E-Alliance Extra

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Medicaid Authorization Updates

The problems that consumers and providers were experiencing with delays in Medicaid re-authorizations due to FSD computer and staffing issues seem to be dying down. However, we continue to meet regularly with advocates and the Department of Social Services Director, Brian Kinkade and Julie Gibson with FSD. At a meeting yesterday Julie discussed the transition of the call center from the private contractor to state staff. The current contract with the private contractor ends at the end of December and state staff will take over those functions beginning January 1st. They are making changes already as they make this transition. It is likely that there will be slow-downs again in November and December during the transition phase. FSD is taking necessary measures to mitigate any problems. However, if you have problems that you or your consumer/client/patient are unable to work through you can contact Glenda Deason at: Glenda.r.deason@dss.mo.gov.

CMS Proposes New Requirements for Discharge Planning

FROM: NAHC Report

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to revise the discharge planning requirements that acute care hospitals (ACH), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), critical access hospitals (CAH), and home health agencies (HHAs), must meet in order to participate in the Medicare and Medicaid programs.

The proposed rule was issued, for the most part, to implement the discharge planning requirements in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). The Act requires CMS to modify the conditions of participation (CoPs) and subsequent interpretive guidance to require providers to take into account quality, resource use, and other measures in the discharge planning process. Specifically, the discharge planning regulations must address the settings to which a patient may be discharged and emphasizes the importance of considering the patient's goals and preferences as part of the discharge planning process.

On October 9, 2014, CMS issued a proposed rule that revises the home health CoPs which includes an update to the discharge/transfer summary requirements. CMS proposed to specify the content of a discharge/transfer summary, and specific timelines for sending the discharge/transfer summary to the follow-up care providers. The proposed changes are included in two separate sections located at §484.60(e) and §484.110(a)(6).

Since the IMPACT Act was passed after the issuance of the proposed rule for the home health CoPs, CMS is withdrawing the proposed discharge/transfer summary content requirements at §484.60(e) and proposing to add a new standard at §484.58 that describes the discharge process and the discharge/transfer summary requirements for HHAs. The proposed timelines that were published in the October 9, 2014 proposed rule at §484.110(e) for when the agency is to send a discharge/transfer summary remain unchanged.

CMS is proposing to require HHAs include in the discharge process regular re-evaluation and modification of the discharge plan as required based on the patient's needs, goals, and treatment preferences. In addition, physician, patient and caregiver involvement must be part of the discharge process and plan. In accordance with the IMPACT Act, for patients discharged to a skilled nursing facility, the HHA, LTCH or IRF must assist patients and their caregivers in selecting a provider by using and sharing data on quality and resource use measures. The discharge evaluation and plan must be completed on a timely basis and be included in the patient's clinical record.

CMS also proposes to require that a discharge/transfer summary be provided to the receiving facility or health care practitioner and it must contain specific information. The amount of information CMS proposed to be included in the discharge/transfer summary looks less like a summary and more like the entire medical record. In addition, many of the required elements are not typically part of the home health medical record and therefore no applicable. However, CMS proposes to require that agencies address even non applicable items by notating "N/A".

The National Association for Home Care & Hospice has serious concerns regarding the burden the propose rule will have on HHAs, specifically as it relates to the discharge/transfer summary requirements.

Comments are due January 4, 2016. We urge all HHAs to review the proposed rule and submit comments.

OASIS Q&A (From the Bureau)

The September 2015 Bureau Talk indicated that there was a set of OASIS Q&As posted on 7/8/15 which were updated for use with the new OASIS C1/ICD10 Data Set. We have been informed that you will NOT find a set of Q&As dated 7/8/15.

The latest CMS OASIS Q&As ARE dated April 2015 and they will contain any new guidance related to ICD 10. Remember, in order to be totally current when researching an OASIS question, you will need to first look your question up in the April 2015 Q&As and then look for any update in the Quarterly Q&As dated April 2015, July 2015 and October 2015.

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