Continuity of Care

Q1. Can the CHC-MCOs extend the Waiver long-term services and supports (LTSS) continuity of care period beyond 180 days and what will be the determinant as to why this period is extended?

   A. This topic can be discussed with the CHC-MCOs. Following the 180-day period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement. The CHC-MCOs will likely seek to use contracted providers who can help meet the goals of improved coordination of care and improving the quality of services. However, in accordance with MAB 99-03-13, the CHC-MCO may extend the continuity of care when clinically appropriate.

Q2. How will the CHC-MCOs select providers after the continuity of care period? Will they require additional credentialing criteria? And when will they begin the process?

   A. This topic should be discussed with the CHC-MCOs. The CHC-MCOs will establish their own credentialing process and may impose additional credentialing criteria. The CHC-MCOs will likely seek providers who help to meet the goals of improved coordination of care and improving the quality of services.

Q3. Is there a requirement for all CHC-MCOs to contract with willing providers for the first six months? How does the "after the continuity of care" period impact the home and community-based and service coordinator providers?

   A. CHC-MCOs are required to contract with all willing and qualified existing LTSS providers of all types for 180 days after CHC implementation. Participants may keep their existing HCBS providers, including service coordinators, for the 180-day continuity of care period after CHC implementation. Following the 180-day period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement.

Q4. When arranging a contract with a CHC-MCO, define what is willing and qualified provider?

   A. A willing LTSS provider is a provider that is willing to contract with the CHC-MCO to provide services for a payment rate that is agreed upon by the provider and the CHC-MCO. A qualified provider is a provider that meets applicable Medical Assistance program participation or waiver requirements for the provider’s provider type. This requirement will remain in effect for LTSS providers for 180 days after the CHC zone start date. Following the 180-day period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement.
Q5. In the earlier PowerPoint it states, "DHS is requiring an extended continuity of care period for nursing facilities." What is the extended time frame?

A. Nursing facility (NF) residents who reside in a NF located in the CHC zone on the implementation date, the continuity of care period extends until the resident’s NF stay ends, the resident is disenrolled from CHC, or the NF is no longer enrolled in Medicaid.

Q6. How will participants be distributed among providers after the 180 days?

A. The participants will have the opportunity to select the CHC-MCO plan that meets their needs. If participants do not select a plan, they will either be assigned to a CHC-MCO plan by the IEB, based on criteria established by the Department of Human Services (Department), or they will be auto-assigned to a plan by the Department. The Department encourages all participants to select their plans. Once participants are enrolled in a CHC-MCO, they can choose their providers from the plan’s provider network.

Q7. How will the CHC-MCOs handle Nursing Home Transition (NHT) after the continuity of care period?

A. CHC-MCOs must provide NHT activities to participants residing in nursing facilities who express a desire to move back to their homes or other community-based settings. The CHC-MCO must provide NHT activities using appropriately qualified staff, whether employed by or under contract with the CHC-MCO. This topic should be discussed with the CHC-MCOs to learn about their plans after the continuity of care period.

Q8. Will the CHC-MCOs contract with the Medicare home health providers to help with continuity of care as well or just contract for Medicaid services?

A. All CHC-MCO providers must be enrolled in the PA Medical Assistance (MA) Program and must be credentialed by and contracted with a CHC-MCO to provide services to CHC participants. If a Medicare home health provider wants to be reimbursed under CHC, the provider should enroll in MA and discuss contracting with the CHC-MCOs.

Q9. If the CHC-MCO does not contract with the service coordination entity or home care agency, how is a participant notified that the service coordination entity or home care agency is being dropped?

A. Participants who transition into CHC at the start date for the CHC zone will have a 180-day continuity-of-care period for their service coordinator and home care agency. This means that the CHC-MCOs are required to continue services through all existing providers, including service coordination entities, for 180 days.

After the 180-day continuity of care period, the CHC-MCOs must notify participants if their service coordinator, service coordination entity will not be subcontracted with the CHC-MCO or if their home care agency is not part of the CHC-MCO’s provider network.
Q10. Will the continuity of care be the same for those transitioning from OPTIONS as CHC waivers?

A. **Revised January 26, 2018** – Assuming the individual remains eligible for the state-funded OPTIONS or ACT 150 program, participants who transition into CHC at the start date for the CHC zone, will continue to receive their services through OPTIONS or ACT 150. The CHC-MCOs must coordinate the participant’s transition into CHC with their Care Manager/Service Coordinator. For participants who are not eligible for long-term services and supports through CHC, the CHC-MCO is primarily responsible for any physical health services the participant may need.

In addition, as permitted by Section V.A.4 of the CHC Agreement, Expanded Services and Value-Added Service, the CHC-MCO may offer participants expanded or value-added services. If offered, the CHC-MCO may feature such services in approved outreach materials. Adding or changing value-added services requires modification of written materials and is subject to approval from the Department.

For more information, please review the CHC Health Plan comparison chart found on the CHC website: [http://www.healthchoices.pa.gov/info/resources/publications/community/index.htm](http://www.healthchoices.pa.gov/info/resources/publications/community/index.htm)

Q11. During the 180-day continuity of care period, are providers required to contact both the SCE & CHC-MCO?

A. During the 180-day continuity of care period, providers should contact and communicate with the CHC-MCOs. Communication with the service coordination entities is not required unless directed to do so by the CHC-MCOs. Providers should discuss this with the CHC-MCOs.

Q12. If a Person-Centered Service Plan (PCSP) is due after the 180-day period, can the service coordinator (SC) work with the participant to review a PCSP before it is expired?

A. If the SC completes a new PCSP that results in a change to the services, the CHC-MCO must comply with the requirement that (1) the MCO must continue all existing HCBS waiver services through existing service providers including the SC for 180 days or (2) until a comprehensive needs assessment has been completed, a PCSP has been developed and implemented, whichever date is later. If the comprehensive needs assessment results in increased services, the new PCSP should be implemented and the CHC-MCO must allow the services to be provided by all existing HCBS waiver providers including the SC for the remainder of the 180-day period.

Q13. If at the end of the 180-day continuity of care period a service coordination entity does not renew with a CHC-MCO, can the consumer switch CHC-MCOs to allow continuity of care?

A. If a participant chooses to transfer to a different CHC-MCO, service coordination will not be covered under the standard 60-day continuity of care period, since service coordination will be viewed as an administrative function of the CHC-MCO.
Q14. If at the end of the 180-day continuity of care period an in-home provider does not renew with a CHC-MCO, can the consumer switch CHC-MCOs to allow continuity of care?

A. If a participant chooses to transfer to a different CHC-MCO during the initial 180-day continuity of care period, the receiving CHC-MCO must continue to provide the previously authorized services for 1) the greater of 60 days or the remainder of the 180 days, or 2) until a comprehensive needs assessment has been completed and a Person-Centered Service Plan (PCSP) has been developed and implemented, whichever date is later.

If a participant chooses to transfer to a different CHC-MCO after the initial 180-day continuity of care period, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.

Q15. Will hospice care or transitions be affected and how?

A. For all participants, the CHC-MCO must comply with continuity of care requirements for continuation of providers, services, and any ongoing course of treatment outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.

Q16. What is the process and timeframes for a participant to select a new personal assistance services provider and service coordination entity after the initial continuity of care period?

A. Participants will receive at least 45 days advance notice from the CHC-MCOs and will have the opportunity to select a new Personal Assistance Services (PAS) provider in the CHC-MCOs provider network. CHC-MCOs will also notify participants whether their service coordinator will continue to provide service coordination. The CHC-MCO must offer the participants a choice of service coordinators from amongst those employed by or under contract with the CHC-MCO. Reference Exhibit V of the CHC Agreement for more detail.

Q17. After the end of a home and community-based participant's continuity of care, when does the newly selected provider receive a service authorization?

A. The newly selected provider will receive an updated Person-Centered Service Plan (PCSP) after the completion of the comprehensive needs assessment.

Q18. Can a CHC-MCO end a service coordination contract before the end of the 180-day continuity of care period for bad performance?

A. Yes, CHC-MCOs may terminate a provider for cause during the continuity of care period, as consistent with 40 P.S. § 991.2117(b).
Q19. Why is there a continuity of care period for nursing home residents when nursing home residents can stay as long as they want?

A. CHC participants who reside in a nursing facility when CHC is implemented in the CHC zone will be permitted to continue receiving care at that facility until the participant either leaves the facility or is disenrolled from CHC, or the facility is no longer enrolled as a provider in the MA program.

Participants admitted to a nursing facility after the CHC implementation date will receive the standard 60-day continuity of care protections.

Q20. If a long-term resident of the nursing facility prior to 1/1/18 exceeds their 15-day bed hold, but is still expected to return to the facility, will their continuity of care be interrupted?

A. As long as the participant remains a resident of the nursing facility, a temporary hospitalization will not interfere with or terminate the continuity of care period even if it exceeds the 15-day bed hold period.

Q21. Is there a provision if a hospital or primary care physician is not contracted with a specific CHC-MCO in the nursing facility coverage area?

A. For all participants, the CHC-MCO must comply with continuity of care requirements for continuation of providers, services, and any ongoing course of treatment outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.

Q22. Who is considered a nursing facility resident for the purposes of the continuity of care period?

A. **Revised January 26, 2018** – A person who was admitted as a resident to and, as of the CHC implementation date, was receiving nursing facility services from a general county, special rehabilitation or hospital based nursing facility which is licensed by the Pennsylvania Department of Health (DOH) and enrolled in the Pennsylvania Medical Assistance Program.