

Policy #13.13

POLICY TITLE:	Transition of Care	POLICY # 13.13	REVIEW DATES	
Topic Area:	Service Delivery	ISSUED BY: Chief Operating Officer		
Applies to:	LRE, Member CMHSPs, Network Providers			
Developed and Maintained by:	Compliance Manager	APPROVED BY: Chief Executive Officer		
Supersedes	N/A	Effective Date: 5/1/2026	Revised Date:	

I. PURPOSE

Lakeshore Regional Entity (LRE) 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)]." This transition of care policy ensures continued access to services during a transition from one provider entity to another or from one managed care entity (MCE) to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

II. POLICY

Organizations serving persons enrolled in Medicaid within the LRE region shall coordinate services and transitions of care with other behavioral and physical health care providers. This includes transitions from fee-for-service (FFS) to a MCE, Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), or PCCM entity or transition from one MCE, PAHP, PCCM, or PCCM entity to another. A transition of care plan shall be developed between providers when a person receiving services is transitioning from one care setting to another. A solid foundation for an effective transition of care plan includes open and timely communication of information between the transferring and receiving entities. The transition of care plan shall be created with the person served, family members and/or guardians, and other appropriate providers. The transition of care plan shall ensure:

- A. That services are delivered consistent with the access the person previously had.
- B. That the person is permitted to retain their current provider for a minimum of 90 days if that provider is not in the receiving entity's network.
- C. That the receiving entity will refer the person to appropriate provider(s) within its network.
- D. That the transferring entity shall, within 14 calendar days, fully comply with requests for historical utilization, providing data, medical records, and other documentation

- as appropriate to the receiving entity, or requests from MDHHS as outlined in the procedure associated with this policy.
- E. The coordination of a timely “warm handoff” for effective knowledge transfer and to ensure continuity of care.

The transferring and receiving entities shall hold the person served harmless for any costs associated with the transition of care between providers (42 CFR 438.106, 42 CFR 438.206).

III. **APPLICABILITY AND RESPONSIBILITY**

This policy applies to all LRE staff, member CMHSPs, and network providers.

IV. **MONITORING AND REVIEW**

This policy will be reviewed by the CEO and designee on an annual basis.

V. **DEFINITIONS**

- A. **Care Coordination/Coordination of Care:** The organization of a person’s care across multiple health care providers.
- B. **Continuity of Care:** The quality of care over time, including both the experience of a “continuous caring relationship” between a person receiving services and 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.
- C. **Managed Care Entity:** 42 CFR 438 recognizes a Prepaid Inpatient Health Plan (PIHP) as a managed care entity (MCE). A PIHP is responsible for management of specialty services related to mental health, developmental disability services, and certain SUD services to Michigan residents enrolled in Medicaid.
- D. **Person Served:** A Medicaid beneficiary with substance use disorder (SUD), mental illness, serious emotional disturbance or developmental disability who is eligible for specialty mental health services and supports.
- E. **Receiving Entity:** The PIHP that is opening for services the transitioning enrollee and receiving the enrollee’s information.
- F. **Setting of Care:** Generally, a place where a person is provided mental health and/or SUD services, including the diagnosis, treatment, and assessment of emotional and mental health disorders and issues. This care includes inpatient and outpatient facilities, in-home care, adult care homes, and more.
- G. **Transition of Care:** The movement of person receiving services from one setting of care to another.
- H. **Transferring Entity:** The PIHP that is closing for services the transitioning person and transferring their information.
- I. **Warm Handoff:** Time-sensitive, person-specific planning identified by either the Transferring or 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.

VI. REFERENCES AND SUPPORTING DOCUMENTS

- A. 42 CFR 438.62 – Continued Services to Enrollees
- B. MDHHS – Transition of Care Technical Requirements, rev. 11/18/2024

VII. RELATED POLICIES AND PROCEDURES

- A. 13.13A – Transition of Care Procedure

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
5/1/2026	NEW policy	