

MDS 3.0 Section Q Implementation
Questions and Answers from Informing LTC Choice conference and emails
June 7, 2010

DATA USE AGREEMENTS (DUA)

1. Do state agencies need a Data Use Agreement to implement Section Q? What circumstances require a Data Use Agreement?

No DUA is needed for individual nursing facilities to refer the names of individuals requesting to talk to someone about the possibility of returning to the community to the local contact agency. The nursing facilities will need to obtain agreement and permission from each individual resident, through their usual signed release of information form, in order to refer that individual's name to the local contact agency.

In order for the local contact agencies to receive Minimum Data Set (MDS) data (i.e. a list of names of individuals from the MDS data set who answered, "Yes, I would like to speak to someone about the possibility of returning to the community" for each nursing facility), states will need a revised Data Use Agreement. CMS is asking state Medicaid agencies to amend their Medicaid MDS Data Use Agreements to include designated local contact/referral agencies in them. The Medicaid Data Use Agreement must be amended to include those local contact agency entities as a custodian to be authorized to obtain individual named referrals from the MDS data base in order to comply with the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) rule. The custodian relationship must be included in the contract or memorandum of understanding between the Medicaid agency and the local contract agency. Using this approach, the local contact agencies are in compliance with privacy protection requirements under HIPAA.

2. Is the Data Use Agreement (DUA) specific to only the Medicaid population?

The Medicaid Agency's Data Use Agreement applies to all nursing facility residents included in the MDS data base.

LOCAL CONTACT AGENCIES

3. Have the roles and responsibilities of the Local Contact Agencies been defined?

- a. **What is the appropriate level of contact by the local contact agency – face-to-face, phone, written?**
- b. **Do they provide information and assistance, or is transition assistance expected?**

The roles and responsibilities for local contact agencies are defined generally by the Section Q process, but states are given great flexibility in defining their particular activities and responsibilities. In general, the local contact agency's role is to contact individuals referred to them by nursing facilities through the Section Q process, provide timely information about choices of services and supports in the community, and collaborate with the nursing facility to organize the transition to community living. The exact mode and content of that contact with the

nursing facility resident is to be determined by each state in response to their goals for providing choices of services and settings to individuals, with substantial input from all stakeholders involved.

These resident contacts have been termed information and assistance¹ or options counseling² under various federal/state programs. In working with state officials to design the Section Q referral process, telephone contact (conversation) with the resident was considered the minimum contact requirement for an initial contact.

The Section Q pilot sites found that a face-to-face contact was needed to begin developing a rapport with the individual and to provide them with adequate information specific to their individual needs and circumstances. In addition, evidence from several states under the Nursing Facilities Transitions grant programs demonstrated that face-to-face contacts were the most effective approach for creating successful transitions and are recommended for Section Q as well.

4. Have all Local Contact Agencies been assigned by the State? If so, how do nursing facilities in each state find out which local contact agency has been assigned by their Medicaid State Agency? Is there a list available that we can distribute to our nursing home members so they can start the process of coordinating with their local contact agencies to prepare for implementation of MDS 3.0 Section Q?

CMS recognizes that each state must look at their current long term care services and resources before designating their local contact agencies and yet also recognizes that residents and nursing home staff will need immediate contacts after MDS 3.0 is implemented on October 1, 2010. As of the end of May 2010, most states have not yet designated their local contact agencies. Since it will take more time for some states to develop their process, CMS is requesting State Medicaid Directors to identify a lead entity and provide point of contact information for each state. This list will be available sometime this summer and CMS will share it with nursing home organizations, states, ombudsmen, Aging and Disability Resource Centers, Centers for Independent Living, etc.

¹ Information and Assistance is a core service required for aging network providers (Area Agencies on Aging) by the Administration on Aging.

² Options counseling, for long term care services and supports, is an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long term care choices in the context of the consumer's needs, preferences, values, and individual circumstances. (National Association of State Units on Aging, *Long-Term Supports Options Counseling*, Independent Living Research Utilization, January 2007, p.4).

The goal for Options Counseling is ensuring that consumers make informed decisions concerning their long term care. The process assists the individual, their family and significant others to understand strengths, needs and preferences and translate this knowledge into support plans, strategies, and service choices available in their community. In the options counseling process, the counselor works with the individual consumer (and their family and/or significant other) so the consumer moves beyond obtaining information to gaining an understanding of how to apply it to their personal situation. The keys to options counseling are person-centered planning and decision support. (ADRC Technical Assistance Exchange, *The Art of Options Counseling*, ADRC-TAE, April 2009, p. 9).

In the interim, your first contact should be your State Medicaid Agency. After states have designated their local contact agencies, CMS will obtain that list and make it available in a central listing. Because the Aging and Disability Resource Center and Money Follows the Person programs have been allocated funds to provide transition planning and services they may be the point of contact in these efforts.

- 5. Are there time frames for responding to the referral and for contacting the resident?**
- a. Will the response times be monitored?**
 - b. Will the outcomes of referrals be documented and reported?**

There are instructions to nursing facilities in the MDS 3.0 Instructors Guide for a “Yes” response to item Q0500A to trigger follow-up care planning and make contact with the designated local contact agency about the resident’s request within 10 business days of a yes response being given.

The goal of follow-up action is to initiate and maintain collaboration between the nursing facility and the local contact agency to support the individual’s expressed interest in the possibility of being transitioned to community living. This includes the facility supporting the individual in achieving their highest level of functioning, the local contact agency providing information about community living services and supports, and collaboration in assisting the individual in transition to community living.

CMS is communicating with State Medicaid Agencies and the Administration on Aging (AoA) about response times for local contact agencies. Each state’s local contact agency will be different and for state’s using Aging and Disability Resource Centers, ADRC penetration may vary. We would expect a reasonable contact response time of within 3 days by phone and within 10 days if an on-site visit is needed. Experiences in the Section Q pilot test showed that states were interested in establishing responsive time frames. For example, during pilot testing, Connecticut set 3 days to contact the person and two weeks to complete the initial face-to-face interview/screen.

CMS will be working with AoA to develop standardized Aging and Disability Resource Center reporting requirements that may be helpful to states. There are currently no regulatory or statutory requirements for MDS 3.0 that address monitoring of the local contact agency response times or the outcomes of referrals. States may establish their own process to monitor performance.

- 6. Will nursing homes be cited by survey staff if the Local Contact Agency does not respond in a timely manner?**

No.

- 7. Is the nursing facility required to follow up once a referral has been made?**

Discharge planning follow-up is already a standard of practice in nursing homes and important for person-centered care. The optional Return to Community Referral Care Area

Trigger checklist states that, “If the local contact agency does not contact the individual resident by telephone or in person within 10 business days, make another follow-up call to the designated local contact agency as necessary.”

8. What type of referral systems are states setting up – electronic, telephone, written?

States are in the process of investigating the proposed features of referral systems. The five states involved in the pilot testing all used telephone referrals because the two-month period to test the process did not allow time to develop an electronic system. For the ongoing operation of a statewide system, Connecticut is developing a web-based, electronic referral system.

SUPPORTS FOR TRANSITION

9. Have any states developed an assessment or interview tool?

Several states have developed client interview tools and assessment tools. Many of those are included in the Reference Manual CD distributed at the conference.

- a. California Preference Interview Tool
- b. Connecticut Transition Challenges Tool
- c. Indiana Post-Transition Checklist
- d. Michigan Introduction Meeting Interview Guide
- e. Michigan Initial Interview Guide

Others are available at: www.adrc-tae.org or www.hcbs.org or www.taformfp.com

10. Since the nursing community staff may not be aware of available programs and supports for seniors and persons with disabilities living in the greater community, will there be more partnerships and resources available to nursing homes?

Formal and case-by-case education regarding community resources will be part of the partnership between nursing facilities and local contact agencies and occur mainly at the state and local level. The nursing home and local contact agency team must explore community care options and conduct appropriate care planning together to develop an array of supports for assisting the resident if a transition back to the community is possible for a resident. There are now enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. available and these resources will grow over time. However, resource availability and eligibility coverage varies across local communities and states, which may be barriers to allowing some resident’s return to the community.

11. Is there a logic model, action plan, or flow chart available for the states who piloted Section Q that outlined roles and responsibilities each partner fulfilled?

Although there is no logic model available, we would suggest reviewing “MDS 3.0 Section Q Pilot Test Interim Report” dated March 10, 2010 which provides helpful information about their respective roles and responsibilities. The report was included on CD provided at the

“Informing LTC Choice: MDS 3.0 Conference on April 16, 2010 or can be downloaded from the web at: <http://taformfp.com/training.aspx?id=1910#lpdsq>

GUARDIAN/LEGAL REPRESENTATIVE

- 12. Since treatment of family vs. guardian is confusing, can CMS clarify the differences? If there is a guardian or other legal representative (including someone with health care power of attorney), do they trump family members in terms of legal authority. In Q1, CMS refers to “family if applicable” and “guardian if applicable”, which seems appropriate. But thereafter, the questions are, “or guardian if the family member is not available”. Availability is not a criteria for decision-making.**

If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative. A guardian is an individual appointed by the court to make decisions instead of the resident. This includes giving and withholding consent for medical treatment. A legally authorized representative is designated by the resident under state law to make decisions on their behalf when they are not able to do so themselves. This includes a medical power of attorney. Encourage the involvement of family or significant others in the discussion if the resident consents. While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved if the resident is uncertain about his or her goals, the response selected must reflect the resident’s perspective if he or she is able to express it.

EXPECTATIONS

- 13. Aren’t nursing homes raising resident expectations when they know that the community system is fragmented and can’t accommodate many more beneficiaries since Medicaid waivers are generally capped?**

MDS 3.0 item Q0500B asks “do you want to talk to someone about the **possibility of returning to the community.**” The nursing home and local agency staffs should guard against raising the resident and their family members’ expectations of what can occur until more information is obtained. The nursing home and local contact agency team must explore community care options/supports and conduct appropriate care planning to determine *if* transition back to the community is possible. Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are now available and will grow over time. Resource availability and eligibility coverage varies across local communities and States and these may present barriers to allowing some resident’s return to their community. Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident’s medical needs, finances and available community transition resources.

- 14. It was stated at the conference that private pay patients would be looked at to monitor their spending down of personal assets. What is the intent of the focus and the legal**

basis for granting access to self-pay patient information (medical and financial) and the potential for subsequent patient targeting?

This issue was not raised at the conference. One possible interpretation is that for individual residents who have applied for Medicaid eligibility, the transition coordinator, with permission of the resident, will monitor the progress of the eligibility determination process to determine if and when the individual may be eligible for Medicaid funded home and community-based services.

INDIVIDUALS WITH MENTAL HEALTH ISSUES

15. What is the facility's responsibility for notifying appropriate community-based authorities when a significant change assessment is completed on a patient indicating a change in care planning and for a patient with a known mental health condition?

This question appears to be getting at the distinction between who to notify for Section Q and who to notify for PASRR. Preadmission Screening and Resident Review (PASRR) requires the facility to notify the state mental health or mental retardation authority (your state agencies for those functions, or their delegated contacts) when certain kinds of changes trigger a Significant Change in Status Assessment. This applies to individuals who are already identified by PASRR Level II as having Severe Mental Illness or Mental Retardation (A1500 = Yes) and also applies to persons for whom Severe Mental Illness may be presenting as a new concern, (A1500 = No), and therefore require a PASRR Level II evaluation and determination.

Section Q requires contact with the designated local contact agency (defined by your state) about a resident's request to talk with someone about the possibility of returning to the community, within 10 business days of a yes response being given. This would not likely be the same as the contacts for PASRR.

The two requirements may occur together when the Significant Change in Status Assessment is triggered by improvement in an individual with Severe Mental Illness such that the individual expresses a desire to consider discharge or other placement options. In that case both referrals should be made, and we hope that the results of a new Level II assessment would be helpful in discussing community living options. Another possibility would be that an individual expresses interest in community living, triggering Section Q referral to the designated local contact agency, but upon responding the local contact agency finds the Level II PASRR documents on the chart reflect needs that cannot be met with available resources in the community. A referral for PASRR Level II should be made to the state mental health or mental retardation authority, discussing whether a Level II reevaluation may be needed to help clarify the current needs and to identify any alternative supports that may be recommended.

If all this sounds complicated, the simple answer is that the facility is always responsible to meet resident's needs with any needed resources. So when in doubt, the facility should

contact all potentially helpful resources, whether or not there is a clear Federal regulatory requirement.

16. Have state laws been considered in the potential release of sensitive mental health information to community placement personnel? If so, have all state laws related to this issue been considered?

We take this question as applying to Section Q, not the Preadmission Screening and Resident Review (PASRR), since PASRR requirements have not changed. MDS 3.0 adds Question A1500, and clarifies the facility's responsibilities under PASRR when a Significant Change in Status Assessment occurs, to assist states and facilities in complying effectively with PASRR, but the PASRR requirements remain as they have been.

The new Section Q process of referral to a local contact agency may involve discussions of the mental health status of the individual resident. The HIPAA (Health Insurance and Portability and Accountability Act) privacy rule does not preempt state laws and rules about mental health information. Since MDS changes, neither federal or state confidentiality rules, mental health information in discussions with local contact agency transition coordinators would be treated in the same manner that the facilities currently handle mental health information with outside health care providers.

If MDS 3.0 data is to be shared, it could only be shared if a Data Use Agreement was in place naming the local contact agency as a custodian.

LAWS, FUNDING, MISC.

17. If a state participates in the Money Follows the Person program, would that program be the local contact agency for that state?

Potentially, but not necessarily.

18. What are the federal laws around MDS Section Q?

It is required by Statute that all residents admitted to a nursing facility be assessed using the minimum data set (MDS) functional assessment tool. Also required by Federal regulation is that this information and other assessment information gathered by the nursing facility be used to develop and implement a comprehensive person-centered care plan for every resident.

19. The CMS Office of External Affairs is forming a work group to develop a general purpose, overview brochure describing and explaining Section Q. Will that brochure be for all payer types?

Yes, that brochure will be developed to give a general overview and explanation of the Section Q process to all nursing facility residents and their families.

20. What federal funding is available for Local Contact Agencies?

Money Follows the Person demonstration project and Aging and Disability Resource Center grant funding can be utilized to support many local contact agency functions. Money Follows the Person and Aging and Disability Resource Center funding is available for outreach and education functions for all client types (i.e. non-Medicaid clients also). Administration on Aging funding for Information and Assistance services and case management services may be used for individuals age 60 and over. Certain Home and Community-Based Services waiver program services such as case management or transition support services may be devoted to support some local contact agency functions.

21. Is Money Follows the Person demonstration grant funding available only for Medicaid eligible clients?

Money Follows the Person program outreach and education funding may be used for all clients, not just Medicaid eligible clients. However, only Medicaid eligible individuals may participate in MFP.

22. Can you provide more information on additional funding for Aging and Disability Resource Centers that may be used for implementing Section Q?

Aging and Disability Resource Center grant funding can be utilized to support many local contact agency functions. Specifically, funding for Aging and Disability Resource Center Outreach and Education functions will cover all client (payer) types (not just Medicaid clients). In addition, Administration on Aging funding for Information and Assistance services and case management services may be used appropriately. Home and Community-Based Services as specified in a state waiver program may be devoted to support some local contact agency functions.

23. Can the Ombudsman program be added to the new CMS *Your Discharge Planning Checklist*?

Yes. Thanks very much for drawing attention to this omission. The issue has been addressed in the electronic version and print version as of May 25, 2010.

24. Are there any state rate setting examples for the Information and Assistance or Transition Coordinator functions?

The scope of information and assistance varies across states. Information and assistance may include case management, or referrals to: chores, housing, legal assistance, Medicaid, health care, home repair, nutrition, transportation, etc. As far as transition coordinator functions, Texas has recently conducted a new procurement for a relocation contractor that includes the Section Q process functions. They pay for the relocations on a cost reimbursement basis and require contractors to submit estimated costs per relocation and do have average cost figures. Nicole Lee at nlee@ascellon.com has a copy of their RFP and Marc Gold (TX) is willing to discuss their reimbursement approach.

25. How should Medicaid and the Ombudsman program work together on transitions?

As mentioned on the May 19th conference call, CMS is planning a July 7, 2010 Technical Assistance conference calls that will address this topic. We expect to have the national associations and several states discuss their collaborations on transitioning individuals from nursing facilities. Please plan on joining us then. Nicole Lee will be sending out the agenda. Please contact her at nlee@ascellon.com if you want your name added to the invitation list or you are not notified by the week before the July 7, 2010 teleconference.