(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2018. Until that applicability date, states are required to continue to comply with § 438.207 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

§ 438.208 Coordination and continuity of care.

(a) *Basic requirement*—(1) *General rule.* Except as specified in paragraphs (a)(2) and (3) of this section, the State must ensure through its contracts, that each MCO, PIHP, and PAHP complies with the requirements of this section.

(2) *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.

(3) *Exception for MCOs that serve dually eligible enrollees.* (i) For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare Advantage Organization (as defined in § 422.2 of this chapter), the State determines to what extent the MCO must meet the identification, assessment, and treatment planning provisions of paragraph (c) of this section for dually eligible individuals.

(ii) The State bases its determination on the needs of the population it requires the MCO to serve.

(b) *Care and coordination of services for all MCO, PIHP, and PAHP enrollees.* Each MCO, PIHP, and PAHP must implement procedures to deliver care to and coordinate services for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following:

(1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity;

(2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee:

(i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

(ii) With the services the enrollee receives from any other MCO, PIHP, or PAHP;

(iii) With the services the enrollee receives in FFS Medicaid; and

(iv) With the services the enrollee receives from community and social support providers.

(3) Provide that the MCO, PIHP or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful;

(4) Share with the State or other MCOs, PIHPs, and PAHPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;

(5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and

(6) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(c) *Additional services for enrollees with special health care needs or who need LTSS*—(1) *Identification.* The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—

(i) Must be specified in the State's quality strategy under § 438.340.

(ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs.

(2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to

comprehensively assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO, PIHP, or PAHP as appropriate.

(3) *Treatment/service plans.* MCOs, PIHPs, or PAHPs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:

(i) Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee;

(ii) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans;

(iii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP;

(iv) In accordance with any applicable State quality assurance and utilization review standards; and

(v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c)(3) of this chapter.

(4) *Direct access to specialists.* For enrollees with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

(d) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with §438.208 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—

(i) On the basis of criteria applied under the State plan, such as medical necessity; or

(ii) For the purpose of utilization control, provided that—