PROCEDURE # 13.13A		EFFECTIVE DATE	REVISED DATE
TITLE:	Transition of Care	5/1/2026	
ATTACHMENT TO		REVIEW DATES	
POLICY #:	13.13		
POLICY TITLE:	Transition of Care		
CHAPTER:	Service Delivery		

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. PROCEDURES

A. Persons receiving services may access continued services upon transition through their primary clinician at the transferring entity. The primary clinician is responsible for working with the person served to develop a transition plan between the transferring and receiving entities.
   1. Transferring entities are to develop and implement a transition plan.
   2. The plan must be created with the person served, family members and/or guardians, and other appropriate providers, with follow-up to communicate the transition plan to all involved.
   3. 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.
   4. In the event that a transition plan cannot be implemented, the transferring entity is to ensure that accurate information is available to support medical decisions by persons served and providers, thoroughly documenting any denial of participation and the reason.

B. During a transition of care, persons served will have access to services consistent with the services previously provided and are permitted to retain their current provider for a minimum of 90 days if their current provider is not in the receiving entity's network.
   1. The receiving entity must assist the person in selecting an in-network provider.

2. Within 14 days of request, the transferring entity must provide all requested historical utilization, data, medical records, and other documentation as appropriate to the receiving entity, or requests from MDHHS.

C. LRE shall have written agreements with the Medicaid Health Plans that serve the region.
   1. Interagency agreements shall meet the requirements of HIPAA and 42 CFR, part 2.

D. Organizations transferring persons enrolled in Medicaid within the LRE region shall electronically exchange information with the receiving entity, including all such data from any other payer or provider that served the person within the preceding five (5) years. At any time while the person is open for services through LRE and up to five (5) years after the closure of services, the transferring entity shall send all such data to any other payer that covers the person or a payer that the person or the person's personal representative specifically requests receive the data. The transferring entity shall send data received from another entity in the electronic form and format it was received (42 CFR 438.62(b)(1)(vi)).
   1. With respect to any data protected by 42 CFR, part 2, a copy of a fully executed section 2 of the Consent to Share Information (MDHHS form 5515) must accompany the transfer of documentation related to SUD treatment services. 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.
   2. LRE will ensure that in the process of coordinating care, the privacy of each person served 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.
   3. As authorized by the person served, LRE provider network members (or their subcontractors) 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.
   4. Information received by the receiving entity must be incorporated into the records of the person served.

E. Staff training on transition of care standards is the promotion of proactive communication between the transferring and receiving entities prior to transition to coordinate the transfer of care.
   1. LRE provider network members shall establish protocols to communicate with the receiving entity within 14 calendar days after the person's transition to confirm receipt of transferred information and to talk through any challenges that may have occurred during the transition.
   2. The receiving entity shall adhere 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 persons 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 persons involved with the court system, transitions of persons from inpatient care to outpatient care, and transitions from incarceration to community. Special attention must be paid to medication continuity during movement and transitions from one setting of care to another to reduce the frequency of medication disruption, 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.

3. The receiving entity shall ensure coordination with appropriate assessment entities (as applicable), to ensure no disruption in the person's services.

F. The transferring and receiving entities will hold the person served harmless for any costs associated with the transition of care between providers. (42 CFR 438.106, 42 CFR 438.206).
G. When necessary, written coordination agreements will be in place between entities.
H. Persons served must be provided with appropriate service without delay resulting from issues of financial responsibility. LRE and/or Community Mental Health Service Programs (CMHSPs) will act ethically to provide services to persons when financial responsibility is disputed.
I. LRE shall ensure that regional CMHSPs have policies/procedures in place that ensure each person has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the person.
    1. The person served must be provided with information on how to contact their designated primary worker and/or entity.
J. LRE must ensure that CMHSPs coordinate the services they provide to the person served:
    1. Between settings of care, including appropriate discharge planning between short-term and long-term hospital and institutional stays.
    2. With the services the person receives from any other PIHP.
    3. With the services the person receives in FFS Medicaid.
    4. With the services the person receives from community and social support providers.
K. CMHSPs within the LRE region will make a best effort to conduct an initial screening of each new person's needs within 90 days of the effective date of enrollment. The CMHSP must make subsequent attempts to conduct an initial screening of each person's needs if the initial attempt to contact them is unsuccessful. Since the PIHP is not an enrollment model, screening once an individual presents for services would meet this agreement.
L. LRE will share with the State and/or other PIHPs results of any identification and assessment of the person's needs to prevent duplication of those activities.
M. LRE will ensure that CMHSP transition of care plans, processes, and procedures are in compliance with these requirements by performing regular (no less than annual) oversight and monitoring activities.

III. CHANGE LOG

Date of Change	Description of Change	Responsible Party
4/30/2026	NEW Procedure development	