HAP CareSource™

ADMINISTRATIVE POLICY STATEMENT
Michigan Health Link

Policy Name & Number	Date Effective
Continuity of Care-MI Health Link-AD-1414	06/01/2024-01/31/2025
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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 documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) 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.

Table of Contents

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 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 CareSource. COC promotes safety and effective healthcare to transitioning members.

C. Definitions
- **Care Coordination** – A process used by a person or team to assist enrollees in accessing Medicare and Medicaid services, as well as social, educational, and other support services, regardless of the funding source for the services and characterized by advocacy, communication, and resource management to promote quality, cost effectiveness and positive outcomes.
- **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 or was determined to be terminally ill and is receiving treatment for such illness.
- **Course of Treatment** – A prescribed order or course of treatment for an individual with a specific condition that is outlined and decided upon ahead of time between the member and provider and may, but is not required to, be part of a treatment plan.
- **Covered Services** – Supports and services considered medically necessary that prevent, diagnose, or treat health impairments and/or attain, maintain, or regain functional capacity.
- **Medically Necessary Services** – Services provided in a way that provides all protections to covered individuals provided by Medicare and Michigan Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. Per Medicaid, determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the most integrated setting, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those supports and services designed to assist the person to attain or

maintain a sufficient level of functioning to enable the person to live in his/her community.

- **Ongoing Treatment Relationship** – Clinical evidence establishes that a member sees or has seen a provider with a frequency consistent with accepted clinical practice for the type of treatment, evaluation, or service required for clinical need(s).
- **Passive Enrollment** – An enrollment process in which an eligible person is enrolled by MDHHS (or vendor) into CareSource after a minimum 60 calendar day advance notification, including plan selection and the choice to select a different plan, make another enrollment decision, decline enrollment, or opt-out of future enrollment.
- **Pre-paid Inpatient Health Plan (PIHP)** – Entities managing Medicaid specialty services under the 1915(b)(c) Waiver consistent with 42 C.F.R. § 401, covering behavioral health (BH), intellectual/developmental disability (IDD) services, and substance use disorder (SUD) services.
- **Primary Care Provider (PCP)** – Practitioner of primary care selected by or assigned to the enrollee responsible for providing and coordinating health care needs, including the initiation and monitoring of referrals for specialty services when required (ie, nurse practitioners, physician assistants [PAs], board-certified physicians, specialists selected by an enrollee).
- **Provider Network** – A network of health care and social support providers, including but not limited to, PCPs, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance use providers, nursing home providers, LTSS providers, pharmacy providers, and other acute care providers employed by or under subcontract with CareSource.
- **Serious and Complex Condition** – In the case of (1) an acute illness, a condition that is serious enough to require specialized medical treatment to avoid a 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, and requires specialized medical care over a prolonged period of time.
- **Terminal Illness** – Medical prognosis of a life expectancy of 6 months or less.
- **Treating Provider** – A practitioner who provides or has provided clinical treatment or evaluation to a member with an ongoing treatment relationship within the past 12 months (ie, PCPs, specialists, PAs, nurse practitioners, psychiatrists, counselors, therapists, not including those who provide non-clinical services or only routine preventative care).

D. Policy

I. Within 30 days of enrollment and in writing, members will receive a letter to take with him/herself to providers that explains the new benefit plan, continuity of care requirements, instructions for provider billing for services, and information on how to join the provider network.

II. Caresource will collaborate with coordinating PIHPs to improve continuity of care, care management and/or coordination, and the provision of BH services.

III. CareSource will maintain an enrollee's current providers and amount, scope, and duration of services at the time of enrollment, including out of network providers. COC service requests from members or others on behalf of members will be reviewed when the following occurs:
   A. For enrollees receiving services from the Habilitation Supports Waiver (HSW) and/or the Specialty Services and Supports Program (SSSP) through the PIHP, the following continuity of care requirements apply to CareSource's services:
      1. Physician/other practitioners: Enrollee may maintain current provider at the time of enrollment for 180 calendar days (CDs). CareSource will honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 CDs from enrollment, whichever is sooner.
      2. Durable medical equipment, vision and dental: CareSource will honor PAs for any item(s) not yet delivered and will review ongoing PAs for medical necessity.
      3. Scheduled surgeries: CareSource will honor specified provider(s) and PA(s) for surgeries scheduled within 180 CDs of enrollment.
      4. Chemotherapy/radiation: Treatment initiated prior to enrollment will be authorized through the course of treatment with the specified provider.
      5. Organ, bone marrow, hematopoietic stem cell transplant: CareSource will honor specified provider(s), PA(s), and plans of care.
      6. Dialysis treatment and home health services: Enrollee may maintain current level of service and same provider at the time of enrollment for 180 CDs.
      7. State plan personal care: Enrollees may maintain current provider(s) and level of services at the time of enrollment for 180 CDs, but individual service plans will be reviewed, updated, and providers secured within 180 CDs.
      8. Enrollees in the HSW will continue to receive waiver services through the PIHP. Waiver services will not change due to enrollment with CareSource.
   B. For all other enrollees, the following apply to CareSource's services:
      1. Physician/other practitioners: Enrollees may maintain current provider(s) at the time of enrollment for 90 CDs. CareSource will honor existing plans of care and PAs until the authorization ends or 180 calendar days from enrollment, whichever is sooner.
      2. Durable medical equipment, vision and dental: CareSource will honor PAs for any item(s) not yet delivered and will review ongoing PAs for medical necessity.
      3. Scheduled surgeries: CareSource will honor specified provider(s) and PAs for surgeries scheduled within 180 CDs of enrollment.
      4. Chemotherapy/radiation: Treatment initiated prior to enrollment will be authorized through the course of treatment with the specified provider.
      5. Organ, bone marrow, hematopoietic stem cell transplant: CareSource will honor specified provider(s), PA(s), and plans of care.
      6. Dialysis treatment: Enrollee may maintain current level of service and same provider at the time of enrollment for 180 CDs.
      7. Home health services: Enrollee may maintain current level of service and same provider at the time of enrollment for 90 CDs.

8. Medicaid nursing facility services: Enrollees may maintain current provider and level of service, as well as rate of pay, at the time of enrollment for up to 90 CDs. The member may remain at the facility through contract with CareSource via single case agreements, on an out-of-network basis, or until the enrollee chooses to relocate.
9. Waiver services: Enrollees may maintain current providers and level of services at the time of enrollment for 90 CDs unless changed during the Person-Centered planning process for services provided by the MI Health Link HBCS waiver. This is not applicable to other enrollees.
10. State plan personal care: Enrollees may maintain current provider(s) and level of services at the time of enrollment for 90 CDs, but individual service plans will be reviewed, updated, and providers secured within 90 CDs. This does not apply to MI Choice HCBS waiver enrollees.

C. CareSource will provide the State plan personal care benefit to enrollees.

IV. During the transition period, change from an existing provider or reductions in the amount, scope or duration of services can only occur in the following circumstances:
1. The enrollee requests a change.
2. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid.
3. CareSource, CMS, or MDHHS identifies provider performance issues that affect an enrollee's health and welfare, particularly quality of care issues and/or fraud.

V. CareSource may authorize other out-of-network services to promote access to and continuity of care. Enrollees maintain improper billing protections.
A. When out-of-network services are authorized and where the service would traditionally be covered under Medicare FFS, CareSource will pay out-of-network health care professionals and section 1861(u) providers of services the amount that providers could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers), regardless of the setting and type of care.
B. When out-of-network services are authorized and where the service would traditionally be covered under Medicaid, CareSource will pay out-of-network providers at established Medicaid fees in effect on the date of service. If Michigan Medicaid has not established a specific rate for the covered service, CareSource will follow Medicaid policy for the determination of the correct payment amount. CareSource reserves to negotiate a lower rate of payment with any provider.
C. For traditional Medicaid nursing home days of care, CareSource may negotiate with nursing facilities (NF) to pay rates that vary from the Medicaid FFS rate as established by the MDHHS. For individuals residing in an NF without an agreed upon rate at the time of an enrollee's effective enrollment date, CareSource will pay, at a minimum, the Medicaid FFS rate and level of service through the continuity of care period or until a negotiated rate is agreed upon. The Quality Assurance Supplement (QAS) will be paid through a directed payment as

approved by CMS through the 42 C.F.R. § 438.6(c) preprint process. CareSource will reimburse NF providers the Medicaid coinsurance rate for days 21 through 100 of a skilled care or rehabilitation day in accordance with published Medicaid policy.

VI. Notice Prior to COC Termination
   A. If an enrollee is receiving any item or service that would not otherwise be covered by CareSource at an in-network level after the continuity of care period, CareSource will notify the enrollee prior to the end of the continuity of care period according to the requirements at 42 C.F.R. §§ 438.404 and 422.568.
   B. If a enrollee is receiving medical care or treatment as an inpatient in an acute care hospital and a contract is terminated with CareSource, CareSource will arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. CareSource will maintain documentation of such transfer of responsibility of medical care or treatment for the enrollee.

E. Conditions of Coverage

COC requirements include a process for inclusion of enrollee data from the electronic exchange of information with a managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan. Data should be included for the previous 5 years. CareSource will verify previous relationships between members and providers, including review of medical records, to establish eligibility for continuity of care. A relationship with a provider is deemed to exist in the following circumstances:

I. Specialists – The member must have seen the specialist at least once within the past 6 months for a nonemergency visit prior to enrollment in a CareSource plan.
II. Primary Care Provider – The member must have seen the primary care provider at least once within the 6 months for a non-emergency visit prior to enrollment into a CareSource plan.
III. Other covered providers – The member may have received services from other providers within the past 6 months prior to enrollment in a CareSource plan.

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 CareSource cannot determine that a relationship exists based on available data, the provider and/or member will be asked to provide documentation of any previous visits from the medical record and/or proof of payment to establish the relationship.

F. Related Policies/Rules

I. CareSource Policies
   A. Medical Necessity Determinations
   B. Out of Network Payment

II. Other Related Rules
   A. Timely and Adequate Notice of Adverse Benefit Determination, 42 C.F.R. § 438.404
   B. Standard Timeframes and Notice Requirements for Organization Determinations, 42 C.F.R. § 422.568.

G. Review/Revision History

	DATE	ACTION
Date Issued	12/13/2023	New policy. Approved at Committee.
Date Revised	03/13/2024	Annual review. Updated H. Approved at Committee.
Date Effective	06/01/2024	
Date Archived	01/31/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Continued Services to Enrollees, 42 C.F.R. § 438.62 (2023).
2. *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 February 27, 2024. www.who.int
3. Continuity of Care, 26 U.S.C. § 9818 (2022).
4. Coordination and Continuity of Care, 42 C.F.R. § 438.208 (2023).
5. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
6. *Medicaid Provider Manual*. Michigan Dept of Human Services; 2023. Updated January 1, 2024. Accessed February 27, 2024. www.mdch.state.mi.us
7. Minimum Operating Standards for MI Health Link Program and MI Health Link HCBS Waiver. Michigan Dept of Health and Human Services. Effective February 1, 2023. Accessed February 27, 2024. www.michigan.gov
8. National Committee for Quality Assurance (NCQA) Health Plan Standards; 2024. Accessed February 27, 2024. www.ncqa.org
9. *Provider Manual.* HAP CareSource; 2024. Accessed February 27, 2024. www.caresource.com