Office of Medicaid Policy and Planning Medicaid Managed Care Transfer of Care Policy

Updated: December 18, 2025

Policy Governance and Version Management

Title:	Office of Medicaid Policy and Planning Medicaid Managed Care Transfer of Care Policy
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Date Approved:	

Version	Posting Date	Summary of Changes
Draft	12/18/2025	Initial Draft

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Background

The Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) is committed to providing continuity of care for members as they transition between various Indiana Health Coverage Programs (IHCP) programs. As Medicaid beneficiaries move between health plans, the OMPP intends to maintain continuity of care for each member and minimize the burden on providers during the transition.

An Indiana Medicaid beneficiary's transition between Medicaid health plans poses unique challenges to ensuring service continuity and effective coordination between responsible entities. Transition of Care (TOC) activities applicable to the IHCP Medicaid Managed Care programs are governed by both regulatory and statutory requirements. The OMPP established its TOC requirements for Medicaid Managed Care Entities (MCEs) in its IHCP programs.

Scope

While other entities may work under comparable requirements, the scope of this Policy is limited to Transition of Care requirements for Indiana IHCP Medicaid MCEs. Accordingly, Medicaid beneficiaries are referred to as "members".

Nothing in this Policy shall be construed as an effort to limit, amend, or reduce requirements established in the MCE contracts. Any conflict between this policy and a MCE contract shall be determined in favor of the contract.

Although the MCE has the authority to delegate activities under this Policy, the MCE remains responsible for oversight to ensure delegated entities meet transition of care requirements.

Critical continuity-of-care periods include, but are not limited to:

- Transitions for members receiving human immunodeficiency virus (HIV), Hepatitis C and/or behavioral health services, especially for those members who have received prior authorization (PA) from their previous MCE or through the fee-for-service (FFS) Prior Authorization contractor
- Transitions for members who are pregnant
- A member's transition into an IHCP program from no coverage, commercial coverage, Traditional Medicaid (FFS) or another managed care program
- A member's transition between MCEs, particularly during an inpatient stay or skilled nursing facility (SNF) stay
- A member's transition between IHCP programs
- A member exiting the IHCP program to receive excluded services
- A member's transition following a medically frail determination
- A member's transition to a new primary medical provider (PMP)
- A member's transition to private insurance or Marketplace coverage
- A member's transition to no coverage
- A member's transition between Healthy Indiana Plan (HIP) benefit plans (i.e. HIP Plus, HIP Basic, and HIP State Plan)

These continuity-of-care periods do not apply to SNFs. If the member chooses to stay in the SNF, the MCE will continue to provide care for the duration of the program. This applies only for members who continue to meet SNF level of care (LOC).

The MCE shall provide continuity of care for the authorization of services as well as choice of providers for ninety (90) calendar days. For a member who meets Home- and Community-Based Services (HCBS) LOC and has an existing care plan approved by the FSSA or another MCE, that care plan will be honored for ninety (90) calendar days from the date of enrollment.

When receiving members from another MCE, FFS or commercial coverage, the MCE will honor the previous care authorizations for one of the following durations, whichever comes first:

- Ninety (90) calendar days from the member's date of enrollment with the MCE
- The remainder of the prior authorized dates or service
- Until the approved units of service are exhausted
- If the MCE has identified outstanding PA decisions at the time of the member's enrollment in a plan to transition to a state-approved service

The date of member enrollment, for purposes of the PA, begins on the date the MCE receives the member's fully eligible file from the state. The MCE must establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment into their plan.

When members enroll in or change MCEs, active authorizations for services or procedures that were not completed in former plan will be the responsibility of new MCE. The prior authorizations may be for specific procedures, such as surgery, or for ongoing procedures authorized for specified durations. Requiring duplicate authorizations from the new health plan places an additional burden on the provider and can delay or inappropriately deny member's treatments or services.

Additionally, when a member transitions to another source of coverage, the MCE shall be responsible for efficiently providing the receiving entity with information on any current service authorizations, utilization data, and other applicable clinical information, such as prevention and wellness programs and case management or care management notes. The MCE Transition Coordinator shall oversee this process. It is the MCE's responsibility to have an adequate number of MCE Transition Coordinator(s) on staff.

Policy Statement

General Transition of Care Requirements

1. The MCE shall develop policies, processes, and procedures to support members transitioning between MCEs or between IHCP programs.
2. The MCE shall identify enrolling or disenrolling members, who are transitioning from or to another MCE or FFS.
3. For all Members transitioning from the MCE, the MCE shall transfer the information necessary to ensure continuity of care, including appropriate TOC data files and member-specific, socio-clinical information.
    a. The MCE shall facilitate the transfer of member's claims/encounter history and Prior Authorization (PA) data between MCEs in accordance with related contract and privacy and security requirements. Transferred member-specific, socio-clinical information is also referred to as the member's transition file. A member's transition file content may vary based on the member's circumstance but shall, at a minimum, include:
        i. The transitioning member's most recent assessments or health needs screening.

ii. The transitioning member's most recent care plan (for transitioning care-managed members and members disenrolling from the MCE, if available).
iii. A list of any open adverse benefit determination notices for which the appeal timeframe has not yet expired and the status of open appeals.
iv. A TOC File Layout/automated process for each member transitioning should be provided to the new MCE. The TOC File should include member information and medical authorizations. This TOC File Layout includes minimally:
    1. File Date
    2. Sending MCE
    3. Program
    4. Member Medicaid ID and demographic information
    5. RCP, NFLOC, Hospice, and Medicare indicators
    6. Current PMP and contact information
    7. Care coordination level and type
    8. Care coordination goals
    9. Care notes and care plan summary
    10. List of providers
    11. List of current authorized services
    12. List of procedure codes
    13. Duration and frequency of authorized services
v. A list of existing or prescheduled appointments, including Non-Emergency Medical Transportation (NEMT), as known.
vi. Any urgent or special considerations about a member's living situation, caregiving supports, communication preferences or other member- specific dynamics that impact the member's care and may not be readily identified in other transferred documents.
vii. For members identified as meeting the high-needs population criteria ('High Needs Members' in Complex Case Management) are those who shall have a warm handoff upon disenrollment from a MCE, when possible.
viii. Additional information as needed to ensure continuity of care.

4. Unless otherwise specified in this Policy or applicable protocols, the MCE shall adhere to the following timeframes related to transition data and transition file content transfer:
    a. The MCE shall transfer claims, prior authorization, and pharmacy data to the appropriate MCE or receiving entity, as directed by OMPP.
    b. The MCE shall initiate a warm handoff, if warranted, and transfer the member's transition of care file to the applicable MCE occurring no later than the member's transition date.
    c. If a MCE receives notice of a transitioning member's enrollment and has not received the applicable transition data file or the member's transition file within five business days of the transition notice date, the MCE will contact the applicable entity on the following business day to request the transition information as needed.
5. The MCE shall ensure any member entering the MCE is held harmless by providers for the costs of medically necessary covered services except for applicable cost sharing.
6. The MCE shall allow a member to complete an existing authorization period established by their previous MCE for a minimum of ninety (90) calendar days.
7. The MCE shall assist the member in transitioning to an in-network provider at the end of the authorization period if necessary.

8. The MCE shall permit the member to continue seeing their provider, regardless of the provider's network status for a minimum of ninety (90) calendar days.
9. The MCE shall allow pregnant members to continue to receive services from their health treatment provider, without any form of prior authorization, until the birth of the child, the end/loss of pregnancy or loss of eligibility.
10. The MCE will be responsible for care coordination after the member has disenrolled from the MCE whenever the member disenrollment occurs during an inpatient stay.
    a. When reimbursement for the stay is based on a diagnosis-related group (DRG) methodology, the admitting MCE is responsible for the entire inpatient stay through member discharge. The admitting MCE is financially responsible for the hospital DRG payment and any outlier payments (without a capitation payment) until the member is discharged from the hospital or the member's eligibility in Medicaid terminates. If the member is transitioning from the admitting MCE to another MCE, the admitting MCE must coordinate discharge plans with the member's new MCE.
    b. In instances when reimbursement for the inpatient stay is based on a LOC methodology, the admitting MCE is responsible for the days of the inpatient stay during which the member is enrolled with the MCE and for the transition of care coordination for the remainder of the stay. The admitting MCE is financially responsible for the per diem payments and any outlier payments (without capitation payment) associated with the days the member remains enrolled with the admitting MCE. If the member is transitioning from the admitting MCE to another MCE or from the admitting MCE to Traditional Medicaid, the receiving MCE or the Traditional Medicaid program is responsible for the per diem payments associated with the days the member is enrolled with the receiving MCE or in Traditional Medicaid, until the member is discharged from the hospital or the member's eligibility for Medicaid terminates. The admitting MCE is responsible for the transition of care coordination with the receiving MCE or with the inpatient provider, as applicable.

MCE Transition of Care Policy Content Requirements

The MCE shall establish a written MCE TOC Policy which shall include, at a minimum, the requirements in 42 CFR § 438.62(b)(1), 42 CFR. § 438.208(b)(2)(ii) and processes and procedures for:

1. Coordination of care for members who have an Ongoing Special Condition.
2. Coordination of member transition from FFS into the MCE.
3. Coordination of member transition from the MCE to another MCE
4. Coordinate services delivered under other sources of coverage including IHCP.
5. Notify the OMPP of members who have had two or more visits to the emergency department for a psychiatric problem or two or more episodes using behavioral health crisis services within the prior 18 months.
6. Educate members in a manner appropriate to member's specific circumstance and capacity on the rights provided under this Policy and the processes for maintaining services during transitions of care.
7. Educate a transitioning member's current provider network on changes to the provider enrollment and reimbursement processes.
8. Coordinate a timely warm handoff if deemed necessary for effective knowledge transfer or to ensure member continuity of care.
9. Promote proactive communication with the receiving entity prior to transition to coordinate the transfer of care.

10. Establish a follow-up protocol to communicate with the receiving entity after the member's transition to confirm receipt of the transferred information and to troubleshoot dynamics that may have resulted from the transition.
11. Other requirements as outlines in this Policy.

Transition of Care Requirements with Change of Providers

1. The MCE shall develop policies, processes, and procedures to support members transitioning between providers when a provider is terminated from the MCE's network.
2. Instances in which a provider leaves the MCE's network for expiration or non-renewal of the contract and the member is in an Ongoing Course of Treatment or has an Ongoing Special Condition, the MCE shall permit the member to continue seeing their provider, regardless of the provider's network status.
3. In instances in which a provider leaves the MCE's network for reasons related to quality of care or program integrity, the MCE shall notify the member and assist the member in transitioning to an appropriate in-network provider that can meet the member's needs.

Definitions and Clarifications of Identified Terms

Managed Care Entity - MCEs are Medicaid managed care entities/health insurance company contracted by the state to manage healthcare. MCEs manage provider networks, authorizations, and payments for services, ensuring coordinated care through a chosen primary doctor.

Receiving Entity - The entity that is enrolling the transitioning member and receiving the member's information.

Transferring Entity - The entity that is disenrolling the transitioning member and transferring the member's information.

Transition of Care - The process of assisting a member to transition between MCEs or between payment delivery systems including transitions that result in the disenrollment from managed care. Transitions of care also include the process of assisting a member to transition between providers upon a provider's termination from the MCE network.

Transition of Care - The process of assisting a member to transition between MCEs or between payment delivery systems including transitions that result in the disenrollment from managed care. Transitions of care also include the process of assisting a member to transition between providers upon a provider's termination from the MCE network.

Warm Handoff - Time-sensitive, member-specific planning for members identified by either the transferring or receiving entity but minimally include: 1) transitioning care-managed members for whom the MCE deems a warm handoff necessary to ensure continuity of care; 2) Members disenrolling due to Medicare eligibility, foster care eligibility, facility admission that results in disenrollment and members disenrolling due to losing eligibility. Warm handoffs require collaborative transition planning between both transferring and receiving entities and if possible, occur prior to the transition.

Compliance and Monitoring

The OMPP shall monitor MCE Transition of Care activity through MCE reporting, desk reviews, and audits and through additional methods as determined by the agency.

Relevant Regulatory and Legislation Citations

42 CFR § 438.10
42 CFR § 438.56
42 CFR § 438.62
42 CFR § 438.208
42 CFR § 438.214
42 CFR § 438.602

Title 405 of the Indiana Administrative Code

Healthy Indiana Plan Scope of Work

- 3.4.8 Pharmacy Continuity of Care
- 3.7.5 Behavioral Health Continuity of Care
- 3.13 Continuity of Care

Hoosier Healthwise Scope of Work

- 3.4.8 Pharmacy Continuity of Care
- 3.7.5 Behavioral Health Continuity of Care
- 3.13 Continuity of Care

Hoosier Care Connect Scope of Work

- 3.8.8 Pharmacy Continuity of Care
- 3.10.3 Behavioral Health Continuity of Care
- 3.15 Continuity of Care

Indiana PathWays for Aging Scope of Work

- 3.6.5 Behavioral Health Continuity of Care
- 3.22 Continuity of Care