



ADMINISTRATIVE POLICY STATEMENT

Indiana Medicaid

Policy Name & Number	Date Effective
Continuity of Care-IN MCD-AD-1637	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 Policy Statements may be superseded by federal and state laws and regulations, as applicable.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.

Table of Contents

A. Subject	2
B. Background	2
C. Definitions	2
D. Policy	2
E. Conditions of Coverage	3
F. Related Policies/Rules	3
G. Review/Revision History	3
H. References	3

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 receive services from an out-of-network provider when an established relationship exists with a provider or if approved prior authorizations (PA) are 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 for transitioning members.

C. Definitions

- **In-Network (Network) Provider** – Any provider, group of providers, or entity that has a network provider agreement with CareSource or a subcontractor and receives Medicaid funding directly or indirectly to order, refer or render covered services.
- **Level-of-Care (LOC)** – The outcome of the measure of an individual's care needs, including nursing home or institutional placement needs.
- **Out-of-Network Provider** – Any provider, group of providers or entity not directly or indirectly employed by or does not have a provider agreement with CareSource or its subcontractors.
- **Transition of Care** – A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.

D. Policy

- I. Requests will be accepted from a member, a member's representative, or a provider on behalf of a member. CareSource follows Indiana Health Coverage Programs (IHCP) requirements to facilitate the exchange of member-specific data and ensure facilitation of care among all stages to enrollment or termination completion.
- II. All transitions of care between healthcare settings are handled according to IHCP requirements, including care coordination guidance, discharge planning and follow-up with providers/members, particularly regarding follow-up after inpatient discharge.
- III. CareSource will provide COC for authorization of services, as well as choice of provider, for 90 days.
 1. For members meeting Home- and Community-Based Services (HCBS) LOC and with an existing care plan approved by the Indiana Family and Social Services Administration (FSSA) or another managed care entity (MCE), that care plan will be honored for 90 days from the date of enrollment.

2. When receiving members from another MCE, fee-for-service or commercial coverage, CareSource will honor previous authorizations for 1 of the following durations, whichever comes first:
 - a. 90 calendar days from the member's date of enrollment with the MCE
 - b. the remainder of the prior authorized dates or service
 - c. until the approved units of service are exhausted
 - d. when CareSource has identified outstanding PA decisions at the time of the member's enrollment in a plan to transition to a state-approved service
- E. Conditions of Coverage
NA
- F. Related Policies/Rules
NA
- G. Review/Revision History

DATE		ACTION
Date Issued	04/22/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	10/01/2026	
Date Archived		

- H. References
1. Continuation of Care Provisions, IND. CODE § 27-13-36-6 (2018).
 2. Continuity of Care and Referrals when Specialty Care Warranted, IND. CODE § 27-13-37-3 (2024).
 3. *Guidance Provided Regarding Continuity of Care for Members Transitioning between IHCP Programs*. Indiana Health Coverage Programs. BT202496. Accessed April 2, 2026. www.in.gov
 4. *Healthy Indiana Plan Policies and Procedures Manual*. Indiana Health Coverage Programs. Accessed April 2, 2026. www.in.gov
 5. *IHCP Aligns Fee-for-Service Continuity of Care with Managed Care*. Indiana Health Coverage Programs. BT202434. Accessed April 2, 2026. www.in.gov
 6. Managed Care, 42 C.F.R. §§ 438 (2024).
 7. Problems with Continuity of Care, Reporting, IND. CODE § 12-24-12-4 (2024).
 8. Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-Stabilization Care Services, 42 C.F.R. § 422.113 (2024).
 9. Standards for Continuity of Care, IND. CODE § 27-13-36-11 (2024).
 10. State Plans for Medical Assistance, 42. U.S.C. § 1396a(e)(5) (2024).