MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Population Health**		
Title:	**Care Management & Transition of Care Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 5	**Review Cycle:** **Author:** Chief Population Health Officer	**Adopted Date: 09.09.2025** **Review Date:**	**Related Policies:** **Behavioral Health Service Philosophy & Treatment Policy**

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

Mid-State Health Network (MSHN) and its provider network adhere to all practice guidelines established by the Michigan Department of Health and Human Services (MDHHS). In accordance with MDHHS, "Medicaid services must be provided without delay to any Medicaid enrollee of a Prepaid Inpatient Health Plan (PIHP) for any and all reasons other than ineligibility for Medicaid [42 CFR 438.62(a)]." Care Management and Transition of Care processes aim to improve the quality of care, enhance outcomes, and control costs with entities working together to develop plans for beneficiaries that eliminate service barriers. A solid foundation for an effective transition of care plan includes open and timely communication of information between the Transferring Entity and the Receiving Entity. A transition of care plan must be developed between providers when a beneficiary is transitioning from one care setting to another.

The MSHN Care Management & Transition of Care Policy ensures continued access to services during a transition from fee-for-service (FFS) to a Managed Care Organization (MCO), PIHP, Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), or PCCM entity or transition from one MCO, PIHP, PAHP, PCCM, or PCCM entity to another when an beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Policy

1. MSHN and its provider network will coordinate services and transitions of care with other behavioral and physical health care providers. Providers will work collaboratively to improve functioning and promote recovery and resiliency.
    i. MSHN and its provider network will implement practices to encourage all beneficiaries eligible for mental health, substance use, and/or co-occurring services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the beneficiary's Medicaid Health Plan.
    ii. MSHN and its provider network will ensure that basic health care screening is performed on beneficiaries who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the beneficiary along with information about the need for intervention and how to obtain it.
2. A good faith effort must be made to ensure that a Transition of Care Plan is developed and put into place or that accurate information is available to support medical decisions by beneficiaries and providers, thoroughly documenting any denial of participation and the reason.
    i. The plan must be created with the beneficiary, family members and/or guardians, and other appropriate providers, with follow-up to communicate the transition of care plan to all involved.

ii. The coordination of a timely "warm handoff" for effective knowledge transfer and to ensure beneficiary continuity of care. The "warm handoff" also applies to minors, with clear coordination and explanations of changes that occur when a youth turns 18 and transitions to the adult mental health care system.

3. During a transition of care, beneficiaries will have access to services consistent with the services previously had and are permitted to retain their current provider for a minimum of 90 days if the beneficiary's current provider is not in the Receiving Entities network. The Receiving Entity must assist the beneficiary in referring and selecting an in-network provider. Ninety (90) days is the minimum timeframe required, and the PIHP has the option to extend the time period at its discretion [42 CFR 438.62(b)(1)(i)(ii)].
    i. The Transferring Entity previously serving a beneficiary must, within 14 calendar days, provide all requested historical utilization, data, medical records, and other documentation as appropriate to the beneficiary's newly Receiving Entity, or requests from MDHHS.
4. Consideration should be given to system-wide, cost-effective interventions and supports that produce the highest level of outcomes.
5. MSHN shall have written agreements with the Medicaid Health Plans in the service area.
6. Interagency agreements shall meet the requirements in 42 CFR Part 2.
7. Outcomes that represent improvements in significant aspects of clinical services and supports will be shared among health care providers to assist in identifying over and underutilization and patterns of service delivery.
8. Health information exchange shall be supported using technology to assure timely and accurate access to pertinent clinical information consistent with related rules and regulations for protected health information and confidentiality per 45 CFR 170.213.
    i. With the approval and/or at the direction of a current or former beneficiary or a beneficiary's personal representative, MSHN will:
        a. Receive all such data for a current beneficiary from any other payer that has provided coverage to the beneficiary within the preceding five (5) years.
        b. At any time, while the beneficiary is open for services with the PIHP and up to five (5) years after closure of services, send all such data to any other payer that covers the beneficiary or a payer that the beneficiary or the beneficiary's personal representative specifically requests receive the data; and
        c. Send data received from another payer in the electronic form and format it was received (42 CFR 438.62(b)(1)(vi)).
        d. With respect to any data protected by 42 CFR Part 2, attempts must be made in good faith and with due diligence to obtain appropriate consent from the beneficiary (or other individual legally authorized to consent under 42 CFR Part 2) to release the beneficiary's information for the purposes generally required within this technical requirement. If such consent is not obtained, data protected by 42 CFR Part 2 is not required to be shared when there is not another legally permissible basis for disclosure.
        e. MSHN will ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR part 160, subparts A and E and 45 CFR part 164, subparts A and E, to the extent that they are applicable.
    ii. As authorized by the beneficiary, MSHN provider network members will include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.

iii. Information sharing across the provider network will focus on essential aspects of the provision of health care and will assist with population health management as well as the coordination of individual care in accordance with requirements for confidentiality and protection of health information.
iv. Information received by the Receiving Entity must be incorporated into the records of the beneficiary.

9. Staff training on transition of care standards is the promotion of proactive communication by the Transferring Entity with the Receiving Entity prior to transition to coordinate the transfer of care.
    i. MSHN provider network members shall establish protocols to follow-up by communicating with the Receiving Entity within 14 calendar days after the beneficiary's transition to confirm receipt of transferred information and to talk through any challenges that may have occurred during the transition.
    ii. The Receiving Entity shall adherence to population-specific care management protocols to ensure continuity of care during the disenrollment and enrollment processes. This can include, but is not limited to, care management protocols surrounding movement of beneficiaries into and out of waiver services, of youth to adult services from children's services, transitions of children to and from Child Caring Institutions, transitions of children and/or adults to and from Foster Care, transitions of beneficiaries involved with the court system, transitions of beneficiaries from inpatient care to outpatient care, and transitions from incarceration to community. Special attention must be paid to medication continuity during movement and transitions of beneficiaries from one setting of care to another to reduce the frequency of medication disruption in all beneficiaries, but especially in youth and children. This is not an exhaustive list and should not be interpreted as the only population-specific care management protocols needed to ensure continuity of care during the disenrollment and enrollment processes.
    iii. The Receiving Entity shall ensure coordination with appropriate assessment entities (as applicable), to ensure no disruption in the beneficiary's services.
10. The Transferring Entity and the Receiving Entity will hold the beneficiary harmless for any costs associated with the transition of care between providers. (42 CFR 438.106, 42 CFR 438.206).
11. When necessary, written coordination agreements will be in place between entities.
12. Beneficiaries must be provided appropriate service without delay resulting from issues of financial responsibility. MSHN and/or Community Mental Health Service Programs (CMHSPs) will act ethically to provide services to beneficiaries when financial responsibility is disputed.
13. MSHN shall ensure that each beneficiary has an ongoing source of care appropriate to the beneficiary's needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary.
    i. The beneficiary must be provided information on how to contact their designated person and/or entity.
14. MSHN must coordinate the services the PIHP furnishes to the beneficiary:
    i. Between settings of care, including appropriate discharge planning between short-term and long-term hospital and institutional stays.
    ii. With the services the beneficiary receives from any other PIHP.
    iii. With the services the beneficiary receives in FFS Medicaid.
    iv. With the services the beneficiary receives from community and social support providers.
15. MSHN will make a best effort to conduct an initial screening of each beneficiary's needs, within 90 days of the effective date of enrollment for all new beneficiaries. MSHN will must make subsequent attempts to conduct an initial screening of each beneficiary's needs if the initial attempt to contact the beneficiary is unsuccessful. Since the PIHP is not an enrollment model, screening once an individual presents for services would meet this agreement.

16. MSHN will share with the State and/or other PIHPs results of any identification and assessment of the beneficiary's needs to prevent duplication of those activities.
17. MSHN will ensure that transition of care plans, processes, and procedures are in compliance with these requirements by performing regular (no less than annual) oversight and monitoring activities.

Applies to

☐ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☐ MSHN CMHSP Participants: ☒ Policy Only ☐ Policy and Procedure
☐ Other: Sub-contract Providers

Definitions

Beneficiary: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians.
CMHSP: Community Mental Health Service Programs
Continuity of Care: The quality of care over time, including both the enrollee's experience of a "continuous caring relationship" with an identified health care professional and the delivery of a "seamless service" through integration, coordination, and the sharing of information across different providers/care settings.
Care Coordination/Coordination of Care: The organization of an enrollee's care across multiple health care providers.
FFS: Fee-for-Service
Managed Care Entity: 42 CFR 438 recognizes a Prepaid Inpatient Health Plan (PIHP) as a managed care entity. A PIHP is responsible for management of specialty services related to mental health, developmental disability services, and certain Substance Use Disorder (SUD) services to Michigan residents enrolled in Medicaid
MCO: Managed Care Organization
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PAHP: Prepaid Ambulatory Health Plan
PCCM: Primary Care Case Management
PIHP: Prepaid Inpatient Health Plan
Receiving Entity: The PIHP that is opening for services the transitioning enrollee and receiving the enrollee's information.
Setting of Care: Generally, a place where an enrollee is provided mental health and/or SUD services, including the diagnosis, treatment, and assessment of emotional and mental health disorders and issues. This can include inpatient and outpatient facilities, in-home care, adult care homes, and more.
Transition of Care: The movement of an enrollee from one setting of care to another.
Transferring Entity: The PIHP that is closing for services the transitioning enrollee and transferring the enrollee's information.
Warm Handoff: Time-sensitive, enrollee-specific planning identified by either the Transferring Entity or the Receiving Entity to ensure continuity of care during transition from one setting of care to another. Warm handoffs require collaborative planning between both entities and when at all possible, collaborative planning should occur prior to the transition.

References/Legal Authority

1. Medicaid Provider Manual
2. MDHHS PIHP Contract
3. MDHHS Transition of Care Technical Requirement
4. 42 CFR 438.62 – Continued Services to Enrollees
5. 42 CFR 438.208 – Coordination and Continuity of Care

Change Log:

Date Of Change	Description of Change	Responsible Party
6/26/2025	New Policy - Reviewed and approved by Clinical Leadership Committee and Utilization Management Committee	Chief Population Health Officer