolve provider and recipient issues to improve services, communication and coordination;

(3) maintain and distribute statistical information and data as required under the MCO contract.

A. A behavioral health service rendered by a physical health provider will be covered by the MCO, even when the primary diagnosis is behavioral health subject to the MCO network/out of network provider requirements. Any payment for a service following medicare payment or payment by a medicare replacement plan

is the responsibility of the CoLTS MCO, whether for behavioral health or physical health. Any services provided by a physical health service provider in an emergency room or in an inpatient setting will be covered by the CoLTS MCO.

B. Transportation services to a behavioral health service are the responsibility of the CoLTS MCO. The MCO will coordinate with the SE when providing transportation out of the eligible recipient's home community, such as out-of-home placement.

C. Laboratory services ordered by a behavioral health provider for an eligible recipient are the CoLTS MCO responsibility when:

(1) the lab work performed by an outside, independent laboratory or a non-behavioral health provider. The SE is responsible for lab work when performed by a behavioral health provider such as, a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital.

(2) the eligible recipient is under treatment in a freestanding psychiatric hospital.

D. Pharmacy benefits for an eligible recipient are the SE's responsibility under specific situations. The SE shall be responsible for payment of all drug items prescribed by a behavioral health provider, such as a psychiatrist, psychologist, psychiatric clinical nurse specialist, and a psychiatric nurse practitioner, certified to prescribe and contracted through the SE.

[8.307.7.13 NMAC- N, 8-1-08; Repealed, 10-15-12]

8.307.7.14 [RESERVED]

[8.307.7.14 NMAC - N, 8-1-08; A, 9-1-09; Repealed, 10-15-12]

8.307.7.15 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER: The following are services available to a MAD eligible recipient who is enrolled in the CoLTS 1915 (c) HCBS waiver. To be eligible for enrollment in the CoLTS 1915 (c) HCBS waiver program, a recipient must meet specific criteria, see long-term care services utilization review instructions for NF LOC. For additional information on the CoLTS 1915 (c) HCBS waiver**,** see 8.307.18 NMAC, *CoLTS 1915 (C) Home and Community Based Services Waiver.*

[8.307.7.15 NMAC - N, 8-1-08; Repealed, 10-15-12]

8.307.7.16 SERVICES EXCLUDED FROM THE COLTS 1915 (B) BENEFIT PACKAGE: For an eligible recipient enrolled in a CoLTS1915 (b) waiver program, the following are non-covered services:

A. services provided in intermediate care facilities for the mentally retarded (ICF/MR), as set forth in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

B. emergency services to undocumented aliens, as set forth in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

C. experimental or investigational procedures, technologies or non-drug therapies, as set forth in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*;

D. case management services provided by the children, youth and families department that are defined as child protective services case management, as set forth in 8.320.5 NMAC, *EPSDT Case Management*;

E. case management services provided by the aging and long-term services department, as set forth in 8.326.7 NMAC, *Adult Protective Services Case Management*;

F. case management services provided by the children, youth and families department, as set forth in 8.326.8 NMAC, *Case Management Services for Children Provided by Juvenile Probation and Parole Officers*;

G. services provided in the schools and specified in the IEP or IFSP, as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*; and

H. For an eligible recipient enrolled in a CoLTS 1915 (b) waiver program, the eligible recipient is not eligible to receive services provided thru the following 1915 (c) waiver programs. These include:

(1) the disabled and elderly waiver;

(2) the developmentally disabled waiver;

(3) the AIDS waiver; and

(4) the medically fragile waiver.

[8.307.7.16 NMAC - N, 8-1-08; A, 9-1-09; Repealed, 10-15-12]

8.307.7.17 VALUE ADDED OR ENHANCED SERVICES: See 8.307.1 NMAC, *General Provisions*.

[8.307.7.17 NMAC - N, 8-1-08; Repealed, 10-15-12]

HISTORY OF 8.307.7 NMAC: [RESERVED]