ADMINISTRATIVE POLICY STATEMENT Michigan Medicaid	
Policy Name & Number	**Date Effective**
Continuity of Care-MI MCD-AD-1382	10/01/2024
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.

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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 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
- **Children in Foster Care** – Individuals placed outside the parental home by and under the supervision of a child placing agency, the court, or the department, up to the child's 18th birthday, 19th birthday for youth committed to the Michigan Children's Institute (MCL 400.203), or 21st birthday for youth participating in the Young Adult Voluntary Foster Care. Children in Foster Care do not include children for whom there has been a delegation of a parent or guardian's powers regarding care, custody, or property of a child or ward under a properly executed power of attorney under the Safe Families for Children Act.
- **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.
- **Continuity of Care** – A process for assuring that care is delivered seamlessly across a multitude of delivery sites and transitions in care throughout the course of the disease process.
- **Course of Treatment** – A prescribed order or ordered course of treatment for a specific 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** – All services provided under Medicaid that CareSource has agreed to provide or arrange to be provided to members.
- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** – This benefit (42 USC Sec. 1396D(R)(5),1396D(A)), also referred to as a well-child visit, is a federal mandate that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

- **Medical Necessity** – Covered services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly.
- **Network Provider** – An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the CareSource for the delivery of covered services to members.
- **Out of Network Provider** – Covered services rendered to a member by a provider who is not part of the CareSource provider network.
- **Post-Stabilization Care Services** – Covered services related to an emergency medical condition provided after a member is stabilized to maintain the stabilized condition in order to improve of resolve the member’s condition.
- **Prepaid Inpatient Health Plan (PIHP)** – Provides behavioral health (BH) services to members excluding the outpatient BH services described in the Michigan Department of Health and Human Services (MDHHS) Medicaid BH and Substance Use Disorder Authorization and Payment Responsibility Grid on the MDHHS website.
- **Primary Care Provider (PCP)** – A family, general practice, or pediatric physician, internal medicine physician, OB/GYN specialist, nurse practitioner, physician assistant, or other physician specialist when appropriate for a member’s health condition responsible for supervising, coordinating, and providing primary care, initiating referrals for specialty care and maintaining continuity and the medical record, which includes documentation of all services provided as well as any specialty or referral services.
- **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 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, and requires specialized medical care over a prolonged period of time.
- **Terminal Illness** – Illness with life expectancy of 6 months or less.
- **Urgent Medical Care** – Medical care provided for a condition that without timely treatment could be expected to deteriorate into an emergency, cause prolonged, temporary impairment in 1 or more bodily function or cause the development of a chronic illness or need for a more complex treatment (eg, abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, suspected fracture). Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

D. Policy
  I. CareSource ensures members continued access to services during transitions from fee-for service to managed care or from 1 managed care entity to another payer, especially 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 CareSource network, and the termination was not related to fraud or a quality-of-care issue.
    B. A newly enrolled member requests continued services from a non-participating health partner (ie, primary care providers, specialists, other covered providers) providing care to the member prior to enrollment. CareSource will allow the maintenance of current providers and levels of services at the time of enrollment for 90 days. CareSource will assist members in selecting a provider in the CareSource network.
    C. A newly enrolled member is or will be receiving services for which a prior authorization (PA) was received from another payer. CareSource will conduct a review of previously authorized services if a change in service is needed or requested. CareSource will honor prior PAs approved by the member's original payer 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. In order to preserve COC for dental services, CareSource will accept and honor prior authorizations in place for a period up to 1 year for members transitioning from Fee for Service Medicaid.
    E. Children in foster care may remain with an established PCP, even if that PCP is out of network. CareSource will authorize and reimburse all required Foster Care Well-Child Exams, including any that occurred with an out of network provider.

  II. COC services will be subject to medical necessity review. CareSource will conduct a review of previously authorized services if a change in service is needed. The following requests will be accepted from members, a member's appointed representative, or providers on behalf of members for consideration of continued services (not an all-inclusive list):
    A. The transitioned member is eligible for continued, clinically equivalent services by an equivalent provider if, during the previous 6 months, that member was treated for a condition that requires follow-up care or additional treatment, or the services have been prior authorized by the previous payer.
    B. CareSource will ensure that pregnant members receive individual maternity care for the duration of pregnancy and post-partum care. A clinic or practice may be designated as the maternity care provider; however, an individual PCP within the

practice must be named and agree to accept responsibility for the enrollee's care for the duration of the pregnancy and post-partum care.

C. Member has been diagnosed with a terminal illness.
D. Member has significant health care needs or complex medical conditions.
E. Member is receiving ongoing services such as dialysis, home health, chemotherapy, or radiation

III. Children's Special Health Care Services (CSHCS)

A. Ancillary Services: In order to preserve COC for ancillary services (ie, therapies, medical supplies), CareSource will accept PAs in place when the CSHCS enrollee is enrolled with CareSource. If the PA is with a non-network ancillary provider, CareSource will reimburse the ancillary provider at the Medicaid rate through the duration of the PA. Upon expiration of the PA, CareSource will review medical necessity according to CareSource procedures and network ancillary services.
B. Durable Medical Equipment (DME): 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.

IV. Collaboration with PIHPs

CareSource will maintain coordinating agreements with PIHPs in the service area for the purpose of referrals, care coordination, grievance and appeal resolution, and overall COC for members served by PIHPs.

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

Medical Necessity Determinations

G. Review/Revision History

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

H. References

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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 August 16, 2024. 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).
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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. Updated July 1, 2024. Accessed August 16, 2024. www.mdch.state.mi.us
9. National Committee for Quality Assurance (NCQA) Health Plan Standards; 2023. Accessed August 16, 2024. www.ncqa.org
10. State of Michigan Contract for Comprehensive Health Care Program for the Michigan Dept of Health and Human Services. State of Michigan; 2024. Accessed August 16, 2024. 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 August 16, 2024. www.cms.gov