CareSource

ADMINISTRATIVE POLICY STATEMENT
Nevada Medicaid

Policy Name & Number	Date Effective
Continuity of Care-NV MCD-AD-1556	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 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. These interventions provided to transitioning members work to promote safety and efficacy.

CareSource maintains a care management program that promotes COC and takes a comprehensive and collaborative approach to coordinating care for members. Programs include, at a minimum, Level 1 care coordination and Level 2 case management pursuant to 42 C.F.R. § 438.62(b)(1)-(2) and 42 C.F.R. § 457.1216, involving partnerships (eg, primary care providers (PCPs), specialists, other providers), member and/or family outreach and education, and the ability to holistically address health care needs. Care coordination and case management also address, not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including behavioral health or related issues, such as lack of social or family support. CareSource ensures that, in the process of coordinating care, each member's privacy is protected with the confidentiality requirements in 45 C.F.R. Parts 160 and 164.

CareSource follows Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) and complies with guidance from the Division of Health Care Financing and Policy (DHCFP). Information published by DHCFP supersedes information in 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.
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** – Federal standards protecting health information from disclosure without patient consent.
- **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.:

1. 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
   a. any covered services and prescription drugs received prior to enrollment without additional PA or other utilization management restrictions
   b. any providers delivering member services, regardless of network status
2. Because a transition is required after the State of Nevada procures CareSource as a managed care program, CareSource will comply with the COC requirements in D.II.A. for a period of 6 months.

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 speciality 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 provider written notice of termination of a network provider by the later of 30 CDs prior to the termination effective 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		
Date Effective	01/01/2026	
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; 2025. Accessed July 16, 2025. 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 July 16, 2025. www.dhcfp.nv.gov
5. Coverage and Authorization of Services, 42 C.F.R. § 438.210 (2024).
6. *Medicaid Services Manual*. Nevada Division of Healthcare Financing and Policy. Updated March 26, 2025. Accessed July 16, 2025. www.dhcfp.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).