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The Role of Minimum Data Set (MDS) Section Q in Pennsylvania's Nursing Home Transition (NHT) Program

History of NHT in PA

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- In 2000 PA was awarded one of the original nursing home transition grants from CMS in the amount of $500,000
  - Pilot project named Pennsylvania Transition to Home (PATH) was established in 4 of Pennsylvania's 67 counties

- In 2008 an enhanced pay-for-performance NHT program was introduced statewide
  - Services provided by network of agencies with 2 agencies assigned to each county
  - Centers for Independent Living provided services to individuals <60 years old; Area Agencies on Aging providing services for >60
  - MDS reports provided to NHTCAs monthly

History of NHT in PA

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- In December 2016 NHT program was opened to any qualified provider of service coordination under Medicaid waivers administered by OLTL
  - Increased provider choice
  - Required re-education to facilities as to who to direct NHT referrals to, including Section Q referrals
  - State no longer able to provide detailed MDS reports to NHT providers
- Beginning 1/1/2018, PA began to roll out its managed long-term care program, Community HealthChoices (CHC), which was fully implemented statewide as of 1/1/2020
  - CHC Managed Care Organizations (MCOs) became responsible to provide NHT services to enrollees as an administrative function
  - A state administered fee-for-service NHT program continues for individuals not qualifying for CHC enrollment

NHT Population

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State fee-for-service program

- Resides in NF
- Wants to transition back to the community
- Has either been in the facility at least 90 days OR has a barrier preventing them from transitioning via the normal NF discharge process

(Aligns closely with Money Follows the Person and MDS Section Q referral requirements)

- As of CHC enrollment individual is no longer eligible for fee-for-service NHT

Community HealthChoices

- MCOs must provide NHT services to any enrolled participant who resides in a NF and has identified need for NHT services in their Person-Centered Service Plan
- Reporting requirements of NHT services only apply to individuals transitioning after NF stay that is:
  - not for short-term rehabilitation;
  - not for respite; and
  - not medically necessary under Medicare definition (i.e., skilled care).

NHT Population

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State fee-for-service program

- Referrals can come from any source (“no wrong door”)
- Participants are provided free choice of the NHT Coordination Agencies (NHTCAs) that are enrolled to provide NHT services in their county
- Upon receiving a referral, the NHTCA is responsible to verify that the individual meets the NHT participant definition
- NHTCA works with participant and others involved to develop the NHT care plan

Community HealthChoices

- MCOs are responsible to update an individual’s Person-Centered Service Plan when they become aware that an enrolled participant wants to transition
- MCOs provide NHT services using internal staff, external agencies they contract with, or a combination
- MCOs participate in data reporting for NHT for required participants which enables monitoring by the state

NHT Goals

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- **Enhance opportunities** for individuals to move into the community by identifying individuals who wish to return to the community
- **Educate individuals and families** about long-term living services
- **Identify and overcome barriers** that prevent transitions
- **Develop the necessary infrastructure** and supports in the community
- **Empower participants**, so they are involved to the extent possible in planning and directing their own transition

How MDS Section Q Can Help

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- A NF resident's positive answer to Q0500: *"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"* requires that a referral be made to the designated Local Contact Agency (LCA)
- States can track answers provided to the questions in Section Q in order to make sure that facility residents are being provided their options and receiving information about transitioning
- The MDS 3.0 manual on the CMS website describes in detail the correct process to follow in asking the Section Q questions

How MDS Section Q Can Help

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Why is it so important that these questions be asked correctly?

- The choice to live in the most integrated setting possible is a civil right, decided by the Supreme Court in *Olmstead v. L.C.*[1]
- The correct administration of MDS Section Q is a necessary part of civil rights compliance for both long-term care facilities and state and administrative agencies
- Skipping questions or not asking or acting on them correctly can create an informational barrier to individuals being able to leave long-term care facilities

1. *Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting*. U.S. Dept. of Health and Human Services, Office of Civil Rights. May 20, 2016

Challenges and Solutions

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Challenge

- Confusion on the part of facilities caused by
  - Frequent turnover of staff
  - Changes to PA's NHT program that necessitate changes in what entities function as the designated LCAs
  - A separate but overlapping process for enrolling individuals into Home and Community-Based Services

Solutions

- Working with nursing facility associations on ways to communicate information
- Offering trainings to facility staff
- Sending out notifications to facilities via a list serve whenever a change in the NHT referral process occurs

Challenges and Solutions

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Challenge

- Relevance/timeliness of the reports pulled from MDS data

Solution

- Encouraging collaborative relationships between facility staff and LCAs

Other Potential Solutions

- Develop a system that provides information directly to the LCAs in real-time (to the extent possible)
- Pull reports more frequently

Challenges and Solutions

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Challenge

- Providing information to the relevant parties while complying with HIPAA
  - Sending reports with participant-specific PHI to LCAs or allowing access to that information
  - Sharing information with stakeholders and advocates

Solutions

- Formal collaborative agreements with specific LCAs authorizing them to receive information pertaining to the participants who will be referred to them
- Sharing aggregate information with stakeholders

Presenter Contact Info

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https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/Nursing%20Home%20Transition.aspx