HAP CareSource™

ADMINISTRATIVE POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Continuity of Care-MI MCD-AD-1382	02/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Continuity of Care

B. Background
Continuity of care (COC) comprises a series of separate health care services so that treatment remains coherent, unified over time, and consistent with a member's health care needs and preferences. To ensure that care is not disrupted, COC becomes a bridge of coverage, allowing members to transition to HAP CareSource's provider network. Newly enrolled members can continue to receive services by an out-of-network provider when an established relationship exists with that provider, and/or the member will be receiving services for which a prior authorization was received from another payer. Existing members may also utilize COC when a participating provider or acute care hospital terminates an agreement with HAP CareSource. COC promotes safety and effective healthcare for transitioning members of all ages.

HAP CareSource follows the Michigan Dept of Health and Human Services (MDHHS) and any applicable state or federal law regarding member transition of services. Any information published by those source supersedes the information in this policy. HAP CareSource will accept requests for continued access during a transition verbally or in writing from a member, a member's representative or the member's provider by contacting member services or the member's care coordinator or care manager.

C. Definitions
- **Continuing Care Patient** – An individual who, with respect to a provider or facility (1) is undergoing a course of treatment for a serious and complex condition, (2) is undergoing a course of institutional or inpatient care, (3) is scheduled to undergo surgery from the provider, including receipt of postoperative care with respect to such a surgery, (4) is pregnant and undergoing a course of treatment for the pregnancy, or (5) is/was determined to be terminally ill and receiving treatment.
- **Course of Treatment** – A prescribed order or ordered course of treatment for a specific member with a specific condition outlined and decided upon ahead of time with the provider and may, but is not required to, be part of a treatment plan.
- **Network Provider** – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity with a HAP CareSource agreement for the delivery of covered services to members.
- **Out of Network Provider** – Covered services rendered to a member by a provider not part of the HAP CareSource provider network.
- **Prepaid Inpatient Health Plan (PIHP)** – Provides behavioral health (BH) services described in the MDHHS Medicaid BH and Substance Use Disorder Authorization and Payment Responsibility Grid on the MDHHS website to members.
- **Primary Care Provider (PCP)** – Providers designated by the member and/or HAP CareSource as responsible for providing or arranging health care services for the member and may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, pediatric physician, nurse

practitioner, physician assistant or other physician specialist as appropriate based on the member's health condition

- **Serious and Complex Condition** – In the case of (1) an acute illness, a condition serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or (2) in the case of a chronic illness or condition, a condition that is life threatening, degenerative, potentially disabling or congenital, requiring specialized medical care over a prolonged period of time.
- **Terminal Illness** – Illness with life expectancy of 6 months or less.

D. Policy
   I. HAP CareSource ensures members continued access to services during transitions from any coverage program when in the absence of continued services the member would undergo serious detriment to health or be at risk of hospitalization or institutionalization. COC service requests will be reviewed when the following occurs:
      A. A health partner is terminated from the HAP CareSource network not related to fraud or a quality-of-care issue.
         1. A good faith effort will be made to provide written notice of termination to members receiving primary care from, or seen on a regular basis by, the terminated provider. Notice will be provided by the later of 30 calendar days (CDs) prior to the effective date of the termination or 15 CDs after receipt or issuance of the termination notice.
         2. All members assigned to a terminating PCP will receive assistance in choosing a new PCP prior to the effective date of the termination.
      B. A newly enrolled member requests continued services from a non-participating health partner (ie, primary care providers, specialists, other covered providers) providing care prior to enrollment. HAP CareSource will allow current providers and levels of services at the time of enrollment for 90 days and will assist members in selecting a provider in the HAP CareSource network.
      C. A newly enrolled member is or will be receiving services for which a prior authorization (PA) was received from another payer. If a change in service is needed or for consideration of continued services, HAP CareSource will conduct a review of medical necessity according to provisions set forth by the State. Prior PAs approved by the member's original payer will be honored for at least 90 days at the current level of services, including the following (not an all-inclusive list):
         1. scheduled surgeries
         2. dialysis
         3. chemotherapy and radiation
         4. organ, bone marrow and hematopoietic stem cell transplants
         5. custom-fabricated and non-custom fabricated durable medical equipment, and transportation
      D. Members pregnant at the time of enrollment can select or remain with the maternity care provider of choice through the postpartum period (ie, up to 12 months after birth).
         1. The providers' scope of practice must include maternity care and meet HAP CareSource credentialing requirements.

2. A clinic or practice may be designated as the provider, but an individual PCP within the practice must be named and agree to accept responsibility for the member's care for the duration of the pregnancy and post-partum care.
3. HAP CareSource will allow a maternity care provider to also be the member's PCP if primary care is within the provider's scope of practice.

E. In order to preserve COC for dental services, HAP CareSource will accept and honor prior authorizations in place for a period up to 1 year for members transitioning from Fee for Service Medicaid.
F. Children in foster care may remain with an established PCP, even if out of network. HAP CareSource will authorize and reimburse all required Foster Care Well-Child Exams, including any that occurred with an out of network provider.

II. Children's Special Health Care Services (CSHCS)
For members in CSHCS, CSHCS transition requirements supersede any others in the event transition requirements conflict.
A. Ancillary Services (ie, therapies, medical supplies): HAP CareSource will accept PAs in place when the CSHCS member is enrolled. If the PA is with a non-network provider, HAP CareSource will reimburse at the Medicaid rate through the duration of the PA. Upon expiration of the PA, medical necessity will be reviewed according to HAP CareSource procedures and network ancillary services.
B. CSHCS members may remain with an established PCP, even if out of network at the time of enrollment. Upon consultation with the family and care team, members may be transitioned to an in-network PCP.
C. Durable Medical Equipment (DME): HAP CareSource will accept PAs in place at the time of transition for non-custom, fitted DME and medical supplies but may utilize review criteria after the expiration of the PA. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment of the equipment.

III. Collaboration with PIHPs
HAP CareSource will maintain coordinating agreements with PIHPs in the service area for the purpose of referrals, care coordination, grievance and appeal resolution, and COC for members served by PIHPs. To facilitate information sharing and improve communication via an electronic, bidirectional exchange, HAP CareSource will provide all relevant member information in accordance with MDHHS-specified format, process, and timelines and ensure that referral information is transmitted to the designated point of contact for referral coordination.

E. Conditions of Coverage

I. COC requirements include a process for inclusion of member data from the electronic exchange of information with HAP CareSource, PIHP or PAHP. Data should be included for the previous 5 years. HAP CareSource will verify previous relationships between members and providers, including review of medical records,

to establish eligibility for COC. A relationship with a provider is deemed to exist in the following circumstances:

A. Specialists – The member must have seen the specialist at least once within the past 12 months for a nonemergency visit prior to enrollment.
B. PCP – The member must have seen the PCP at least once within the 6 months prior to enrollment for a non-emergency visit.
C. Other covered providers – The member may have received services from other providers within the 6 months prior to enrollment. HAP CareSource will review, assess and coordinate those services if it is determined that the member will suffer serious detriment or be considered at risk for hospitalization or institutionalization.

If it cannot be determined that a relationship exists based on available data, the provider and/or member will be asked to provide documentation of previous visits and/or proof of payment to establish the relationship.

II. HAP CareSource may extend any COC timeframe at its discretion. During the COC period, the member will be assisted with selecting a network provider(s), ensuring referral to an appropriate provider(s) of services following the end of the COC period.

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	09/27/2023	New policy. Approved at Committee.
Date Revised	03/13/2024	Annual review. Added D.II.D-E, III. Updated H. Approved at Committee.
	08/28/2024	Review. Added D.I.E. Updated references. Approved at Committee.
	10/22/2025	Annual review. Updated references. Approved at Committee.
Date Effective	02/01/2026	
Date Archived		

H. References

1. Continued Service to Enrollees, 42 C.F.R. § 457.1216 (2010).
2. Continued Services to Enrollees, 42 C.F.R. § 438.62 (2023).
3. *Continuity and Coordination of Care: A practice Brief to Support Implementation of the WHO Framework on Integrated People-Centered Health Services*. World Health Organization; 2018. Accessed October 13, 2025. www.who.int
4. Continuity of Care, 26 U.S.C. § 9818 (2022).
5. Coordination and Continuity of Care, 42 C.F.R. § 438.208 (2023).
6. *Provider Manual*. HAP CareSource; 2025. Accessed October 13, 2025. www.hap.org
7. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930

8. *Medicaid Provider Manual*. Michigan Dept of Human Services. Accessed October 13, 2025. www.mdch.state.mi.us
9. National Committee for Quality Assurance (NCQA) Health Plan Standards; 2023. Accessed October 13, 2025. www.ncqa.org
10. State of Michigan Contract for Comprehensive Health Care Program for the Michigan Dept of Health and Human Services, Amendment 2. State of Michigan; 2025. Accessed October 13, 2025. www.michigan.gov
11. The No Surprises Act's continuity of care, provider directory, and public disclosure requirements. Centers for Medicaid and Medicare Services; 2021. Accessed October 13, 2025. www.cms.gov