# ADMINISTRATIVE POLICY STATEMENT
# Michigan Health Link

| Policy Name & Number | Date Effective |
|---|---|
| Continuity of Care-MI Health Link-AD-1414 | 02/01/2025 |
| **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.

CareSource complies with federal and state legislation and guidance regarding COC. The Michigan Department of Health and Human Services (MDHHS) publishes provider information on the state website and supersedes any information in this policy.

C. Definitions
- **Care Coordination** – A process to assist members in accessing 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 regimen to be followed for a specific period of time based on current treatment standards.
- **Covered Services** – Supports and services considered medically necessary that prevent, diagnose, or treat health impairments and/or attain, maintain, or regain functional capacity.
- **Individual Integrated Care and Supports Plan (IICSP)** – Comprehensive document allowing members, Care Coordinators, providers, and others to stay current with a member's overall status and the progress of goals and treatments.
- **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, supports and services designed to assist the person to attain or maintain a sufficient level of functioning to enable living in the 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).
- **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 selected by or assigned to a member responsible for providing and coordinating health care, including the initiation and monitoring of referrals for specialty services when required (ie, nurse practitioners, physician assistants [PAs], board-certified physicians, specialists).
- **Provider Network** – A network of health care and social support 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, not including those who provide non-clinical services or only routine preventative care.

D. Policy

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

II. CareSource will share data and member information as necessary to ensure a smooth transition with the necessary parties (Centers for Medicare and Medicaid Services [CMS], MDHHS, and/or any receiving health plan) as determined by MDHHS and CMS, including, but not limited to, prior authorization data, care plans, health risk assessments, and provider network information.

III. COC requests are accepted from the member, a member representative, or a provider on behalf of the member either verbally or in writing. Minimum time periods for COC protections are as follows:
   A. Physician, Practitioners, Home Health

1. Enrollees receiving services from the PIHP Managed Specialty Services and Supports Program (MSSSP) or Habilitation Supports Waiver (HSW): CareSource will maintain current providers and level of services at the time of enrollment for 180 calendar days (CDs).
2. All other enrollees: CareSource will maintain current providers and level of services at the time of enrollment for 90 CDs.

B. Plans of Care, Prior Authorizations (PAs): CareSource will honor existing plans of care and PAs until the authorization ends or 180 CDs from enrollment, whichever is sooner.
C. Durable Medical Equipment, Vision and Dental: CareSource will honor PAs for item(s) not yet delivered and will review ongoing PAs for medical necessity.
D. Scheduled Surgeries: CareSource will honor specified provider(s) authorized and PA(s) for surgeries scheduled within 180 CDs of enrollment.
E. Chemotherapy and Radiation: Treatment initiated prior to enrollment must be authorized by CareSource through the course of treatment with the specified provider.
F. Organ, Bone Marrow, and Hematopoietic Stem Cell Transplant: CareSource will honor specified provider(s), PA(s), and plans of care.
G. Dialysis: Enrollees may maintain the current level of service and same provider at the time of enrollment for 180 CDs.
H. HSW Services: Enrollees in the HSW will continue to receive waiver services through the PIHP. Waiver services will not change due to enrollment with CareSource.
I. Medicaid Nursing Facility Services: 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, if the enrollee at the time of enrollment:
    1. resides in the nursing home
    2. resides in a bed not certified for both Medicare and Medicaid
    3. requires nursing home care and has a family member or spouse residing on an out of network nursing home
    4. requires nursing home care and resides in a retirement community that includes a nursing home not in the CareSource's network
J. MI Choice Home and Community Based Services Waiver (HCBS)
Enrollees previously participating in HCBS waiver: CareSource will maintain current providers and level of services at the time of enrollment for 90 CDs unless changed during the IICSP process or until the member is reassessed.
K. Personal Care Services: For individuals enrolled with CareSource, then disenrolling, then returning to CareSource, services will be continued based on services received at disenrollment. If the member did not receive services external to CareSource during disenrollment, the member can be out of CareSource for 3 months or as long as the personal care assessment has not expired, whichever is longest, to receive continuity of care. If services were received external to CareSource during disenrollment, CareSource will honor the most recent amount, scope and duration of the services received during

disenrollment. CareSource can reassess a member's current condition with the personal care assessment and provide the care the member requires per current needs at any time during the COC period, which is as follows:

1. 180 days for individuals receiving services through the PIHP under the MSSSP or HSW
2. 90 days for all other individuals

IV. During the transition period, a 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 COC period, CareSource

will notify the enrollee prior to the end of the 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 COC 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 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

I. CareSource is required to first review Medicare and Medicaid utilization data provided by CMS and MDHHS to determine which providers have existing relationships with enrollees. Data should be included for the previous 5 years. CareSource will review, assess, and coordinate services if determined that the enrollee 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. An attestation that a relationships exists is not sufficient. 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. Primary Care Provider – The member must have seen the PCP at least once within the 12 months for a non-emergency visit prior to enrollment.
C. Other covered providers – The member may have received services from other providers within the past 12 months prior to enrollment.

II. The protections afforded to members to maintain a current provider under COC requirements are not applicable when the provider is subject to termination for quality-of-care issues or fraud.

## 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.

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

## G. Review/Revision History

| | DATE | ACTION |
|---|---|---|
| **Date Issued** | 12/13/2023 | New policy. Approved at Committee. |
| **Date Revised** | 03/13/2024<br>10/23/2024 | Annual review. Updated H. Approved at Committee.<br>Out of cycle review (RDM). Added D.II., updated D.III. & E.I.A-C to 12 months. Updated references. |
| **Date Effective** | 02/01/2025 | |
| **Date Archived** | | |

## 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 October 1, 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. Updated October 1, 2024. Accessed October 1, 2024. www.mdch.state.mi.us
7. Medical Assistance Program; Approval; Acceptance of Medicare Rates by Hospital as Payments in Full; Enrollment Plan; Pharmaceutical Benefit; Financial Incentives; Performance Bonus Incentive Pool; Distribution of Funds from Performance Bonus Incentive Pool; Substance Abuse Disorders; Availability of Data to Vendor; Definitions, MICH. COMP. LAWS § 400.105d (2023).
8. MI Health Link Continuity of Care. Mich. Dept of Health and Human Services. Revised August, 2023. Accessed October 1, 2024. www.michigan.gov
9. 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 October 1, 2024. www.michigan.gov
10. National Committee for Quality Assurance (NCQA) Health Plan Standards; 2024. Accessed October 1, 2024. www.ncqa.org
11. *Provider Manual.* HAP CareSource; 2024. Accessed October 1, 2024. www.caresource.com

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