QUALITY PERFORMANCE INCENTIVE PAYMENT FOR DISCHARGE PLANNING FORM

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

The purpose of this form is to collect information necessary to qualify for Quality Performance Incentive Payments for Discharge Planning to Chronic Disease and Rehabilitation (CDR) Hospitals.

SECTION I: Instructions

- Answer all questions in this form and email the completed form to hospital_escalations@state.ma.us. Both electronic and written signatures will be accepted.
- Please submit a form for each MassHealth member that entered the 45-day nonpayment period for whom the CDR hospital is seeking Quality Performance Incentive Payments for Discharge Planning.
- **Forms will only be accepted for members that the hospital billed for using occurrence code 22 during the 45-day nonpayment period.**
- Forms should be submitted quarterly for any members for whom the hospital is seeking a Quality Performance Incentive Payments for Discharge Planning. Only forms submitted according to the timeframes listed below will be accepted/reviewed:

Nonpayment period	**Forms must be submitted between:**
October 1st – December 31st	January 1st – February 15th
January 1st – March 31st	April 1st – May 15th
April 1st– June 30th	July 1st – August 15th
July 1st – September 30th	October 1st – November 15th

- The director of case management, director of admissions, or staff member of equivalent position within the hospital must complete and sign the attached attestation at the end of this form. A quality incentive payment will be denied if a completed attestation form is not included. The staff member must attest to the completeness and veracity of the information included on this form.
- Note: Quality Performance Incentive Payments for Discharge Planning may be denied if the Executive Office of Health and Human Services (EOHHS) determines from the submitted form that the hospital did not make full or complete efforts to discharge a member.

Please complete all applicable sections.

SECTION II: Member Information and Medical Information

Name:	DOB:	MH ID:

Acute hospital transferred from:

Date of admission to CDR hospital:

Name of CDR hospital:

CDR hospital admitting diagnosis codes (list maximum 8 codes):	CDR hospital primary stay diagnosis codes (list maximum 8 codes):

Date of anticipated discharge from CDR hospital per admission assessment and plan:

Dates of service at Administrative Day Level of Care (billed using occurrence code 22) within 45-day non-payment period:

Actual date of discharge from CDR hospital (if applicable):

If member was discharged to a nursing facility, please provide the name of the nursing facility:

If member was discharged to the community, please provide discharge location:

If member's actual date of discharge was later than anticipated discharge date, or if member is still at CDR hospital, please provide a brief explanation:

MassHealth claim number(s) (ICN) associated with the 45-day nonpayment period (Note: the ICN is the 13-digit number assigned to the billed claim):
ICN number(s): _____

Note: Appropriate use of occurrence code 22 will impact whether hospital qualifies for the quality performance incentive payment.

Please describe in detail below the reason for the member's hospital stay. Additionally, if applicable, please describe the reason(s) the member's actual discharge date differed from the anticipated discharge date. Limit 100 words.

SECTION III: Guardianship/Conservatorship/Healthcare Proxy and Barriers to Discharge

A. Did member require or have an activated healthcare proxy before the 45-day nonpayment period? ☐ Require ☐ Have ☐ Not applicable

B. Did member require or have guardianship before the 45-day nonpayment period? ☐ Require ☐ Have ☐ Not applicable

C. Did member require or have conservatorship before the 45-day nonpayment period? ☐ Require ☐ Have ☐ Not applicable

D. Was guardianship/conservatorship/healthcare proxy a barrier to discharge before the 45-day nonpayment period?
☐ Yes ☐ No

E. If yes in question D, please respond to the to questions a) and b).

a) Did the hospital attempt to resolve the guardianship/conservatorship/healthcare proxy issue before or during the 45-day nonpayment period?

☐ Yes ☐ No

☐ Before ☐ During ☐ Both

b) If yes to question a), were the attempt(s) successful?

☐ Yes ☐ No

Please list why/why not here. Limit 100 words.

c) Did the hospital petition for a guardian/conservator before or during the 45-day nonpayment period?

☐ Yes ☐ No

☐ Before ☐ During ☐ Both

If yes, please provide details and date of petition here. Limit 100 words.

SECTION IV: Referrals for Community Services

A. Please check the following community services only if they were needed for the member. Please also indicate whether the hospital attempted to arrange for the service for the member.

Behavioral health services (SUD)	☐ Needed	☐ Hospital made effort to arrange for service
Community health center	☐ Needed	☐ Hospital made effort to arrange for service
Continuous skilled nursing	☐ Needed	☐ Hospital made effort to arrange for service
Day habilitation	☐ Needed	☐ Hospital made effort to arrange for service
Dialysis services	☐ Needed	☐ Hospital made effort to arrange for service
Durable medical equipment (including oxygen and respiratory therapy equipment)	☐ Needed	☐ Hospital made effort to arrange for service
Home health	☐ Needed	☐ Hospital made effort to arrange for service
Medical/surgical supplies	☐ Needed	☐ Hospital made effort to arrange for service
Community nursing facility services	☐ Needed	☐ Hospital made effort to arrange for service
Nurse practitioner	☐ Needed	☐ Hospital made effort to arrange for service
Orthotic	☐ Needed	☐ Hospital made effort to arrange for service
Personal care	☐ Needed	☐ Hospital made effort to arrange for service
Prosthetic	☐ Needed	☐ Hospital made effort to arrange for service
Therapy (PT, OT, or SLP)	☐ Needed	☐ Hospital made effort to arrange for service

B. If applicable, please indicate if the member has applied for, been approved for (with date), or been denied (with date) for the following waiver program services, and if the hospital assisted in the waiver application:

	Applied	Approved	Denied	Date of Approval or Denial	Hospital-Assisted
ABI-RHA Waiver (Acquired Brain Injury with Residential Habilitation)	☐	☐	☐	___ / ___ / _____	☐
ABI-N Waiver (Acquired Brain Injury with Non-Residential Habilitation)	☐	☐	☐	___ / ___ / _____	☐
MFP-RS Waiver (Money Follows the Person with Residential Supports)	☐	☐	☐	___ / ___ / _____	☐
MFP-CL Waiver (Money Follows the Person with Community Living)	☐	☐	☐	___ / ___ / _____	☐
FEW (Frail Elder Waiver)	☐	☐	☐	___ / ___ / _____	☐

SECTION V. Unavailable Community Placement / Nursing Facility Referrals and Placement

If community placement was not available to the member during or before the 45-day nonpayment period, please indicate if the member could have been safely cared for in a nursing facility.

A. Was the member eligible for nursing facility placement during or before the 45-day nonpayment period?

☐ Eligible ☐ Not Eligible ☐ Not applicable

B. If eligible, did the member need any of the following specialty nursing services:

☐ Ventilator
☐ Tracheostomy
☐ Amyotrophic Lateral Sclerosis (ALS) services
☐ Multiple Sclerosis (MS) services
☐ Services of Mental Illness or Disorder
☐ Acquired Brain Injury / Traumatic Brain Injury Services
☐ Services for Bariatric Patients
☐ Total Parenteral Nutrition (TPN)
☐ Other Special Nursing Facility Services

Please list here:

.....

.....

C. If the member needed services listed in question B, did the CDR hospital make referrals to appropriate nursing facilities that provide the above-listed specialty services during the 45-day nonpayment period?

☐ Yes ☐ No

D. If yes to question C, please list here the names of the nursing facilities providing specialty services to which a referral was made, the date(s) of the referral(s), and the frequency of referral(s). Please include proof of referrals in a separate document submitted along with this form. Limit 100 words.

.....

.....

.....

.....

E. Did any nursing facility listed in question D cite lack of MassHealth long-term care coverage as reason for not accepting the member?

☐ Yes ☐ No

F. If member was clinically eligible for nursing facility placement before or during the 45-day nonpayment period and did NOT need specialty nursing facility services as described in question B, did the CDR hospital make referrals to all nursing facility providers within a 25-mile radius of the hospital during the 45-day nonpayment period?

☐ Yes ☐ No

G. If yes to question F, please list here the names of the nursing facilities to which a referral was made, the date(s) of the referral(s), and the frequency of referral(s). Please include proof of referrals in a separate document submitted along with this form. Limit 100 words.

.....

.....

.....

.....

H. Did any nursing facility referred to in questions F or G cite lack of MassHealth long-term care coverage as a reason for not accepting the member?
☐ Yes ☐ No

I. Was member's / family's preferred geographic region a barrier to discharge?
☐ Yes ☐ No

J. If the CDR hospital had difficulty finding a nursing facility willing to take the member, was the case escalated to MassHealth?
☐ Yes ☐ No
If yes, please list the date(s) the case was escalated: _____

SECTION VI: SUD (substance use disorder) and BH (behavioral health):

A. Does member have diagnosis of SUD or BH?
☐ Yes ☐ No

B. If yes to question A, please list the diagnosis here: _____

C. If yes to question A, did member give signed consent to engage community-based SUD/BH service providers in the discharge planning process?
☐ Yes ☐ No
If yes, please list the date of the signed consent: _____

D. If yes to question C, and if member has been discharged from hospital, did the member's discharge plan incorporate community-based SUD/BH services post discharge?
☐ Yes ☐ No ☐ N/A (member not discharged yet)

CDR Hospital Provider Attestation to Discharge Planning Information

I, _____ (printed staff name), hereby certify under the pains and penalties of perjury that I am the director of case management/admissions or equivalent position at, _____ (name of hospital), located at _____ (hospital address), and that the information provided in this attestation regarding MassHealth member _____ (name of MassHealth member), is a true and accurate representation.

Under the pains and penalties of perjury, I hereby certify that the above information is true and correct.

Signature: _____ Date: _____

Please email the completed form to hospital_escalations@state.ma.us. Note that both electronic and written signatures will be accepted.

Clear Print