HAP CareSource™

ADMINISTRATIVE POLICY STATEMENT
Michigan HIDE SNP

Policy Name & Number	Date Effective
Continuity of Care-MI Coordinated Health-AD-1555	01/01/2026
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 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 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. These interventions provided to transitioning members work to promote safety and efficacy.

HAP CareSource adheres to all transition requirements for services in order to ensure COC and deliver quality care, enabling members to avoid preventable disease, manage chronic illnesses and disabilities, and maintain or improve health and quality of life. Care will address social determinants of health (SDoH) and health-related social needs (HRSN) to reduce health disparities experienced by different subpopulations to ultimately achieve health equity. Quality care includes continuity and coordination of care across all care and service settings, including transitions. HAP CareSource complies with federal and state laws, including information published by the Michigan Dept of Health and Human Services (MDHHS).

C. Definitions
- **Care Coordination** – A process to assist members in accessing services regardless of the funding source, characterized by advocacy, communication, and resource management to promote quality, cost effectiveness and positive outcomes.
- **Care Coordinator (CC)** – A MI-licensed registered nurse (RN), nurse practitioner (NP), physician's assistant (PA), limited licensed or fully licensed Bachelor's or Master's social worker, or clinical nurse specialist (CNS) employed or contracted with HAP CareSource accountable for providing the full range of care coordination services and trained in person-centered planning techniques.
- **Health Risk Assessment (HRA)** – A comprehensive assessment of a member's medical, psychosocial, cognitive and functional status to determine medical, behavioral health (BH), long-term supports and services (LTSS) and social needs documented in the health record and results used in the development of the ICP.
- **Individualized Care Plan (ICP)** – The plan of care developed by a member, the CC and the Integrated Care Team (ICT), incorporating multiple elements (ie, assessment results, preferences for care, supports and services, providers and benefits, reassessment date). Also referred to as person-centered plan or plan of care (POC) and maintained in the EHR with evidence of acceptance, including member and/or provider(s) signature(s) when appropriate per ICP guidance.

- **Integrated Care Team (ICT)** – A team including the member, chosen allies or legal representative, primary care physician, CC, LTSS representative(s), or PIHP representative(s), as applicable, and others as needed working to develop, implement and maintain the ICP and coordinate the delivery of services and benefits.
- **Pre-paid Inpatient Health Plan (PIHP)** – Manager of Medicaid specialty services under the MI 1115 Behavioral Health (BH) Demonstration for members needing BH or intellectual/development disability (IDD) services.
- **Primary Care Provider (PCP)** – Practitioner of primary care (ie, APRN, NP, PA, board-certified or specialist physicians) selected or assigned to a member and responsible for providing and coordinating health care needs, including initiation and monitoring of referrals for specialty services when required.
- **Provider Network** – The collective group of providers with contracts with HAP CareSource for the delivery of covered services, including, but not limited to, physical, behavioral, pharmacy and ancillary service providers.
- **State Plan Personal Care** – Services that address physical assistance needs and enable members to live in personal homes, adult foster care or homes for the aged, including hands-on assistance all activities of daily living (ADLs).
- **Treating Provider** – Someone who provides or has provided clinical treatment or evaluation to the member and who has, or has had, an ongoing treatment relationship within the past 12 months.

D. Policy
   I. General Guidelines
      A. Members who lose Medicaid eligibility will be offered a 3-month period of continued enrollment to minimize risks and maximize COC during temporary eligibility loss.
      B. MDHHS-required data sharing systems and processes will be used to enable care coordination. To minimize the duplicate data entry burden on providers with certified EHRs who have or will soon achieve meaningful use stage 1 through compliance, automated electronic data exchange from providers using the Office of the National Coordinator (ONC) compliant protocols and formats will be supported.
      C. Coordinating Agreements will be established and maintained with all PIHPs in the service area (coordinating PIHPs) utilizing a standardized template provided by MDHHS that addresses, at a minimum, processes for member referrals, access to and coordination of care, grievance and appeal resolution and other requirements mandated by MDHHS. Agreements will be updated at least annually to incorporate necessary modifications or remedies to improve COC, care management and the provision of health care services.
      D. The role of ICT is to work collaboratively with the member and other team members to ensure that COC requirements are met. The care coordinator is responsible for assuring completion of these tasks.
      E. HAP CareSource will send all agreed upon materials listed in the MI Contract to newly enrolled members within 10 CDs of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date of coverage, whichever occurs later. This list includes (not all inclusive)

1. proof of health insurance coverage with an effective date
2. charges for which the member will be liable
3. provider letter for the member to take to providers that explains the member's benefit plan, COC requirements, and instructions on provider billing
4. requirements for use of HAP CareSource's network providers

II. Continuity of Care Requirements

A member's current providers and amount, scope and duration of services at the time of enrollment will be maintained, including out of network providers. Transition requirements vary based on the service and population, in accordance with the requirements and timelines set forth below.

- Members in the Habilitation Supports Waiver (HSW) will receive waiver services through the PIHP, which will not change due to HAP CareSource enrollment.
- State Plan Personal Care benefits will be provided to members by HAP CareSource.

Provider Type	Transition Requirement for HSW and Members Receiving Services through PIHP under the MI 1115 BH Demonstration
Physician/Other Practitioners	Maintain current provider at enrollment for 180 calendar days (CDs). Honor existing POCs and PAs until expiration or 180 CDs from enrollment, whichever is sooner.
DME	Honor PAs when item has not been delivered; review ongoing PAs for medical necessity.
Scheduled Surgeries	Honor specified provider and PAs for surgeries scheduled within 180 CDs of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to enrollment is authorized through the course of treatment with the specified provider.
Organ/Bone Marrow, Hematopoietic Stem Cell Transplant	Honor specified provider, PAs and POC.
Dialysis Treatment	Maintain current level of service and same provider at enrollment for 180 CDs.
Vision and Dental	Honor PAs when an item has not been delivered.
Home Health	Maintain current level of service and same provider at enrollment for 180 CDs.
State Plan Personal Care	Maintain current provider and level of services at enrollment for 180 CDs. ICP must be reviewed/updated and providers secured within 180 CDs of enrollment. If this requirement is not met, the COC period will remain in place until met. Services can be increased or reduced during a COC period if a reassessment is conducted utilizing the Personal Care Assessment, and the ICP is updated with member approval.

Transition Requirements	Contractor Transition Requirements for All Other Enrollees
Physician/Other Practitioners	Maintain current provider at enrollment for 90 CDs. Honor existing POCs and PAs until expiration or 180 CDs from enrollment, whichever is sooner.
DME	Honor PAs when item has not been delivered; review ongoing PAs for medical necessity.

Schedule Surgeries	Honor specified provider and PAs for surgeries scheduled within 180 CDs of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to enrollment is authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and POCs.
Dialysis Treatment	Maintain current level of service and same provider at enrollment for 180 CDs.
Vision and Dental	Honor PAs when an item has not been delivered.
Home Health	Maintain current level of service and same provider at enrollment for 90 CDs.
Medicaid Nursing Facility Services	Member may remain at facility through contract via single case agreement or on an out of network basis until the member chooses to relocate.
Waiver Services	Maintain current providers and level of services at enrollment for 90 CDs unless changed during the person-centered planning process provided by the HBCS waiver.
State Plan Personal Care	Maintain current provider and level of services at enrollment for 90 CDs. ICP must be reviewed/updated and providers secured within 90 CDs of Enrollment. If this requirement is not met, the COC period will remain in place until met. Services can be increased or reduced during a COC period if a reassessment is conducted utilizing the Personal Care Assessment, and the ICP is updated with member approval.

A. Service Provision Changes
   Any reduction, suspension, denial or termination of previously authorized services must trigger the required notice under 42 C.F.R. §§ 438.404, and 422.568. During the transition periods above, changes from existing provider(s) or reductions in the amount, scope and duration of services can occur in the following circumstances:
   1. The member requests a change.
   2. The provider chooses to discontinue providing services as currently allowed by Medicare or Medicaid.
   3. HAP CareSource, Centers for Medicare and Medicaid Services (CMS) or MDHHS identifies provider performance issues affecting a member's health and welfare.
   4. Circumstances as described in the above charts.

B. Transitioning Disenrolled HAP Members Who Return to HAP CareSource
   A COC period will be allowed for personal care services (PCS).
   1. Services will be based on services received at disenrollment.
      a. If no PCS was received during disenrollment, the member can be out of HAP CareSource for 3 months OR as long as the personal care assessment has not expired, whichever is longest, to receive COC.
      b. If PCS were received during disenrollment, HAP CareSource will honor the most recent amount, scope and duration of services received during disenrollment unless 1 of the criterion referenced in section A above is met.
   2. The COC period is as follows:

a. 180 days for members receiving services through the PIHP under the MI 1115 BH Demonstration or HSW.
b. 90 days for all other members.

C. HAP CareSource will accept and honor PAs in place for members for a period of up to 1 year for all dental services.
D. HAP CareSource may authorize other out-of-network services to promote access to services and COC. These requests will be reviewed on a case-by-case basis.

III. Provider Transitions
A. During the transition periods outlined above, members will be allowed access to any provider seen within the previous 12 months, as indicated in CareConnect360, or reported by the member or provider prior to transition, even if the provider is not in network. HAP CareSource will advise members and providers if and when care was received that would not otherwise be covered in-network.
1. On an ongoing basis, and as appropriate, out-of-network providers will be contacted to provide information on becoming in-network.
2. Out-of-network nursing facilities will be offered Single Case Agreements if the facility does not participate in the network and the member
a. resides in the nursing facility at the time of enrollment
b. has a family member or spouse that resides in the nursing facility
c. requires nursing facility care and resides in a retirement community that includes a nursing facility

B. HAP CareSource will provide written notice of termination of providers and/or facilities from the network irrespective of whether the termination was for cause or without cause. Good faith efforts will be made to provide notice of for-cause terminations of providers that involve
1. a PCP or BH provider at least 45 CDs before the termination effective date, written notice will be made and 1 attempt at telephonic notice, unless the member opted out of calls, for any member who was a patient of the PCP or BH provider within the past 3 years
2. specialty types other than primary care or BH at least 30 CDs before the termination effective date, written notice will be provided to members assigned to, currently receiving care from, or have received care within the past 3 months

IV. Transferring Care/Service Plans and Liabilities
HAP CareSource will accept and honor established care and/or service plans provided on paper or electronically transferred from FFS, PACE, other payors or other plans when members transition with care/service plans in place until the ICP is developed. HAP CareSource will also ensure timely transfer of an ICP, HRA, and any other data to support COC to others when a member is disenrolling from HAP CareSource.
A. If a member is receiving medical care or treatment as an inpatient in an acute care hospital at the time HAP CareSource coverage is terminated, HAP CareSource will arrange for COC or treatment for the current episode of illness until such medical care or treatment is fully transferred to a treating provider agreeing to assume responsibility for such care or treatment for the remainder of that hospital episode and

subsequent follow-up care. HAP CareSource will maintain documentation of such transfer of responsibility.

B. For hospital stays otherwise reimbursed under Medicare or the MI Medicaid Program on a per diem basis, HAP CareSource will be liable for payment for medical care or treatment provided to a member until the effective date of disenrollment.
C. For hospital stays otherwise reimbursed under Medicare or the MI Medicaid Program on a DRG basis, HAP CareSource will be liable for payment for any inpatient medical care or treatment provided to a member where the discharge date is after the effective date of disenrollment.

V. Transitions Prior to the End of the Transition Period
HAP CareSource may choose to transition the member to a network specialist or LTSS provider before the end of the transition period only if all the following criteria are met:
A. The HRA and additional assessments, if applicable, are complete.
B. The ICP is developed with member input and includes a transition plan to be updated and agreed to with the new provider, as necessary.
C. A member agrees to the transition and ICP prior to expiration of the transition period.

E. Conditions of Coverage

Generally, an ongoing treatment relationship is recognized when the clinical evidence establishes that the member sees, or has seen, the provider with a frequency consistent with accepted clinical practice for the type of treatment, evaluation and/or service required for clinical need(s).

A. Treating providers include PCPs, specialists, PAs, APRNs, psychiatrists, counselors and therapists.
B. Treating providers are not those who provide services that are non-clinical in nature like chore services or provide only routine preventative care like preventive dental.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	07/16/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. Eligibility to Elect MA Plan for Special Needs Individuals, 42 C.F.R. § 422.52(d) (2020).
2. Emergency and Post-Stabilization Services, 42 C.F.R. § 438.114(e) (2025).
3. Exclusions from Coverage and Medicare as Secondary Payor, 42 U.S.C. 1395y (2025).
4. General Administrative Requirements, 42 C.F.R. Part 401 (2016).

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

5. *HAP CareSource HIDE SNP Two-way Contract*. State of Michigan Procurement. Accessed July 1, 2025. www.michigan.gov
6. *HAP CareSource Provider Manual*. HAP CareSource; 2026. www.caresource.com
7. *Michigan Medicaid Provider Manual*. Michigan Department of Health and Human Services. Updated July 1, 2025. Accessed July 1, 2025. www.mdch.state.mi.us
8. Standard Timeframes and Notice Requirements for Organization Determinations, 42 C.F.R. § 422.568 (2025).
9. Timely and Adequate Notice of Adverse Benefit Determination, 42 C.F.R. §§ 438.404-(2025).