Continuity of Care

People who enroll in MI Health Link (MHL) have the right to continue to see providers who are not in the MHL health plan's network during the Continuity of Care period. Communication between the enrollee, providers, and the MHL health plan is essential to ensure providers are identified so services can be provided and covered by the MHL health plan. The MHL health plan must work to bring enrollees' current providers into the MHL health plan's network.

1. Out-of-Network Providers Covered by Continuity of Care Protections

An enrollee's primary care physician, specialists, hospitals, clinics, dentists, personal care provider and other providers are covered by continuity of care requirements. Continuity of care does not extend to durable medical equipment providers or ancillary service providers (e.g. suppliers of medical supplies or laboratories). Although continuity of care does not extend to these types of providers, the MHL health plan must still provide continuity of care for services and the MHL health plan is responsible for finding an in-network provider to deliver services without disruption.

2. Identifying Enrollees' Providers

The MHL health plan is required to first review Medicare and Medicaid utilization data provided by the Centers for Medicare and Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) to determine which providers have existing relationships with enrollees. Continuity of care protection is automatic for providers which are verified through utilization data to meet the prior relationship requirement.

3. Prior Relationship with a Provider

The enrollee must have a relationship with a provider to establish continuity of care. A relationship is deemed to exist in the following circumstances:

Specialists: The enrollee must have seen the specialist at least *once* within the twelve months prior to enrollment into a MHL health plan for a nonemergency visit.

Primary Care Provider: The enrollee must have seen the primary care provider at least *once* within the twelve months prior to enrollment into a MHL health plan for a non-emergency visit.

Other Covered Providers: The enrollee must have received services from other providers within the past twelve months prior to enrollment into a MHL health plan.

If the MHL health plan cannot determine if a relationship exists based on the available data, the MHL health plan can then ask the provider and enrollee to provide documentation of the visit from the medical record or proof of payment to establish the relationship. An attestation that a relationship exists is not sufficient.

4. Requesting Continuity of Care Coverage

The MHL health plan must ask the enrollee about any upcoming appointments to ensure agreements are in place with out-of- network providers. If data is not available to establish relationship with the enrollee's provider, the enrollee, his or her appointed representative, power of attorney, guardian, or conservator may request continuity of care. The enrollee's out-of-network provider may also request continuity of care on behalf of the enrollee. Requests for continuity of care should be made by contacting the MHL health plan's member services department or the enrollee's MHL Care Coordinator. Requests can be made verbally or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with the MHL health plan.

5. Processing a Continuity of Care Request

Generally, MHL health plans must start processing a request for continuity of care within five working days after the request is received. The MHL health plan has a maximum of 30 days to complete the request. However, if the enrollee's medical condition requires more immediate attention (e.g., an upcoming appointment); the MHL health plan must complete the request within 15 days. If there is a risk of harm to the enrollee or rescheduling of the appointment would be required, the request must be completed within three days of the request. The MHL health plan may verbally convey Continuity of Care approval with the requester and record such approval in the enrollee's record.

6. Services from an Out-Of-Network Provider before a Continuity of Care Request

If the criteria for the prior relationship as outlined above are satisfied, an out-of-network provider can be reimbursed retroactively for services provided without an approved continuity of care request as long as the provider submits the request for payment within thirty days of the first date of service.

7. Quality Review

The MHL health plan must cover services during the continuity of care period for providers that do not have documented quality of care concerns that would cause the MHL health plan to exclude the provider based on state or federal requirements.

8. Personal Care Providers

The MHL health plan must allow choice of personal care service providers including paying family members or friends to provide the service if the non-agency provider meets the criteria to enroll in the MHL health plan's network.

The MHL health plan may enter into an agreement for non-agency personal care providers when a permissible exclusion is identified through a background check. The MHL health plan may allow for this exclusion if the enrollee is informed of the details of the permissible exclusion and agrees, in writing, to allowing the person to provide personal care to the enrollee during the continuity of care period. During this time period, the enrollee can seek alternatives to receiving personal care services if the MHL health plan does not continue the agreement beyond the required continuity of care period.

Under no circumstance must the MHL health plan enter into an agreement if it is discovered the personal care provider falls under the policy for mandatory exclusion from providing personal care services.

9. Time Periods for Continuity of Care Protections

These time periods are the minimum required and the MHL health plan has the option to extend these periods at its discretion.

Physicians, Practitioners, Home Health and Personal Care Providers

For people receiving services from the PIHP Specialty Services and Supports Program or Habilitation Supports Waiver, the MHL health plan must maintain current providers and level of services at the time of enrollment for 180 days.

For all other enrollees, the MHL health plan must maintain current providers and level of services at the time of enrollment for 90 days.

Scheduled Surgeries

The MHL health plan must honor surgeries and the associated providers that were authorized within 180 days prior to enrollment.

Dialysis

The MHL health plan must maintain the current level of service and same provider at the time of enrollment for 180 days.

Chemotherapy and Radiation

Treatment initiated prior to enrollment must be authorized by the MHL health plan through the course of treatment with the specified provider. Course of treatment is defined as a prescribed regimen to be followed for a specific period of time based on current treatment standards.

Organ, Bone Marrow, and Hematopoietic Stem Cell Transplant

The MHL health plan must honor the specified provider, prior authorizations, and plans of care.

Durable Medical Equipment

The MHL health plan must honor prior authorizations when the item has not been delivered and must review ongoing prior authorizations for medical necessity.

Dental and Vision

The MHL health plan must honor prior authorization when an item has not been delivered.

MI Choice Home and Community Based Services (HCBS) Waiver services

For enrollees previously participating in the MI Choice HCBS waiver, the MHL health plan must maintain the providers and level of services at the time of enrollment until the enrollee is reassessed. Through the waiver slot approval process, MDHHS will confirm that the residential and non-residential settings are in compliance with the HCBS Final Rule. Continuity of care protections are applicable only to the MI Choice services which are also covered by the MHL HCBS waiver.

Nursing Facilities

Enrollees residing in an out-of-network nursing facility at the time of enrollment into the MHL health plan will not have to move from the facility. An enrollee has the right to live in an out-of-network nursing home for the life of the MHL program if the enrollee:

- Resides in the nursing home at the time of enrollment in MI Health Link, or
- Resides in a bed not certified for both Medicare and Medicaid (applicable to both in network and out of network providers) at the time of enrollment in MI Health Link, or
- Requires nursing home care and has a family member or spouse that resides in an out of network nursing home, or
- Requires nursing home care and resides in a retirement community that includes a nursing home which is not in the health plan's network.

This continuity of care protection is available as long as the enrollee resides in the nursing facility. Continuity of care in a nursing facility is automatic. The enrollee does not have to make a request for continuity of care.

The MHL health plan must enter into a single-case agreement with the nursing facility and reimburse the nursing facility as an in-network provider. Single-case agreements are effective as long as the resident requires nursing facility home.

Prescriptions

The MHL health plan must cover at least a temporary 30-day supply of the drug for at least 90 days if:

- The enrollee is taking a drug that is not on the MHL health plan's drug list, or
- The MHL health plan's rules do not cover the amount ordered by the prescriber, or
- The drug requires prior approval by the MHL health plan, or
- The enrollee is taking a drug that is part of a step therapy restriction

The enrollee can ask the MHL health plan to make an exception to cover a drug that is not on the drug list.

Prescriptions in a Nursing Facility

The MHL health plan must refill prescriptions for enrollees in a nursing facility for a minimum of 91 days and the MHL health plan must refill the drug multiple times during the first 90 days of enrollment, as needed. This gives the prescriber time to change the drugs to ones on the drug list or ask for an exception.