CareSource

ADMINISTRATIVE POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Continuity of Care-NV MP-AD-1536	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 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
- **Active Course of Treatment** includes ongoing treatment for the following:
  - a life-threatening condition (ie, a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted)
  - a serious acute condition (ie, a disease or condition requiring complex ongoing care which the member is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits)
  - second or third trimester of pregnancy through the postpartum period
  - a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated 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 from the provider or facility; (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; (4) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (5) is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.
- **Covered Services** – Health care services that are (1) covered by a specific benefit provision; (2) not excluded; and (3) determined to be medically necessary per medical policies and nationally recognized guidelines that are all the following:
  - provided for the purpose of preventing, diagnosing, or treating a sickness, injury, behavioral health disorder, substance use disorder, or symptoms
  - consistent with nationally recognized scientific evidence and prevailing medical standards and clinical guidelines
  - not provided for the convenience of members, providers, or any other person
- **Serious and Complex Condition** – In the case of (1) an acute illness, a condition 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 life expectancy that is 6 months or less.
- **Terminated** – With respect to a contract, the expiration or nonrenewal of a contract excluding termination due to failure to meet applicable quality standards or fraud.

D. Policy
   I. A review of medical necessity is required for COC. CareSource will review requests submitted by members or on behalf of members in the following circumstances:
      A. Newly enrolled, CareSource members who may qualify for COC coverage:
         1. The member chooses to receive care from a non-network provider. If the provider acting as the primary care provider (PCP) as allowed by applicable state law is not in the CareSource network, coverage will be extended as follows:
            a. eligibility up to 90 calendar days after the coverage effective date, if
               01. the PCP does not participate in another plan for which a member is eligible through the Marketplace
               02. the provider is providing an active course of treatment or is the member's PCP
               03. the provider is delivering continuing care, ending after 90 days or the date on which the member is no longer a continuing care patient, whichever is earliest
            b. pregnant at enrollment and through the postpartum period
            c. until death if diagnosed with a terminal illness
         2. The member is or will be receiving services for which a PA was received from another plan or payer.
      B. Terminations of contractual relationships between CareSource and providers and/or facilities will result in changes to provider network status. Termination must have occurred for reasons other than fraud or quality of care issues (ie, for cause). Reimbursement will be provided if the provider agrees to provide treatment under the terms of the terminated contract, including the rates of payment that existed prior to termination, and not seek payment from the member for any service. Requests will be reviewed when **any** of the following occurs:
         1. The member is receiving an active course of treatment from a PCP or provider seen on a regular basis. Continuing coverage will be granted for up to 120 days from the date of the contract termination.
         2. The member is pregnant. Continuing care may occur through the 90th day after the date of delivery or the date of the end of the pregnancy if the pregnancy does not end in delivery.
         3. The member has a terminal illness. Continuing care may occur until the member no longer needs healthcare services.

II. Once CareSource is notified that a provider or facility is leaving the network or there is a change in the provider's facility affiliation, CareSource will make a good faith effort to notify members who are seen on a regular basis by the provider or receive primary care from the provider in writing within 30 days prior to the effective date of the change or otherwise as soon as possible. Continuing care members will also be provided an opportunity to notify CareSource of the need for transitional care.

III. Health care services rendered by a provider disenrolled from the network or a non-network provider as described in this policy will only be covered when the health care services would otherwise be covered services if provided by a network provider, and the provider agrees to comply with the following:
   A. accept payment at the rates CareSource pays network providers of the same specialty or sub-specialty
   B. accept such payment as payment in full and not charge the member any more than the member would have paid if the provider was a network provider
   C. comply with CareSource's quality assurance standards
   D. provide CareSource with necessary medical information related to the care provided
   E. comply with policies and procedures, including, but not limited to, procedures regarding referrals, obtaining prior authorization, and providing covered services pursuant to a treatment approved by CareSource

E. Conditions of Coverage

Prior authorization is required for COC coverage.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	05/21/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. Continuity of Care, 42 U.S.C. §300gg–113 (2023).
2. Coverage for Continued Medical Treatment Required in Certain Policies; Exceptions; Regulations. NEV. REV. STAT. 689A.04036 (2003).
3. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
4. *Nevada Evidence of Coverage*. CareSource; 2026. Accessed May 12, 2025. www.caresource.com
5. Network Adequacy Standards. 45 C.F.R § 156.230 (2021).

6. Required Provision in Certain Plans Concerning Coverage for Continued Medical Treatment; Exceptions; Regulations. NEV. REV. STAT. 695C.1691 (2003).
7. *The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements*. Centers for Medicare and Medicaid Services; 2021. Accessed August 8, 2024. www.cms.gov