



ADMINISTRATIVE POLICY STATEMENT

Nevada Medicaid

Policy Name & Number	Date Effective
Continuity of Care-NV MCD-AD-1556	10/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Continuity of Care

B. Background

Continuity of care (COC) ensures that treatment remains consistent, unified and tailored to a member's needs by bridging coverage during provider and/or member transitions. New members can receive care from out-of-network providers if an established relationship or prior authorization exists. Existing members may use COC if a provider or hospital ends an agreement with CareSource. These measures promote safe and effective care during transitions.

CareSource's care management program supports COC through comprehensive, collaborative coordination including Level 1 care coordination and Level 2 case management per federal regulations. It involves partnerships with providers, member and family outreach, and addresses complex health needs, including co-morbidities and behavioral health. Member privacy is protected under Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards. CareSource complies with Nevada laws and Dept of Health Care Financing and Policy (DHCFP) guidance, with DHCFP information taking precedence over this policy.

C. Definitions

- **Health Insurance Exchange (HIX)** – A market where individuals, families, and small businesses can learn about health coverage options, compare plans based on cost, benefits, and other important factors, and choose and enroll in coverage. Nevada Health Link is the State-designated HIX.
- **Managed Care Organization (MCO)** – An organization administering health care delivery that influences utilization and cost of health care services, measures performance, and provides members with services through contracted providers.
- **Network** – A group of doctors, health care professionals, hospitals, and facilities with which CareSource has written agreements to provide medical care to members.
- **Nevada Check Up (NCU)** – Children's Health Insurance Program provided under Title XXI of the Social Security Act to families with incomes that exceed Medicaid eligibility limits but are equal to or less than 205% of the federal poverty level.
- **Participating Provider** – A provider with a contractual agreement with CareSource and included in the CareSource provider network.
- **Primary Care Provider (PCP)** – The participating physician, other licensed practitioner (eg, physician assistant, nurse practitioner, certified nurse midwife), group practice, health center, clinic, or other individual or entity selected by or assigned to the member to provide and coordinate all health care needs and to initiate and monitor referrals for specialized services, when required.
- **Seriously Emotionally Disturbed (SED)** – Persons under 18 diagnosed within the preceding 12 months with a disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorder (DSM)*, as adopted by NAC 433.050, other than a mental disorder designated as a Code V disorder, a developmental disorder or a disorder caused by an alcohol or other substance use disorder (SUD), which substantially interferes with or limits the child from developing social, behavioral, cognitive,

- communicative or adaptive skills or activities relating to family, school or community. The term does not include disorders which are temporary or those that are an expected response to stressful events.
- **Serious Mental Illness (SMI)** – Persons 18 or older diagnosed within the preceding 12 months with a *DSM*-defined disorder, adopted in NAC 433.050, other than an addictive disorder, mental retardation, irreversible dementia or a disorder caused by an abuse of alcohol or drugs, which interferes with/ 1 or more major life activities.
 - **Terminal Illness** – An illness with a life expectancy of 6 months or less if the illness runs a normal course.

D. Policy

I. General Guidelines

- A. CareSource will be responsible for members at the point of enrollment and ensure smooth transitions for the following members currently served via Fee for Service (FFS) or another contractor (not an all-inclusive list):
 1. members with medical conditions, such as
 - a. pregnancy, especially if high risk
 - b. major organ or tissue transplantation services in process
 - c. terminal illness
 - d. intractable pain
 - e. behavioral or mental health conditions
 2. members receiving, at the time of enrollment
 - a. chemotherapy and/or radiation therapy
 - b. significant outpatient treatment or dialysis
 - c. prescription medications or durable medical equipment (DME)
 - d. behavioral health (BH) services
 - e. mental health or SUD treatment as ordered by a Court under the jurisdiction of the State of Nevada
 - f. Long-Term Services and Supports (LTSS), including but not limited to personal care services and/or home health services
 - g. other services not included in the Medicaid or NCU State Plan but covered by Medicaid under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for children and as otherwise described under 42 C.F.R. 438.210
 3. members who, at enrollment are or have
 - a. scheduled for inpatient surgery(-ies)
 - b. currently in the hospital
 - c. prior authorization (PA) for procedures and/or therapies for dates after the enrollment date
 - d. post-surgical follow-up visits scheduled after the enrollment date
 - e. released from a correctional facility under the jurisdiction of the State of Nevada within the prior 6 months
- B. CareSource network providers are the only entities with authority to make SED or SMI determinations for CareSource members. Other determinations will be rejected. Determinations made by

1. authorized entities referenced in the *Medicaid Services Manual (MSM)* will be considered valid for members transitioning from FFS to managed care
 2. CareSource network providers will be considered valid for members who transition from managed care to FFS
 3. appropriately licensed mental health practitioners within the 12-month period preceding initial Medicaid or NCU eligibility will be considered valid for either FFS recipients or members
- C. Prior to transferring a member, CareSource will send the receiving payer or provider(s) information regarding health conditions within 5 calendar days (CDs) of learning of transfer, or sooner, as medical needs dictate. Information will include the name of the assigned PCP, and information indicating, without limitation, whether the member is
1. hospitalized
 2. pregnant
 3. receiving dialysis
 4. chronically ill and/or diagnosed with (not an all-inclusive list)
 - a. congestive heart failure
 - b. coronary arterial disease
 - c. hypertension, excluding mild hypertension
 - d. hemophilia
 - e. diabetes
 - f. chronic obstructive pulmonary disease
 - g. asthma
 - h. high-risk or high-cost SUD, including opioid use disorders
 - i. co-morbid (physical health and behavioral health) conditions
 - j. SED and SMI status
 - k. children, youth or adults with special health care needs
 - l. members needing LTSS
 - m. high-risk pregnancy, including pregnant members with a mental health diagnosis, SUD, or a history of a mental health diagnosis or SUD
 - n. severe cognitive and/or developmental limitation
 - o. Human Immunodeficiency Virus (HIV)
 - p. complex conditions, including, but not limited to, cystic fibrosis, cerebral palsy, sickle cell anemia
 - q. justice-involved populations not enrolled in targeted case management
 - r. members in supportive housing
 5. homeless/transient status
 6. receiving outpatient treatment and/or awaiting prior authorization for evaluation or treatment
 7. receiving behavioral or mental health services
 8. receiving Nevada Early Intervention Services in accordance with an Individualized Family Service Plan
 9. involved in or pending authorization for major organ or tissue transplantation
 10. scheduled for surgery or post-surgical follow-up on a date subsequent to transition

11. scheduled for prior authorized procedures and/or therapies on a date subsequent to transition
 12. receiving SUD treatment
 13. receiving prescription medications
 14. receiving DME or currently using rental equipment
 15. receiving case management (referral must include the case manager's name and phone number)
 16. receiving LTSS, such as, but not limited to, personal care services and/or home health services
- D. CareSource will coordinate with residential behavioral health providers, including any outside CareSource's geographic service area(s), for members receiving both Medicaid/NCU-funded and non-Medicaid/NCU-funded residential addiction and mental health services. CareSource will actively participate in discharge planning and ensure COC upon discharge.
- II. Continuity of Care Requirements
- A. CareSource will review all COC requests received from members, providers or on behalf of members on an individual basis. For members transitioning from another Medicaid, NCU provider or FFS and meeting populations in D.I.A., CareSource will comply with the following for no less than 90 CDs from the enrollment date and reimburse providers at a minimum of the Medicaid or NCU FFS rate. Members will maintain access to
1. any covered services and prescription drugs received prior to enrollment without additional PA or other utilization management restrictions
 2. any providers delivering member services, regardless of network status
- B. Transitions of Hospitalized Members
- The notification process will occur as soon as the transition is known to CareSource and in accordance with any State contracts. When a member transfers to another payer or FFS while hospitalized, CareSource will notify
1. the receiving payer, if the member changes payers
 2. the receiving provider(s) providing direct care, if changing payers or transitioning to FFS
 3. the State's Quality Improvement Organization (QIO)-like vendor, if the member is transitioning to FFS
- C. Transitions between CareSource and HIX or the Insurance Product
- A member may change Medicaid or NCU eligibility status during a care episode and become eligible for HIX coverage or other nonexchange coverage (eg, individual, employer-based, Medicare coverage). Other payers will be notified of relevant member information in compliance with HIPAA and other privacy laws.
- D. Transitions for Children with an SED Determination between CareSource and Medicaid/NCU Specialty Managed Care Plans
- The State may/can carve out coverage for children with an SED determination and implement a specialty managed care plan. For any eligible, CareSource will
1. follow the requirements for transitioning members to another payer
 2. have a procedure in place to notify the State of any potentially eligible

3. facilitate transitions for any transitioning back from the State's specialty plan to CareSource
- E. Transitions of Child Welfare-Involved Children from FFS to CareSource for children receiving Medicaid or NCU benefits through FFS while in the custody of the child welfare system (eg, foster care, juvenile justice) becoming eligible for and enrolling with CareSource, the following COC requirements apply:
 1. For no less than 12 months from the enrollment date, the member will maintain access in accordance with requirements under EPSDT to the provider(s) and level of services received while in FFS.
 2. CareSource will reimburse the Division of Child and Family Services and county child welfare agencies no less than what providers are paid under the Medicaid or NCU State Plan, as applicable, regardless of network status.
 3. Any service provider(s) affiliated with or employed by the State or county child welfare systems treating the member prior to the transition will be offered a single case agreement or added to the CareSource network.

III. Provider Network Changes

CareSource will provide written notice of termination of a network provider by the later of 30 CDs prior to the effective termination date or 15 CDs after receipt of termination notice to each member receiving primary care from or seen on a regular basis by the terminated provider. If a provider contract was terminated due to medical incompetence or professional misconduct, the following COC requirements do not apply:

- A. If a CareSource member is receiving medical treatment for a medical condition from a provider whose contract is terminated during the course of the treatment, the member may continue medical treatment with the provider until the later of the 120th day after the date the contract is terminated if
 1. actively undergoing a medically necessary course of treatment
 2. agreeing with the provider that the COC is desirable
- B. If the above medical condition is pregnancy, the COC period will last until the 45th day after the date of delivery or, if the pregnancy does not end in delivery, the date of the end of the pregnancy.
- C. The provider will receive reimbursement for provided treatment if agreeing
 1. to provide medical treatment under the terms of the contract with CareSource that existed before the termination of the contract
 2. to not seek payment from the member for any medical service provided that the provider could not have received if still under contract with CareSource

E. Conditions of Coverage

When notified that a Member has been transferred to another payer or to FFS, the CareSource will transfer and/or receive relevant patient information, medical records, and other pertinent materials according to CareSource policies.

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	08/13/2025	New policy. Approved at Committee.
Date Revised	07/01/2026	Annual review. Removed D.II.A.2. Updated references. Approved at Committee.
Date Effective	10/01/2026	
Date Archived		

H. References

1. "Adult with a Serious Mental Illness" and "Child with a Serious Emotional Disturbance" Defined for Counting Purposes, NEV. ADMIN. CODE § 433.040 (1997).
2. *CareSource Provider Manual*. CareSource; 2026. Accessed June 25, 2026. www.caresource.com
3. Continued Services to Enrollees, 42 C.F.R. § 438.62 (2024).
4. *Contract for Services*. Nevada Dept of Health and Human and Services; 2025. Accessed June 25, 2026. www.dhcfp.nv.gov
5. Coverage and Authorization of Services, 42 C.F.R. § 438.210 (2024).
6. *Medicaid Services Manual*. Nevada Health Authority. Accessed June 25, 2026. <https://www.nevadamedicaid.nv.gov/>
7. Regulations, NEV. REV. STAT. § 433.324 (2019).
8. Required Provision in Certain Plans Concerning Coverage for Continued Medical Treatment; Exception; Regulation, NEV. REV. STAT. § 695G.164 (2003).