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Ohio's Money Follows the Person (MFP)
Demonstration Project
CFDA # 93.791



MDS 3.0 Section Q “Local Contact Agency” Implementation Community Living Specialist (CLS) Frequently Asked Questions (12/16/10)

The provider agreement requires the CLS to provide the resident a copy of the Relocation Workbook. Does the CLS have to provide a relocation workbook to residents who do not need transition assistance and/or to residents who are applicants of the HOME Choice Transition Program?

No. All applicants of the HOME Choice Transition Program automatically receive a relocation workbook from the HOME Choice Intake and Care Coordination Unit so there is no need to provide a duplicate to the resident. As required in the provider agreement, if a resident meets HOME Choice eligibility, the CLS is required to assist the resident in the completion of a HOME Choice application. If the CLS assists the resident in the completion of a HOME Choice application, then there is no need to provide a copy of the relocation workbook.

Likewise if the community living specialist meets with a resident and determines that very little resource assistance is needed, it may not be necessary to provide the relocation workbook. The relocation workbook helps residents determine community living needs and desires and is organized to provide assistance to residents with long term institutional stays and may not be a helpful tool for all residents.

Will the HOME Choice Intake and Care Coordination Unit (HCICCU) batch the referrals per week by nursing facility location?

Yes. The HCICCU will try and batch the referrals by nursing facility location to provide efficiencies for the CLS provider. However, batching by nursing facility may result in a higher number of referrals per week for a CLS provider than requested. In the event that the batch is larger than the weekly allocation requested, the HCICCU will notify the CLS provider to assure that the larger referral number is acceptable.

How should the CLS handle a referral with pending Medicaid?

The HCICCU will put all pending Medicaid referrals in the Medicaid referral category. The HCICCU will provide payment for pending Medicaid and Medicaid residents. If the CLS provider has access to the CRIS-e system, check eligibility before completing the face to face meeting. Notify the HCICCU if you find that the payer source for the referral is incorrect. The HCICCU will then provide guidance on next steps for the particular case.

How should a CLS handle a referral for a resident who has already received a long term care consultation (LTCC)?

At this time, the HCICCU is asking the PAA to check PIMS for LTCC history. If the resident already received a LTCC AND the PAA feels that the resident would not benefit from yet another face to face meeting, the PAA should notify the HCICCU by completing and submitting the top portion of the Community Living Plan Addendum AND Section B only. The resident does not need to sign the addendum in these instances. The HCICCU will NOT process payment for residents who do not

receive a face to face meeting. The information contained in Section B is necessary for case reconciliation and for notification to the nursing facility of feasibility. See the 11/15/10 fact sheet for guidance to nursing facilities on the determination of feasibility.

If a resident already had a long term care consultation, but circumstances have changed upon MDS Section Q referral, can the PAA repeat the face to face meeting?

Yes. In these instances, the PAA will complete the entire addendum including the receipt of the resident signature and submit to the HCICCU. The PAA will receive payment for the face to face meeting.

What will the CLS provider do if the guardian refuses to allow contact with the resident?

Guidance from the Centers for Medicare and Medicaid Services on September 22, 2010 included the following question and answer regarding guardianship.

“Question #18. Are there special considerations for individuals with a court appointed guardian?”

Yes. Each State has its own guardianship law and these will not change as a result of MDS 3.0. Remember that Section Q does not make a decision about leaving the facility and returning to a community based setting. Section Q simply asks the resident if they ... “want to talk to someone about the possibility of returning to the community?”

A guardian/legally authorized representative is defined in the MDS 3.0 Resident Assessment Instrument (RAI) manual as a person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment..

If the resident has a court appointed guardian, the resident should still be asked the question (Q0500B) unless state law prohibits asking the resident. If the resident is unable to respond, then ask the family, significant other, or legal guardian. A guardian, family member or legally authorized individual should not be consulted to the exclusion of the resident.

In some guardianship situations, the decision-making authority regarding the individual’s care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes.

As part of your assessment research, the letters of guardianship should be checked, because the guardian’s powers may be limited and exclude the right to make healthcare decisions. A referral to the local contact agency should be made if the resident wishes, even if they have a legal guardian, durable power of attorney for health care or a legally authorized representative, in accordance with state law.”

The CLS provider should work with the nursing facility to verify the scope of guardianship authority. The CLS provider and nursing facility should then follow the guardianship authority since we must operate “in accordance with Ohio law”. If there are problems, please feel free to call the HCICCU at MFP@jfs.ohio.gov or 1-888-221-1560.

If the guardian refuses to allow the resident to meet with the CLS, what should the CLS do?

The CLS should complete the top portion of the community living plan addendum with a check in the box “guardian refused” under the header “if the face to face meeting did not occur within 10 days of HCICCU notification, please explain why”. The CLS provider should submit the addendum to the HCICCU for case reconciliation. In this case, sending only page 1 is acceptable. The CLS provider

will NOT be paid for the referral since a face to face meeting did not occur. We recommend that the CLS provider, upon receipt from the HCICCU of the weekly referral list, first contact the nursing facility and/or guardians by phone so that cases that will not result in a face to face are quickly resolved for CLS efficiency purposes.

If the CLS provider receives several cases that do not result in face to face meetings due to LTCC and/or guardian refusal, can the CLS request additional cases from the HCICCU?

Yes. For example, if the CLS weekly amount is 10 cases and the CLS finds that 5 of the 10 are quickly resolved due to LTCC and/or guardian refusal, the CLS may call the HCICCU and request an additional 5 cases for the week. The CLS provider does not need to wait until the following week to receive additional referrals unless the CLS provider chooses to do so.

Where can the CLS provider go to retrieve the latest “how-to” guide and forms?

New CLS providers will receive the latest copies of the guide and forms upon acceptance of the first set of referrals. CLS providers may also send a request via e-mail to MFP@jfs.ohio.gov. In February 2011, the guide and forms will be posted at <http://jfs.ohio.gov/OHP/consumers/homechoice.stm>.