



Subject: Clinical Practice	Procedure: Provider to Provider Transfers	
Last Updated: 6/12/2026	Owner: Managed Care Operations (MCO)	Pages: 3

I. PURPOSE:

To define and describe operational guidelines for directly operated and contract providers when a person served transfers between providers.

II. DEFINITIONS:

None.

III. PROCEDURE:

- A. When a person served requests a transfer of care to a new provider under the same level of care, the primary case holder will assist the person with a transfer.
 - 1. When a person served notifies their primary case holder of their desire to change providers, the primary case holder explores the reason(s) for the requested change and attempts to resolve any identified issues.
 - 2. If the identified issues cannot be resolved, the primary case holder assists the person served in selecting a new provider.
- B. The primary case holder assists the person served in coordinating with the new provider.
 - 1. An ongoing services appointment is scheduled with the new provider.
 - 2. The primary case holder communicates with the new provider, as needed, for optimal continuity of care.
 - 3. The original provider opens a program admission to the new provider in the FOCUS Electronic Medical Record (EMR).
 - 4. If the person served does not attend the scheduled appointment with the new provider:
 - a. Both providers will make two outreach attempts to reschedule the appointment and proceed with the transition to the new provider.
 - b. If these engagement attempts are unsuccessful, the person served remains open to the original provider, and the new provider is no longer involved.

5. The original provider's prescriber will provide a minimum of thirty (30) days, and whenever possible, will provide sixty (60) days of medications or prescriptions to the person served.
6. Once the person has attended their first appointment with the new provider:
 - a. The original provider closes their program admission and makes the new provider the primary within the admission layer.
 - b. The original provider early terminates their agency's authorizations in the FOCUS EMR.
 - c. The person served is now open to the new provider, who is responsible for coordinating all services and treatment needs. The original provider is no longer responsible for any care coordination.
7. The new provider requests authorizations for their agency in the FOCUS EMR.
8. Admission layers and authorizations for ancillary providers will not be impacted.
- C. When a person served contacts a new primary clinical provider to initiate services and it is determined that they are already open for services to another primary provider through MCCMH, then:
 1. The new provider assists the person in scheduling an appointment with their agency.
 2. The new provider contacts the original provider to notify them of the upcoming transfer.
 3. The two providers communicate for optimal continuity of care.
 4. The original provider opens a program admission to the new provider in the FOCUS Electronic Medical Record (EMR).
 5. If the person served does not attend the scheduled appointment with the new provider:
 - a. Both providers will make two outreach attempts to reschedule the appointment and proceed with the transition to the new provider.
 - b. If these engagement attempts are unsuccessful, the person served remains open to the original provider, and the new provider is no longer involved in the person served's treatment.
 6. The original provider's prescriber will provide a minimum of thirty (30) days, and whenever possible, will provide sixty (60) days of medications or prescriptions to the person served.

7. Once the person has attended their first appointment with the new provider:
 - a. The original provider closes their program admission and makes the new provider the primary within the admission layer.
 - b. The original provider early terminates their agency's authorizations in the FOCUS EMR.
 - c. The person served is now open to the new provider, who is responsible for coordinating all services and treatment needs. The original provider is no longer responsible for any care coordination.
8. The new provider requests authorizations for their agency in the FOCUS EMR.
9. Admission layers and authorizations for ancillary providers will not be impacted.

IV. REFERENCES:

None.

V. RELATED POLICIES

- A. MCCMH MCO Policy 2-010, "Standards for Clinical Service Documentation"
 1. Exhibit: "MCCMH Outreach Procedure"
- B. MCCMH MCO Policy 4-020, "Medicaid and Non-Medicaid Notice of Adverse Benefit Determination"
- C. MCCMH MCO Policy 12-001, "Access, Eligibility, Admission, Discharge"

VI. EXHIBITS:

None

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	11/02/2021	Creation of Procedure	MCCMH MCO Division
2	1/07/2022	Implementation of Procedure	MCCMH MCO Division
3	3/27/2025	Update to Procedure	MCCMH MCO Division
4	6/12/2026	Update to Procedure	MCCMH MCO Division