(1) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) Timing of documentation. Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:

(1) At the time it enters into a contract with the State.

(2) At any time there has been a significant change (as defined by the State) in the MCO’s, PIHP’s, or PAHP’s operations that would affect adequate capacity and services, including—

(i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area or payments; or

(ii) Enrollment of a new population in the MCO, PIHP, or PAHP.

(d) State review and certification to CMS. After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must certify to CMS that the MCO, PIHP, or PAHP has complied with the State’s requirements for availability of services, as set forth in §438.206.

(e) CMS’ right to inspect documentation. The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.
(i) Meet the primary care requirement of paragraph (b)(1) of this section; and
(ii) 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+Choice plan, the State determines to what extent the MCO must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals.

(ii) The State bases its determination on the services it requires the MCO to furnish to dually eligible enrollees.

(b) Primary care and coordination of health care services for all MCO, PIHP, and PAHP enrollees. Each MCO, PIHP, and PAHP must implement procedures to deliver primary care to and coordinate health care service 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 primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

(3) Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee’s needs to prevent duplication of those activities.

(4) 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—(1) Identification. The State must implement mechanisms to identify 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 improvement strategy in § 438.202; and

(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 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 having special health care needs in order 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 health care professionals.

(3) Treatment plans. If the State requires MCOs, PIHPs, and PAHPs to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

(i) Developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

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

(iii) In accord with any applicable State quality assurance and utilization review standards.

(4) Direct access to specialists. For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with § 438.208(c)(2)) 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.